2022 HEALTH BENEFITS GUIDE

LACERS
LA CITY EMPLOYEES' RETIREMENT SYSTEM

LACERS Health Benefits

This booklet is a reference guide of the retiree health benefits and health plan options offered by the Los Angeles City Employees' Retirement System (LACERS). The services to be provided shall be in accordance with agreements between the health plan carriers and LACERS. As the Program Administrator, the LACERS Board of Administration reserves the right, as provided in Chapter 11, Division 4 of the Los Angeles Administrative Code, to terminate any plan benefits at the beginning of any plan year, or at any time, when, in the opinion of the Board, it is necessary for the administration of any individual plan or the medical and dental program. Contact LACERS if you would like the appropriate Service Agreement, Evidence of Coverage, or Certificate of Insurance for a LACERS-sponsored plan. In the event of any discrepancies between this document and the various ordinances governing the receipt of health benefits or reimbursements, the legal text found in the ordinances shall govern at all times.

Health Insurance Portability and Accountability Act (HIPAA)

Effective April 2003, HIPAA, a federal privacy rule for health information, placed strict limits on how your health information can be used. 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 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.

LACERS
LA CITY EMPLOYEES' RETIREMENT SYSTEM

Los Angeles City Employees' Retirement System
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Email Health Plan Questions: LACERS.health@lacers.org
Email General Questions: LACERS.services@lacers.org
Website: www.LACERS.org
MyLACERS Portal: https://mylacers.lacers.org

About Your Health Benefits

2022 Retired Member Health Benefits Guide

LACERS health benefits are for Retired Members and eligible Survivors. Use this Guide as your resource to:

- Familiarize yourself with your eligibility for benefits;
- Compare medical and dental plans;
- Help you with enrollment in LACERS-sponsored health plans; and
- Change your and your eligible dependents' health plan coverage.

We encourage you to keep this Guide as a reference for the 2022 plan year.

Subscribe to the Official LACERS YouTube Channel

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

Take Advantage of Your MyLACERS Online Account

Keep track of your personal LACERS information such as your service and service credit, beneficiaries on file, and correspondence with LACERS staff through your secured online account. Opening and maintaining a secured MyLACERS account provides you access to your confidential information that is less vulnerable to a hacking attempt. As a retiree, your MyLACERS account is also the easiest way to view, download, and print your Direct Deposit statements and 1099-R tax forms. Don't have a MyLACERS account yet? Request a PIN be mailed to you by visiting the LACERS website to get started.

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 will only cover matters related to your LACERS' financial benefits.

A California Uniform Statutory Form Power of Attorney is also sufficient for all LACERS' retirement and health benefits decisions.

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Health Plan Eligibility

Retired Member Eligibility

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

Eligible Dependents[1]

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

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

A "dependent child" includes:

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

Dependent Eligibility Verification

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

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

Domestic Partnership Eligibility

In order for your domestic partner and the children or your domestic partner to be eligible for a LACERS health plan, you must have one of the following:

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

Survivor Eligibility

Your eligible Surviving Spouse/Domestic Partner (Survivor) who receives a Continuance or a Survivorship allowance from LACERS is also eligible to enroll in LACERS' health plans. (Additional Information on page 13)

Former spouses and domestic partners of Retired Members are <u>not</u> eligible to enroll in LACERS' health plans.

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

Enrolling in a Health Plan

When to Enroll

Generally, you may enroll in a LACERS health plan:

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

Open Enrollment Period

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

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

Last Year - Extended Open Enrollment Period

Due to unusual circumstances, in 2020 LACERS had an extended Open Enrollment period. In 2021, we return to normal. Retired Members/Survivors requesting changes to medical and/or dental plans, adding dependents, or new enrollments from those not previously enrolled will be accepted from October 15 through November 15, 2021.

Due to those unusual circumstances in 2020, Retired Members/Survivors who made plan changes/added dependents/enrolled anew may not be eligible to participate in this year's Open Enrollment if those previous changes went into effect after January 31, 2021. Absent a recognized Qualifying Event, these Retired Members/Survivors may not make plan changes or add dependents until the 2023 Open Enrollment Period (October-November of 2022).

Qualifying Events

A qualifying event is an unusual occurrence that triggers a special enrollment period for an individual or family to enroll in LACERS coverage outside of the regular annual Open Enrollment period. Qualifying Events include such life events as the birth or adoption of a child, moving out of/into a LACERS HMO service area, getting married, and involuntarily losing health coverage. If you experience a Qualifying Event, you may enroll or change plans within:

- 60 days of the Retiree turning age 55
- 90 days of the Retiree turning age 65 (based on Medicare eligibility)
- 30 days of relocation out of or into a LACERS HMO plan zip code service area
- 30 days of a LACERS HMO plan zip code service area becoming available or unavailable
- 30 days of being involuntarily terminated from a non-LACERS medical plan (LACERS requires proof of termination)

Selecting a Health Plan and Enrolling

1. Review the premiums, subsidies, deductions, and benefit information provided in this Guide to understand the benefits each plan offers and any costs you may have.
2. Make your medical and/or dental plan selections.
3. Obtain health plan enrollment forms from www.lacers.org, by emailing LACERS Health Benefits directly at lacers.health@lacers.org, or by calling (800) 779-8328.
4. Complete all applicable sections of the health plan enrollment forms.
5. Submit your completed forms back to LACERS as described on the forms.

Family Account Changes

When Your Health Plan Coverage Begins

Your health coverage starts:

- The first of the month following your retirement effective date; or
- The first of the month following the processing of your enrollment request

Canceling Your Health Plan

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

Adding a New Dependent

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

You have 30 days from the date of your family status change to add a new dependent to your health plan. To add a new dependent, you must complete and submit a *LACERS Medical/Dental Plan Family Account Change Form* and a *Certification of Dependent or Survivor Status for Health Coverage Form.* Both forms are available online at LACERS.org. Your dependent's health plan coverage will begin on the first day of the month after your form is processed. A completed Family Account Change Form must be received by the 10th of the month in order for the coverage to be effective the first of the following month. If your dependent(s) have Medicare (A&B or B, only), Senior Plan Enrollment Form(s) are required and due by the 10th of the month.

If your dependent is Medicare-eligible, additional forms will be required to enroll in a LACERS medical plan. These forms are available upon request by contacting LACERS Health Benefits Division.

Deleting a Dependent

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

Health plan enrollment forms are available from www.lacers.org, upon request by emailing lacers.health@lacers.org, or by calling (800) 779-8328.

Family Account Changes (continued)

Deleting an Ineligible Dependent

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

LACERS reserves the right to terminate your dependent's health plan coverage should we discover your dependent is no longer eligible to participate in a LACERS health plan.

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

Medicare and LACERS Health Benefits

Medicare Part B Enrollment

Upon turning age 65, Retirees and/or dependents are **required** to enroll in and maintain Medicare Part B in order to qualify for a LACERS medical plan premium subsidy and to enroll/remain enrolled in a LACERS medical plan (as provided in the Los Angeles Administrative Code {Secs. 4.1111(f) and 4.1126(c) and LACERS Board Rules (HBA 2.d)).

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

Please note: Retirees and dependents who do not use standardized legal names for all governmental systems (e.g., use different names for different systems, such as "Joe" in LACERS' system, but "Joseph" with the Social Security Administration) may have difficulty when enrolling. This is especially possible when there is a mismatch in names when applying for Medicare and enrolling in a LACERS Medicare plan. Name mis-matches can result in delays/denials in enrolling. Please be sure to provide only standardized names on enrollment documents.

Medicare Part A Enrollment

If you qualify for Medicare Part A premium free, you are **required** to enroll in Part A. If you are not entitled to Medicare Part A premium free, you are **not required** to enroll in Medicare Part A.

You may receive Medicare Part A premium-free if you:

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

Contact your local Social Security Administration (SSA) office to determine if you are eligible for Medicare Part A premium-free.

Proof of Medicare Enrollment

Once enrolled in Medicare, provide a copy of your Medicare card or Social Security Administration Benefit Verification Letter to LACERS with the proper completed Senior Plan Enrollment forms. Maintain your Medicare enrollment by paying your monthly Medicare Part B premiums.

If you do not enroll in Medicare by age 65 ***AND*** *maintain your Medicare coverage, your LACERS medical plan premium subsidy will cease, you may be charged additional premiums, and your existing LACERS medical plan coverage will be terminated. Additionally, the Centers for Medicare & Medicaid Services (CMS) may charge you ongoing late enrollment penalties and LACERS may collect from you out of your retirement allowance all medical premiums paid on your behalf while you were ineligible for a subsidy.*

Exception — Living Outside the U.S.

