

2027 HEALTH BENEFITS GUIDE



LACERS
LA CITY EMPLOYEES'
RETIREMENT SYSTEM

YOUR 2027 CITY OF LOS ANGELES RETIREE BENEFITS

The City of Los Angeles appreciates the contributions that our Members have made in making our City a great place to live, work, and play. We are committed to supporting the health and well-being of our Retirees, Eligible Survivors and dependents with valuable and comprehensive health care coverage and wellness programs.

This 2027 Health Benefits Guide is a summary of the Los Angeles City Employees' Retirement System (LACERS) Retiree Health plans effective January 1, 2027. This publication provides essential information to guide you through your health care elections.

Please keep in mind that summary plan descriptions, coverage certificates, policies, contracts, and similar documents prevail when questions of coverage arise. Additionally, be aware that adjustments may occur due to legal requirements or other reasons.

LACERS AT YOUR SERVICE

LACERS has an appointment-based system for all Members who need in-person assistance. There are three options for appointments: in person, virtual, and by telephone. Make an appointment online at lacers.org/book-appointment or call (800) 779-8328. Please be aware that the appointment schedule is subject to change.

Appointments aren't necessary if you only drop off documents and do not need staff assistance.

Type and Contact Information		Hours
	Phone: (800) 779-8328 RTT: (888) 349-3996 Fax: (213) 473-7284	Mon/Wed/Thur/Fri: 7 a.m. – 3:30 p.m. Tues: 7 a.m. – 3 p.m.
	Mailing Address: 977 N. Broadway, Los Angeles, CA 90012-1728	—
	In-Person Appointments / Document Drop-Off: 977 N. Broadway, Los Angeles, CA 90012-1728	Mon-Fri: 8 a.m. – 4 p.m.
	Virtual Appointments: By Appointment, via Zoom	Mon-Fri: 8 a.m. – 4 p.m.
	General questions: LACERS.Services@lacers.org Health plan questions: LACERS.Health@lacers.org	—
	Website: LACERS.org MyLACERS Portal: https://mylacers.lacers.org Secure Document Upload: lacers.org/secure-upload YouTube: youtube.com/@lacersofficial	Available 24/7

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OPEN ENROLLMENT

Oct. 15 to Nov. 16, 2026

Documentation deadline: Nov. 16, 2026

Benefits take effect Jan. 1, 2027

Open Enrollment is your only opportunity to make health coverage selections for yourself and your eligible dependents for 2027, unless you experience a qualifying life event change such as retirement.

You will receive your 2027 Open Enrollment Health Plan Statement by mail. Please review all the information on your Open Enrollment Health Plan Statement. You can also view your current coverage in your MyLACERS account at <https://mylacers.lacers.org>.

Your 2026 benefit elections will continue in 2027 unless you make a change during Open Enrollment.

If you want to make changes, all required forms for subscribers under age 65 are available online at lacers.org/post/health-benefit-forms. Subscribers aged 65 and above, please call LACERS to request forms at (800) 779-8328 or email your request to LACERS.Health@lacers.org.

WHAT'S NEW FOR THE 2027 PLAN YEAR?

Kaiser Permanente Senior Advantage: An Over-the-Counter (OTC) benefit has been added. The OTC benefit reduces out-of-pocket costs for common health and wellness products. **Anthem Blue View Vision:** Contact lens allowance increased to \$150, and frame frequency limit reduced to every 12 months.

SCAN Health Plan will be available in Sonoma County, CA. **Anthem Medicare Preferred (PPO)** Adult Day Center and Personal Home Helper are discontinued for 2027. In-Home Support hours are tripling from 30 to 90 hours annually.

INFORMATION YOU CAN FIND ONLINE

New Retiree or changing your health and dental plans?

Forms are available at lacers.org/post/health-benefit-forms.

Are you covering dependents and/or are a Survivor?

Forms are available at lacers.org/post/health-benefit-forms.

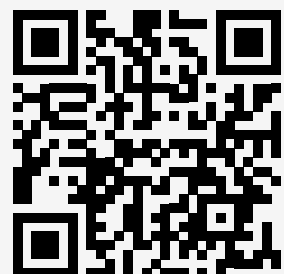
Gather required documents (see Pages 6-7), and complete and submit the *Certification of Dependent and Survivor Status for Health Coverage* and *LACERS Medical Plan Enrollment Form* and/or *LACERS Dental Plan Enrollment Form*.



lacers.org/post/health-benefit-forms

Create Your MyLACERS Online Account

Keep track of your personal LACERS information and benefits through a secure online account at <https://mylacers.lacers.org>. Make sure your address, phone number, and current health insurance coverage is correct. Members who participate in the Medical Premium Reimbursement Program (MPRP) will not have a medical plan listed.



<https://mylacers.lacers.org>

YOUR CHECKLISTS

THE OPEN ENROLLMENT CHECKLIST

- ☐ Receive and review your 2027 Open Enrollment Health Plan Statement. This is a snapshot of your coverage as of Aug. 19, 2026.
- ☐ Verify your address, phone number, and email address are current. If they are not, please update via your MyLACERS account or submit completed forms from lacers.org/post/change-address.
- ☐ Review your dependent information and check their eligibility status (Page 6). To add/remove dependents, see Page 10.
- ☐ Review your health plan options, premiums, and deductions in this Health Benefits Guide.
- ☐ If you decide to enroll or change plans, make your enrollment elections.
- ☐ Submit all your forms and supporting documentation to LACERS by Nov. 16, 2026.

NEW RETIREE/ELIGIBLE SURVIVOR ENROLLMENT CHECKLIST

Your Active Member medical and dental plans through the Personnel Department's Employee Benefits are completely separate from LACERS Retiree Health plans. Consequently, your current primary care physician (PCP) and medical referrals will not carry over into retirement. To maintain health coverage into retirement, you must actively enroll in a LACERS Retiree Health plan.

- ☐ Review enrollment information on Page 8, and if you are a Survivor, see also Page 17.
- ☐ Review Medicare information on Pages 11-13.
- ☐ Review this Health Benefits Guide to understand your health plan options.
- ☐ Submit your health enrollment forms and all supporting documentation to LACERS within 60 days of your retirement date or 60 days of death of Member.



Secure Document Upload: lacers.org/secure-upload

Email / Fax: LACERS.Health@lacers.org / (213) 473-7284

Mail: 977 N. Broadway, Los Angeles, CA 90012-1728

Drop off at LACERS: 977 N. Broadway, Los Angeles, CA 90012-1728



Delays over 90 days in submitting required retirement or Continuance/Survivorship documents may result in delayed enrollment or disenrollment from LACERS health plans.

LACERS HEALTH ENROLLMENT ELIGIBILITY

ELIGIBILITY

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

- A Retired City Employee who receives a monthly Retirement Allowance from LACERS, or
- An Eligible Surviving Spouse/Domestic Partner (Eligible Survivor) who receives a Continuance or a Survivorship Allowance from LACERS.

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

ELIGIBLE DEPENDENTS

- Spouse
- Domestic partner (registered with LACERS or your state)
- Dependent children under age 26, except in circumstances where an adult child is eligible to enroll in an employer-sponsored plan
- Disabled children unable to engage in gainful employment whose disability occurred before age 26
- Grandchild under age 26, if the Member or spouse/domestic partner have legal custody of grandchild, or is a child of a currently enrolled eligible child

Dependent children include children born to you or adopted by you, stepchildren living with you, children whom you have legal custody or guardianship, and your spouse's or domestic partner's children.

These individuals are dependents eligible for health coverage and may differ from the definition of dependents in income tax determinations.

REQUIRED DEPENDENT ELIGIBILITY VERIFICATION

- ☐ Copy of certified marriage certificate
- ☐ Proof of domestic partnership (see next section)
- ☐ Children's birth certificates
- ☐ Proof of Social Security Number for each dependent
- ☐ Proof of children's disability, if applicable
- ☐ Proof of legal custody or guardianship

The translation agency, Languages4You has the required certification to transcribe foreign language documents. They can be reached at (818) 720-7105 or by email at: languages4you@aol.com.

REQUIRED DOMESTIC PARTNERSHIP ELIGIBILITY VERIFICATION

- ☐ An *Affidavit of Domestic Partnership Form* on file with LACERS, (forms available at lacers.org/post/domestic-partnership)
- ☐ Proof of your legally registered domestic partnership in the State of California, or
- ☐ Proof of a legal union validly formed in another jurisdiction that is substantially equivalent to a domestic partnership and is recognized under California law.

CONSIDERING YOUR HEALTH PLAN CHOICES

We know selecting a health plan for you and your family is one of the most important decisions for health, wellness, and financial reasons. Here are some questions you may use to guide your decision making.

- What are my usual health care needs?
 - How frequently do I use services?
 - Do I need care from specialists?
 - Do I need specific prescription medications?
- Which doctors and hospitals do I want to provide my care?
 - Do I prefer specific doctors or hospitals?
- Does the plan provide access to the doctors and hospitals I want?
- Do I prefer to receive health care from an HMO or PPO?
- What are the costs (premiums, copayments, deductibles, and coinsurance)?



LACERS cannot approve or deny claims and services. Our role is strictly limited to contacting the insurance provider and monitoring to ensure they follow the timeline(s) listed in the Evidence of Coverage (EOC).

RESOURCE: EVALUATING DOCTORS AND HOSPITALS

Name and Websites	Description
Cal Hospital Compare calhospitalcompare.org	Compares the quality of hospitals in California.
U.S. Department of Health and Human Services medicare.gov/care-compare	Find and compare different types of Medicare providers like physicians, hospitals, nursing homes, and others.
Medical Board of California mbc.ca.gov	The California state agency that licenses medical doctors, investigates complaints, disciplines those who violate the law, conducts physician evaluations, and facilitates rehabilitation where appropriate.
State of California Center for Data Insights and Innovation cdii.ca.gov/consumer-reports	Includes the State of California-sponsored “Report Card” for quality ratings on health plans, consumer health care complaints, and other quality ratings.
National Committee for Quality Assurance (NCQA) reportcards.ncqa.org/	Compares the performance of NCQA-accredited health plans and health care clinicians and practices across the U.S.

WHEN TO ENROLL

You may enroll in a LACERS health plan during your retirement process, within 60 days of retirement effective date, or during the LACERS annual Open Enrollment period. Standardized legal names should be used as name mismatches may cause processing delays. **No action is needed if you are already enrolled in a retiree health plan and do not want to make changes. Your health plan will remain in effect for the next plan year.**

New Retirees and Eligible Survivors who do not submit their enrollment forms to LACERS within the 60-day window will lose coverage and may not apply until the next Open Enrollment period, unless you experience a Qualifying Event (see Page 9).

If your retirement documents are not completed and submitted within 90 days of your effective retirement date, your health coverage may be terminated until the next Open Enrollment. Open Enrollment generally occurs mid-October to mid-November.

If you may be laid off, please contact LACERS immediately.

QUALIFYING EVENTS

Retired Members/Eligible Survivors expecting to or are experiencing a qualifying event are encouraged to speak to a LACERS Health Counselor, who can be contacted at LACERS.Health@lacers.org or (800) 779-8328.

Qualifying Event	Request Period for Benefit Changes
Retiree turning age 55	Within 60 days of event
Retiree turning age 65	Within 90 days of event
Relocation out of a LACERS HMO plan service area	Within 30 days of event
Relocation into a LACERS HMO plan service area	
Involuntarily terminated from a non-LACERS health plan (such as loss of employer's coverage as an employee or dependent; no longer qualifies for current coverage due to age; expiration of COBRA benefits; or change in current plan's service area)	Within 30 days of event
Family status change, such as new marriage/ domestic partnership or birth or adoption of a child	



A dependent who turns age 65 and is not currently enrolled in the Member/Eligible Survivor's medical plan is not considered a qualifying event. He/she is not eligible to be added to the health plan until Open Enrollment unless they experience a qualifying event.

WHEN HEALTH PLAN COVERAGE BEGINS

For New Retirees, health coverage begins a) the first of the month following your retirement effective date, or b) if your retirement effective date is the first of the month, then at the same time as your retirement effective date. Retirees turning 65 will have coverage effective their birth month if required documents are submitted on time.

For all other situations and persons: if all required and completed forms are submitted by the **10th of the month** for processing, health coverage begins the first of the following month.

DISENROLLING FROM A LACERS HEALTH PLAN

Submit a *LACERS Medical/Dental Plan Cancellation Form* by the **10th of the month** for the cancellation to be effective the first of the following month. If anyone on the plan is Medicare-eligible, a *Voluntary Senior Plan Disenrollment Form* must also be included. Contact the LACERS Health Benefits Section for these forms.

ADDING NEW DEPENDENTS

If you have a family status change, such as a new marriage/domestic partnership or the birth/adoption of a child, you may make changes within 30 days of the status change without having to wait until Open Enrollment.

Submit a *LACERS Medical/Dental Plan Family Account Change Form (FAC)* and a *Certification of Dependent or Survivor Status for Health Coverage Form*.

Required documents include marriage certificate or proof of domestic partnership, children's birth certificates, or proof of legal custody or guardianship, and a copy of Social Security Card or redacted tax document showing dependents' names and Social Security Numbers. Non-English documents need to be translated. The translation agency, Languages4You, has the required certification to transcribe foreign language documents.

A *Family Account Change Form* must be received by the **10th of the month** for coverage to begin the first day of the following month. Additionally, a copy of the dissolution documents or death certificate for any prior marriages or domestic partnerships must be submitted.

If your dependent is Medicare-eligible, additional forms will be required. Contact the LACERS Health Benefits Section for these forms.

REMOVING DEPENDENTS

Submit a *LACERS Medical/Dental Plan Family Account Change Form* by the **10th of the month** for the dependent's coverage cancellation to be effective the first of the following month. If your dependents have Medicare, a *Voluntary Senior Plan Disenrollment Form* is required.

If a dependent becomes ineligible for the LACERS health plan coverage (e.g., divorce, overaged), you must cancel their health coverage within 60 days of the status change, otherwise they may not be offered an opportunity to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) (see Page 66).

LACERS reserves the right to terminate your dependent's health plan coverage and recoup overpaid subsidies should we discover your dependent is no longer eligible.



LACERS HEALTH BENEFITS AND MEDICARE

LACERS Members/Eligible Survivors and their eligible dependents must enroll in Medicare (managed by the Centers for Medicare & Medicaid Services (CMS)) when eligible to maintain their LACERS health plan coverage. Medicare-eligible persons should apply for Medicare with the Social Security Administration three months prior to their 65th birthday, or sooner, if eligible.

MEDICARE PART A

(Hospital Insurance)

If you qualify for Medicare Part A premium-free, you are required to enroll in Part A. If it is not free for you, you do not need to enroll in Part A. You may receive Part A premium-free for one of these reasons:

- Started with the City after April 1, 1986,
- Have 10 years of earnings history with Social Security outside of City employment, or
- Through your spouse, if they are eligible for Part A premium-free. You may qualify even if you are divorced, or your spouse is deceased.

MEDICARE PART B

(Medical Insurance)

You are required to enroll in and pay your Medicare Part B to remain in a LACERS medical plan and continue to qualify for a LACERS medical subsidy. The Medicare Part B premium amounts generally change every year.

- Only LACERS Retired Members may be reimbursed (non-taxable) for their basic/standard Medicare Part B premium if all the below requirements are met:
 - Enrolled in both Medicare Parts A & B,
 - Enrolled in a LACERS Senior Plan or are participating in the LACERS MPRP (see Page 28), and
 - Receiving a medical subsidy from LACERS.

MEDICARE PART D

(Prescription Drug Coverage)

Medicare Part D is already integrated into LACERS medical plans. If you enroll in Medicare Part D separate from your LACERS plan, your LACERS medical coverage and subsidy will terminate.

