LACERA

Comparison of Medical Plans

2018

Effective July 1, 2018

Indemnity Medical Plans

- Anthem Blue Cross I
- Anthem Blue Cross II
- Anthem Blue Cross Prudent Buyer Plan

Health Maintenance Organizations (HMOs)

- Cigna Network Model Plan (Arizona and California only)
- Kaiser Permanente (California only)
- UnitedHealthcare

This chart represents a summary of benefits only. Additional benefit information is provided by each insurance carrier. This chart does not replace or modify the official documents that legally govern each plan's operation.

The benefits offered by all LACERA-administered health plans change when an enrolled member permanently moves outside the provider network area. Moving to a location outside the coverage area can impact your plan's rates and coverage levels.

Comparison of Medical Plans

	Indemnity Insurance Plans			HMOs		
	Anthem Blue Cross I	**Anthem Blue Cross II**	**Anthem Blue Cross Prudent Buyer Plan**	**Cigna Network Model Plan**	**Kaiser Permanente**	**UnitedHealthcare[4]**
Calendar Year Deductibles/Copayments	$100 – individual; $100 – family	$500 – individual; $1,500 – family	$100 – individual; $200 – family	None	None	None
Annual Maximum Out-of-Pocket Expenses (for most services)	N/A	$2,500, including deductible (Does not include amounts over allowable charges)	N/A	$1,500 – individual; $3,000 – family	Maximum copays of $1,500 per individual, $3,000 per family	Maximum copays of $2,000 per individual, $6,000 per family
Lifetime Maximum Benefits	$1,000,000	$1,000,000	$1,000,000	Unlimited	Unlimited	Unlimited
Hospital Benefits						
Room and Board	$75 per day maximum[1]; $150 per day maximum special care unit[1]	90% for PPO hospital[2]; 80% non-PPO for semi-private room; special care unit up to 2.5 times semi-private room rate	80% Prudent Buyer; 70% non–Prudent Buyer with $75 per day maximum; $150 per day intensive care (for non–Prudent Buyer)	No charge	No charge	No charge
Surgical Services	80%[1]	80%	80% Prudent Buyer; 70% non–Prudent Buyer	No charge for inpatient or outpatient	No charge for inpatient; $5 copay for outpatient	No charge for inpatient or outpatient
Hospital Services and Supplies	100%[1]	90% PPO hospital[2]; 80% non-PPO hospital	80% Prudent Buyer; 70% non–Prudent Buyer (up to $250 per day for non–Prudent Buyer)	No charge	No charge	No charge
Hospital Admission Authorization Requirements	Preadmission authorization required in advance (on first business day following emergency admission) unless covered by Medicare Part A. $200 deductible for unauthorized hospital admission or late notice	Preadmission authorization required in advance (on first business day following emergency admission) unless covered by Medicare Part A. $200 deductible for unauthorized hospital admission or late notice	Authorization by a Prudent Buyer physician required. Non–Prudent Buyer physicians must contact Anthem Blue Cross	Authorization by a Cigna HealthCare physician required within 48 hours in case of emergency outside service area	Authorization by a Kaiser Permanente physician required within 24 hours or as soon as reasonably possible in case of emergency outside service area	Authorization by a participating UnitedHealthcare medical group or physician required. Within 24 hours in case of emergency
Nursing Benefits						
Skilled Nursing Facility Care	70% (in-network) or 50% (out-of-network) up to $150 per day for up to 100 days per calendar year[1]	70% (in-network) or 50% (out-of-network) up to 100 days per calendar year[1]	80% of semi-private room rate for up to 100 days per confinement period	No charge; CA limited to 100 days per contract year; AZ limited to 60 days per contract year	No charge; limit 100 days per benefit period	No charge; up to 100 days per benefit period
Private Duty Nurses	80% in accordance with requirements	80% in accordance with requirements	80% in accordance with requirements	No charge if authorized by a Cigna HealthCare physician (100 visits per contract year together with Home Healthcare)	No charge if authorized by Kaiser Permanente physician	No charge (if medically necessary)
Home Healthcare	100% in accordance with requirements[1]	100% in accordance with requirements[1]	100% in accordance with requirements	No charge; CA limited to 100 days per contract year; AZ limited to 60 days per contract year. Includes outpatient Private Duty Nursing subject to medical necessity.	No charge if authorized by Kaiser Permanente physician	No charge; 100 visits maximum per calendar year
Hospice Care	100% up to plan limitations, in accordance with requirements[1]	100% in accordance with requirements[1]	100% up to plan limitations, in accordance with requirements[1]	No charge	No charge if authorized by Kaiser Permanente physician (up to 100 2-hour visits per calendar year)	No charge when authorized by a UnitedHealthcare participating physician or medical group. Prognosis of life expectancy of one year or less.
Emergency Benefits						
Inpatient	$75 per day[1] maximum; $150 per day maximum special care unit[1]	90% PPO hospital[2]; 80% non-PPO hospital	80% Prudent Buyer; 70% non–Prudent Buyer	No charge	No charge	No charge