You may not need to enroll in Medicare if you reside permanently outside the U.S. and Its Territories. However, you may be penalized if you do not enroll in Medicare or allow your Medicare premium payments to lapse and later decide to reside in the U.S. Contact the SSA regarding Medicare rules, regulations, or penalties that may affect your medical plan coverage.

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

Medicare and LACERS Health Benefits (continued)

Medicare Part B Reimbursement

LACERS will reimburse the Retired Member for the basic Medicare Part B premium if the Retired Member is:

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

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

Please note that LACERS does not reimburse Survivors or dependents any part of their Medicare Part B premium. However, a retired Member enrolled as a dependent in a LACERS medical plan who meets the definition of an Eligible Retiree as provided in LAAC Section 4.1113(b) shall be eligible for the basic Medicare Part B premium reimbursement and shall be subject to and responsible for complying with the Board Rules, Administrative Policies and Procedures, and contract provisions.

Exception – Out-of-Country Retirees

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

Medicare Part D

Do not enroll in Medicare Part D separate from your LACERS plan.

Medicare Part D is already integrated into your LACERS medical plan. Enrolling or disenrolling in Medicare Part D on your own or through a non-LACERS group plan will cause your LACERS medical coverage to be terminated and will make you ineligible for a LACERS medical plan subsidy.

Exception — Medical Premium Reimbursement Program

If you are enrolled in the Medical Premium Reimbursement Program and your non-LACERS plan does not include Medicare Part D, you should enroll in supplemental Medicare Part D insurance in order to maintain creditable coverage.

Medicare Part D Low Income Subsidy

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for extra help, call the Centers for Medicare & Medicaid Services (CMS), the Social Security Administration (SSA), or your state's Medicaid office. The contact information for CMS and SSA are provided on the back cover of this Guide. Please check the internet for contact information for your state's Medicaid office.

Medicare and LACERS Health Benefits (continued)

Income-Related Monthly Adjustment Amount (IRMAA) and Modified Adjusted Gross Income (MAGI)

CMS assesses higher-income earning Medicare enrollees an Income-Related Monthly Adjustment Amount (IRMAA) based on their Modified Adjusted Gross Income (MAGI), which is added to their Medicare Part B and Part D basic premium rates.

Important: You must pay any Medicare Part B and Part D surcharges assessed by CMS or your Medicare Part B and Part D enrollment will be canceled. Because you are required to maintain your Medicare enrollment in order to continue receiving your LACERS medical plan premium subsidy, failure to pay your IRMAAs to CMS will result in the termination of your LACERS medical benefits.

Note: LACERS does not apply your medical subsidy toward, or reimburse to you, any Medicare-related IRMAA costs.

Medicare Part D Late Enrollment Penalty (LEP)

Medicare Part D provides enrollees prescription drug coverage and LACERS requires all retirees to enroll in Medicare Part D when they first become eligible. If you did not enroll in Medicare Part D (i.e., through a LACERS group plan) at the time you were first eligible or did not have prescription drug coverage at least equivalent to Medicare prescription drug coverage, you will pay a penalty assessed by CMS. You will have to pay this penalty for as long as you are enrolled in Medicare Part D, even if you later enroll in a LACERS medical plan.

If CMS determines that you and/or your dependent are subject to the Medicare Part D Late Enrollment Penalty (LEP), CMS will notify your LACERS medical plan to begin the collection process. In turn, your medical plan will notify you of the LEP and request LACERS to submit the LEP payment. Since your LACERS subsidy covers only the basic medical premium, and not any penalties assessed by Medicare, the LEP amount must be taken from your retirement allowance.

Please be advised that for any Late Enrollment Penalty issues, you must contact CMS directly at (800) MEDICARE [(800) 633-4227].

Termination Due to Medicare Lapse

If you lapse on your Medicare Part B premiums and are terminated from your LACERS medical plan, your and your dependents' Medicare Part D will also be canceled. Your LACERS medical subsidy will terminate, your basic Medicare Part B premium reimbursement terminates, and Kaiser Senior Advantage Members will be charged the full monthly Non-Medicare plan premium retroactively to the date that Medicare coverage ended. CMS may assess lifetime penalties when you re-enroll in Medicare Part B and Part D.

CMS Medicare Plan Requirement

The Centers for Medicare & Medicaid Services (CMS) allows you to have only one Medicare Advantage plan or Medicare Part D Prescription Drug plan. If you enroll in a Medicare Advantage or a Medicare Part D Prescription Drug plan outside of your LACERS medical plan, you will lose your LACERS medical coverage, even if you enroll in a plan from the same insurance company but sponsored by a different organization (for example, the CALPERS Kaiser Permanente Senior Advantage HMO plan).

Consider the Medicare Easy Pay Program to avoid a lapse in coverage. www.medicare.gov (800) MEDICARE [(800) 633-4227]

Your LACERS Medical Subsidy

Member Subsidy Eligibility

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

Subsidy amounts are set annually by the LACERS Board of Administration or by ordinance, pursuant to the authority granted by the Los Angeles Administrative Code. Your subsidy amount is based on your whole years of Service and Service Credit, age, and Medicare status.

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

Medical Plan Premium	–	Subsidy	=	Retirement Allowance Deduction

In order to be eligible for a medical subsidy, you must:

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

* **Example:** If you are age 55+ and worked full-time or part-time for the City for 10 years and 11 months, you would have 10 whole years of Service. Alternatively, if you worked full-time or part-time for the City for 9 years and 11 months, you would NOT be eligible for a subsidy.

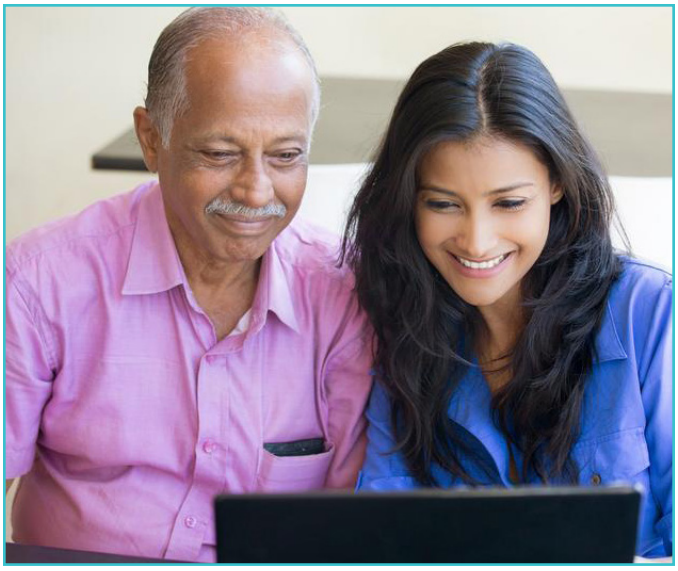
How Your Medical Subsidy is Calculated

For Retired Members who are:

- **Under Age 65 or**
- **Age 65 or older with Medicare Part B only**

Full-time employees receive 4% of the maximum medical subsidy for each year of Service Credit (a minimum of 10 years of Service is required). Any balance of the subsidy not used for your Retired Member coverage may be applied toward the cost of your dependent's medical plan coverage. Any unused subsidy cannot be received as cash compensation.

Part-time employees who have at least 10 years of Service are eligible to receive 40% of the maximum medical subsidy. For each year of Service Credit above ten years, you receive an additional 4% of the maximum medical subsidy. For more information on eligibility and how to calculate your medical subsidy, please contact LACERS.



Your LACERS Medical Subsidy (continued)

Service Credit	% of Maximum Subsidy	2022 Subsidy Amount
1 - 10	40%	$753.80
11	44%	$829.18
12	48%	$904.56
13	52%	$979.94
14	56%	$1,055.32
15	60%	$1,130.70
16	64%	$1,206.08
17	68%	$1,281.46
18	72%	$1,356.84
19	76%	$1,432.22
20	80%	$1,507.60
21	84%	$1,582.98
22	88%	$1,658.36
23	92%	$1,733.74
24	96%	$1,809.12
25+	100%	$1,884.50

Any balance of subsidy not used for retiree coverage may be applied toward the cost of the dependent health plan coverage.

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

For Retired Members who are age 65 or older with Medicare Parts A and B

If you are enrolled in Medicare Parts A and B, your maximum monthly subsidy amount will be based on your years of Service Credit and the one-party premium of the LACERS Senior Plan in which you are enrolled:

Service Credit	% of Maximum Subsidy
1-14	75% of one-party Monthly Premium
15-19	90% of one-party Monthly Premium
20+	100% of one-party Monthly Premium

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

Taxability of Your Medical Subsidy

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

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

Any portion of your medical subsidy that is used to pay for coverage for any other individual who is not your tax dependent may be taxable.