- An exception is if you participate in the LACERS Medical Premium Reimbursement Program, and your non-LACERS plan does not include Medicare Part D, you should enroll in supplemental Medicare Part D insurance to maintain creditable coverage.
- Another exception is if you are required to pay for the Income Related Monthly Adjustment Amount (IRMAA) Medicare Part D surcharge. Payment of the Part D IRMAA does not enroll you in a non-LACERS Part D plan. (See IRMAA on Page 12).

CONTINUING YOUR LACERS MEDICAL COVERAGE

LACERS will mail out a packet with Medicare Information sheets, a *Medicare Acknowledgment Form*, and *LACERS senior health enrollment forms* three months prior to your or your dependent's 65th birthday. The *LACERS senior health enrollment forms* should be filled out as soon as possible after receipt of the packet or form. Signature dates valid for 90 days and may expire if all required documents are not submitted at the same time. If you have not received such a packet, please contact LACERS at (800) 779-8328.

You are only allowed to enroll in a single Medicare Advantage plan or Medicare Part D Prescription Drug plan. Enrolling in a LACERS medical plan fulfills this requirement. If you later enroll in a plan outside of LACERS, you will lose your LACERS medical coverage.

PROOF OF MEDICARE ENROLLMENT

Once enrolled in Medicare, provide a copy of your Medicare card or Social Security Administration Benefit Verification Letter showing your Medicare Beneficiary Identifier (MBI) with the completed *LACERS senior health enrollment forms* to LACERS. You must maintain your Medicare enrollment by paying your monthly Medicare premiums and any surcharges. The Medicare Easy Pay Program can help avoid a lapse in coverage. You can sign up through your Medicare online account at [medicare.gov](https://www.medicare.gov).

POSSIBLE HELP WITH MEDICARE PREMIUMS

You may be able to get help to pay for your Medicare Part D under the Low-Income Subsidy (LIS) (also known as “Extra Help”). Contact SSA and your state’s Medicaid office to see if you qualify.

POSSIBLE MEDICARE PENALTIES OR SURCHARGES

MEDICARE PART D LATE ENROLLMENT PENALTY (LEP)

The late enrollment penalty (LEP) will be added to your Medicare Part D premium if you are without Part D or other creditable prescription drug coverage for a period of 63 or more days in a row after your initial Medicare enrollment period. You generally must pay the penalty for as long as you have Medicare drug coverage, even if you change medical plans. The penalty amount changes every year and depends on how long you did not have Part D coverage.

If you are subject to LEP, the amount will be taken from your retirement allowance. You may request a reconsideration through Medicare and the prescription drug plan.

MEDICARE INCOME-RELATED MONTHLY ADJUSTMENT AMOUNT (IRMAA)

CMS assesses an Income-Related Monthly Adjustment Amount (IRMAA) when the Medicare enrollee’s modified adjusted gross income from two years prior exceeds a certain amount. IRMAA is a surcharge on top of your basic/standard Medicare premium rates. IRMAA is a federally mandated surcharge separate from your LACERS medical plan and premiums. The IRMAA surcharge is for Part B and Part D and it is payable by you, not LACERS. LACERS does not apply the medical subsidy, nor reimburses, for any IRMAA costs.

Non-payment or partial payments of IRMAA will cause Medicare to request that LACERS cancel your medical plan coverage. When CMS reinstates your Medicare coverage, contact the LACERS Health Benefits Section to be reinstated to your LACERS medical plan. LACERS medical plan coverage reinstatement is neither automatic nor guaranteed.



For further information, visit [medicare.gov/basics/costs/medicare-costs](https://www.medicare.gov/basics/costs/medicare-costs). You may request to lower an IRMAA by contacting Social Security or visit [ssa.gov/medicare/lower-irmaa](https://www.ssa.gov/medicare/lower-irmaa).

TERMINATION OF LACERS MEDICAL COVERAGE DUE TO MEDICARE LAPSE OR NONCOMPLIANCE

If you lapse on your Medicare Part B premiums and any surcharges, you and any enrolled dependents may be terminated from your LACERS medical plan and lose Medicare Part D coverage, your LACERS medical subsidy, and Medicare Part B premium reimbursement. CMS may also assess lifetime penalties when you re-enroll in Medicare Part B and D.

CMS may impose a lifetime penalty for lapsed Medicare coverage and require you to wait for Medicare's Open Enrollment period to re-enroll for Medicare coverage.

In the event of noncompliance contact LACERS and Medicare immediately. LACERS medical plan coverage reinstatement is neither automatic nor guaranteed. Once Medicare Compliant, please contact LACERS as soon as possible for enrollment forms.

If you or your eligible dependent are enrolled in Kaiser Senior Advantage and your Medicare Part B coverage lapses, you or your eligible dependent will be disenrolled from the Kaiser Senior Advantage plan and temporarily enrolled in the Kaiser HMO non-Medicare plan. The full monthly Kaiser non-Medicare plan premium will be charged retroactive to the date of disenrollment from Kaiser Senior Advantage.

If you otherwise fail to maintain Medicare entitlement or fail to adhere to the single Medicare plan requirement, you may lose your LACERS medical plan coverage and medical subsidy. You are only allowed to enroll in a single Medicare Advantage plan or Medicare Part D Prescription Drug plan.





LACERS RETIRED MEMBER MEDICAL SUBSIDY

LACERS provides a medical subsidy that covers a monthly cost of coverage (known as a premium) for Retired Members and eligible dependents. The medical subsidy is a monthly dollar credit applied to the medical premium cost.

Your subsidy amount is based on your whole years (minimum 10 years) of Service (part-time employees) or Service Credit (full-time employees), age, and Medicare status. Your subsidy may or may not cover the total cost of your monthly premium. If your subsidy is less than the monthly premium, the balance is deducted from your retirement allowance. Any unused subsidy cannot be received as cash compensation.

For those Tier 1 LACERS Members who retired on or after July 1, 2011, and did not make additional retirement contributions pursuant to the Los Angeles Administrative Code (LAAC) § 4.1003(c), please use the 2027 Health Benefits Guide Supplement - Tier 1 Capped for your subsidy information and monthly deduction charts.

For Tier 3 LACERS Members, hired by the City on or after February 21, 2016, please use the 2027 Health Benefits Guide Supplement - Tier 3 for your subsidy information and monthly deduction charts.

To be eligible for a medical subsidy, you must:

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

Your LACERS medical subsidy is not taxable when used to pay for medical coverage for yourself, your spouse, your child under age 26, or anyone claimed as a tax dependent on your federal income tax form. See Taxability of Your Health Benefits on Page 76.

The LACERS medical subsidy is taxable for a surviving domestic partner.



HOW THE LACERS MEMBERS MEDICAL SUBSIDY IS CALCULATED

The LACERS medical subsidy amounts are set annually by the LACERS Board of Administration or by ordinance, pursuant to the Los Angeles Administrative Code.

For Retired Members who are under age 65, or are 65 or older with Medicare Part B only:

- Full-time employees receive 4% of the maximum medical subsidy for each whole year of Service Credit.
- Part-time employees need a minimum of 10 years of Service to be eligible to receive 40% of the maximum medical subsidy. For each whole year of Service Credit above ten years, you receive an additional 4% of the maximum medical subsidy.

TIER 1 RETIRED MEMBERS

Service/ Service Credit	% of Maximum Subsidy	2027 Subsidy Amount
1 - 10	40%	\$1,055.16
11	44%	\$1,160.68
12	48%	\$1,266.19
13	52%	\$1,371.71
14	56%	\$1,477.22
15	60%	\$1,582.74
16	64%	\$1,688.26
17	68%	\$1,793.77
18	72%	\$1,899.29
19	76%	\$2,004.80
20	80%	\$2,110.32
21	84%	\$2,215.84
22	88%	\$2,321.35
23	92%	\$2,426.87
24	96%	\$2,532.38
25+	100%	\$2,637.90

For Retired Members who are age 65 or older with Medicare Parts A & B, the maximum medical subsidy is based on your whole years of Service/Service Credit (beginning at 10 whole years) and the one-party premium of the LACERS Senior Plan in which you are enrolled.

TIER 1 RETIRED MEMBERS

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



If you have Medicare Parts A & B, are enrolled in a LACERS Senior Plan, and are covering dependents, the amount of subsidy available for your dependents will be the same as if you were enrolled in the corresponding Under-65 plan. LAAC § 4.1111 (e)(4). See Page 73.

SUBSIDY ELIGIBILITY REQUIREMENTS FOR LACERS MEMBERS

Became LACERS Member On or Before April 22, 1990

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

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

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

* Service/Service Credit in Determining Health Subsidy

Included in Determining Health Subsidy

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

Not Included in Determining Health Subsidy

- Non-LACERA (e.g., CalPERS) reciprocity
- LACERA Safety Members. Refer to LAAC § 4.1130 (a)(8) on Page 73
- Public Service Buyback
- Water and Power Employees' Retirement Plan Service after January 1, 2014, due to suspension of reciprocity

Visual of Part-Time Subsidy Calculation

Whole Years of Service		% of Maximum Subsidy	2027 Subsidy Amount
10		40%	See medical subsidy chart on Page 15; See dental subsidy chart on Page 63
11 to 25+	*On/before 04/22/1990: based on <u>Service</u>	4% for each full additional year	
	*After 04/22/1990: based on Service Credit		

ELIGIBLE SURVIVOR BENEFITS

If a LACERS Member dies, his or her Survivor (surviving spouse or domestic partner) may be eligible for a Continuance or Survivorship Allowance if they were married or in a domestic partnership:

- At the time of the Member's retirement,
- One year prior to the Member's retirement, and
- At the time of the Member's death.

Former or ex-spouses and ex-domestic partners are not eligible for LACERS health benefits. Purchased continuances are not eligible for LACERS health benefits.

Within 60 days of the death of a LACERS Member or a Retiree, a Survivor who is:

Eligible for Continuing Benefits	Ineligible for Continuing Benefits But Was Covered as A Dependent At Time of the LACERS Member's Death
• May re-enroll into the same current medical and/or dental plans if the Eligible Survivor was covered as a dependent at the time of the LACERS Member's or Retiree's death, and • The LACERS Continuance or Survivorship Allowance is of sufficient amount to cover monthly health premium deductions. • Survivors can prepay the premiums for the full year if their allowance is not sufficient to cover the monthly health premium deductions.	A packet containing information about continuing health care coverage through COBRA will be provided to the Survivor.

Health enrollment forms not submitted to LACERS within the 60-day window will result in the termination of the Survivor's medical and/or dental coverage on the last day of the Retiree's death month.

Continuance documents not submitted within 90 days will result in the Survivor's coverage termination. Re-enrollment eligibility will not occur until the next Open Enrollment period.

An Eligible Survivor may receive a monthly medical subsidy from LACERS. The Eligible Survivor medical subsidy amount is based on the LACERS Member's or Retired Member's years of Service or Service Credit (minimum of 10 years), when the deceased LACERS Member would have turned age 55, and the Survivor's eligibility for Medicare.

The Eligible Survivor's medical subsidy does not extend to dependents. The full cost of dependents' premiums will be deducted from your monthly Continuance or Survivorship Allowance. Any unused medical subsidy cannot be received as cash compensation nor used to cover the cost of dependents.

The medical subsidy will be taxable if you are an Eligible Surviving Domestic Partner. See Taxability of Your Health Benefits on Page 76.

HOW THE ELIGIBLE SURVIVOR MEDICAL SUBSIDY IS CALCULATED

The LACERS medical subsidy amounts are set annually by the LACERS Board of Administration or by ordinance, per the Los Angeles Administrative Code.

FOR TIER 1 AND TIER 3 ELIGIBLE SURVIVORS WHO ARE UNDER AGE 65, OR 65 OR OLDER WITH MEDICARE PART B ONLY:

For each whole year of the LACERS Member's or Retired Member's Service and Service Credit, beginning at 10 whole years, an Eligible Survivor receives an additional 4% of the maximum Survivor medical subsidy. To receive the maximum medical subsidy, the LACERS Member or Retired Member must have had at least 25 whole years of Service Credit.

Service/ Service Credit	% of Maximum Subsidy	2027 Subsidy Amount
1 - 10	40%	\$510.78
11	44%	\$561.85
12	48%	\$612.93
13	52%	\$664.01
14	56%	\$715.09
15	60%	\$766.16
16	64%	\$817.24
17	68%	\$868.32
18	72%	\$919.40
19	76%	\$970.47
20	80%	\$1,021.55
21	84%	\$1,072.63
22	88%	\$1,123.71
23	92%	\$1,174.78
24	96%	\$1,225.86
25+	100%	\$1,276.94

FOR TIER 1 AND TIER 3 ELIGIBLE SURVIVORS WHO ARE AGE 65 OR OLDER WITH MEDICARE PARTS A & B:

Maximum medical subsidy is based on each whole year of the Member's Service Credit (beginning at 10 whole years) and the monthly premium for one-party of the LACERS Senior Plan. To receive the maximum medical subsidy, the LACERS Member or Retired Member must have had at least 20 whole years of Service and Service Credit.

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

ELIGIBLE SURVIVOR DENTAL SUBSIDY

Survivors are not eligible for dental subsidies but may enroll in a LACERS dental plan and have the monthly premium deducted from their Continuance or Survivorship Allowance.

LACERS HEALTH BENEFIT OPTIONS

MEDICAL PLAN CHOICES*

	PPO ⁶ (U.S. and Its Territories ¹)	HMO ⁶ (CA Only ²)	Outside U.S. and Its Territories
Under age 65 (non-Medicare)	Anthem Blue Cross (Anthem) PPO	- Anthem Blue Cross (Anthem) HMO - Kaiser Permanente (Kaiser) HMO	Anthem Blue Cross PPO Out-of-Country Plan ^{4,5}
Age 65 or older with Medicare Part B Only	Anthem PPO	- Anthem HMO - Kaiser Senior Advantage HMO	
Age 65 or older with Medicare Parts A & B	- Anthem Medicare Preferred (PPO) - Anthem Life & Health Medicare Plan (Medicare Supplement)	- Kaiser Senior Advantage HMO - SCAN Health Plan³ - UnitedHealthcare (UHC) Medicare Advantage HMO (CA, AZ, and NV)	
Dual Care Household, where at least one subscriber is age 65+ with Medicare Parts A & B, and the other person(s) is either under age 65 or at least age 65 with Medicare Part B only	- Anthem PPO + Anthem Medicare Preferred (PPO) - Anthem PPO + Anthem Life & Health Medicare Plan (Medicare Supplement)	- Kaiser HMO + Kaiser Senior Advantage HMO - Anthem HMO + SCAN Health Plan³ - Anthem HMO + UHC (CA) Medicare Advantage HMO	

* See Pages 29-45 for more information on each plan. See Page 74 for official plan names.

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

MEDICAL PREMIUM REIMBURSEMENT PROGRAM (MPRP)

If you reside outside of a LACERS HMO zip code service area or outside of California, and you have coverage through a federally qualified HMO or state-regulated non-LACERS medical plan, you may be eligible to participate in the MPRP. Please refer to Page 28 for MPRP information.

MEDICAL PPO AND HMO PLAN DIFFERENCES

See below chart. For differences between Anthem's Medicare Preferred and Medicare Supplement plan, please see Pages 23, 25, and 41-43.