Outpatient	100% at a hospital only[1]	80%	80% Prudent Buyer; 70% non–Prudent Buyer	$50 copay; waived if admitted; $25 copay for urgent care center	$5 at Kaiser Permanente facility; waived if admitted directly to the hospital	$50; waived on admission
Ambulance	80% for transportation to first hospital where care is given	80% for transportation to first hospital where care is given	80%	No charge when true emergency authorized by a Cigna HealthCare physician	No charge if emergency	No charge when medically necessary
Outpatient Benefits						
Doctor's Office Visits	80%	80%	80% Prudent Buyer; 70% non–Prudent Buyer	$5 copay	$5 copay	$5 copay
Preadmission X-Ray and Lab Tests	100%[1]	100%[1]	100% Prudent Buyer; 70% non–Prudent Buyer	No charge	No charge	No charge with an office visit
Routine Checkups, CA only						
—Adult	$25 copay; covered in-network only; maximum of $250	$25 copay; covered in-network only; maximum of $250	$25 copay; covered in-network only; maximum of $250	$5 copay	$5 copay	$5 copay; no charge for age 2 and under
—Children Under 17	$25 copay in-network; 80% out-of-network	$25 copay in-network; 80% out-of-network	$25 copay in-network; out-of-network covered up to $20			
Immunizations	Not covered except for children under age 17	Not covered except for children under age 17	Not covered except for children under age 17	No charge (after $5 office visit copay, if applicable)	No charge if generally available	$5 copay; no charge for age 2 and under
Outpatient Surgical Services	100%[1]	100%[1] (80% hospital facility fees)	100%[1] Prudent Buyer (Hospital facility fees: 80% Prudent Buyer; 70% non–Prudent Buyer)	No charge	$5 copay	No charge
Physical Therapy	80% in accordance with requirements	80% in accordance with requirements	80% Prudent Buyer; 70% non–Prudent Buyer	$20 copay; limited 20 days for all therapies combined (unlimited days based on medical necessity for CA only)	$5 copay	Inpatient: no charge; outpatient: $5 copay
Speech Therapy	80% in accordance with requirements	80% in accordance with requirements	80% in accordance with requirements	$20 copay; limited 20 days for all therapies combined (unlimited days based on medical necessity for CA only)	$5 copay	Inpatient: no charge; outpatient: $5 copay
Maternity	80% in accordance with requirements	80% in accordance with requirements	80% Prudent Buyer; 70% Non-Prudent Buyer; in accordance with requirements	$5 copay for initial visit to confirm pregnancy; no charge for subsequent maternity visits	$5 copay	No charge; office visit copays are waived after initial office visit copay
Prescription Drug Benefits						
Prescription Drugs	**Retail:** 80% in-network; 60% out-of-network **Mail order:** $10 generic/$30 brand/$50 non-preferred brand/ $150 specialty copay for 90-day supply (Copay prorated for less than 90-day supply)	**Retail:** 80% in-network; 60% out-of-network **Mail order:** $10 generic/$30 brand/$50 non-preferred brand/ $150 specialty copay for 90-day supply (Copay prorated for less than 90-day supply)	**Retail:** 80% in-network; out-of network coverage may vary. Contact Anthem Blue Cross for more information. **Mail order:** $10 generic/$30 brand/$50 non-preferred brand/ $150 specialty for a 90-day supply /specialty copay prorated for less than 90-day supply	**Retail:** $7 copay for 30-day supply; **Mail order:** $14 copay for 90-day supply	$7 copay for up to 100-day supply; can be in person, through mail order, by telephone, or online at www.kp.org/myhealthmanager	**Retail:** $7 copay for 30-day supply; **Mail order:** $7 copay for 90-day supply
Mental Health and Substance Abuse Benefits						
Inpatient	$75 per day[1] maximum; $150 per day maximum intensive care[1]	90% PPO; 80% non-PPO	80% Prudent Buyer; 70% non–Prudent Buyer	No charge for an unlimited number of days	No charge; for an unlimited number of days	No charge; for an unlimited number of days (both Mental Health and Substance Abuse)
Outpatient	80% of covered expenses	80% of covered expenses	80% Prudent Buyer; 70% non–Prudent Buyer	No charge for an unlimited number of visits	$5 copay per visit; for an unlimited number of visits	Mental Health: $5 copay; for an unlimited number of visits, must be authorized through UnitedHealthcare Behavioral Health[5] Substance Abuse: No charge; for an unlimited number of visits (Includes Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment)
Vision Benefits						
Eye Exams	Covered after accident only[3]	Covered after accident only[3]	Not covered	$10 copay; limit one exam every 12 months through Cigna Vision	$5 copay	$5 copay through PCP[5]
Lenses	Covered after accident[3] and after eye surgery	Covered after accident[3] and after eye surgery	One pair, after eye surgery	Covered after cataract surgery	Not covered	Not covered
Frames	Covered after accident[3] or eye surgery only	Covered after accident[3] or eye surgery only	Not covered	Not covered	Not covered	Not covered
Hearing Care Benefits						
Hearing Exams	Covered after accident only[3]	Covered after accident only[3]	Not covered	Not covered	$5 copay	$5 copay
Hearing Aids	Covered after accident only[3]	Covered after accident only[3]	Not covered	Not covered	Not covered	$5,000 annual benefit maximum per calendar year. Limited to one hearing aid (including repair and replacement) per hearing impaired ear every three years.