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

Your subsidy may be taxable if it is used to cover a child who is a child of a domestic partner.

All Retired Members and eligible Survivors must complete and submit a *Certification of Dependent or Survivor Status for Health Coverage Form* when adding medical plan dependents. This form is available at lacers.org or by calling (800) 779-8328.

Consult your tax advisor or the Internal Revenue Service for more information.

Eligible Survivor Benefits

Survivor Eligibility

An eligible Survivor is the surviving spouse or domestic partner of a:

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

Or

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

An eligible Survivor may continue receiving medical and/or dental coverage at the time of death of a LACERS Member if he/she:

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

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

Eligible Survivor Medical Subsidy

The eligible Survivor subsidy is based on:

1. The Member's years of Service Credit (minimum of 10 years of Service)
2. When the deceased Member would have turned age 55*
3. The Survivor's eligibility for Medicare

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

How a Medical Subsidy is Calculated for an Eligible Survivor

If an eligible Survivor is:

- **Under age 65** or
- **Age 65 or older with Medicare Part B only**

The maximum monthly medical subsidy amount will be equivalent to the lowest cost standard plan one-party Non-Medicare monthly premium. In order for the eligible Survivor to receive this amount, the Member must have had at least 25 years of Service Credit. Otherwise, the eligible Survivor may receive 4% of the maximum subsidy for each year of your Service Credit (a minimum of ten years of Service is required).

The medical subsidy may only be applied toward the eligible Survivor participating in a LACERS medical plan or the MPRP. Any unused subsidy cannot be received as cash compensation or used to cover the cost of the health plan for a dependent. Eligible Survivors must pay the full cost of their dependents' premiums through deductions from their monthly Continuance or Survivorship allowances.

Eligible Survivor Benefits (continued)

Eligible Survivor Subsidy Table, Under 65 or 65 and Over with Medicare Part B, Only

Service Credit	% of Maximum Subsidy	2022 Subsidy Amount
1 - 10	40%	$360.10
11	44%	$396.11
12	48%	$432.12
13	52%	$468.12
14	56%	$504.13
15	60%	$540.14
16	64%	$576.15
17	68%	$612.16
18	72%	$648.17
19	76%	$684.18
20	80%	$720.19
21	84%	$756.20
22	88%	$792.21
23	92%	$828.22
24	96%	$864.23
25+	100%	$900.24

In order to quality for a subsidy the Member must have at least 10 years of Service.

If your eligible Survivor is age 65 or older with Medicare Parts A and B

The maximum monthly medical subsidy amount will be equivalent to the one-party monthly premium of the LACERS Senior Plan in which the eligible Survivor is enrolled. In order for the eligible Survivor to receive this amount, the Member must have had at least 20 years of Service Credit.

Eligible Survivors are not eligible to receive any medical subsidy toward coverage for their dependents; they must pay the full cost of their dependents' premiums through deductions from the monthly Continuance or Survivorship allowances.

Service Credit	% of Maximum Subsidy
1-14	75% of one-party Monthly Premium
15-19	90% of one-party Monthly Premium
20+	100% of one-party Monthly Premium

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

Dental Subsidy

Survivors are not eligible for a dental subsidy. However, they may enroll in a LACERS dental plan and have the monthly premium deducted from their Continuance or Survivorship allowance. See pages 48-51 for Dental Benefits information.

Medical Premium Reimbursement Program (MPRP)

Medical Premium Reimbursement Program

LACERS MPRP is available to you if you meet all of the following four criteria:

1. Reside more than three months out of the year (based on your home address on file with LACERS):
   - Outside of California, and within the U.S. & Its Territories; or
   - Within California, but outside the authorized zip code service areas of a LACERS HMO or Medicare Advantage HMO Plan.
2. Have at least 10 years of Service.
3. Are at least age 55 or older.
4. Are not enrolled in a LACERS medical plan.

Under this program, LACERS may reimburse you up to the amount of your monthly medical subsidy for medical premiums you pay to a federally-qualified HMO or state-regulated non-LACERS medical plan. You may also be reimbursed for vision insurance and Medicare Part D premiums if they are not part of your non-LACERS medical plan. Premium reimbursements are paid on a quarterly basis upon submission of MPRP claim forms.

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

2022 MPRP Maximum Reimbursement		
Medicare Status	**Member Subsidy**	**Survivor Subsidy**
Under 65 or Part B only	$1,884.50	$900.24
Medicare Parts A & B	$494.67	$494.67
Medicare Parts A & B and covering dependent	$1,130.97	N/A

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

Your eligible Survivor may participate in the MPRP based on your eligibility.

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

Any Member who receives a rebate of any portion of his/her medical plan premium for which the Member has been reimbursed by LACERS under the MPRP shall report the rebate to LACERS and provide supporting documentation. Should LACERS become aware of a rebate made to a Member for medical plan premiums reimbursed under the MPRP, and should the Member refuse to reimburse LACERS for its portion of the rebate as calculated in Board Rule HBA 5.0(f), the portion of the rebate due to LACERS shall be included in the Member's taxable income reported to the IRS and the State of California (if applicable).

COBRA

COBRA

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

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

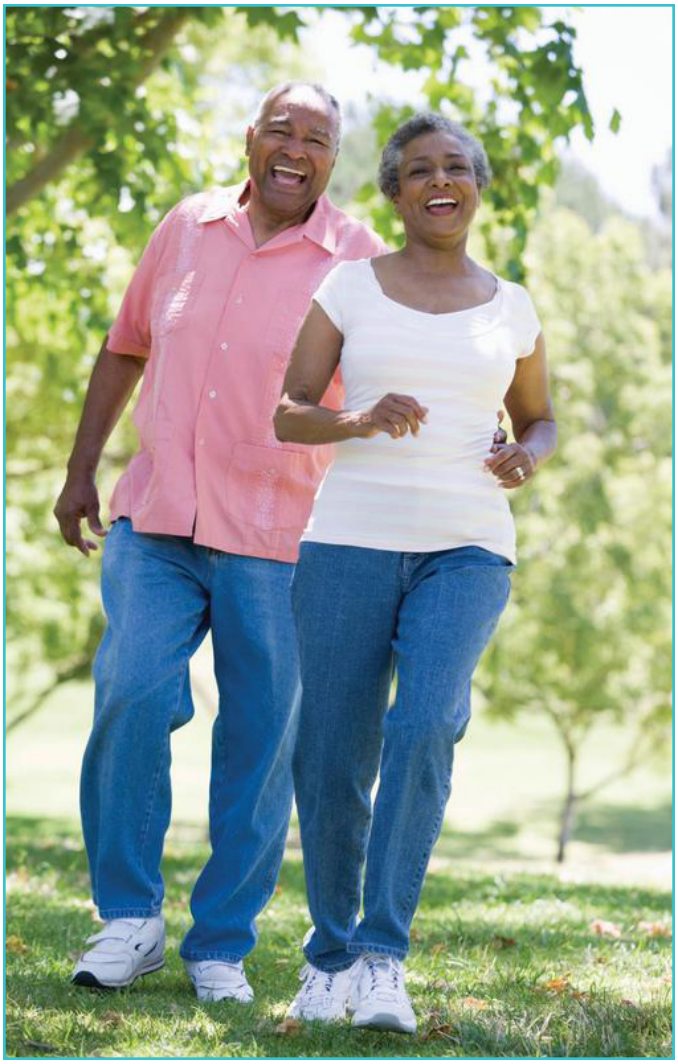
You must inform LACERS within 60 days of the COBRA qualifying event or your dependents will lose their rights to continue their coverage. LACERS will notify your dependents of their rights to continue coverage and payment procedures.

