LACERA

# Comparison of Medical Plans

2018

**For those enrolled in Medicare Parts A and B**

**Effective July 1, 2018**

## Medicare Supplement Plan

- **Anthem Blue Cross III**

## Medicare Advantage Prescription Drug (MA-PD) HMOs

- **Kaiser Permanente Senior Advantage**
- **UnitedHealthcare Medicare Advantage HMO**
- **SCAN Health Plan**

**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
## (For Medicare-Eligible Members Enrolled in Medicare Parts A and B)

| | Medicare Supplement | Medicare Advantage Prescription Drug (MA-PD) HMOs | | |
|---|---|---|---|---|
| | **Anthem Blue Cross III** | **Kaiser Permanente Senior Advantage** | **SCAN[1]** | **UnitedHealthcare Medicare Advantage HMO** |
| **Outpatient Benefits** | | | | |
| **Doctor's Office Visit** | 20% of Medicare-approved charges | $5 copay | $5 copay | $5 copay |
| **Preadmission X-ray and Lab Tests** | 20% of Medicare-approved charges | No charge | No charge | No charge with an office visit copay |
| **Routine Checkups** | Not covered | No charge | $5 copay | No charge |
| **Immunizations** | Not covered | No charge | No charge | No charge with an office visit copay |
| **Outpatient Surgical Services** | 20% of Medicare-approved charges | $5 copay per procedure | No charge | No charge |
| **Physical Therapy** | 20% of Medicare-approved charges | $5 copay | $5 copay | No charge with an office visit copay |
| **Speech Therapy** | 20% of Medicare-approved charges | $5 copay | $5 copay | No charge with an office visit copay |
| **Maternity** | Covered the same as an illness for services covered by Medicare | $5 copay | Covered as any illness | Covered in accordance with Medicare guidelines |
| **Chiropractic Care** | 20% of Medicare-approved charges | $5 copay for Medicare-covered services[3] | $5 copay for Medicare-covered services[3] | $5 copay for Medicare-covered services[3] |
| **Transportation** | Not covered | Not covered | No charge for unlimited number of rides to medical or dental appointments | Not covered |
| **Prescription Drug Benefits** | | | | |
| **Prescription Drugs** | **Retail:** 80% in-network, 60% out-of-network<br>**Mail order:** $10 generic/ $30 brand/$50 non-preferred brand/$150 specialty copay for mail order for 90-day supply[4] | $7 copay for up to 100-day supply; covers dental prescriptions | **Retail:** $7 generic/$15 brand<br>**Mail order:** $7 generic/ $15 brand for 90-day supply | $7 copay for 30-day supply (or for 90-day mail order supply for maintenance medications only) |
| **Mental Health and Substance Abuse Benefits** | | | | |
| **Inpatient** | Plan pays all Medicare inpatient deductibles for approved Medicare days; 190-day lifetime maximum | No charge; for unlimited number of days | No charge; 90 days per benefit period. 190-day lifetime maximum in Medicare facility.[2] | No charge; 190-day lifetime maximum if admitted to Medicare-approved psychiatric hospital |
| **Outpatient** | 20% of Medicare-approved charges; up to 50 professional visits per year | $5 copay for each visit per calendar year for an unlimited number of visits | $5 copay for each visit per calendar year. No charge for severe mental illness | $5 copay; unlimited visits |
| **Substance Abuse** | 20% of Medicare-approved charges | Inpatient: No charge as per plan limitations;<br>Outpatient: $5 per individual visit; $2 per group visit | $5 copay; unlimited visits | Same as Mental Health Inpatient and Outpatient |
| **Vision Benefits** | | | | |
| **Eye Exams** | Not covered | $5 copay | $5 copay for Medicare-covered, medically-necessary eye exam | $5 copay |
| **Lenses** | Not covered unless 1st lens after eye surgery | Eyewear (frames/lenses/ contacts) purchased from plan optical sales every 24 months; $150 allowance | Not covered | Not covered |
| **Frames** | Not covered unless after eye surgery | | Not covered | Not covered |
| **Hearing Care Benefits** | | | | |
| **Hearing Exams** | One per calendar year; 80% | $5 copay | $5 copay | $5 copay |
| **Hearing Aids** | 50% up to $300 lifetime maximum | Not covered | $600 allowance, every 24 months | Not covered |