Features	PPO	HMO
Accessing Health Care Providers	Nationwide (U.S. and its territories) access to a network of physicians, providers, and hospitals (known as preferred providers or in-network providers).	Contracted physicians, providers, and hospitals that provide services at a fixed price. Limited to the plan's service area (county or zip codes).
Selecting a Primary Care Physician (PCP)	All enrollees will have an assigned PCP, but each enrollee can choose not to go through their PCP.	Enrollee selects a PCP who will work with the enrollee to manage his/her health care needs.
Seeing a Specialist	Allows enrollee to access without a referral or advance approval.	Enrollee is required to have an advanced approval from the health plan.
Obtaining Care	Encourages enrollees to seek services from in-network providers as cost is lower due to copays and lower coinsurance percentages. Allows enrollees to see out-of-network providers. However, the cost is higher as enrollees are required to pay a higher coinsurance percentage of the bill. Any bill amount over the plan's Usual & Customary rates are the enrollee's responsibility. This additional cost does not count toward the out-of-pocket maximum. Once the annual deductible is met, enrollees are responsible for paying coinsurance and copayments up to the annual out-of-pocket maximum. Once the out-of-pocket maximum is met, the plan pays 100% of services and claims for the calendar year.	Requires enrollees to obtain care from providers who are part of the network. Once the out-of-pocket copay maximum is met, the plan pays 100% of services and claims for the calendar year. Requires enrollees to pay the total cost of services if care is obtained outside the HMO's network without a referral from the health plan (except for emergency care services).
Paying for Services	Limits the amount preferred providers can charge for services. Considers the PPO plan payment plus any deductibles and copayments you make as a payment in full for services by a preferred provider.	Requires enrollees to make a small copayment for most services.



MEDICAL INSURANCE CARDS

Your medical insurance card(s) take 7-10 business days after the effective date to be mailed from the medical plan.

QUICK GLANCE: UNDER AGE 65 / NON-MEDICARE PLANS

These are summary charts. Refer to the benefit charts on Pages 29-32 for out-of-network costs for Anthem PPO. See each plan's Evidence of Coverage for plan details and limitations.

Description	Anthem PPO	Anthem HMO	Kaiser HMO
Service Area	U.S. and its territories	CA only	CA only
Annual In-Network Deductible	\$750 for individual / \$1,500 for family where at least one member must satisfy the \$750 per individual deductible	N/A	N/A
Annual Out-of-Pocket Maximum	\$5,000 for individual; N/A for family	\$500 for individual / \$1,500 for family	\$500 for individual / \$1,500 for family
In-Network Physician Office Visit	\$20 copay	\$20 copay	\$20 copay
In-Network Telehealth	\$20 copay	\$0 copay	\$0 copay
In-Network Urgent Care Visit	100% subject towards \$20 copay	\$20 copay	\$20 copay
Emergency Room Visit	Anthem pays 90% after deductible	\$100 copay; waived if admitted ¹	\$100 copay; waived if admitted ¹
Ranking of Premium ²	High	Middle	Low

¹If admitted for observation, copay is not waived.

²This is the ranking of the monthly premium and does not take into account the medical subsidy; Members refer to the deduction charts on Pages 50-57 and Survivors on Pages 58-59 to see how much the premium deduction from your allowance would be.

QUICK GLANCE: MEDICARE PART B ONLY PLANS

These are summary charts. Refer to the benefit charts on Page 33-36 for out-of-network costs for Anthem PPO. See each plan's Evidence of Coverage for plan details and limitations.

Description	Anthem PPO	Anthem HMO	Kaiser Senior Advantage
Service Area	U.S. and its territories	CA only	CA only
Annual In-Network Deductible	Medicare Part B deductible for individual and family	Not applicable	Not applicable
Annual Out-of-Pocket Maximum	\$5,000 for individual / Not applicable for family	\$500 for individual / \$1,500 for family	\$500 for individual / Not applicable for family
In-Network Physician Office Visit	Anthem pays 20% after deductible	\$20 copay	\$15 copay
In-Network Telehealth	Anthem pays 20% after deductible	\$0 copay	\$0 copay
In-Network Urgent Care Visit	Anthem pays 20% after deductible	\$20 copay	\$15 copay
Emergency Room Visit	Anthem pays 20% after deductible if admitted – 90% for hospital services, Anthem pays 20% after deductible for professional services	\$100 copay; waived if admitted ¹	\$50 copay; waived if admitted ¹
Ranking of Premium ²	High	Middle	Low

¹If admitted for observation, copay is not waived.

²This is the ranking of the monthly premium and does not take into account the medical subsidy; Members refer to the deduction charts on Pages 50-57 and Survivors on Pages 58-59 to see how much the premium deduction from your allowance would be.

QUICK GLANCE: SENIOR PLANS (MEDICARE PARTS A & B)

These are summary charts. Refer to the plan's Evidence of Coverage for plan details and limitations.

	Anthem Medicare Preferred (PPO)	Anthem Life & Health (Medicare Supplement)	Kaiser Senior Advantage	SCAN Health Plan	UnitedHealthcare
Service Area	U.S. and its territories	U.S. and its territories	CA only	CA only	CA, NV, and AZ
Annual In-Network Deductible	Not applicable	Medicare Part B deductible	Not applicable	Not applicable	Not applicable
Annual Out-of-Pocket Maximum	\$0 for individual / Not applicable for family	Not applicable	\$500 individual / Not applicable for family	\$3,400 individual / Not applicable for family	\$6,700 individual / Not applicable for family
In-Network Physician Office Visit	No charge	Anthem pays 20% after deductible	\$15 copay	\$10 copay	\$15 copay
In-Network Telehealth	No charge	Anthem pays 20% after deductible	\$0 copay	No charge	\$0 copay
In-Network Urgent Care Visit	No charge in U.S. and while traveling	Anthem pays 20% after deductible	\$15 copay	\$10 copay	\$15 copay
Emergency Room Visit	No charge in U.S. and while traveling	Anthem pays 20% after deductible within U.S. or traveling	\$50 copay; waived if admitted ¹	\$50 copay; waived if admitted	\$50 copay; waived if admitted
Ranking of Premium²	High	Highest	Middle Low	Lowest	CA – Middle AZ – Middle High NV – Low

¹If admitted for observation, copay is not waived.

²This is the ranking of the monthly premium and does not take into account the medical subsidy; Members refer to the deduction charts on Pages 50-57 and Survivors on Pages 58-59 to see how much the premium deduction from your allowance would be.

FOR RETIREES AND SURVIVORS UNDER AGE 65 (NON-MEDICARE) LIVING IN THE UNITED STATES AND ITS TERRITORIES

Anthem Blue Cross HMO (CA only)

Choose a Primary Care Physician from Anthem Blue Cross HMO's participating physicians. A different Primary Care Physician may be chosen for each person enrolled in your plan.

An Anthem HMO arbitration form must be completed and submitted if you and/or your dependent enroll in this plan.

All services except emergency care services must be obtained from an in-network provider.*

Kaiser Permanente HMO (CA only)

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

Anthem Blue Cross PPO (United States and its territories)

The Anthem PPO plan, also known as Prudent Buyer in California and BlueCard PPO (Non-California Resident) in non-California states, gives you the choice of receiving services from in-network or out-of-network physicians, providers, and hospitals. In-network physicians, providers, and hospitals may provide more benefit coverage at a reduced cost.

FOR RETIREES AND SURVIVORS AGE 65 OR OLDER WITH MEDICARE PART B ONLY LIVING IN THE UNITED STATES AND ITS TERRITORIES

Anthem HMO (CA only) and Blue Cross Medicare Rx Prescription Drug Plan (PDP) with Senior Rx Plus

All services except emergency care services must be obtained from an in-network provider.*

(Continued to next column.)

Kaiser Senior Advantage HMO (CA only)

All services except emergency care services must be obtained from a Kaiser provider.

Anthem PPO and Blue Cross Medicare Rx (PDP) with Senior Rx Plus

This Anthem PPO plan is also known as Prudent Buyer in CA, and PPO (non-California Resident) in non-CA states.

* Reminder: Anthem only pays for the number of visits and type of special care that your primary care physician (PCP) approves. Call your PCP if you need more care. If your care isn't approved before services are provided, you will have to pay for it (except for emergency services).

If you receive covered non-emergency services at an Anthem Blue Cross HMO hospital or facility in California at which, or as a result of which, you receive services provided by a non-Anthem Blue Cross HMO provider, you will pay no more than the same cost sharing that you would pay for the same covered services received from an Anthem Blue Cross HMO provider.



FOR RETIREES AND SURVIVORS AGE 65 OR OLDER WITH MEDICARE PARTS A & B, LIVING IN THE UNITED STATES AND ITS TERRITORIES

LACERS offers the following Senior Plans: three Medicare Advantage HMO plans, one Medicare PPO plan, and one Medicare Supplement plan. When enrolling in a Senior Plan, a separate Senior Enrollment Plan form is required for each person who has Medicare.

Medicare Advantage HMO Plans

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

A Medicare Advantage plan is a medical plan where you receive benefits directly from the Medicare Advantage HMO plan rather than directly from Medicare. In some cases, a Medicare Advantage HMO plan provides more benefits than traditional Medicare (Parts A & B).

The physicians and hospitals under these plans are Medicare-approved. You coordinate your care through a Primary Care Physician (PCP) whom you choose from participating physicians.

For Medicare Advantage HMO, all services except emergency care services must be obtained from an in-network provider. If you will be traveling/visiting outside your service area or out of the country, contact the plan directly for how Emergency Services are provided.

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

Medicare Preferred PPO Plan

- Anthem Blue Cross Medicare Preferred (PPO) Plan

This plan is also known as Anthem Blue Cross Passive PPO Medicare. This is a Medicare-approved plan that is a single integrated program, providing all health care services covered by Original Medicare and benefits above and beyond. The Anthem

Medicare Preferred Plan must follow Medicare rules and provide all benefits provided by Medicare.

Persons in this plan must have Medicare Parts A & B. The Part D coverage is Blue Cross Medicare Rx (PDP) with Senior Plus.

The Anthem Medicare Preferred (PPO) allows Members to go to any doctor or hospital that accepts Medicare in the United States and its territories.

Medicare Supplement Plan

- Anthem Blue Cross Life & Health Medicare Plan

Persons in this plan must have Medicare Parts A & B. The Anthem Life & Health Medicare Plan fully supplements Medicare Parts A & B. All services must meet Medicare's authorized service requirements. Under this plan, Medicare pays 80% of the Medicare-authorized amount, and Anthem pays the remaining 20% after the Medicare Part B deductible has been reached. The plan also covers certain benefits, such as hearing aids, that are not covered by Medicare. The Part D coverage is Blue Cross Medicare Rx (PDP) with Senior Plus.

You may choose from a list of in-network or any out-of-network physicians, providers, and certified hospitals that accept Medicare anywhere in the United States and its territories. Your benefit coverage may be less if you use an out-of-network physician, provider, or hospital.

FOR DUAL CARE HOUSEHOLDS LIVING IN THE UNITED STATES AND ITS TERRITORIES

Your household is a “dual care” household when at least one person (the Retired Member, Survivor, or eligible dependent) is covered by both Medicare Parts A & B and the others are either under age 65 or at least age 65 with Medicare Part B only.

LACERS offers five medical plan combinations for dual-care households.

Persons with Medicare Parts A & B	Persons Under Age 65 or with Medicare Part B Only
Medicare Advantage HMO plans	
Kaiser Senior Advantage HMO (CA only)	Kaiser HMO (CA only)/ Kaiser Senior Advantage HMO (CA only)
SCAN Health Plan Medicare Advantage HMO (CA only)	Anthem HMO (CA only)
UnitedHealthcare Medicare Advantage HMO (CA only)	Anthem HMO (CA only)
Medicare Preferred PPO plan	
Anthem Medicare Preferred (PPO) Plan	Anthem PPO
Medicare Supplement plan	
Anthem Life & Health Medicare Plan	Anthem PPO

See Pages 29-48 for more information on each plan.



LIVING OUTSIDE THE UNITED STATES

AVAILABLE HEALTH PLANS WHEN LIVING PERMANENTLY OUTSIDE THE UNITED STATES

If you permanently live outside the United States and its territories, the following health plans are available to you³:

- Medical: Anthem Blue Cross PPO Out-of-Country
- Vision: Anthem Blue View Vision
- Dental: Delta Dental PPO

Regardless of your age or Medicare status, the premium and allowance deduction amounts for the LACERS Anthem PPO Out-of-Country Plan are the same as the LACERS non-Medicare, under age 65 Anthem Blue Cross PPO plan.

Medicare and Living Outside the United States

If you live or travel outside the United States and its territories, Medicare does not cover you because Medicare does not subsidize services received outside the United States and its territories.

If you permanently live outside the United States and its territories, you do not need to enroll in Medicare.

However, if you later decide to return to live in the United States and its territories, and are over age 65, you are required to enroll in Medicare to enroll in a LACERS medical plan. Please contact the Social Security Administration (SSA) regarding Medicare rules, regulations, or penalties that may affect your medical plan coverage if you return to the United States.

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

LACERS will not reimburse basic Medicare Part B premiums while you are enrolled in the Anthem PPO Out-of-Country plan because it is not a LACERS Senior Plan.

Key Features of the Medical Plan	• Paid by reimbursement only • Claim forms are required • May take 90-120 days, depending on the claims and completeness of paperwork submitted. Contact Anthem directly for more information.
Medical Services	• Must meet U.S. standards of care¹
Prescription Drugs	• \$10 copay per 30-day supply (All Anthem Blue Cross approved drugs) • Copay will not apply toward your calendar year deductible
Medically Necessary Hearing Aids	• No deductible • Up to \$2,000 per ear every 36 months
Key Medical Plan Benefits	• \$500 deductible/person • 70% reimbursement of UCR² charges • Up to \$10,000 out-of-pocket maximum per calendar year, 100% reimbursement thereafter • Up to \$2,000,000 lifetime maximum

¹ As defined by the American Medical Association (www.ama-assn.org).

² UCR = Usual and Customary Rates as defined by Anthem Blue Cross.

³ Members must update their LACERS address to their out of country address in order to enroll in Anthem Blue Cross Out-of-Country PPO.

MEDICAL PREMIUM REIMBURSEMENT PROGRAM (MPRP)

Retirees and Eligible Survivors have the option to receive their LACERS medical subsidy as a quarterly medical premium reimbursement if all the following conditions are met:

- Based on your home address on file with LACERS, more than three consecutive months out of the year, you live:
 - Outside of California but within the United States and its territories, or
 - Within California but outside the authorized zip code service areas of a LACERS HMO or Medicare Advantage HMO plan
- You are not enrolled in a LACERS medical plan, and
- Your non-LACERS medical insurance policy is a comprehensive federally qualified or state-regulated medical insurance plan.

Under this program, Retirees may receive up to their medical subsidy or monthly cost of medical premiums, whichever is lower, and Eligible Survivors may be reimbursed up to the cost of their non-LACERS plan's one-party premium or eligible medical subsidy, whichever is lower.

If vision insurance and Medicare Part D premiums are not part of your non-LACERS medical plan, your medical subsidy may be used to reimburse these.

The following do not qualify for reimbursement: rebated portions of medical premiums, dental coverage, health savings account premiums, catastrophic health plans, short-term medical plans, fixed-indemnity plans, limited-benefit plans, accidental insurance plans, health care sharing ministries, and long-term care plans.

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

2027 MPRP Maximum Reimbursement		
Medicare Status	Retired Member Subsidy	Survivor Subsidy
Under Age 65 or Medicare Part B only	\$2,637.90	\$1,276.94
Medicare Parts A & B	\$914.41	\$914.41
Medicare Parts A & B and covering an Under Age 65 or Medicare Part B only dependent	\$1,548.98	N/A



Contact LACERS for an MPRP Information Packet and the reimbursement schedule or refer to the [LACERS.org](https://www.lacERS.org) website.