Your dependents will have:

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

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

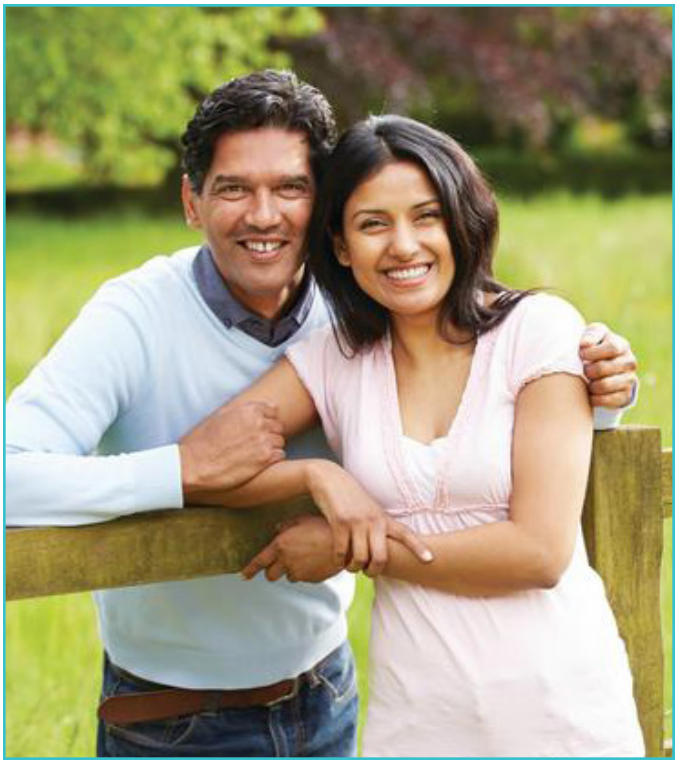
- LACERS no longer offers medical or dental coverage;
- The monthly premium is not paid within the 30-day grace period;
- Your dependents enroll as employees in another group plan;
- Your spouse/domestic partner remarries or enters into a new domestic partnership and is covered under another plan; or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



Settling Disputes

Settling Disputes

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



Arbitration

Anthem Blue Cross HMO, Kaiser Permanente HMO and Senior Advantage, SCAN Health Plan, and UnitedHealthcare medical plans, and the DeltaCare USA 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, Members 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).

LACERS Health Benefit Options

The medical plan choices available to you and your dependents are based on where you live and your and/or your dependents' age and Medicare status:

- Under Age 65
- Age 65 or older with Medicare Part B Only
- Age 65 or older with Medicare Parts A and B
- Dual Care Households
- Living Outside the U.S. and Its Territories

Medical Plan Choices

If you are under age 65:

- Kaiser Permanente HMO (CA only)[1]
- Anthem Blue Cross PPO
- Anthem Blue Cross HMO (CA only)[1]

If you are age 65 or older with Medicare Part B only:

- Kaiser Permanente Senior Advantage HMO (CA only)[1]
- Anthem Blue Cross PPO
- Anthem Blue Cross HMO (CA only)[1]

If you are age 65 or older with Medicare Parts A and B:

- Kaiser Permanente Senior Advantage HMO (CA Only)[1]
- Anthem Blue Cross Medicare Preferred (PPO) Plan
- SCAN Health Plan (CA)[1,2]
- UnitedHealthcare Medicare Advantage HMO (CA, AZ, & NV)[1]

Dual Care Households (at least one subscriber age 65 or older with Medicare Parts A and B and one subscriber under age 65, or age 65 or older with Medicare Part B only):

- Anthem Blue Cross PPO + Anthem Blue Cross Medicare Preferred (PPO) Plan
- Kaiser Permanente HMO + Kaiser Permanente Senior Advantage HMO (CA only)[1]
- Anthem Blue Cross HMO + SCAN Health Plan (CA only)[1,2]
- Anthem Blue Cross HMO + UnitedHealthcare Medicare Advantage HMO (CA only)[1]

If you are living outside the U.S. and Its Territories:

- Anthem Blue Cross PPO Out-of-Country Plan[1,3]

Dental Plan Choices

- Delta Dental PPO℠
- DeltaCare® USA HMO

Medical Premium Reimbursement Program (MPRP)

If you are living outside of a LACERS HMO zip code service area or outside California, LACERS may reimburse the medical premiums you pay to a federally qualified HMO or state-regulated non-LACERS medical plan.

1. Available in authorized zip code service areas only. Contact the medical plan to verify that your zip code is a covered area.
2. Available in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco, Santa Clara, Napa, Sonoma, Stanislaus and Ventura counties in California.
3. The Anthem Blue Cross PPO non-Medicare premium rates and deductions apply outside the U.S. Medicare Part B premiums are not reimbursed while residing outside the U.S.

LACERS Medical Plans

Preferred Provider Organization (PPO)

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

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

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

Health Maintenance Organization (HMO)

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

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

Your PCP will:

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

For Members Who Are Under Age 65

Anthem Blue Cross HMO (CA Only)

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

Kaiser Permanente HMO (CA Only)

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

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

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

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

LACERS Medical Plans (continued)

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

LACERS offers Senior Plans for Medicare-eligible Retired Members who reside in the United States and Its Territories.

For Members enrolled in Medicare Part B only, LACERS offers:

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

For Members enrolled in Medicare Parts A and B, LACERS offers four Medicare Advantage HMO plans and one Medicare PPO plan:

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

Medicare Advantage HMO Plans

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

A Medicare Advantage plan is an HMO medical plan with a Medicare contract. Instead of receiving benefits from Medicare, you receive benefits directly from the Medicare Advantage HMO plan. The physicians and hospitals under these plans are Medicare-approved. In some cases, a Medicare Advantage HMO plan provides more benefits than traditional Medicare Parts A and B.

Kaiser Permanente Senior Advantage HMO, SCAN Health Plan, and UnitedHealthcare HMO are Medicare Advantage HMO plans. You coordinate your care through a Primary Care Physician (PCP) whom you choose from a network of participating physicians.

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

Medicare Preferred (PPO) Plan

Anthem Blue Cross Medicare Preferred (PPO) Plan

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

Members and dependents covered by the Anthem Blue Cross Life and Health Medicare Plan (Medicare Supplement Plan) will be automatically enrolled in this new plan as of January 1, 2022. You don't have to do anything. It is recommended that you inform your doctor's office about the transition to this new plan as soon as possible so that there is no confusion with coverage when the new plan takes effect on January 1, 2022.

Rather than transitioning, Members can choose another plan offered by LACERS by opting out of the Anthem Medicare Preferred (PPO)

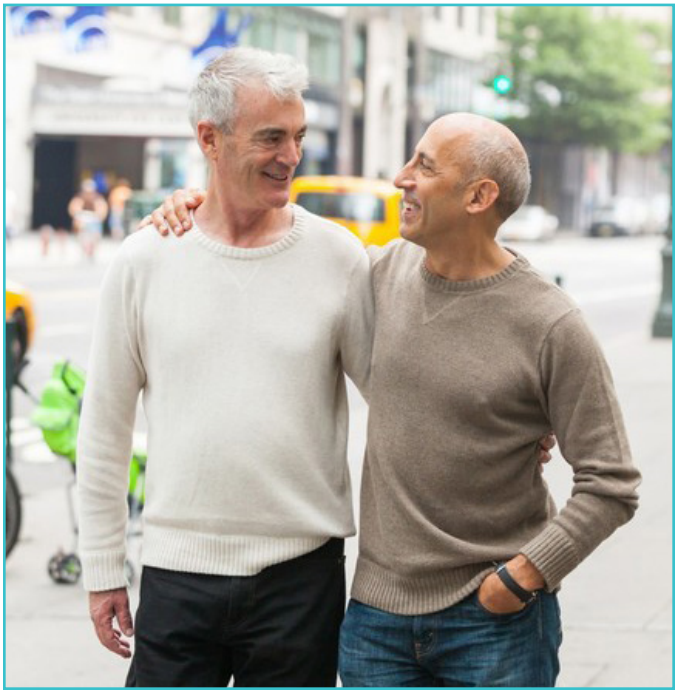
LACERS Medical Plans (continued)

during the Open Enrollment period October 15 – November 15, 2021. By opting out of the Anthem Medicare Preferred (PPO), Members will be responsible for electing an available alternative plan.

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

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

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



For Members Residing Outside the U.S. and Its Territories

Anthem Blue Cross PPO Out-of-Country

The Anthem Blue Cross PPO Out-of-Country medical plan is the only LACERS medical plan available to you if you reside permanently outside the U.S.[1]

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

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

LACERS Medical Plans (continued)

Premium and Deduction Amounts

For Members residing outside the U.S., the premium and deduction amounts for the LACERS Anthem Blue Cross PPO Out-of-Country Plan are the same as those for the LACERS non-Medicare Anthem Blue Cross PPO plan for Members under age 65, regardless of the age or Medicare status of the Member.

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

Living Abroad and Medicare

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

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

Anthem Blue Cross PPO Out-of-Country prescription drug coverage provides creditable coverage equivalent to Medicare Part D benefits, so you will not be penalized by Medicare for not having Medicare Part D while out of the country. Because you will not be enrolled in a Medicare plan, LACERS will not reimburse your Medicare Part B premiums while you are enrolled in the Anthem Blue Cross PPO Out-of-Country plan.