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## (For Medicare-Eligible Members Enrolled in Medicare Parts A and B)


| | Medicare Supplement | Medicare Advantage Prescription Drug (MA-PD) HMOs | | |
|---|---|---|---|---|
| | **Anthem Blue Cross III** | **Kaiser Permanente Senior Advantage** | **SCAN[1]** | **UnitedHealthcare Medicare Advantage HMO** |
| **Calendar Year Deductibles** | None | None | None | None |
| **Annual Maximum Out-Of-Pocket Expenses (for most services)** | None | Maximum copayments of $1,500 – individual $3,000 – family | $3,400 | $6,700 |
| **Lifetime Maximum Benefits** | Unlimited | Unlimited | Unlimited | Unlimited |
| **Hospital Benefits** | | | | |
| **Room and Board** | Plan pays all Medicare inpatient deductibles for approved Medicare days | No charge | No charge | No charge |
| **Surgical Services** | Plan pays all Medicare inpatient deductibles for approved Medicare days | No charge | No charge | No charge |
| **Hospital Services and Supplies** | Plan pays all Medicare inpatient deductibles for approved Medicare days | No charge | No charge | No charge |
| **Nursing Benefits** | | | | |
| **Skilled Nursing Facility Care** | Plan pays Medicare daily deductible for days 21–100; no coverage beyond 100 days | No charge; 100 days per benefit period in a Medicare-certified facility | No charge; 100 days per benefit period in a Medicare-certified facility | No charge; 100 days per benefit period in a Medicare-certified facility |
| **Private Duty Nurses** | Not covered | No charge if authorized by a Kaiser Permanente physician | No charge when medically necessary only, per Medicare guidelines | No charge when medically necessary only, per Medicare guidelines |
| **Home Healthcare** | 100% of all remaining costs not covered by Medicare | No charge for Medicare-covered Home Health and no charge for part-time intermittent care if authorized by a Kaiser Permanente physician | No charge for Medicare-covered Home Health. See (1) below for expanded coverage info | No charge when medically necessary only, per Medicare guidelines |
| **Hospice Care** | 100% of all remaining costs not covered by Medicare | No charge if authorized by a Kaiser Permanente physician | No charge | No charge, provided care is in accordance with Medicare guidelines |
| **Emergency Benefits** | | | | |
| **Inpatient** | Plan pays all Medicare inpatient deductibles for approved Medicare days | $5 copay; waived if admitted | No charge | No charge |
| **Outpatient** | 20% of Medicare-approved charges | $5 copay; waived if admitted | $25 copay; waived if admitted | $50 copay; waived if admitted |
| **Ambulance** | 20% of Medicare-approved charges | No charge for emergency | No charge | No charge (if medically necessary) |

[1] SCAN includes expanded coverage for Independent Living Power™ services. Qualifying members are eligible for up to $600 per month of these additional services.
- — No charge for personal care coordination via phone
- — $15 copay per month for emergency response system
- — $15 copay per visit for alternative caregiver visit to a member's home when his or her regular caregiver is not available
- — $15 copay per visit for adult day care to provide relief for regular caregiver
- — No copay for up to five days in a facility when regular caregiver is unavailable
- — $15 copay per visit for transportation escort to medical, dental, optometric or other necessary appointments
- — $15 copay per visit for personal care such as assistance with bathing, dressing, eating, getting in and out of bed, moving about/walking and grooming
- — $15 copay per visit for homemaker services such as light cleaning, grocery shopping, laundry and meal preparation
- — No copay for home-delivered meals
- — No copay for inpatient custodial care up to 5 days in a facility. Medicare will not pay for a stay in a facility if the services received are primarily for those purposes.
- — SilverSneakers by Tivity Health Fitness Program available at no extra cost.

[2] Note: Visit or day limits do not apply to certain mental healthcare described in the evidence of coverage.

[3] Manual manipulation of the spine to correct subluxation that can be demonstrated by X-ray, when the manipulation is prescribed by plan physician and performed by plan provider.

[4] Copayment for specialty drugs will be prorated if you receive less than a 90-day supply

[5] UnitedHealthcare Medicare Advantage HMO includes coverage for Solutions for Caregiver's services — No charge for advice, information and referrals. See the Caregiver flyer included in the materials received after enrollment in the plan for additional services.

# 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<br>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. Hmong | LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-786-6464, Ext. 1. |
| 4. 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. |
| 5. 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. |
| 6. Hindi | ध्यान द: यद आप हदी बोलते ह तो आपके लए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। पर कॉल कर 1-800-786-6464, Ext. 1. |
| 7. 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. |
| 8. Arabic | ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-786-6464، Ext. 1. |
| 9. Korean | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-786-6464, Ext. 1 번으로 전화해 주십시오. |
| 10. Thai | เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-786-6464, Ext. 1. |
| 11. Russian | ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-786-6464, Ext. 1. |
| 12. 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。 |
| 13. Armenian | ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-786-6464, Ext. 1: |
| 14. Cambodian | ប្រុងប្រយ័ត្នប្រសិនបើអ្នកនិយាយភាសាខ្មែរអ្នកមានសេវាកម្មជំនួយភាសាឥតគិតថ្លៃនៅចំពោះមុខអ្នក។ ទូរស័ព្ទមកលេខ 1-800-786-6464, Ext. 1 ។ |
| 15. Punjabi | ਧਆਨ ਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-786-6464, Ext. 1 'ਤੇ ਕਾਲ ਕਰੋ। |


200 – 12,000 – 06/18