MEDICAL PLAN BENEFIT COMPARISON CHARTS

RETIRED MEMBERS, DEPENDENTS, AND SURVIVORS UNDER AGE 65

Summary of Benefits	Anthem Blue Cross PPO		Anthem Blue Cross HMO	Kaiser Permanente HMO
	Network Benefits	Non-Network Benefits		
Calendar Year Deductible				
Individual	\$750		Not applicable	Not applicable
Family	\$1,500; at least one family member must satisfy the \$750 per individual deductible			
Annual Out-of-Pocket Maximum				
Individual	\$5,000		\$500	\$500
Family	Not applicable		\$1,500	\$1,500
Lifetime Maximum				
	Unlimited		Unlimited	Unlimited
Preventive Care				
Routine Physical Examination	No charge (may include lab & X-ray)		\$20 copay	\$20 copay
Pap Smear, Pelvic & Breast Annual Exam	No charge	Routine preventative mammogram and any other routine services is payable at 100% for out-of-network providers at UCR. Deductible does not apply.	No charge after \$20 office visit copay	No charge after \$20 office visit copay
Mammography	Preventative mammogram is payable at 100% for in-network deductible. Deductible does not apply.			No charge
Physician Services				
Office Visit	\$20 copay	Anthem pays 70% UCR ¹ after deductible	\$20 copay	\$20 copay
Specialist Care			No charge	No charge
Inpatient Surgery	Anthem pays 90% after deductible			
Outpatient Surgery				
Telehealth/Virtual Visits	\$20 copay	Anthem pays 70% UCR ¹ after deductible	\$0 copay	\$0 copay

This information is a summary. Refer to the plan's Evidence of Coverage for full details and limitations.

RETIRED MEMBERS, DEPENDENTS, AND SURVIVORS UNDER AGE 65 (CONT.)

Summary of Benefits	Anthem Blue Cross PPO		Anthem Blue Cross HMO	Kaiser Permanente HMO
	Network Benefits	Non-Network Benefits		
Inpatient Hospital Room & Board				
	Anthem pays 90% after deductible	Anthem pays 80% UCR ¹ after deductible	No charge	No charge
Other Health Services				
Allergy Tests & Treatments	Anthem pays 90% after deductible	Anthem pays 70% UCR ¹ after deductible	\$20 copay	No charge after \$20 office visit copay
Lab & X-ray			No charge	No charge
Physical & Speech Therapy			\$20 copay; for Physical & Speech Therapy: limit of 60 days combined per illness/per injury	\$20 copay
Dialysis & ESRD Services				
Skilled Nursing Facility (limit 100 days/calendar year)				
Home Health Care	Anthem pays 90% after deductible; limit up to 60 visits/calendar year	Anthem pays 70% UCR ¹ after deductible; limit up to 60 visits/calendar year	No charge; limit up to 100 visits/calendar year	No charge ² ; up to 100 visits per accumulation period
Hospice Services	Anthem pays 80% after deductible; contact Anthem Blue Cross Member Services for details		No charge; limits apply	No charge

This information is a summary. Refer to the plan's Evidence of Coverage for full details and limitations.

RETIRED MEMBERS, DEPENDENTS, AND SURVIVORS UNDER AGE 65 (CONT.)

Summary of Benefits	Anthem Blue Cross PPO		Anthem Blue Cross HMO	Kaiser Permanente HMO
	Network Benefits	Non-Network Benefits		
Ambulance	Anthem pays 90% after deductible	Anthem pays 70% UCR ¹ after deductible	No charge	No charge ³
Durable Medical Equipment				No charge; formulary applies
Chiropractic Services (limit 30 visits/ calendar year)	\$20 copay		\$20 copay, 60 days max per illness/ injury; the chiro rider benefit is subject towards \$15 copay, 30 visit max per calendar year	\$15 copay; combined 30 visits per 12-month period ²
Acupuncture Services (limit 30 visits/calendar year)	\$20 copay; payable at 90% after deductible.		\$20 copay	
Emergency Services				
Emergency Room Visit	Anthem pays 90% after deductible	Anthem pays 90% after deductible	\$100 copay; waived if admitted	\$100 copay; waived if admitted ⁸
Urgent Care Visit	100% subject towards \$20 copay	Covered 70% of UCR ¹ after deductible	\$20 copay	\$20 copay
Mental Health (MH) ² /Chemical Dependency (CD) ²				
Inpatient	Anthem pays 90% after deductible (MH/CD)	Anthem pays 80% UCR ¹ after deductible (MH/CD)	No charge (MH/CD)	No charge; unlimited (MH); In acute medical facility (CD)
Outpatient	\$20 copay	Anthem pays 70% UCR ¹ after deductible	\$20 office visit copay (MH & CD); No Charge Facility (MH & CD)	\$20 copay (MH/ CD); \$10 (MH), \$5 (CD) copay for group; unlimited

This information is a summary. Refer to the plan's Evidence of Coverage for full details and limitations.

RETIRED MEMBERS, DEPENDENTS, AND SURVIVORS UNDER AGE 65 (CONT.)

Summary of Benefits	Anthem Blue Cross PPO		Anthem Blue Cross HMO	Kaiser Permanente HMO
	Network Benefits	Non-Network Benefits		
Hearing Services ⁹				
Hearing Exam	Covered under your Routine Physical Examination Benefit		\$20 copay	\$20 copay
Medically Necessary Hearing Aid (every 36 months)	No deductible: up to \$2,000 per ear every 36 months		Up to \$2,000 per ear every 36 months	\$2,000 limit per ear every 36 months
Retail Prescription Drugs ⁵	Up to 30-day supply ⁶	—	Up to 30-day supply ⁶	Up to 30-day supply ⁷
Generic	\$10 copay	Anthem pays 80%; deductible does not apply	\$10 copay	\$15 copay
Brand	\$30 copay		\$30 copay	\$35 copay
Non-formulary	\$50 copay		\$50 copay	Not applicable
Mail Order ⁴ Prescription Drugs	Up to 90-day supply ⁶	—	Up to 90-day supply ⁶	Up to 100-day supply ⁷
Generic	\$20 copay	Not covered	\$20 copay	\$30 copay
Brand	\$60 copay		\$60 copay	\$70 copay
Non-formulary	\$100 copay		\$100 copay	Not applicable

This information is a summary. Refer to the plan's Evidence of Coverage for full details and limitations.

1. UCR = Usual & Customary Rates.
2. Please review your Evidence of Coverage for plan details.
3. No charge per trip when defined as an emergency.
4. You must order your prescriptions through your medical plan's Mail Order vendor. The vendor's contact information is available from your medical plan.
5. For certain injectable drugs (except insulin), a different copayment may be required. Contact your medical plan for details.
6. \$0 copay for select generics. Note: Specialty Drugs (Generic and Brand) 20% coinsurance with maximum copay of \$100.
7. Specialty Drugs (Generic and Brand) Copay of \$100. Most specialty drugs only come as a 30-day supply from a plan pharmacy.
8. If admitted for observation, copay is not waived.
9. The hearing aid allowance covers some or most of the cost of your hearing aid, which could depend on the prescription or type of hearing aid that would be prescribed.

RETIRED MEMBERS, DEPENDENTS, AND SURVIVORS AGED 65 OR OLDER WITH MEDICARE PART B ONLY

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

This information is a summary. Refer to the plan's Evidence of Coverage for full details and limitations.

RETIRED MEMBERS, DEPENDENTS, AND SURVIVORS AGED 65 OR OLDER WITH MEDICARE PART B ONLY (CONT.)

Summary of Benefits	Anthem Blue Cross PPO (Medicare)		Anthem Blue Cross HMO (Medicare)	Kaiser Permanente Senior Medicare Advantage HMO
	Network Benefits	Non-Network Benefits		
Other Health Services				
Allergy Tests & Treatments	Anthem pays 100%		\$20 copay	No charge after \$15 office visit copay
Lab & X-ray			No charge	No charge
Physical & Speech Therapy	Anthem pays 20% after deductible		\$20 copay; for Physical & Speech Therapy: limit of 60 days combined per illness/per injury	\$15 copay
Dialysis & ESRD Services				
Skilled Nursing Facility (limit 100 days/calendar year)	Anthem pays 90% after deductible	Anthem pays 70% UCR ¹ after deductible	No charge	No charge
Home Health Care	Anthem pays 20% after deductible		No charge; limit up to 100 visits/calendar year	No charge when prescribed by Plan physician (limited to service area)
Hospice Services	Contact Anthem Blue Cross Member Services – Benefits are case specific		No charge; limits apply	No charge
Ambulance	Anthem pays 20% after deductible		No charge	No charge when defined as an emergency
Durable Medical Equipment				No charge; formulary applies
Transportation to medical appointments/pharmacy	Not applicable		Not applicable	24 one-way trips per calendar year (up to 50 miles per trip); limits apply

This information is a summary. Refer to the plan's Evidence of Coverage for full details and limitations.

RETIRED MEMBERS, DEPENDENTS, AND SURVIVORS AGED 65 OR OLDER WITH MEDICARE PART B ONLY (CONT.)

Summary of Benefits	Anthem Blue Cross PPO (Medicare)		Anthem Blue Cross HMO (Medicare)	Kaiser Permanente Senior Medicare Advantage HMO
	Network Benefits	Non-Network Benefits		
Chiropractic Services (limit 30 visits/calendar year)	Medicare authorized visits: \$10 copay	Medicare authorized visits: Anthem pays 70% UCR ¹ after deductible	\$20 copay, 60 days max per illness/injury; the Chiro Rider benefit is subject towards \$15 copay, 30 visit max per calendar year	\$15 copay; combined 30 visits per 12-month period ²
Acupuncture Services (limit 30 visits/calendar year)	Medicare authorized visits: \$10 copay	Medicare authorized visits: Anthem pays 70% UCR ¹ after deductible	\$20 copay	
Emergency Services				
Emergency Room Visit	Anthem pays 20% after deductible if admitted – 90% for hospital services, Anthem pays 20% after deductible ² for professional services		\$100 copay; waived if admitted	\$50 copay; waived if admitted ⁶
Urgent Care Visit	Anthem pays 20% after deductible		\$20 copay	\$15 copay
Mental Health (MH) ² /Chemical Dependency (CD) ²				
Inpatient	Anthem pays 90% after deductible (MH/CD)	Anthem pays 80% UCR ¹ after deductible (MH/CD)	No charge (MH/CD)	No charge per admission as covered by Medicare (MH/CD)
Outpatient	Anthem pays 50% after deductible (MH/CD)	Anthem pays 50% after deductible (MH/CD)	\$20 office visit copay (MH & CD); No Charge Facility (MH & CD)	\$15 copay; \$7 copay (MH), \$5 copay (CD) for group visits; unlimited
Hearing Services				
Hearing Exam	Covered under your Routine Physical Examination Benefit		\$20 copay	\$15 copay
Medically Necessary Hearing Aid ⁸ (every 36 months)	No deductible: up to \$2,000 per ear every 36 months		Up to \$2,000 per ear every 36 months	\$2,000 limit per ear every 36 months

This information is a summary. Refer to the plan's Evidence of Coverage for full details and limitations.

RETIRED MEMBERS, DEPENDENTS, AND SURVIVORS AGED 65 OR OLDER WITH MEDICARE PART B ONLY (CONT.)

Summary of Benefits	Anthem Blue Cross PPO (Medicare)		Anthem Blue Cross HMO (Medicare)	Kaiser Permanente Senior Medicare Advantage HMO
	Network Benefits	Non-Network Benefits		
Retail Prescription Drugs⁴	Up to 30-day supply^{4,5}	—	Up to 30-day supply^{4,5}	Up to 100-day supply
Generic	\$0 copay for select generics/ \$5 copay generics	See Evidence of Coverage	\$0 copay for select generics/\$5 copay for generics	Generic- \$15 Brand- \$15
Preferred Brand	\$25 copay		\$25 copay	
Non-Preferred Drugs, including Specialty Drugs, and Non-Formulary Drugs	\$50 copay		\$50 copay	Not applicable
Mail Order^{3,4} Prescription Drugs	Per 90-day supply	—	Up to 90-day supply^{3,4,5}	Up to 100-day supply
Generic	\$0 copay for select generics/ \$10 copay generics ⁷	Not covered	\$0 copay for select generics/ \$10 copay ⁷	Generic- \$15 Brand- \$15
Preferred Brand	\$50 copay		\$50 copay	
Non-Preferred Drugs, including Specialty Drugs, and Non-Formulary Drugs	\$100 copay		\$100 copay	Not applicable

This information is a summary. Refer to the plan's Evidence of Coverage for full details and limitations.

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

RETIRED MEMBERS, DEPENDENTS, AND SURVIVORS AGE 65 OR OLDER WITH MEDICARE PARTS A & B

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

This information is a summary. Refer to the plan's Evidence of Coverage for full details and limitations.

RETIRED MEMBERS, DEPENDENTS, AND SURVIVORS AGE 65 OR OLDER WITH MEDICARE PARTS A & B (CONT.)

Summary of Benefits	Kaiser Permanente Senior Medicare Advantage HMO	SCAN Health Plan Medicare Advantage HMO	UnitedHealthcare Medicare Advantage HMO
Other Health Services			
Allergy Tests & Treatments	No charge after \$15 office visit copay	No charge	No charge after \$15 office visit copay
Lab & X-ray	No charge		No charge
Physical & Speech Therapy	\$15 copay		No charge after \$15 office visit copay
Dialysis and ESRD Services			
Skilled Nursing Facility	No charge; limit 100 days/ calendar year	No charge; limit 100 days/calendar year	No charge; limit 100 days/calendar year
Home Health Care	No charge when prescribed by Plan physician (limited to service area)	No charge	No charge
Hospice Services	No charge	No charge	Per Medicare guidelines
Ambulance	No charge when defined as emergency	No charge	No charge
Durable Medical Equipment	No charge; formulary applies		\$0 copay
Chiropractic Services	\$15 copay; combined 30 visits per 12-month period ¹	\$10 copay; limit 20 visits/ calendar year	\$15 copay; limit 30 visits/year (CA), limit 12 visits/year (NV & AZ)
Acupuncture Services		\$10 copay; limit 20 visits/ calendar year	\$15 copay; limit 30 visits/year (CA), limit 12 visits/year (NV & AZ)
Emergency Room Visit	\$50 copay; waived if admitted ⁶	\$50 copay; waived if admitted	\$50 copay; waived if admitted

This information is a summary. Refer to the plan's Evidence of Coverage for full details and limitations.

RETIRED MEMBERS, DEPENDENTS, AND SURVIVORS AGE 65 OR OLDER WITH MEDICARE PARTS A & B (CONT.)

Summary of Benefits	Kaiser Permanente Senior Medicare Advantage HMO	SCAN Health Plan Medicare Advantage HMO	UnitedHealthcare Medicare Advantage HMO
Urgent Care Visit	\$15 copay	\$10 copay	\$15 copay
Transportation	24 one-way trips per calendar year (up to 50 miles per trip); limits apply, advance notice required ¹	Unlimited rides; 75-mile maximum radius; \$0 copay ¹	Up to 30 one-way trips per year to medical appointment/pharmacy, up to 50 miles away ¹
Home Delivered Meals	Up to 84 meals, three meals/day for a 4-week period after discharge from an inpatient stay ¹	Meal delivery is limited to four weeks, a maximum of 84 meals every year.	Up to 30 days following inpatient and skilled nursing facility discharge with \$0 copay; 28 refrigerated home-delivered meals ¹ . Other discharge benefits available. Please contact UHC for details.
Mental Health (MH)¹/Chemical Dependency (CD)¹			
Inpatient	No charge/admission as covered by Medicare; unlimited (MH/CD)	No charge/admission as covered by Medicare; unlimited (MH/CD)	No charge (MH/CD); unlimited
Outpatient	\$15 copay; \$7 copay (MH), \$5 copay (CD) group visits; unlimited	No charge; unlimited (MH/CD)	\$15 copay; unlimited visits
Hearing Services			
Hearing Exam	\$15 copay	\$10 copay	No charge
Medically Necessary Hearing Aid ⁷	\$2,000 allowance per ear every 36 months	\$4,000 limit; for one or two hearing aids every two years	No deductible; limits: CA: \$2,000 per ear every 3 years, NV & AZ: \$500 every 2 years

This information is a summary. Refer to the plan's Evidence of Coverage for full details and limitations.