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

Care Management Programs

If you have chronic health issues, LACERS medical plans offer care management and disease management programs. Many of these programs have been recognized by national organizations for excellence and effectiveness. For more information, contact your health plan provider.

LACERS Vision Plans

Kaiser Permanente

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

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

Kaiser Permanente Vision Benefit

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

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

See Vision Plan Comparison Chart on page 35.

Anthem Blue View Vision

If enrolled in a LACERS medical plan other than Kaiser Permanente, vision coverage is provided by Anthem Blue View Vision.

Anthem Blue View Vision in-network coverage includes an annual routine eye exam (every 12 months) after your copayment is met. In addition, eyeglass lenses (every 12 months), frame allowance (every 24 months), or contacts (every 12 months) are covered up to the plan allowances. When you see a Blue View Vision doctor, you'll get the most out of your Anthem Blue View Vision benefit and have lower out-of-pocket costs.

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

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

Out of Network Claims Department
Anthem Blue View Vision
Mail: Attn: OON Claims, P.O. Box 8504
Mason, OH 45040-7111
Fax: (866) 293-7373
Email: oonclaims@eyewearspecialoffers.com

Medical Plan Comparison Charts

Retired Members, Dependents and Survivors under Age 65

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

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

Medical Plan Comparison Charts (continued)

Retired Members, Dependents and Survivors under Age 65

Summary of Benefits	Anthem Blue Cross PPO		Anthem Blue Cross HMO	Kaiser Permanente HMO
	Network Benefits	Non-Network Benefits		
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	$20 copay
Dialysis & ESRD Services				
Skilled Nursing Facility *(limit 100 days/calendar year)*			No charge	No charge[2]
Home Health Care	Anthem pays 90% after deductible; limit up to 60 visits/calendar year	Anthem pays 70% UCR[1] after deductible; limit up to 60 visits/calendar year	No charge; limit up to 100 visits/calendar year	No charge[2]
Hospice Services	Anthem pays 80% after deductible; contact Anthem Blue Cross member services for details		No charge; limits apply	No charge
Ambulance	Anthem pays 90% after deductible	Anthem pays 70% UCR[1] after deductible	No charge	No charge[3]
Durable Medical Equipment				No charge; formulary applies
Chiropractic Services *(limit 30 visits/calendar year)*	$20 copay		$20 copay	$15 copay
Acupuncture Services *(limit 30 visits/calendar year)*	$20 copay		$20 copay	$15 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			$20 copay	$20 copay

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

Medical Plan Comparison Charts (continued)

Retired Members, Dependents and Survivors under Age 65

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

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

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

Medical Plan Comparison Charts (continued)

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

Summary of Benefits	Anthem Blue Cross PPO (Medicare)		Anthem Blue Cross HMO (Medicare)	Kaiser Permanente Senior Medicare Advantage HMO
	Network Benefits	Non-Network Benefits		
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

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

Medical Plan Comparison Charts (continued)

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

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

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

Medical Plan Comparison Charts (continued)

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

Summary of Benefits	Anthem Blue Cross PPO (Medicare)		Anthem Blue Cross HMO (Medicare)	Kaiser Permanente Senior Medicare Advantage HMO
	Network Benefits	Non-Network Benefits		
Mental Health (MH)[2]/Chemical Dependency (CD)[2]				
Inpatient	Anthem pays 90% after deductible (MH/CD)	Anthem pays 80% UCR[1] after deductible (MH/CD)	No charge (MH/CD)	No charge per admission as covered by Medicare (MH/CD)
Outpatient	Anthem pays 50% after deductible (MH/CD)	Anthem pays 50% after deductible (MH/CD)	$20 office visit copay (MD & CD); No Charge Facility (MD & CD)	$15 copay; $7 copay (MH), $5 copay (CD) for group visits; unlimited
Hearing Services				
Hearing Exam	Covered under your Routine Physical Examination Benefit		$20 copay	$15 copay
Medically Necessary Hearing Aid *(every 3 calendar years)*	No deductible: up to $2,000 per ear every 36 months		up to $2,000 per ear every 36 months	$2,000 limit per ear every 36 months
Retail Prescription Drugs[4]	*Up to 30-day supply[4,5]*		*Up to 30-day supply[4,5]*	*Up to 100-day supply*
Generic	$0 copay for select generics/ $5 copay generics	See Evidence of Coverage	$10 copay	Generic- $15 Brand- $15
Preferred Brand	$25 copay		$30 copay	
Non-Preferred Brands/ Non-Formulary	$50 copay		$50 copay	Not applicable
Mail Order[3,4] Prescription Drugs			*Up to 90-day supply[3,4,5]*	*Up to 100-day supply*
Generic	$0 copay for select generics/ $10 copay generics[7]	Not covered	$20 copay[7]	Generic- $15 Brand- $15
Preferred Brand	$50 copay		$60 copay	
Non-Preferred Brands/ Non-Formulary	$100 copay		$100 copay	Not applicable
Specialty Tier	Copay of 20% coinsurance with a maximum copay of $100	Copay of 20% coinsurance with a maximum copay of $100	Copay of 20% coinsurance with a maximum copay of $100	Not applicable

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

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

Medical Plan Comparison Charts (continued)

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

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

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

Medical Plan Comparison Charts (continued)

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

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

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

Medical Plan Comparison Charts (continued)

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

Summary of Benefits	Anthem Blue Cross Medicare Preferred (PPO)	Kaiser Permanente Senior Medicare Advantage HMO	SCAN Health Plan Medicare Advantage HMO	UnitedHealthcare Medicare Advantage HMO
Emergency Room Visit	No charge in U.S. and while traveling	$50 copay; waived if admitted[6]	$50 copay; waived if admitted	$50 copay; waived if admitted
Urgent Care Visit		$15 copay	$10 copay	$15 copay
Transportation	12 one-way trips per calendar year; limits apply, advance notice required[1]	24 one-way trips per calendar year; limits apply, advance notice required[1]	Unlimited rides; 75-mile maximum radius; $0 copay[1]	Up to 30 one-way trips per year to medical appointment/pharmacy, up to 50 miles away[1]
Home Delivered Meals	Up to 14 meals per qualifying event, up to four events per year, no charge[1]	Up to 84 meals, three meals/day for a four-week period, one instance/year[1]	Unlimited, no charge[1]	Three meals/day for four-week period following discharge, when referred by case manager[1]
Mental Health (MH)[1]/Chemical Dependency (CD)[1]				
Inpatient	No charge/admission as covered by Medicare; unlimited (MH/CD)	No charge/admission as covered by Medicare; unlimited (MH/CD)	No charge/admission as covered by Medicare; unlimited (MH/CD)	No charge (MH/CD); unlimited
Outpatient	No charge for Medicare-covered therapy/hospitalization	$15 copay; $7 copay (MH), $5 copay (CD) group visits; unlimited	No charge; unlimited (MH/CD)	$15 copay; unlimited visits
Hearing Services				
Hearing Exam	No charge[1]	$15 copay	$10 copay	No charge
Medically Necessary Hearing Aid	No deductible; up to $2,000 per ear every 36 months	$2,000 allowance per ear every 36 months	$4,000 limit; for one or two hearing aids every two years	No deductible; limit $2,000 per ear every 3 years (CA); limit $500 every 2 years (NV & AZ)

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

Medical Plan Comparison Charts (continued)

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

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

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

SCAN Health Plan and Anthem Medicare Preferred (PPO) Subscribers

Enhanced Social Services Programs

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

Benefit	SCAN Health Plan Independent Living Power (ILP)[1]	Anthem Blue Cross Medicare Preferred (PPO)
Service Areas	Available in CA - Los Angeles, Orange, Riverside, San Diego counties, only	Throughout the U.S.
Personal Emergency Response System	• Includes installation & monthly monitoring • $0 copay	• One in-home system and monthly monitoring • No charge
Transportation to Provider Visits	• Unlimited taxi rides per year • No charge[1]	• 12 one-way trips per year to medical visits, pharmacy, SilverSneakers, etc. within service area; 60 mile limit • Advanced scheduling required • No charge
Caregiver Relief *(Alternative Caregiver Provides Services When The Regular Caregiver Is Not Available)*	• In-home visits when regular caregiver cannot be there • Services include companionship, assistance with bathing, dressing, and light meal preparation. • Adult day care – physical, social or intellectual exercises and stimulation for seniors • $15 per visit[1]	• At state-licensed adult day center, up to one eight-hour day per week • Prior plan approval required • Direct member reimbursement, claims must be submitted • No charge; up to $80 reimbursement per visit
Personal Care and Homemaker Service	• Services include light housekeeping, laundry and meal preparation, grocery shopping, companionship, assistance with bathing and dressing • $15 per visit[1]	• Services include light housekeeping *(cleaning, laundry, dishes, etc.)*, help with dressing, eating, bathing/showering, and transferring/mobility help in home; Up to 124 hours/year, 4 hours/day max • Prior plan approval required • Direct member reimbursement, claims must be submitted; Reimbursed up to $100 per day
Home Delivered Meals	• Unlimited • No charge[1]	• Healthy Meals Program; Up to 14 meals per qualifying event, up to four events per year • No charge
Bathroom Safety/ Assistive Equipment	• $0 copay	• Up to $200 every year for items allowed by Medicare