Carrier Notes:

Anthem Blue Cross Plans I, II, and Prudent Buyer

Coinsurance payment is the percentage of eligible charges after you meet the plan deductible, unless otherwise noted. **All plan reimbursements are based on negotiated rates or usual and customary charges.** Usual and Customary charges are the maximum amounts the plan will pay for a service based on what providers in that geographic area charge for similar services or supplies.

[1] Indicates deductible waived.

Anthem Blue Cross II

[2] For non–Medicare members only.

Anthem Blue Cross I and II

[3] Treatment must be due to an accidental injury while insured and treatment must be received within two years of accident.

HMOs

Medical care must be received from HMO or contracted provider, physician or facility.

Mental Health Benefits for California Base Contracts: refer to evidence of coverage.

UnitedHealthcare

[4] Refer to UnitedHealthcare HMO Schedule of Benefits and Evidence of Coverage for detailed plan information.

[5] Your PCP is your Preferred Care Provider in the UnitedHealthcare HMO.

NON-DISCRIMINATION NOTICE

The LACERA-Administered Retiree Healthcare Benefits Program complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. LACERA does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The LACERA-Administered Retiree Healthcare Benefits Program:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Cassandra Smith, Director, or Leilani Ignacio, Retiree Healthcare Division.

If you believe that LACERA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Cassandra Smith, Director, Retiree Healthcare, or Leilani Ignacio:
LACERA
P.O. Box 7060, Pasadena, CA 91109-7060
Telephone: (800) 786-6464, then press 1, or (626) 564-6132
Fax: (626) 564-6799
Email: healthcare@lacera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Cassandra Smith or Leilani Ignacio are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	**Message About Language Assistance**
1. Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-786-6464, Ext. 1.
2. Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-786-6464, Ext. 1。
3. French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-786-6464, Ext. 1.
4. German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-786-6464, Ext. 1.
5. Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-786-6464, Ext. 1.
6. Persian	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-786-6464, Ext. 1 تماس بگیرید.
7. Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-786-6464, Ext. 1.
8. Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-786-6464, Ext. 1.
9. Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-786-6464، Ext. 1.
10. Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-786-6464, Ext. 1 번으로 전화해 주십시오.
11. Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-786-6464, Ext. 1.
12. Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-786-6464, Ext. 1.
13. Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-786-6464, Ext. 1 まで、お電話にてご連絡ください。
14. French Creole (Haitian)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-786-6464, Ext. 1.
15. Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-786-6464, Ext. 1.

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