RETIRED MEMBERS, DEPENDENTS, AND SURVIVORS AGE 65 OR OLDER WITH MEDICARE PARTS A & B (CONT.)

Summary of Benefits	Kaiser Permanente Senior Medicare Advantage HMO	SCAN Health Plan Medicare Advantage HMO	UnitedHealthcare Medicare Advantage HMO
Retail Prescription Drugs³	Up to 100-day supply	Up to 100-day supply	Up to 30-day supply
Generic ⁵	Generic- \$15 Brand- \$15	\$5-\$10 copay	Tier I generic \$10/unit ⁴
Preferred Brand ⁵		\$20 copay	Tier II brand \$20/unit ⁴
Non-Preferred Brands/ Non-Formulary ⁵	Not applicable	Non-Preferred Brands \$20 copay; Non-Formulary not covered	Tier III & IV \$50/unit ⁴
Mail Order Prescription Drugs^{2,3}	Up to 100-day supply	Up to 100-day supply	Up to 90-day supply ⁴
Generic	Generic- \$15 Brand- \$15	\$10-\$20 copay	Tier I generic \$20
Preferred Brand		\$40 copay	Tier II brand \$40
Non-Preferred Brands/ Non-Formulary	Not applicable	Non-Preferred Brands \$40 copay; Non-Formulary not covered	Tier III & IV \$100

This information is a summary. Refer to the plan's Evidence of Coverage for full details and limitations.

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



RETIRED MEMBERS, DEPENDENTS, AND SURVIVORS AGE 65 OR OLDER WITH MEDICARE PARTS A & B

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

This information is a summary. Refer to the plan's Evidence of Coverage for full details and limitations.



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

RETIRED MEMBERS, DEPENDENTS, AND SURVIVORS AGE 65 OR OLDER WITH MEDICARE PARTS A & B (CONT.)

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

This information is a summary. Refer to the plan's Evidence of Coverage for full details and limitations.



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

RETIRED MEMBERS, DEPENDENTS, AND SURVIVORS AGE 65 OR OLDER WITH MEDICARE PARTS A & B (CONT.)

Summary of Benefits	Anthem Blue Cross Medicare Preferred (PPO)	Anthem Blue Cross Life & Health Medicare Plan (Medicare Supp.)
Hearing Services⁵		
Hearing Exam	No charge ¹ ; Limited to a \$70 maximum	Covered under your Routine Physical Exam
Medically Necessary Hearing Aid	No deductible; up to \$2,000 per ear every 3 calendar years*	No deductible; up to \$2,000 per ear every 36 months
Retail Prescription Drugs³	Up to 30-day supply	Up to 30-day supply
Generic ⁴	\$0 copay for select generics, \$5 copay generics	\$0 copay for select generics, \$5 copay generics
Preferred Brand ⁴	\$25 copay	\$25 copay
Non-Preferred Drugs, including Specialty Drugs, and Non-Formulary Drugs ⁴	\$50 copay	\$50 copay
Mail Order Prescription Drugs^{2,3}	Up to 90-day supply	Up to 90-day supply
Generic	\$0 copay for select generics, \$10 copay generics	\$0 copay for select generics, \$10 copay generics
Preferred Brand	\$50 copay	\$50 copay
Non-Preferred Drugs, including Specialty Drugs, and Non-Formulary Drugs	\$100 copay	\$100 copay

This information is a summary. Refer to the plan's Evidence of Coverage for full details and limitations.

1. Review your Evidence of Coverage for plan details.
2. All Mail Order prescriptions must be ordered through your medical plan's mail order vendor or participating pharmacy directory. Contact your medical plan for Mail Order vendor contact information. The Anthem Part D Mail Order information is available in your Evidence of Coverage.
3. For certain injectable drugs (except insulin) a different copayment may be required. Contact your medical plan for details.
4. For Anthem diabetic supplies, a different copay may be required. Please see your Evidence of Coverage.
5. The hearing aid allowance covers some or most of the cost of your hearing aid, which could depend on the prescription or type of hearing aid that would be prescribed.



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

SCAN HEALTH PLAN AND ANTHEM MEDICARE PREFERRED (PPO) SUBSCRIBERS

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

Enhanced Social Services Program Benefit	SCAN Independent Living Power (ILP) ¹	Anthem Blue Cross Medicare Preferred (PPO) ²
Service Areas	<i>Only in Los Angeles, Orange, Riverside, San Bernardino and San Diego counties</i>	<i>Throughout the U.S. and its territories</i>
Personal Emergency Response System	- Includes installation & monthly monitoring \$0 copay	- One in-home system and monthly monitoring \$0 copay
Transportation to Provider Visits	- Unlimited taxi rides per year - No charge¹	12 one-way trips per year to medical visits, pharmacy, SilverSneakers, etc. within the service area; 60 mile-limit - Advanced scheduling required - No charge
Caregiver Relief (Alternative Caregiver Provides Services When The Regular Caregiver Is Not Available)	- In-home visits when the regular caregiver cannot be there - Services include companionship, assistance with bathing, dressing, and light meal preparation - Adult daycare – physical, social, or intellectual exercises and stimulation for seniors \$15 per visit¹	In-Home Support; Up to 90 hours per year of assistance with daily living activities
Personal Care and Homemaker Service	- Services include light housekeeping, laundry and meal preparation, companionship, assistance with bathing and dressing \$15 per visit¹	N/A

1. \$1,200 allowance per month for all ILP services combined.

2. Anthem Medicare Supplement plan enrollees (Anthem Life and Health Medicare plan) are not eligible for these benefits.

SCAN HEALTH PLAN AND ANTHEM MEDICARE PREFERRED (PPO) SUBSCRIBERS (CONT.)

Enhanced Social Services Program Benefit	SCAN Independent Living Power (ILP) ¹	Anthem Blue Cross Medicare Preferred (PPO) ²
Home Delivered Meals	Meal delivery is limited to four weeks, a maximum of 84 meals every year; no charge¹	Healthy Meals; Up to 56 meals per year, no charge
Bathroom Safety/ Assistive Equipment	\$0 copay	Up to \$200 every year for items allowed by Medicare, order online or through the app
Over the Counter	Not applicable	- Includes cough and cold, incontinence, and first aid \$30 per quarter, up to \$120/year
Health Fitness Tracker	Not applicable	Includes one fitness tracking device every 2 years

1. \$1,200 allowance per month for all ILP services combined.

2. Anthem Medicare Supplement plan enrollees (Anthem Life and Health Medicare plan) are not eligible for these benefits.

KAISER PERMANENTE SENIOR ADVANTAGE SUBSCRIBERS

Enhanced Social Services Program Benefit	Kaiser Permanente Senior Advantage
Over the Counter	- Includes common health and wellness products, blood pressure monitors, and diabetic supplies delivered to your home \$70 per quarter, minimum order value is \$25 - Unused portion of quarterly benefit will not carry forward - Request catalog and place order by phone at (833) 569-2360 or online at kp.org/otc/ca, no retail locations, no reimbursement - Contact Member Service Center at (800) 443-0815 if you have questions

MEDICAL PLAN PREMIUMS (INCLUDES VISION BENEFITS)

	PPO		HMO/Senior Plans				
	U.S.	U.S.	CA			AZ	NV
	Anthem Blue Cross (PPO) / Medicare Preferred (PPO)	Anthem Blue Cross (PPO) / Life & Health Medicare Plan (Med Supp)	Kaiser Permanente/ Sr. Advantage ¹	SCAN Health Plan & Anthem Blue Cross HMO ³	United-Health-care HMO & Anthem Blue Cross HMO ³	United-Healthcare HMO	
Retiree/Survivor Only	Monthly Premiums						
Under 65 or over 65 w/Medicare Part B only ¹	\$1,982.71	\$1,982.71	\$1,276.94	\$1,654.26	\$1,654.26	N/A	N/A
65 or older w/Medicare Parts A & B	\$455.13	\$914.41	\$272.04	\$226.93	\$439.11	\$439.08	\$349.40
Retiree/Survivor & 1 Dependent	Monthly Premiums						
Both under 65 or both 65 or older w/Medicare Part B only	\$3,960.39	\$3,960.39	\$2,553.88	\$3,303.49	\$3,303.49	N/A	N/A
Retired Member under 65 and Dependent age 65 or older w/Medicare Parts A & B	\$2,432.81	\$2,892.09	\$1,548.98	\$1,876.16	\$2,088.34	N/A	N/A

Note: Premium rates include Vision benefits. All of the above rates are effective from January 1, 2027 through December 31, 2027.

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

MEDICAL PLAN PREMIUMS (INCLUDES VISION BENEFITS) (CONT.)

	PPO		HMO/Senior Plans				
	U.S.	U.S.	CA			AZ	NV
	Anthem Blue Cross (PPO) / Medicare Preferred (PPO)	Anthem Blue Cross (PPO) / Life & Health Medicare Plan (Med Supp)	Kaiser Permanente/ Sr. Advantage ¹	SCAN Health Plan & Anthem Blue Cross HMO ³	United-Healthcare HMO & Anthem Blue Cross HMO ³	United-Healthcare HMO	
Retired Member 65 or older w/Medicare Parts A & B and Dependent under 65	\$2,432.81	\$2,892.09	\$1,548.98	\$1,876.16	\$2,088.34	N/A	N/A
Retired Member & Dependent both 65 or older, both w/Medicare Parts A & B	\$905.23	\$1,823.79	\$544.08	\$448.83	\$873.19	\$873.13	\$693.77
Retiree/Survivor & Family²	Monthly Premiums						
Retired Member & Family under 65 or 65 or older w/Medicare Part B only ¹	\$4,661.57	\$4,661.57	\$3,320.04	\$4,300.98	\$4,300.98	N/A	N/A

Note: Premium rates include Vision benefits. All of the above rates are effective from January 1, 2027 through December 31, 2027.

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

MEDICAL PLAN PREMIUMS (INCLUDES VISION BENEFITS) (CONT.)

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	PPO		HMO/Senior Plans				
	U.S.	U.S.	CA			AZ	NV
	Anthem Blue Cross (PPO) / Medicare Preferred (PPO)	Anthem Blue Cross (PPO) / Life & Health Medicare Plan (Med Supp)	Kaiser Permanente/ Sr. Advantage ¹	SCAN Health Plan & Anthem Blue Cross HMO ³	United-Healthcare HMO & Anthem Blue Cross HMO ³	United-Healthcare HMO	
Retired Member under 65, 1 Dependent 65 or older w/Medicare Parts A & B and at least 1 Dependent w/o Medicare	\$3,133.99	\$3,593.27	\$2,315.14	\$2,873.65	\$3,085.83	N/A	N/A
Retired Member 65 or older w/Medicare Parts A & B and Family w/o Medicare	\$3,133.99	\$3,593.27	\$2,315.14	\$2,873.65	\$3,085.83	N/A	N/A
Retired Member & 1 Dependent 65 or older both w/Medicare Parts A & B, and at least 1 Dependent w/o Medicare	\$1,606.41	\$2,524.97	\$1,310.24	\$1,446.32	\$1,870.68	N/A	N/A

Note: Premium rates include Vision benefits. All of the above rates are effective from January 1, 2027 through December 31, 2027.

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

MEDICAL MONTHLY ALLOWANCE DEDUCTIONS (RETIRED MEMBERS)

Monthly deductions are charged to Retired Members to cover the difference between the plan premium and the available eligible subsidy. The premium amount is reduced by the subsidy based on the Retired Member's whole years of Service Credit, and the remaining balance is deducted from the Retired Member's monthly Retirement Allowance.

Medical Plan
Premium

Your LACERS
Medical Subsidy

Retirement
Allowance Deduction

For LACERS Members who are Tier 1 Members and have not made additional retirement contributions, please refer to the **2027 Health Benefits Guide Supplement — Tier 1 Capped** for your subsidy information and monthly deduction charts. For LACERS Members who are retiring as Tier 3 (i.e., hired by the City on or after February 21, 2016 and made additional contributions towards retirement benefits), please refer to the **2027 Health Benefits Guide Supplement — Tier 3** for your subsidy information and monthly deduction charts. Contact LACERS or refer to the [LACERS.org](https://www.lacers.org) website for more information.

If you are an Eligible Survivor, please see Page 58 for your Medical with Vision monthly allowance deductions.

Your subsidy amount is based on your whole years (minimum 10 years) of Service (part-time employees) or Service Credit (full-time employees), age, and Medicare status. Your subsidy may or may not cover the total cost of your monthly premium. If your subsidy is less than the monthly premium, the balance is deducted from your retirement allowance. Any unused subsidy cannot be received as cash compensation.

To be eligible for a medical subsidy, you must:

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



TIER 1 RETIRED MEMBER ONLY UNDER AGE 65 OR WITH MEDICARE PART B ONLY

	PPO (U.S.)	HMO (CA)	
	Anthem	Kaiser	Anthem HMO
Monthly Premiums	\$1,982.71	\$1,276.94	\$1,654.26
Service/Service Credit*	Monthly Allowance Deduction		
1 - 10	\$927.55	\$221.78	\$599.10
11	\$822.03	\$116.26	\$493.58
12	\$716.52	\$10.75	\$388.07
13	\$611.00	\$0.00	\$282.55
14	\$505.49	\$0.00	\$177.04
15	\$399.97	\$0.00	\$71.52
16	\$294.45	\$0.00	\$0.00
17	\$188.94	\$0.00	\$0.00
18	\$83.42	\$0.00	\$0.00
19	\$0.00	\$0.00	\$0.00
20	\$0.00	\$0.00	\$0.00
21	\$0.00	\$0.00	\$0.00
22	\$0.00	\$0.00	\$0.00
23	\$0.00	\$0.00	\$0.00
24	\$0.00	\$0.00	\$0.00
25+	\$0.00	\$0.00	\$0.00

* Please refer to Pages 14-16 for Retired Member Medical Subsidy Eligibility and how subsidy is calculated by employment type.

TIER 1 RETIRED MEMBER ONLY WITH MEDICARE PARTS A & B

	PPO (U.S.)		HMO Senior Plans				
	Anthem Blue Cross Medicare Preferred (PPO) Plan	Anthem Blue Cross Life & Health Medicare Plan (Med. Supp.)	CA		CA	AZ	NV
			Kaiser Sr. Advantage	SCAN Health Plan	UnitedHealthcare HMO		
Monthly Premiums	\$455.13	\$914.41	\$272.04	\$226.93	\$439.11	\$439.08	\$349.40
Service/ Service Credit*	Monthly Allowance Deduction						
10 to 14	\$113.78	\$228.60	\$68.01	\$56.73	\$109.78	\$109.77	\$87.35
15 to 19	\$45.51	\$91.44	\$27.20	\$22.69	\$43.91	\$43.91	\$34.94
20 to 24	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
25+	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

* Please refer to Pages 14-16 for Retired Member Medical Subsidy Eligibility and how subsidy is calculated by employment type.