1. $650 allowance per month for all ILP services combine

Vision Plan Comparison Chart

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

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

Medical Plan Premiums (Includes Vision Benefits)

	PPO	HMO/Senior Plans				
	U.S.	CA			NV	AZ
	Anthem Blue Cross (PPO) & Medicare Preferred (PPO) Plan	Kaiser Permanente/ Sr. Advantage[1]	SCAN Health Plan & Anthem Blue Cross HMO[3]	United Healthcare HMO & Anthem Blue Cross HMO[3]	United Healthcare HMO	
Retired Member Only	**Monthly Premiums**					
Under 65 or over 65 w/Medicare Part B only[1]	$1,337.99	$900.24	$1,069.05	$1,069.05	N/A	N/A
65 or older w/Medicare Parts A & B	$494.67	$262.47	$268.95	$283.76	$254.50	$355.76
Retired Member & 1 Dependent	**Monthly Premiums**					
Both under 65 or both 65 or older w/Medicare Part B only	$2,670.95	$1,800.48	$2,133.07	$2,133.07	N/A	N/A
Retired Member under 65 and Dependent 65 or older w/Medicare Parts A & B	$1,827.63	$1,130.97	$1,332.97	$1,347.78	N/A	N/A
Retired Member 65 or older w/Medicare Parts A & B and Dependent under 65	$1,827.63	$1,130.97	$1,332.97	$1,347.78	N/A	N/A
Retired Member & Dependent both 65 or older, both w/Medicare Parts A & B	$984.31	$524.94	$532.87	$562.49	$503.97	$706.49

Medical Plan Premiums (Includes Vision Benefits)

	PPO	HMO/Senior Plans				
	U.S.	CA			NV	AZ
	Anthem Blue Cross (PPO) & Medicare Preferred (PPO) Plan	Kaiser Permanente/ Sr. Advantage[1]	SCAN Health Plan & Anthem Blue Cross HMO[3]	United Healthcare HMO & Anthem Blue Cross HMO[3]	United Healthcare HMO	
Retired Member & Family[2]	**Monthly Premiums**					
Retired Member & Family under 65 or 65 or older w/Medicare Part B only[1]	$3,146.47	$2,340.62	$2,779.44	$2,779.44	N/A	N/A
Retired Member under 65, 1 Dependent 65 or older w/Medicare Parts A & B and at least 1 Dependent w/o Medicare	$2,303.15	$1,671.11	$1,979.34	$1,994.15	N/A	N/A
Retired Member 65 or older w/Medicare Parts A & B and Family w/o Medicare	$2,303.15	$1,671.11	$1,979.34	$1,994.15	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	$1,459.83	$1,036.98	$1,179.24	$1,208.86	N/A	N/A

Note: Premium rates include Vision benefits. All of the above rates are effective from January 1, 2022 through December 31, 2022.

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

Medical Monthly Allowance Deductions

Retired Member

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

For those LACERS Members who retired on or after July 1, 2011, and who have not made additional retirement contributions pursuant to Los Angeles Administrative Code Section 4.1003(c), please refer to the 2022 Health Benefits Guide Supplement for your subsidy information and monthly deduction charts. For more information, contact LACERS.

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

	PPO (U.S.)	HMO (CA)	
	Anthem Blue Cross	Kaiser Permanente	Anthem Blue Cross HMO
Monthly Premiums	**$1,337.99**	**$900.24**	**$1,069.05**
Service Credit	**Monthly Allowance Deduction**		
1 - 10	$584.19	$146.44	$315.25
11	$508.81	$71.06	$239.87
12	$433.43	$0.00	$164.49
13	$358.05	$0.00	$89.11
14	$282.67	$0.00	$13.73
15	$207.29	$0.00	$0.00
16	$131.91	$0.00	$0.00
17	$56.53	$0.00	$0.00
18	$0.00	$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

Medical Monthly Allowance Deductions (continued)

Retired Member Only with Medicare Parts A & B

	PPO (U.S.)	HMO/Senior Plans				
	Anthem Blue Cross Medicare Preferred (PPO) Plan	CA – Kaiser Permanente Sr. Advantage	CA – SCAN Health Plan	CA – United-Healthcare HMO	AZ – United-Healthcare HMO	NV – United-Healthcare HMO
Monthly Premiums	**$494.67**	**$262.47**	**$268.95**	**$283.76**	**$355.76**	**$254.50**
Service Credit	**Monthly Allowance Deduction**					
1 to 14	$123.67	$65.62	$67.24	$70.95	$88.94	$63.62
15 to 19	$49.47	$26.25	$26.89	$28.38	$35.58	$25.45
20 to 24	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
25+	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Medical Monthly Allowance Deductions (continued)

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

	PPO (U.S.)	HMO (CA)	
	Anthem Blue Cross	Kaiser Permanente	Anthem Blue Cross HMO
Monthly Premiums	**$2,670.95**	**$1,800.48**	**$2,133.07**
Service Credit	**Monthly Allowance Deduction**		
1-10	$1,917.15	$1,046.68	$1,379.27
11	$1,841.77	$971.30	$1,303.89
12	$1,766.39	$895.92	$1,228.51
13	$1,691.01	$820.54	$1,153.13
14	$1,615.63	$745.16	$1,077.75
15	$1,540.25	$669.78	$1,002.37
16	$1,464.87	$594.40	$926.99
17	$1,389.49	$519.02	$851.61
18	$1,314.11	$443.64	$776.23
19	$1,238.73	$368.26	$700.85
20	$1,163.35	$292.88	$625.47
21	$1,087.97	$217.50	$550.09
22	$1,012.59	$142.12	$474.71
23	$937.21	$66.74	$399.33
24	$861.83	$0.00	$323.95
25+	$786.45	$0.00	$248.57

Medical Monthly Allowance Deductions (continued)

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

	PPO (U.S.)	HMO/Senior Plan (CA)		
	Anthem Blue Cross Medicare Preferred (PPO) Plan	Kaiser Permanente Sr. Advantage	Anthem Blue Cross HMO/ SCAN Health Plan	Anthem Blue Cross HMO/ UnitedHealthcare HMO
Monthly Premiums	**$1,827.63**	**$1,130.97**	**$1,332.97**	**$1,347.78**
Service Credit	**Monthly Allowance Deduction**			
1-10	$1,073.83	$377.17	$579.17	$593.98
11	$998.45	$301.79	$503.79	$518.60
12	$923.07	$226.41	$428.41	$443.22
13	$847.69	$151.03	$353.03	$367.84
14	$772.31	$75.65	$277.65	$292.46
15	$696.93	$0.27	$202.27	$217.08
16	$621.55	$0.00	$126.89	$141.70
17	$546.17	$0.00	$51.51	$66.32
18	$470.79	$0.00	$0.00	$0.00
19	$395.41	$0.00	$0.00	$0.00
20	$320.03	$0.00	$0.00	$0.00
21	$244.65	$0.00	$0.00	$0.00
22	$169.27	$0.00	$0.00	$0.00
23	$93.89	$0.00	$0.00	$0.00
24	$18.51	$0.00	$0.00	$0.00
25+	$0.00	$0.00	$0.00	$0.00

Medical Monthly Allowance Deductions (continued)

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

	PPO (U.S.)	HMO/Senior Plan (CA)		
	Anthem Blue Cross Medicare Preferred (PPO) Plan	Kaiser Permanente Sr. Advantage	Anthem Blue Cross HMO/ SCAN Health Plan	Anthem Blue Cross HMO/ UnitedHealthcare HMO
Monthly Premiums	**$1,827.63**	**$1,130.97**	**$1,332.97**	**$1,347.78**
Service Credit	**Monthly Allowance Deduction**			
1-10	$1,456.63	$934.12	$1,131.26	$1,134.96
11	$1,456.63	$934.12	$1,131.26	$1,134.96
12	$1,456.63	$929.80	$1,131.26	$1,134.96
13	$1,456.63	$854.42	$1,131.26	$1,134.96
14	$1,456.63	$779.04	$1,131.26	$1,134.96
15	$1,382.43	$664.29	$1,029.26	$1,030.75
16	$1,382.43	$588.91	$953.88	$955.37
17	$1,382.43	$513.53	$878.50	$879.99
18	$1,363.58	$438.15	$803.12	$804.61
19	$1,288.20	$362.77	$727.74	$729.23
20	$1,163.35	$261.14	$625.47	$625.47
21	$1,087.97	$185.76	$550.09	$550.09
22	$1,012.59	$110.38	$474.71	$474.71
23	$937.21	$35.00	$399.33	$399.33
24	$861.83	$0.00	$323.95	$323.95
25+	$786.45	$0.00	$248.57	$248.57

Medical Monthly Allowance Deductions (continued)

Retired Member and Dependent with Medicare Parts A & B

	PPO (U.S.)	HMO/Senior Plans				
	Anthem Blue Cross Medicare Preferred (PPO) Plan	CA – Kaiser Permanente Sr. Advantage	CA – SCAN Health Plan	CA – United-Healthcare HMO	AZ – United-Healthcare HMO	NV – United-Healthcare HMO
Monthly Premiums	**$984.31**	**$524.94**	**$532.87**	**$562.49**	**$706.49**	**$503.97**
Service Credit	**Monthly Allowance Deduction**					
1-10	$613.31	$328.09	$331.16	$349.67	$439.67	$313.09
11	$613.31	$328.09	$331.16	$349.67	$439.67	$313.09
12	$613.31	$323.77	$331.16	$349.67	$439.67	$313.09
13	$613.31	$248.39	$331.16	$349.67	$439.67	$313.09
14	$613.31	$173.01	$331.16	$349.67	$439.67	$313.09
15	$539.11	$58.26	$229.16	$245.46	$324.66	$213.27
16	$539.11	$26.25	$153.78	$170.08	$249.28	$137.89
17	$539.11	$26.25	$78.40	$94.70	$173.90	$62.51
18	$520.26	$26.25	$26.89	$28.38	$98.52	$25.45
19	$444.88	$26.25	$26.89	$28.38	$35.58	$25.45
20	$320.03	$0.00	$0.00	$0.00	$0.00	$0.00
21	$244.65	$0.00	$0.00	$0.00	$0.00	$0.00
22	$169.27	$0.00	$0.00	$0.00	$0.00	$0.00
23	$93.89	$0.00	$0.00	$0.00	$0.00	$0.00
24	$18.51	$0.00	$0.00	$0.00	$0.00	$0.00
25+	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Medical Monthly Allowance Deductions (continued)

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

	PPO (U.S.)	HMO/Senior Plan (CA)		
	Anthem Blue Cross Medicare Preferred (PPO) Plan	Kaiser Permanente Sr. Advantage	Anthem Blue Cross HMO/ SCAN Health Plan	Anthem Blue Cross HMO/ UnitedHealthcare HMO
Monthly Premiums	**$2,303.15**	**$1,671.11**	**$1,979.34**	**$1,994.15**
Service Credit	**Monthly Allowance Deduction**			
1-10	$1,932.15	$1,474.26	$1,777.63	$1,781.33
11	$1,932.15	$1,474.26	$1,777.63	$1,781.33
12	$1,932.15	$1,469.94	$1,777.63	$1,781.33
13	$1,932.15	$1,394.56	$1,777.63	$1,781.33
14	$1,932.15	$1,319.18	$1,777.63	$1,781.33
15	$1,857.95	$1,204.43	$1,675.63	$1,677.12
16	$1,857.95	$1,129.05	$1,600.25	$1,601.74
17	$1,857.95	$1,053.67	$1,524.87	$1,526.36
18	$1,839.10	$978.29	$1,449.49	$1,450.98
19	$1,763.72	$902.91	$1,374.11	$1,375.60
20	$1,638.87	$801.28	$1,271.84	$1,271.84
21	$1,563.49	$725.90	$1,196.46	$1,196.46
22	$1,488.11	$650.52	$1,121.08	$1,121.08
23	$1,412.73	$575.14	$1,045.70	$1,045.70
24	$1,337.35	$499.76	$970.32	$970.32
25+	$1,261.97	$424.38	$894.94	$894.94

For those LACERS Members who retired on or after July 1, 2011, and who have not made additional retirement contributions pursuant to Los Angeles Administrative Code Section 4.1003(c), please refer to the 2022 Health Benefits Guide Supplement for your subsidy information and monthly deduction charts. For more information, contact LACERS.

Medical Monthly Allowance Deductions (continued)

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

	PPO (U.S.)	HMO (CA)	
	Anthem Blue Cross	Kaiser Permanente	Anthem Blue Cross HMO
Monthly Premiums	**$3,146.47**	**$2,340.62**	**$2,779.44**
Service Credit	**Monthly Allowance Deduction**		
1-10	$2,392.67	$1,586.82	$2,025.64
11	$2,317.29	$1,511.44	$1,950.26
12	$2,241.91	$1,436.06	$1,874.88
13	$2,166.53	$1,360.68	$1,799.50
14	$2,091.15	$1,285.30	$1,724.12
15	$2,015.77	$1,209.92	$1,648.74
16	$1,940.39	$1,134.54	$1,573.36
17	$1,865.01	$1,059.16	$1,497.98
18	$1,789.63	$983.78	$1,422.60
19	$1,714.25	$908.40	$1,347.22
20	$1,638.87	$833.02	$1,271.84
21	$1,563.49	$757.64	$1,196.46
22	$1,488.11	$682.26	$1,121.08
23	$1,412.73	$606.88	$1,045.70
24	$1,337.35	$531.50	$970.32
25+	$1,261.97	$456.12	$894.94

Medical Monthly Allowance Deductions (continued)

Eligible Survivor not in Medicare or with Medicare Part B Only

	PPO (U.S.)	HMO (CA)	
	Anthem Blue Cross	Kaiser Permanente	Anthem Blue Cross HMO
Monthly Premiums	**$1,337.99**	**$900.24**	**$1,069.05**
Service Credit	**Monthly Allowance Deduction**		
1-10	$977.89	$540.14	$708.95
11	$941.88	$504.13	$672.94
12	$905.87	$468.12	$636.93
13	$869.87	$432.12	$600.93
14	$833.86	$396.11	$564.92
15	$797.85	$360.10	$528.91
16	$761.84	$324.09	$492.90
17	$725.83	$288.08	$456.89
18	$689.82	$252.07	$420.88
19	$653.81	$216.06	$384.87
20	$617.80	$180.05	$348.86
21	$581.79	$144.04	$312.85
22	$545.78	$108.03	$276.84
23	$509.77	$72.02	$240.83
24	$473.76	$36.01	$204.82
25+	$437.75	$0.00	$168.81

Medical Monthly Allowance Deductions (continued)

Eligible Survivor with Medicare Parts A & B

	PPO (U.S.)	HMO/Senior Plans				
	Anthem Blue Cross Medicare Preferred (PPO) Plan	CA – Kaiser Permanente Sr. Advantage	CA – SCAN Health Plan	CA – United-Healthcare HMO	AZ – United-Healthcare HMO	NV – United-Healthcare HMO
Monthly Premiums	**$494.67**	**$262.47**	**$268.95**	**$283.76**	**$355.76**	**$254.50**
Service Credit	**Monthly Allowance Deduction**					
1 to 14	$123.67	$65.62	$67.24	$70.94	$88.94	$63.62
15 to 19	$49.47	$26.25	$26.89	$28.38	$35.58	$25.45
20+	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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

LACERS Dental Plans

LACERS offers two dental plans – Delta Dental PPO℠ and the DeltaCare USA® DHMO.

Regardless of dental plan choice, please contact your plan's Member Services prior to receiving major dental treatment to ensure that the services are covered under the plan.