TIER 1 RETIRED MEMBER AND DEPENDENT UNDER AGE 65 OR WITH MEDICARE PART B ONLY

	PPO (U.S.)	HMO (CA)	
	Anthem	Kaiser	Anthem HMO
Monthly Premiums	\$3,960.39	\$2,553.88	\$3,303.49
Service/Service Credit*	Monthly Allowance Deduction		
1 - 10	\$2,905.23	\$1,498.72	\$2,248.33
11	\$2,799.71	\$1,393.20	\$2,142.81
12	\$2,694.20	\$1,287.69	\$2,037.30
13	\$2,588.68	\$1,182.17	\$1,931.78
14	\$2,483.17	\$1,076.66	\$1,826.27
15	\$2,377.65	\$971.14	\$1,720.75
16	\$2,272.13	\$865.62	\$1,615.23
17	\$2,166.62	\$760.11	\$1,509.72
18	\$2,061.10	\$654.59	\$1,404.20
19	\$1,955.59	\$549.08	\$1,298.69
20	\$1,850.07	\$443.56	\$1,193.17
21	\$1,744.55	\$338.04	\$1,087.65
22	\$1,639.04	\$232.53	\$982.14
23	\$1,533.52	\$127.01	\$876.62
24	\$1,428.01	\$21.50	\$771.11
25+	\$1,322.49	\$0.00	\$665.59

* Please refer to Pages 14-16 for Retired Member Medical Subsidy Eligibility and how subsidy is calculated by employment type.

TIER 1 RETIRED MEMBER UNDER AGE 65 OR WITH MEDICARE PART B ONLY AND DEPENDENT WITH MEDICARE PARTS A & B (DUAL CARE)

	PPO (U.S.)		HMO/Senior Plan (CA)		
	Anthem / Anthem Blue Cross Medicare Preferred (PPO) Plan	Anthem / Anthem Blue Cross Life & Health Medicare Plan (Med. Supp.)	Kaiser HMO / Kaiser Sr. Advantage	Anthem HMO / SCAN Health Plan	Anthem HMO / UnitedHealthcare HMO
Monthly Premiums	\$2,432.81	\$2,892.09	\$1,548.98	\$1,876.16	\$2,088.34
Service/Service Credit*	Monthly Allowance Deduction				
1 - 10	\$1,377.65	\$1,836.93	\$493.82	\$821.00	\$1,033.18
11	\$1,272.13	\$1,731.41	\$388.30	\$715.48	\$927.66
12	\$1,166.62	\$1,625.90	\$282.79	\$609.97	\$822.15
13	\$1,061.10	\$1,520.38	\$177.27	\$504.45	\$716.63
14	\$955.59	\$1,414.87	\$71.76	\$398.94	\$611.12
15	\$850.07	\$1,309.35	\$0.00	\$293.42	\$505.60
16	\$744.55	\$1,203.83	\$0.00	\$187.90	\$400.08
17	\$639.04	\$1,098.32	\$0.00	\$82.39	\$294.57
18	\$533.52	\$992.80	\$0.00	\$0.00	\$189.05
19	\$428.01	\$887.29	\$0.00	\$0.00	\$83.54
20	\$322.49	\$781.77	\$0.00	\$0.00	\$0.00
21	\$216.97	\$676.25	\$0.00	\$0.00	\$0.00
22	\$111.46	\$570.74	\$0.00	\$0.00	\$0.00
23	\$5.94	\$465.22	\$0.00	\$0.00	\$0.00
24	\$0.00	\$359.71	\$0.00	\$0.00	\$0.00
25+	\$0.00	\$254.19	\$0.00	\$0.00	\$0.00

* Please refer to Pages 14-16 for Retired Member Medical Subsidy Eligibility and how subsidy is calculated by employment type.

TIER 1 RETIRED MEMBER WITH MEDICARE PARTS A & B AND DEPENDENT UNDER AGE 65 OR WITH MEDICARE PART B ONLY (DUAL CARE)

	PPO (U.S.)		Senior Plans (CA) / HMO		
	Anthem Medicare Preferred (PPO) Plan / Anthem PPO	Anthem Life & Health Medicare Plan (Med. Supp.) / Anthem PPO	Kaiser Sr. Advantage / Kaiser HMO	SCAN Health Plan / Anthem HMO	UnitedHealthcare HMO / Anthem HMO
Monthly Premiums	\$2,432.81	\$2,892.09	\$1,548.98	\$1,876.16	\$2,088.34
Service/ Service Credit*	Monthly Allowance Deduction				
1 - 10	\$2,091.46	\$2,206.28	\$1,344.95	\$1,705.96	\$1,759.01
11	\$2,091.46	\$2,206.28	\$1,344.95	\$1,705.96	\$1,759.01
12	\$2,091.46	\$2,206.28	\$1,344.95	\$1,705.96	\$1,759.01
13	\$2,091.46	\$2,206.28	\$1,250.18	\$1,705.96	\$1,759.01
14	\$2,091.46	\$2,206.28	\$1,144.67	\$1,705.96	\$1,759.01
15	\$2,023.19	\$2,069.12	\$998.34	\$1,671.92	\$1,693.14
16	\$2,023.19	\$2,069.12	\$892.82	\$1,637.92	\$1,659.14
17	\$2,023.19	\$2,069.12	\$787.31	\$1,532.41	\$1,553.63
18	\$2,023.19	\$2,069.12	\$681.79	\$1,426.89	\$1,448.11
19	\$2,001.10	\$2,047.03	\$576.28	\$1,321.38	\$1,342.60
20	\$1,850.07	\$1,850.07	\$443.56	\$1,193.17	\$1,193.17
21	\$1,744.55	\$1,744.55	\$338.04	\$1,087.65	\$1,087.65
22	\$1,639.04	\$1,639.04	\$232.53	\$982.14	\$982.14
23	\$1,533.52	\$1,533.52	\$127.01	\$876.62	\$876.62
24	\$1,428.01	\$1,428.01	\$21.50	\$771.11	\$771.11
25+	\$1,322.49	\$1,322.49	\$0.00	\$665.59	\$665.59

* Please refer to Pages 14-16 for Retired Member Medical Subsidy Eligibility and how subsidy is calculated by employment type.

TIER 1 RETIRED MEMBER AND DEPENDENT WITH MEDICARE PARTS A & B

	PPO (U.S.)		HMO Senior Plans				
	Anthem Medicare Preferred (PPO) Plan	Anthem Life & Health Medicare Plan (Med. Supp.)	CA		CA	AZ	NV
			Kaiser Sr. Advantage	SCAN Health Plan	UnitedHealthcare HMO		
Monthly Premiums	\$905.23	\$1,823.79	\$544.08	\$448.83	\$873.19	\$873.13	\$693.77
Service/ Service Credit*	Monthly Allowance Deduction						
1 - 10	\$563.88	\$1,137.98	\$340.05	\$278.63	\$543.86	\$543.82	\$431.72
11	\$563.88	\$1,137.98	\$340.05	\$278.63	\$543.86	\$543.82	\$431.72
12	\$563.88	\$1,137.98	\$340.05	\$278.63	\$543.86	\$543.82	\$431.72
13	\$563.88	\$1,137.98	\$245.28	\$278.63	\$543.86	\$543.82	\$431.72
14	\$563.88	\$1,137.98	\$139.77	\$278.63	\$543.86	\$543.82	\$431.72
15	\$495.61	\$1,000.82	\$27.20	\$244.59	\$477.99	\$477.96	\$379.31
16	\$495.61	\$1,000.82	\$27.20	\$210.59	\$443.99	\$443.96	\$345.31
17	\$495.61	\$1,000.82	\$27.20	\$105.08	\$338.48	\$338.45	\$239.80
18	\$495.61	\$1,000.82	\$27.20	\$22.69	\$232.96	\$232.93	\$134.28
19	\$473.52	\$978.73	\$27.20	\$22.69	\$127.45	\$127.42	\$34.94
20	\$322.49	\$781.77	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
21	\$216.97	\$676.25	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
22	\$111.46	\$570.74	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
23	\$5.94	\$465.22	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
24	\$0.00	\$359.71	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
25+	\$0.00	\$254.19	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

* Please refer to Pages 14-16 for Retired Member Medical Subsidy Eligibility and how subsidy is calculated by employment type.

TIER 1 RETIRED MEMBER WITH MEDICARE PARTS A & B AND FAMILY UNDER AGE 65 OR WITH MEDICARE PART B ONLY (DUAL CARE)

	PPO (U.S.)		Senior Plans (CA) / HMO		
	Anthem Medicare Preferred (PPO) Plan / Anthem PPO	Anthem Life & Health Medicare Plan (Med. Supp.) / Anthem PPO	Kaiser Sr. Advantage / Kaiser HMO	SCAN Health Plan / Anthem HMO	UnitedHealthcare HMO / Anthem HMO
Monthly Premiums	\$3,133.99	\$3,593.27	\$2,315.14	\$2,873.65	\$3,085.83
Service/ Service Credit*	Monthly Allowance Deduction				
1 - 10	\$2,792.64	\$2,907.46	\$2,111.11	\$2,703.45	\$2,756.50
11	\$2,792.64	\$2,907.46	\$2,111.11	\$2,703.45	\$2,756.50
12	\$2,792.64	\$2,907.46	\$2,111.11	\$2,703.45	\$2,756.50
13	\$2,792.64	\$2,907.46	\$2,016.34	\$2,703.45	\$2,756.50
14	\$2,792.64	\$2,907.46	\$1,910.83	\$2,703.45	\$2,756.50
15	\$2,724.37	\$2,770.30	\$1,764.50	\$2,669.41	\$2,690.63
16	\$2,724.37	\$2,770.30	\$1,658.98	\$2,635.41	\$2,656.63
17	\$2,724.37	\$2,770.30	\$1,553.47	\$2,529.90	\$2,551.12
18	\$2,724.37	\$2,770.30	\$1,447.95	\$2,424.38	\$2,445.60
19	\$2,702.28	\$2,748.21	\$1,342.44	\$2,318.87	\$2,340.09
20	\$2,551.25	\$2,551.25	\$1,209.72	\$2,190.66	\$2,190.66
21	\$2,445.73	\$2,445.73	\$1,104.20	\$2,085.14	\$2,085.14
22	\$2,340.22	\$2,340.22	\$998.69	\$1,979.63	\$1,979.63
23	\$2,234.70	\$2,234.70	\$893.17	\$1,874.11	\$1,874.11
24	\$2,129.19	\$2,129.19	\$787.66	\$1,768.60	\$1,768.60
25+	\$2,023.67	\$2,023.67	\$682.14	\$1,663.08	\$1,663.08

* Please refer to Pages 14-16 for Retired Member Medical Subsidy Eligibility and how subsidy is calculated by employment type.

TIER 1 RETIRED MEMBER AND FAMILY UNDER AGE 65 OR WITH MEDICARE PART B ONLY

	PPO (U.S.)	HMO (CA)	
	Anthem	Kaiser**	Anthem HMO
Monthly Premiums	\$4,661.57	\$3,320.04	\$4,300.98
Service/Service Credit*	Monthly Allowance Deduction		
1 - 10	\$3,606.41	\$2,264.88	\$3,245.82
11	\$3,500.89	\$2,159.36	\$3,140.30
12	\$3,395.38	\$2,053.85	\$3,034.79
13	\$3,289.86	\$1,948.33	\$2,929.27
14	\$3,184.35	\$1,842.82	\$2,823.76
15	\$3,078.83	\$1,737.30	\$2,718.24
16	\$2,973.31	\$1,631.78	\$2,612.72
17	\$2,867.80	\$1,526.27	\$2,507.21
18	\$2,762.28	\$1,420.75	\$2,401.69
19	\$2,656.77	\$1,315.24	\$2,296.18
20	\$2,551.25	\$1,209.72	\$2,190.66
21	\$2,445.73	\$1,104.20	\$2,085.14
22	\$2,340.22	\$998.69	\$1,979.63
23	\$2,234.70	\$893.17	\$1,874.11
24	\$2,129.19	\$787.66	\$1,768.60
25+	\$2,023.67	\$682.14	\$1,663.08

*Please refer to Pages 14-16 for Retired Member Medical Subsidy Eligibility and how subsidy is calculated by employment type.

** Those enrolled in Kaiser Senior Advantage who have only Part B of Medicare are charged the same premiums as those who have both Parts A & B of Medicare.

MEDICAL MONTHLY ALLOWANCE DEDUCTIONS (ELIGIBLE SURVIVORS)

Monthly deductions are charged to Eligible Survivors to cover the difference between the plan premium and the available eligible subsidy. The premium amount is reduced by the subsidy based on the Retired Member's or the LACERS Member's whole years of Service Credit, and the remaining balance is deducted from the Survivor's monthly Continuance or Survivorship Allowance. For a Survivor to qualify for a medical subsidy, see Page 17 for more information.

TIER 1 AND TIER 3 ELIGIBLE SURVIVOR UNDER AGE 65 OR WITH MEDICARE PART B ONLY

	PPO (U.S.)	HMO (CA)	
	Anthem	Kaiser	Anthem HMO
Monthly Premiums	\$1,982.71	\$1,276.94	\$1,654.26
Service/ Service Credit*	Monthly Allowance Deduction		
1 - 10	\$1,471.93	\$766.16	\$1,143.48
11	\$1,420.86	\$715.09	\$1,092.41
12	\$1,369.78	\$664.01	\$1,041.33
13	\$1,318.70	\$612.93	\$990.25
14	\$1,267.62	\$561.85	\$939.17
15	\$1,216.55	\$510.78	\$888.10
16	\$1,165.47	\$459.70	\$837.02
17	\$1,114.39	\$408.62	\$785.94
18	\$1,063.31	\$357.54	\$734.86
19	\$1,012.24	\$306.47	\$683.79
20	\$961.16	\$255.39	\$632.71
21	\$910.08	\$204.31	\$581.63
22	\$859.00	\$153.23	\$530.55
23	\$807.93	\$102.16	\$479.48
24	\$756.85	\$51.08	\$428.40
25+	\$705.77	\$0.00	\$377.32

* Please refer to Pages 14-16 for Retired Member Medical Subsidy Eligibility and how subsidy is calculated by employment type.

TIER 1 AND TIER 3 ELIGIBLE SURVIVOR WITH MEDICARE PARTS A & B

	PPO (U.S.)		HMO Senior Plans				
	Anthem Medicare Preferred (PPO) Plan	Anthem Life & Health Medicare Plan (Medicare Supp.)	CA		CA	AZ	NV
			Kaiser Sr. Advantage	SCAN Health Plan	UnitedHealthcare HMO		
Monthly Premiums	\$455.13	\$914.41	\$272.04	\$226.93	\$439.11	\$439.08	\$349.40
Service/Service Credit*	Monthly Allowance Deduction						
1 to 14	\$113.78	\$228.60	\$68.01	\$56.73	\$109.78	\$109.77	\$87.35
15 to 19	\$45.51	\$91.44	\$27.20	\$22.69	\$43.91	\$43.91	\$34.94
20+	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

* Please refer to Pages 14-16 for Retired Member Medical Subsidy Eligibility and how subsidy is calculated by employment type.

AVAILABLE LACERS VISION PLANS

Your vision premiums are incorporated into the medical premiums. The following carriers will provide your vision coverage:

If your medical carrier is:	Then your vision coverage will be from:
Anthem Blue Cross HMO or PPO	Anthem Blue View Vision
Anthem Medicare Preferred (PPO)*	
Anthem Life & Health Medicare	
SCAN Health Plan HMO	
UnitedHealthcare HMO	
Kaiser Permanente HMO or Senior Advantage	Kaiser Permanente

KAISER PERMANENTE

If you are enrolled in a LACERS Kaiser medical plan, you receive vision benefits directly from Kaiser. Vision services outside the Kaiser network are not covered.

ANTHEM BLUE VIEW VISION

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

You may choose from a list of in-network or out-of-network providers. Your benefit coverage may be less if you use an out-of-network provider. If you receive care from an out-of-network provider, send your claims to:

Out of Network Claims Department

Anthem Blue View Vision

Mail: Attn: OON Claims, P.O. Box 8504

Mason, OH 45040-7111

Fax: (866) 293-7373

Email: oonclaims@eyewearspecialoffers.com



* A note for Anthem Medicare Preferred PPO enrollees:

Those in the Anthem Medicare Preferred PPO plan will have two plans of vision benefits. When you visit your optometrist, they will have both of your vision plans in their system. This means when you use all the benefits from your Blue View Vision plan, you can begin using your Anthem Medicare Preferred PPO vision benefits.