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

Delta Dental PPO℠

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

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

DeltaCare® USA DHMO

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

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

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

Dental Subsidy[2] Eligibility

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

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

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

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

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

2. For the purposes of this Guide, subsidy information is based on full-time employment.

LACERS Dental Subsidy

2022 Dental Subsidy

Service Credit	% of Maximum	Delta Dental PPO Subsidy Amount	DeltaCare USA DHMO Subsidy Amount
1 - 10	40%	$17.84	$6.04
11	44%	$19.62	$6.64
12	48%	$21.41	$7.25
13	52%	$23.19	$7.85
14	56%	$24.98	$8.46
15	60%	$26.76	$9.06
16	64%	$28.54	$9.66
17	68%	$30.33	$10.27
18	72%	$32.11	$10.87
19	76%	$33.90	$11.48
20	80%	$35.68	$12.08
21	84%	$37.46	$12.68
22	88%	$39.25	$13.29
23	92%	$41.03	$13.89
24	96%	$42.82	$14.50
25+	100%	$44.60	$15.10

Dental Plan Comparison Chart

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

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

Dental Plan Premiums and Deductions

Dental Plan Premium Rates

Coverage Level	Delta Dental PPO	DeltaCare USA DHMO
Retired Member	$51.16	$15.10
Retired Member + 1	$101.45	$28.19
Retired Member + Family[1]	$146.56	$32.59

1. A family consists of two or more dependents.

Dental Monthly Allowance Deductions

	Retired Member Only		Retired Member & One Dependent		Retired Member & Family	
	Delta Dental PPO	DeltaCare USA DHMO	Delta Dental PPO	DeltaCare USA DHMO	Delta Dental PPO	DeltaCare USA DHMO
Monthly Premiums	**$51.16**	**$15.10**	**$101.45**	**$28.19**	**$146.56**	**$32.59**
Service Credit	**Monthly Allowance Deduction**					
1-10	$33.32	$9.06	$83.61	$22.15	$128.72	$26.55
11	$31.54	$8.46	$81.83	$21.55	$126.94	$25.95
12	$29.75	$7.85	$80.04	$20.94	$125.15	$25.34
13	$27.97	$7.25	$78.26	$20.34	$123.37	$24.74
14	$26.18	$6.64	$76.47	$19.73	$121.58	$24.13
15	$24.40	$6.04	$74.69	$19.13	$119.80	$23.53
16	$22.62	$5.44	$72.91	$18.53	$118.02	$22.93
17	$20.83	$4.83	$71.12	$17.92	$116.23	$22.32
18	$19.05	$4.23	$69.34	$17.32	$114.45	$21.72
19	$17.26	$3.62	$67.55	$16.71	$112.66	$21.11
20	$15.48	$3.02	$65.77	$16.11	$110.88	$20.51
21	$13.70	$2.42	$63.99	$15.51	$109.10	$19.91
22	$11.91	$1.81	$62.20	$14.90	$107.31	$19.30
23	$10.13	$1.21	$60.42	$14.30	$105.53	$18.70
24	$8.34	$0.60	$58.63	$13.69	$103.74	$18.09
25+	$6.56	$0.00	$56.85	$13.09	$101.96	$17.49

Reminders

Taxability of Your Health Benefits

All Retired Members enrolling dependents, and all eligible Survivors, must complete and submit a *Certification of Dependent or Survivor Status for Health Coverage Form*. Please obtain the form from the LACERS website or call (800) 779-8328. The portion of your medical subsidy used to provide medical benefits to your non-tax dependents may be reported as taxable income to the IRS for federal tax purposes.

A spouse is automatically considered a tax dependent and medical coverage will not result in imputed income. Other than this, LACERS cannot determine for you if your dependents are eligible to be claimed for federal income tax purposes.

Those who fail to complete the *Certification of Dependent or Survivor Status for Health Coverage Form* may have the portion of their medical subsidy used to cover any persons other than themselves reported to the IRS as taxable income.

Those eligible Survivors who fail to complete the Certification of Dependent or Survivor Status for Health Coverage Form may have their entire medical subsidy reported to the IRS as taxable income.

Note: If you have further questions, please contact the IRS and/or consult a tax professional regarding the annual dependent requirements for federal income tax purposes. Additionally, state regulations are different for each state. Please call your state income tax authority.

Helpful Hints

- Retired Members must be age 55 or older and have at least 10 years of Service to be eligible for the monthly medical subsidy.
- A qualifying event allows Retired Members to enroll or make changes to the LACERS health plan outside of the open enrollment period.
- A Survivor must be an eligible surviving spouse/domestic partner receiving a Continuance or Survivorship allowance in order to receive a LACERS medical plan premium subsidy.
- Survivors are not eligible for a dental subsidy.
- Retired Members and their dependents are required to enroll in Medicare Part B upon turning age 65 and provide proof of enrollment to LACERS.
- Enrollment in Medicare Part A is required only if it is premium-free (at no cost).
- **If you lapse on your Medicare Part B premiums, you will be terminated from your LACERS medical plan and your Medicare Part D will be cancelled. You may be assessed lifetime penalties by Medicare (CMS) when you re-enroll in Medicare Part B or Part D.**

Glossary

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

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

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

Claim: A plan participant's request to a benefit plan or insurer for the payment of certain benefits.

CMS: See Centers for Medicare & Medicaid Services.

COBRA: See Consolidated Omnibus Budget Reconciliation Act of 1986.

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

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

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

Copayment (Copay): The predetermined (flat) fee that an individual pays for certain health care services.

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

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

Dependent: A spouse, domestic partner or eligible child or grandchild enrolled in the Member's LACERS health plan.

Dual Care: A LACERS medical insurance option available to Members whose households consist of at least one enrollee (Member or dependent) covered by both Medicare Parts A and B and at least one enrollee who is under age 65 or over age 65 but covered by Medicare Part B only.

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

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

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

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

Glossary (continued)

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

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

Member: A LACERS Retired Member or an eligible Survivor.

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

PCP: See Primary Care Physician.

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

PPO: See Preferred Provider Organization.

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

Premium: The monthly cost of insurance coverage for a LACERS Retired Member and any dependents.

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

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

Reimbursement: A repayment of basic Medicare Part B premiums to eligible retired Members who are receiving a medical subsidy, enrolled in both Medicare Parts A and B, and enrolled in a LACERS medical plan or participating in the Medical Premium Reimbursement Program (MPRP).

Retired Member: A person retired from LACERS on either a service or a disability pension.

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

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

Service Credit: Service Credit is based on actual hours worked and determines the amount of medical and/or dental subsidy a retired Member will receive.

Glossary (continued)

Subsidy: A benefit for eligible LACERS Retired Members and their eligible Surviving Spouses/Domestic Partners that assists with the cost of health insurance. It is applied toward the cost of the Member's monthly premium. Only Retired Members may be eligible for dental subsidies (NOT dependents or eligible Surviving Spouses/Domestic Partners).

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

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

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

LACERS Well

Our Mission

To enhance your quality of life and retirement by providing resources and activities that promote optimal health and wellness.

What is LACERS Well?

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

What LACERS Well offers?

Our commitment to you is to provide fun, engaging, and informative events.

More About LACERS Well

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

For more information visit www.lacers.org/lacerswell, contact LACERS at (800) 779-8328, or by email at lacerswell@lacers.org.

Foundation for LACERS Well program

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

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

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

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

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

Notes

Health Plan and Other Important Contact Information

Resources	Member Services Phone Numbers		Websites
Anthem Blue Cross HMO	(866) 940-8303	TTY 711	www.anthem.com/ca
Anthem Blue Cross Medicare Preferred (PPO) Plan	(833) 360-3662 PDP (Rx) (833) 848-8730, after 1/1/22	TTY 711 TTY 711 PDP (Rx)	www.anthem.com/ca
Anthem Blue Cross Medicare RX (PDP) with SeniorRx Plus	(866) 470-6265	TTY 711	www.anthem.com/ca
Anthem Blue Cross PPO	(866) 940-8303	TTY 711	www.anthem.com/ca
Anthem Blue View Vision	(866) 723-0515	TTY 711	www.anthem.com/ca
California Department of Managed Health Care	(888) 466-2219	TDD (877) 688-9891	www.dmhc.ca.gov
DeltaCare® USA	(800) 422-4234	TTY 711	www.deltadentalins.com
Delta Dental PPO	(800) 765-6003	TTY 711	www.deltadentalins.com
Kaiser Permanente HMO	(800) 464-4000	TTY 711	https://my.kp.org/lacers
Kaiser Permanente HMO Senior Advantage	(800) 443-0815	TTY 711	https://my.kp.org/lacers
LACERS Customer Service	(800) 779-8328	RTT (888) 349-3996	www.LACERS.org
Centers for Medicare & Medicaid Services (CMS)	(800) MEDICARE (800) 633-4227	TTY (877) 486-2048	www.medicare.gov
SCAN Health Plan	(800) 559-3500 CA	TTY 711	www.scanhealthplan.com/lacers
Social Security Administration	(800) 772-1213	TTY (800) 325-0778	www.ssa.gov
UnitedHealthcare Medicare Advantage HMO	(800) 457-8506 CA, AZ, NV	TTY 711 CA, AZ, NV	www.uhcretiree.com