For example, if your frames cost more than the Blue View Vision \$150 frames allowance, your Anthem Medicare Preferred plan's frame allowance can be used on top.

VISION PLAN COMPARISON CHART

Vision Benefits	Anthem Blue View Vision (Non-Kaiser Permanente plan members)		Kaiser Permanente
	In-Network Provider ⁶	Out-of-Network Provider (Maximum Reimbursement)	
Exam	Every 12 months ¹		\$20 Kaiser Permanente HMO, \$15 Kaiser Permanente Senior Advantage
—	\$20 copay	Up to \$49	
Lenses and Options	Every 12 months ^{1,3}		Every 24 months
Single Vision Bifocal Trifocal Lenticular Tint/photochromic Scratch coating Polycarbonate	Paid in full ²	Up to \$45 Up to \$65 Up to \$85 Up to \$125 Up to \$5 Not covered Not covered	Up to \$150 for all frames, lenses or contacts
Progressive	\$30 additional copay; Premium Tier 4: 20% retail price	Up to \$85	
Frame Allowance	Every 12 months ¹		
One pair	\$150 allowance, then 20% off any remaining balance; \$120 allowance of a pair of eyeglass frames from Costco	Up to \$70	
Contact Lenses Allowance	Every 12 months ^{1,2,4} (Instead of glasses)		
Elective conventional or	Up to \$150, then 15% off any remaining balance	Up to \$105	
Elective disposable or	Up to \$150, no additional discount	Up to \$105	
Medically Necessary	Paid in full ⁵	Up to \$210	

This information is a summary. Refer to the plan's Evidence of Coverage for full details and limitations.

1. Based on your last date of service.
2. Patients choosing contacts will be next eligible for lenses in 12 months.
3. You may also choose to receive 40% off additional complete pairs of glasses or 20% off when purchasing additional lenses or frames separately, and 20% off sunglasses and lens options from any in network Anthem Blue View Vision provider.
4. Your plan includes Anthem Blue View Vision doctor professional services for contact lens fitting when buying contact lenses.
5. Medically necessary contact lenses are covered in full when Anthem Blue View Vision benefit criteria are met and verified by an Anthem Blue View Vision network doctor for eye conditions that would prohibit the use of glasses.
6. For a PLUS provider the exam copay is zero and frame allowance increases by \$50.

AVAILABLE LACERS DENTAL PLANS

DENTAL PLAN CHOICES

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

LACERS offers two dental plans: Delta Dental PPOSM and DeltaCare USA[®] DHMO.

Regardless of your dental plan choice, LACERS advises you to obtain a dental treatment plan from your provider and review coverage levels with Delta Dental's Member Services before receiving treatments.

Double coverage is not allowed for LACERS Members and Survivors already enrolled as a Subscriber or Dependent on each other's plan.



Delta Dental PPO dental insurance ID cards will not be mailed but are available online and can be printed from the Delta Dental website. DeltaCare DHMO dental insurance ID cards will be mailed and can be accessed online.

DELTA DENTAL PPOSM

You may visit any licensed dentist in the United States and its territories but will maximize plan value by choosing from the large Delta Dental PPOSM network. The PPO network dentists agreed to reduced contracted rates and cannot bill for additional fees. The next best option is to visit a Delta Dental Premier[®] dentist but costs will be higher compared to a PPO dentist, though it may or may not be lower compared to a non-Delta Dental dentist.

Under this plan, after meeting the deductible, enrollees pay a certain percentage (known as coinsurance) of each covered service. You are also responsible for any non-covered services and any amount over your annual maximum.

If you visit a non-Delta Dental dentist, you have no cost protections and will be responsible for paying any amount your dentist charges above your allowance for any services you received (referred to as "balance billing").

DELTACARE USA[®] DHMO

Enrollees select a primary dentist from the DeltaCare USA[®] network, either in California or select parts of Nevada. For each covered service, you pay a pre-determined copay. For a current list of DeltaCare USA[®] dentists, visit deltadentalins.com or call Delta Dental Customer Service at (800) 422-4234.

LACERS DENTAL SUBSIDY

LACERS provides a dental subsidy for Retired Members only. The dental subsidy is a monthly dollar credit applied to the dental premium (monthly cost of coverage). The LACERS dental subsidy is based on the maximum dental subsidy available to City of Los Angeles' Active Members.

To be eligible for a LACERS dental subsidy, Retired Members must:

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

Your dental subsidy amount will be based on whole years of Service Credit. However, dental subsidies are not available for dependents or Survivors.

Retired Members and Survivors may still enroll dependents in a LACERS dental plan and have their premium costs deducted from the monthly allowance.

2027 DENTAL SUBSIDY FOR TIER 1 AND TIER 3 RETIRED MEMBERS

Service/Service Credit*	% of Maximum	Delta Dental PPO Subsidy Amount	DeltaCare USA DHMO Subsidy Amount
1 - 10	40%	\$20.81	\$6.28
11	44%	\$22.89	\$6.91
12	48%	\$24.97	\$7.54
13	52%	\$27.05	\$8.16
14	56%	\$29.13	\$8.79
15	60%	\$31.21	\$9.42
16	64%	\$33.29	\$10.05
17	68%	\$35.37	\$10.68
18	72%	\$37.45	\$11.30
19	76%	\$39.54	\$11.93
20	80%	\$41.62	\$12.56
21	84%	\$43.70	\$13.19
22	88%	\$45.78	\$13.82
23	92%	\$47.86	\$14.44
24	96%	\$49.94	\$15.07
25+	100%	\$52.02	\$15.70

LACERS DENTAL PLAN COMPARISON CHARTS

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

This information is a summary. Refer to the plan's Evidence of Coverage for full details and limitations.

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

DENTAL PLAN PREMIUM RATES

Coverage Level	Delta Dental PPO	DeltaCare USA DHMO
Retired Member	\$53.77	\$15.70
Retired Member & 1 dependent	\$106.64	\$29.31
Retired Member & 2+ dependents	\$154.05	\$33.89

TIER 1 AND TIER 3 DENTAL MONTHLY ALLOWANCE DEDUCTIONS**

	Retired Member Only		Retired Member & One Dependent		Retired Member & Family	
	Delta Dental PPO	DeltaCare USA DHMO	Delta Dental PPO	DeltaCare USA DHMO	Delta Dental PPO	DeltaCare USA DHMO
Monthly Premiums	\$53.77	\$15.70	\$106.64	\$29.31	\$154.05	\$33.89
Service/ Service Credit*	Monthly Allowance Deduction					
1 - 10	\$32.96	\$9.42	\$85.83	\$23.03	\$133.24	\$27.61
11	\$30.88	\$8.79	\$83.75	\$22.40	\$131.16	\$26.98
12	\$28.80	\$8.16	\$81.67	\$21.77	\$129.08	\$26.35
13	\$26.72	\$7.54	\$79.59	\$21.15	\$127.00	\$25.73
14	\$24.64	\$6.91	\$77.51	\$20.52	\$124.92	\$25.10
15	\$22.56	\$6.28	\$75.43	\$19.89	\$122.84	\$24.47
16	\$20.48	\$5.65	\$73.35	\$19.26	\$120.76	\$23.84
17	\$18.40	\$5.02	\$71.27	\$18.63	\$118.68	\$23.21
18	\$16.32	\$4.40	\$69.19	\$18.01	\$116.60	\$22.59
19	\$14.23	\$3.77	\$67.10	\$17.38	\$114.51	\$21.96
20	\$12.15	\$3.14	\$65.02	\$16.75	\$112.43	\$21.33
21	\$10.07	\$2.51	\$62.94	\$16.12	\$110.35	\$20.70
22	\$7.99	\$1.88	\$60.86	\$15.49	\$108.27	\$20.07
23	\$5.91	\$1.26	\$58.78	\$14.87	\$106.19	\$19.45
24	\$3.83	\$0.63	\$56.70	\$14.24	\$104.11	\$18.82
25+	\$1.75	\$0.00	\$54.62	\$13.61	\$102.03	\$18.19

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

** Dental subsidies are not available to dependents or Survivors.

LACERS WELL

LACERS Well is an innovative program dedicated to supporting Retired Members, Survivors, their spouses/ domestic partners, and eligible dependents in enhancing their quality of life and retirement.

This program, offered free of charge, is made possible through the support of LACERS health plans: Anthem Blue Cross, Kaiser Permanente, UnitedHealthcare, SCAN, Blue View Vision, and Delta Dental.

Members of LACERS Well can enjoy a wide range of benefits, including:

- Participation incentives and rewards to encourage engagement
- A variety of online fitness events and classes to promote physical health
- Online technology classes to help stay connected and informed
- Champion-led outdoors events
- Workshops and seminars on topics such as nutrition, financial planning, and mental health
- Wellness meet-ups with fellow LACERS Retirees to socialize and support each other

Start your journey to a healthier and more fulfilling retirement!

For more information: visit lacers.org/lacers-well, or send an email to LacersWell@lacers.org.



Follow us on Facebook! Join the Members-only private Facebook group for the latest news and events: facebook.com/lacerswell

COBRA

COBRA (Consolidated Omnibus Budget Reconciliation Act) allows your dependents to continue health coverage, at their own expense, after they have been terminated from your LACERS health plans for the following qualifying events:

- Legal separation
- Divorce
- Termination of domestic partnership
- Marriage of dependent child
- Dependent child reaches age limit on plan
- Death of the Retired Member (dependent not eligible for Continuation or Survivorship Allowance; children who receive a Continuation Allowance are not eligible for LACERS' health benefits)

(Continued on next page.)

The Retired Member or Survivor must inform LACERS within 60 days of the COBRA-qualifying event for dependents to maintain their rights to continue their coverage. LACERS will notify dependents of COBRA information.

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

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

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

SETTLING DISPUTES AND ARBITRATION

SETTLING DISPUTES

If you wish to file a complaint against your health plan with the State of California's Department of Managed Health Care (DMHC), you may do so only after you have contacted your health plan and used the plan's grievance process. However, you may immediately file a complaint with the DMHC in an emergency. You may also file a complaint with the DMHC if the health plan has not satisfactorily resolved your grievance within 30 days of filing. You can see more from the DMHC at www.dmhc.ca.gov/File-a-Complaint/Contact-Your-Health-Plan.aspx

California's Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) authorizes the DMHC to license and regulate health care service plans including the LACERS Anthem Blue Cross HMO, Anthem Blue Cross Medicare Preferred (PPO), Anthem Blue Cross Life & Health Medicare Plan (Medicare Supplement), Anthem Blue Cross PPO, Anthem Blue View Vision, Kaiser Permanente HMO and Senior Advantage, SCAN Health Plan, and UnitedHealthcare medical and the Delta Dental PPO and DeltaCare USA HMO dental plans.

ARBITRATION

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

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

ABBREVIATIONS AND GLOSSARY

CMS: Centers for Medicare & Medicaid Services

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1986

EOC: Evidence of Coverage

HIPAA: Health Insurance Portability and Accountability Act

HMO: Health Maintenance Organization

IRMAA: Income-Related Monthly Adjustment Amount

LEP: Late Enrollment Penalty

LIS: Low-Income Subsidy

MPRP: LACERS Medical Premium Reimbursement Program

PCP: Primary Care Physician

PDP: Prescription Drug Plan

PPO: Preferred Provider Organization

SSA: Social Security Administration

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

ENTITIES/ORGANIZATIONS GLOSSARY

Centers for Medicare & Medicaid Services (CMS)

The federal agency that administers the Medicare program. CMS works in partnership with the state to administer Medicaid, the State Children's Health Insurance Program (CHIP), and health insurance portability standards. Annually, CMS publishes Medicare Parts A & B premiums and deductibles, and Part D IRMAA. See also Income-Related Monthly Adjustment Amount (IRMAA) and Social Security Administration (SSA). For questions about CMS, contact CMS using the back of this Guide.

Social Security Administration (SSA)

SSA works, in relation to CMS, to process Medicare applications, Medicare replacement cards, and provide general Medicare information. SSA will tell you if you have to pay IRMAA on top of your basic/standard Medicare Part B and D premiums. If you have any questions about SSA, contact SSA using the back of this Guide. See also CMS and IRMAA.



HEALTH INSURANCE TERMS AND GLOSSARY

Claim

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

Coinsurance

The percentage of costs of an approved covered health care service you pay (20%, for example) after you've paid your deductible. Generally, plans with low monthly premiums have higher coinsurance and plans with higher monthly premiums have lower coinsurance.

Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)

COBRA provides certain former employees, Retired Members, spouses, former spouses, and dependent children the right to temporarily continue health coverage at the group premium rate, plus an administrative fee.

Copayment (Copay)

A fixed amount (\$20, for example) you pay for a covered health care service after you've paid your deductible. Generally, plans with lower monthly premiums have higher copayments, while plans with higher monthly premiums usually have lower copayments.

Deductible

The amount you pay for covered health care services before your insurance plan starts to pay. For example, under the Anthem PPO plan with a \$750 deductible, you pay the first \$750 of covered services yourself. After you pay your deductible, you pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.

Evidence of Coverage (EOC)

A document that describes the coverage offered. EOCs for LACERS-sponsored health plans may be found online at lacers.org/evidence-coverage.

Formulary

A listing of prescription medications or durable medical equipment that are covered by a medical plan. Prescription Formulary is also called a drug list.

Generic Drug

A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

Health Insurance Carrier

A health insurance company that sells and fulfills insurance contracts. LACERS contracts with health insurance carriers to provide health insurance to its Retired Members, Eligible Survivors, and eligible dependents.

Health Maintenance Organization (HMO)

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Income-Related Monthly Adjustment Amount (IRMAA)

A surcharge on top of the basic/standard Medicare Part B and Part D premiums if your modified adjusted gross income of two years prior (i.e., 2027 IRMAA is based on 2025 tax return information) is above annual thresholds determined by Centers for Medicare & Medicaid Services (CMS). Please contact CMS and SSA for more details.

Medicare

A federal health insurance program for people 65 and older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Network

A defined group of providers who have contracted with a health insurance company to provide health care services.

Out-of-Pocket Maximum

The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance for

in-network care and services, your health plan pays 100% of the costs of covered benefits. The out-of-pocket limit doesn't include: Your monthly premiums, deductibles, anything you spend for services your plan doesn't cover, out-of-network care and services, and costs above the allowed amount for a service that a provider may charge.

Plan year

A 12-month period of benefits coverage under a group health plan. LACERS' health plan year is January 1 to December 31.

Preferred Provider Organization (PPO)

A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Premium

The monthly cost of insurance coverage. In addition to your premium, you usually have to pay other costs for your health care, including a deductible, copayments, and coinsurance.

Primary Care Physician (PCP)

A physician (M.D. — Medical Doctor or D.O. — Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Reasonable and Customary (R & C) Fee

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R & C amount is sometimes used to determine the allowed amount.

Service Area

A geographic area where a health insurance plan accepts Members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan will end your coverage if you move out of the plan's service area.

LACERS HEALTH PLANS AND HEALTH TERMS GLOSSARY

Anthem Blue Cross Life & Health Medicare Plan (Medicare Supplement):

A Medicare Supplement plan offered by Anthem Blue Cross and is available to Retired Members, Survivors, and eligible dependents with Medicare Parts A & B. Medicare is primary for medical services and Anthem is secondary. Medicare Part D (Rx) is assigned to Anthem. This plan is also known as Assurance Plus 1.

Anthem Blue Cross Medicare Preferred (PPO) Plan

A Medicare Advantage PPO plan offered by Anthem Blue Cross and available to Retired Members, Survivors, and eligible dependents with Medicare Parts A & B. Your Medicare Parts A, B, and D (Rx) are assigned to Anthem. All claims go to Anthem.

Deduction

An amount taken from a Retired Member's or Eligible Survivor's monthly retirement, Continuance, or Survivorship Allowance to cover the difference between their plan premium and their available eligible subsidy amount.

Dependent

A spouse/domestic partner, and/or eligible child(ren) or grandchild(ren) enrolled in the Retired Member's and Survivor's LACERS health plan. Former or ex-spouses and ex-domestic partners are not eligible dependents for LACERS health benefits. See Page 6 for more details.

Dual Care

A LACERS medical insurance option available to Retired Members and Survivors whose households consist of at least one enrollee (Retired Member, Survivor, or dependent) who has both Medicare Parts A & B and at least one person who does not have Medicare or only has Medicare Part B.

Medical Premium Reimbursement Program (MPRP)

A LACERS program that reimburses Retired Members and Eligible Survivors who have non-LACERS medical plans for their plan premiums up to the amount of their subsidy eligibility. MPRP participants must live outside California or reside outside of a LACERS CA HMO or Medicare Advantage HMO zip code service area.

Reimbursement

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

Reimbursement – Anthem Medicare Preferred (PPO) Enhanced Benefits

A repayment by Anthem Medicare Preferred (PPO) to a plan Member who directly paid for eligible claims for Caregiver Relief. See Pages 44-45 for Anthem Medicare Preferred (PPO) Enhanced Social Services Program.

Reimbursement – Medical Premium Reimbursement Program (MPRP)

A repayment of medical insurance premium to a Retired Member or Eligible Survivor, up to the Retired Member's or Eligible Survivor's medical subsidy, for their non-LACERS sponsored medical insurance plan, of which direct payments were made to their non-LACERS sponsored health plan. Refer to Page 28 for MPRP information.

Reimbursement – Medicare Part B Premium

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

Senior Plan

A medical insurance plan that coordinates with Medicare.

U.S. Territories

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



LACERS TERMS AND GLOSSARY

Continuance Allowance

A lifetime monthly benefit provided to a qualified beneficiary after the death of a Retired Member.

Eligible Surviving Spouse/Domestic Partner (Survivor)

The surviving spouse or domestic partner of a Retired Member or of a LACERS Member who died prior to retirement, and is eligible for a Continuance or Survivorship benefit from LACERS. Former or ex-spouses and ex-domestic partners are not eligible for LACERS health benefits.

LACERS Member

Any person who is or was a Civilian employee or one of the few specific Sworn classifications to the City of Los Angeles, including employees on leave without pay status, excluding employees of the Department of Water and Power.

Power of Attorney (POA)

Power to act for another; the legal authority to act for another person in legal and business matters.

Retired Member

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

Service

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

Service Credit

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

Subsidy

A benefit for eligible LACERS Retired Members and Eligible Survivors that assists with the cost of health insurance. It is applied toward the cost of the Retired Member's or Eligible Survivor's monthly premium. Both Retired Members and eligible Survivors may qualify to receive a LACERS medical subsidy. (See Pages 14-18.) Only Retired Members may be eligible for dental subsidy (i.e., neither dependents nor Eligible Survivors are eligible for a LACERS dental subsidy).

Survivor

See Eligible Surviving Spouse/Domestic Partner. Former or ex-spouses and domestic partners are not eligible to receive LACERS health benefits.

Survivorship Allowance

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



RELATED ORDINANCES

The following excerpts from the Los Angeles Administrative Code (LAAC) and LACERS Board Manual are related to the information in this guide. These excerpts are current at the time of the printing of this publication. The full text of the LAAC may be found online at https://codelibrary.amlegal.com/codes/los_angeles/latest/laac/0-0-0-7036. The full text of the LACERS Board Manual may be found online at lacers.org/board-manual.

LAAC § 4.1003(c)

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

LAAC § 4.1111 (e)(4) and LAAC § 4.1126 (d)(4)

Dependent Subsidy [Tier 1 and Tier 3 Provisions]. The amount of the medical plan premium subsidy which is applied toward the coverage of dependents of a retiree enrolled in both Part A and Part B of Medicare shall not exceed that amount which may be applied toward the coverage of the dependent(s) of a retiree not enrolled in both Parts A and Part B of Medicare with the same years of Service Credit and covered by the same medical plan.

LAAC § 4.1111(f) and 4.1126(e)

Medicare Enrollment and Assignment [Tier 1 and Tier 3 Provisions]. Retirees who are eligible to enroll in Medicare Part B must do so in order to qualify to receive the subsidy provided in Subsections [of Sections 4.1111 and 4.1126]. The Board may require [R]etirees to enroll in and assign to LACERS any coverage that is provided by Medicare in order

to qualify to receive the subsidy provided in this section, except that [R]etirees who are not entitled to premium free Part A of Medicare are not required to enroll in Part A.

LAAC § 4.1113(b) and 4.1128(b)

Eligible Retiree [Tier 1 and Tier 3 Provisions]. In order to participate in the Medicare Part B Basic Premium Reimbursement Program, a retiree must be eligible to receive a medical plan premium subsidy, enrolled in Medicare Parts A and B, and either enrolled in a Medicare supplemental or coordinated plan administered by the Board or be a participant in the Medical Premium Reimbursement Program. Only retired employees may participate in this program.

LAAC § 4.1130 (a)(8)

LACERA Health Reciprocity. The Agreement shall not extend reciprocal health insurance subsidy credit for retiree health insurance to safety members of LACERA or to members of any CITY retirement systems other than LACERS.

LACERS Board Manual § 4.1 HBA 2.d

At age 65 (or sooner if eligible for Medicare insurance), Eligible Primary Subscribers and their Medicare eligible dependents must enroll in a LACERS Medicare [Senior] plan. (LAAC §4.1103.2)

LACERS Board Manual § 4.1 HBA 5.f

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

OFFICIAL HEALTH PLAN NAMES

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

NOTICES

ABOUT THIS PUBLICATION

This Health Benefits Guide is only a general summary of certain benefits. It does not include the details of all exclusions and limitations. The information printed herein is current at the time of printing. The digital up-to-date version may be found online at lacers.org/health-benefits-guide.

HEALTH BENEFITS AND HEALTH PLANS FROM LACERS

The health benefits and health plan options offered by LACERS are to be provided according to agreements between the health plan carriers and LACERS. The LACERS Board of Administration reserves the right as Program Administrators to terminate any plan benefits at any time when the Board deems it is necessary for the administration of any individual plan or the medical and dental programs.

If there are any discrepancies between this publication and the various ordinances governing health benefits or reimbursements, the legal text in the ordinances always governs.

YOUR RESPONSIBILITIES

You have the responsibility to read and understand, to the best of your ability, all information about your LACERS health care benefits or ask for help if you need further clarification.

Each health plan has its own exclusions, limitations, arbitration provisions, and contracts with Medicare with respect to the health care services they can provide to Enrollees. These provisions are not included in this guide.

Please refer to the carrier's plan documents and read and understand them carefully as they apply to the plan you are enrolled in. When available, each plan's Evidence of Coverage (EOC) will be on LACERS' website at lacers.org/evidence-coverage. You may contact LACERS if you would like the appropriate Service Agreement or Certificate of Insurance for a LACERS-sponsored plan.

To protect your and your family's rights, notify LACERS and let your health plan know of any changes in addresses and contact information. You should keep a copy of any notices you send to all parties and entities for your records.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

If you ask LACERS to contact your health plan on your behalf, you must provide us with your written authorization to do so and allow the health plan to provide LACERS with your health information.

Contact LACERS for your plan's authorization form at LACERS.Health@lacers.org or call LACERS Member Service Center at (800) 779-8328 / RTT (888) 349-3996.

DURABLE POWER OF ATTORNEY

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

- The LACERS Special Durable Power of Attorney form will only cover matters related to your LACERS financial benefits. The form and instructions can be found at lacers.org/post/power-attorney.
- The California Uniform Statutory Form Power of Attorney is sufficient for all your LACERS retirement benefits decisions.
- The Statutory (California or your state) Advance Health Care Directive is a document that enables a Member to designate someone to make health care decisions for them.
- Health plan changes fall under “financial/retirement benefits.” Services/treatments fall under the Advance Health Care Directive.

Without a valid and approved POA on file, only the Member can fill out and sign the LACERS form(s). The same is true for the dependent-specific Senior Form: only the dependent may sign the dependent’s own Senior Form.

MEDICARE INCOME-RELATED MONTHLY ADJUSTMENT AMOUNT (IRMAA)

For IRMAA information, please see Page 12.

TAXABILITY OF YOUR HEALTH BENEFITS

Enrolling non-tax dependents may result in portions of your medical subsidy that is used to cover non-tax dependents to be reported to the IRS as taxable income. Tax dependent definition aligns with the federal tax law definition.

All Retired Members enrolling dependents, and all Eligible Survivors, must complete and submit a *Certification of Dependent or Survivor Status for Health Coverage Form*. This form may be found online at lacers.org/post/health-benefit-forms. If you fail to submit this form, a portion of your medical subsidy may be reported as taxable income. If you do not have internet access, please call the LACERS Member Service Center at (800) 779-8328 / RTT (888) 349-3996.



SUBSIDY CALCULATION WORKSHEET FOR RETIREES WITH MEDICARE PARTS A & B WHO ARE COVERING ELIGIBLE DEPENDENTS

This worksheet will help you understand how to calculate the Retired Member's and the dependent(s)' subsidy portions. This worksheet only applies to Retired Members with Medicare Parts A & B who are covering eligible dependents in their LACERS Medical Plan.*

Eligible Survivors covering eligible dependents do not have a dependent subsidy portion; the Survivor's medical subsidy only covers the Eligible Survivor.

Retired Member's Medicare Status:	Dependent(s)' Medicare Status
Medicare Parts A & B	☐ No Medicare ☐ Part B only ☐ Parts A & B
Retired Member's Medical Plan	Dependent(s)' Medical Plan:

Retired Member Portion of Medical Subsidy			
1	Enter Service Credit years, rounded down to the closest whole year Example: 16.9523 years of Service Credit → 16 years		years
2	From Page 15's "For Retired Members Who Are Age 65 or older with Medicare Parts A & B" chart, refer to Line 1 above and enter the corresponding subsidy percentage.		%
3	Enter your medical plan's 1-Party Premium amount (Page 46)	\$	
4	Retiree Medical Subsidy Portion. Multiply Line 3 with Line 2.	\$	
Dependent Portion of Medical Subsidy (Retiree's Excess Subsidy)			
5	From Page 15's "For Retired Members Who Are Under Age 65, or Age 65 or older with Medicare Part B Only" chart, refer to Line 1 above and enter the corresponding subsidy dollar.	\$	
6	Enter the monthly medical premium amount for the corresponding 1-Party Under 65 medical plan from Page 46.	\$	
7	Dependent Medical Subsidy Portion**. Subtract Line 6 from Line 5. If the amount is negative, enter "0" (zero). LAAC § 4.1111 (e)(4)	\$	
Medical Subsidy Available			
8	Total Medical Subsidy. Add Line 4 and Line 7. This should be the total medical subsidy applied to the monthly medical premium.	\$	
Medical Plan Premium Deduction			
9	Enter the monthly premium amount of the medical plan covering the Retired Member and eligible dependents (Pages 46-48).	\$	
10	Total Medical Deduction. Subtract Line 8 from Line 9. <i>This amount should match one of the Medical Monthly Allowance Deduction (Retired Members) charts located on Pages 54-56.</i>	\$	

* For Retirees with Medicare Parts A & B wishing to cover dependents under age 65 or with Medicare Part B Only, UnitedHealthcare AZ and NV plans are not available options. See Page 26 for available medical plan combinations.

** The Dependent Portion of Medical Subsidy cannot be applied to the Retiree's minimum deduction to zero-out the minimum deduction for Retirees with 10 to 19 years of Service/Service Credit.

FREQUENTLY ASKED QUESTIONS

For more FAQs, visit lacers.org/frequently-asked-questions

LACERS Retiree or Survivor:

Q1. When will I receive my new ID Cards?

A. Medical ID card: You will receive medical ID cards from the medical plan via mail within 7 to 10 business days after your effective date. You and/or your provider may contact the medical plan for your ID number if you need it before your physical card is received.

Dental ID card: Delta Dental PPO does not issue ID cards. The dental provider can verify your eligibility in Delta Dental's system using your name, date of birth, and SSN. *If you are a New Retiree/Survivor, your name will be in the Delta Dental system after your first Retirement Allowance/Continuance check is issued.*

Q2. Will/does LACERS pay my Medicare premiums?

A. No, LACERS does not pay your Medicare premiums. If you are a Retiree with Medicare Parts A & B and meet the eligibility requirements listed on Page 71, LACERS will reimburse the monthly basic/standard Medicare Part B premium only. The Medicare Part B reimbursement appears as a credit on your *Statement of Earnings and Deductions*.

Please ensure you pay your premiums by contacting the Social Security Administration (SSA) and/or Medicare. *If you do not pay your Medicare premiums, refer to Pages 12 and 13 for the consequences.* If you have questions regarding your Medicare premium bill, please contact SSA or Medicare. Their contact information is on the back cover of this Guide.

Active City of Los Angeles Employee who submitted required retirement documents:

Q1. Do I need to do anything?

A. Yes, because LACERS Health Plan enrollment is **NOT** automatic. Active coverage ends the month of your retirement, or if your retirement date is the first of the month then it ends the previous month. *If you do not complete the LACERS health enrollment forms to have coverage, you will not have coverage until next year, unless you experience a Qualifying Event. See Pages 8-10 for general information and Pages 6-7 for documents required for dependent eligibility verification.*

Q2. Can my health insurance stay the same?

A. No, because the Active Employees' medical carrier options, benefits, premiums, and subsidies are different with what is offered to Retired Members. This Guide summarizes the retiree health benefits, premiums, and subsidies.

Q3. Why am I seeing double deductions on my first Retirement Allowance/Continuance check?

A. LACERS' medical premiums are prepaid before the first day of coverage. Your health insurance coverage is effective before you receive your first retirement allowance check from LACERS, so your first retirement check will have two months' worth of deduction (past month and prepaid).

For example: Your retirement date is 7/21/2027. Your completed LACERS health enrollment forms with all required documents are for an effective date of 8/1/2027. But your first retirement allowance is 8/31/2027, so it will have deductions for the months of August (past) and September (prepaid).

Q4. I didn't use up all of my retiree health subsidy. What happens to the remaining amount?

A. The subsidy is strictly used to offset the premium cost only. Any unused subsidy cannot be received as cash compensation. LACERS does not have an equivalent program to the Employee Benefits' Cash-in-Lieu program.



Type and Contact Information		Hours
	Phone: (800) 779-8328 RTT: (888) 349-3996 Fax: (213) 473-7284	Mon/Wed/Thur/Fri: 7 a.m. – 3:30 p.m. Tues: 7 a.m. – 3 p.m.
	Mailing Address: 977 N. Broadway, Los Angeles, CA 90012-1728	—
	In-Person Appointments / Document Drop-Off: 977 N. Broadway, Los Angeles, CA 90012-1728	Mon-Fri: 8 a.m. – 4 p.m.
	Virtual Appointments: By Appointment, via Zoom	Mon-Fri: 8 a.m. – 4 p.m.
	General questions: LACERS.Services@lacers.org Health plan questions: LACERS.Health@lacers.org	—
	Website: LACERS.org MyLACERS Portal: https://mylacers.lacers.org Secure Document Upload: lacers.org/secure-upload YouTube: youtube.com/@lacersofficial	Available 24/7

RESOURCES AND CONTACT INFORMATION

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