LACERA

Comparison of Medical Plans

2018

Effective July 1, 2018

Health Maintenance Organizations (HMOs) and Medicare Advantage Prescription Drug (MA-PD) HMOs

- Kaiser Permanente – Colorado
- Kaiser Permanente – Georgia
- Kaiser Permanente – Hawaii
- Kaiser Permanente – Oregon

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, which legally govern each plan's operation.

The health plans and benefit designs available from the LACERA-administered options change when an enrolled member permanently moves outside the provider network area. Moving to a location outside the coverage area will impact your eligibility to be enrolled in the health plan, the benefit designs available and the rates you pay.

Note: The benefit levels contained in this booklet are subject to approval by the Centers for Medicare and Medicaid Services (CMS) and may be adjusted during the plan year.

BASIC (UNDER 65 OR OVER 65 WITHOUT MEDICARE COVERAGE) HMOs

	Kaiser Permanente – Colorado	Kaiser Permanente – Georgia	Kaiser Permanente – Hawaii	Kaiser Permanente – Oregon
Calendar Year Deductible/Copayment	None	None	None	None
Annual Maximum Out-of-Pocket Expenses (for most services)	Individual – $2,000 Family – $4,500	Individual – $2,000 Family – $4,000	Individual – $2,500 (including prescription drugs) Family (3 or more) – $7,500 (including prescription drugs)	Individual – $600 Family – $1,200
Lifetime Maximum Benefits	None	None	Unlimited	None
Hospital Benefits				
Room and Board	$250 copay per admission	$250 copay per admission	$50/day	No charge
Surgical Services	Inpatient – no charge Outpatient – $50 copay	Inpatient – no charge Outpatient – $100 copay	No charge	Inpatient – no charge Outpatient – $5 copay
Hospital Services and Supplies	Durable medical equipment covered at 80%	Durable medical equipment covered at 80%	Durable medical equipment covered at 80%; diabetes equipment covered at 50%	No charge
Hospital Admission Authorization Requirements	No authorization needed when referred by a Kaiser Permanente physician	Authorization required for hospital admissions	Authorization required by a Kaiser Permanente Medical Group physician	Authorization required by a Kaiser Permanente physician
Nursing Benefits				
Skilled Nursing Facility Care	No charge; 100 days per period	$250 copay per admission; 100 days per year	No charge; 120 days per accumulated period	No charge; 100 days per year
Private Duty Nurses	No charge if in service area only and referred by a network provider	No charge if authorized	Not covered	Not covered
Home Health Care	No charge if authorized	No charge if authorized	No charge if authorized	No charge if authorized; limited to 130 days
Hospice Care	No charge	No charge if authorized	No charge if authorized	No charge
Emergency Benefits				
Inpatient	$100 copay (waived if admitted)	$100 (waived if admitted)	$50/visit within service area; 20% copay outside of service area (waived if admitted)	$75 copay (waived if admitted)
Outpatient	$100 copay	$100 (waived if admitted)	$50/visit within service area; 20% copay outside of service area	$75 copay (waived if admitted)
Ambulance	20% copay; max. of $500 per trip	$100 copay	No charge	$75 copay
Outpatient Benefits				
Doctor's Office Visits	$5 copay ($25 copay for after-hours care; $15 copay for specialist visit)	$15 copay	$15 copay	$5 copay
Preadmission Diagnostic X-ray and Lab Tests	Included in office visit copay	No charge	No charge	No charge
Routine Checkups				
– Adults	No charge	No charge	No charge	No charge
– Children Under 17	No charge	No charge	No charge	No charge
Immunizations	$5 copay; no charge if preventive	$15 copay; no charge if preventive	No charge	No charge for routine
Outpatient Surgical Services	$50 copay	$100 copay	$15 copay	$5 copay
Physical Therapy	$250 copay inpatient; $5 copay outpatient; limited to 20 visits per year	$15 copay	$15 copay	$5 copay; up to 20 visits per therapy, per calendar year
Speech Therapy	$250 copay inpatient; $5 copay outpatient; limited to 20 visits per year	$15 copay	$15 copay	$5 copay; up to 20 visits per therapy, per calendar year
Maternity	$5 copay	$15 copay for 1st visit; no charge thereafter	No charge (after confirmation of pregnancy)	Hospitalization – no charge; doctor's office visit – no charge
Prescription Drug Benefits				
Prescription Drugs	$10 copay for up to 60-day supply	$15 generic/$30 brand copay for up to 30-day supply at Kaiser Permanente; $25 generic/$40 brand copay for up to 30-day supply at Rite Aid or Walgreens	$10 copay for up to 30-day supply	$5 copay for up to 30-day supply
Mental Health Benefits				
Inpatient	$250 per admission	$250 copay	$50/day*	No charge
Outpatient	$5 copay	$15 copay	$15 copay*	$5 copay
Substance Abuse Benefits				
Inpatient	$250 per admission	$250 copay per admission (detox only)	$50/day	No charge
Outpatient	$5 copay	$15 copay	$15 copay	$5 copay
Residential Day	$250/admission	Not covered	20% of applicable charges up to 60 days per calendar year	No charge
Vision/Hearing Care Benefits				
Eye Exams	$5 copay	$15 copay	$15 copay	$5 copay
Lenses	$150 credit toward lenses, contact lenses or frames combined every 2 years	$100 credit toward lenses, contact lenses or frames combined every 2 years	Not covered	Not covered
Frames			Not covered	Not covered
Hearing Exam	$5 copay	$15 copay (if exam copay applies)	$15 copay	$5 copay
Hearing Aids	Not covered	Not covered	Covered at 40%	Covered for children only

*When prescribed by a physician, services for serious mental illness will be provided in accordance with state law.

RETIREE WITH MEDICARE MA-PD HMOs

	Kaiser Permanente – Colorado	Kaiser Permanente – Georgia	Kaiser Permanente – Hawaii	Kaiser Permanente – Oregon
Calendar Year Deductible/Copayment	None	None	None	None
Annual Maximum Out-of-Pocket Expenses (for most services)	Individual – $2,500	Individual – $2,000	Individual – $2,500 Family – $7,500	Individual – $600
Lifetime Maximum Benefits	None	None	Unlimited	None
Hospital Benefits				
Room and Board	$250 copay per admission	$250 copay per admission	$50/day	No charge
Surgical Services	Inpatient – no charge; outpatient – $50 copay	Inpatient – no charge; outpatient – $100 copay	No charge	No charge
Hospital Services and Supplies	Durable medical equipment covered at 80%	No charge	No charge	No charge
Hospital Admission Authorization Requirements	No authorization needed when referred by a Kaiser Permanente physician	Authorization required for hospital admissions	Authorization required by a Kaiser Permanente Medical Group physician	Authorization required by a Kaiser Permanente physician
Nursing Benefits				
Skilled Nursing Facility Care	No charge; 100 days per period	$250 copay per admission; 100 days per period	No charge; 100 days per year	No charge; 100 days for Medicare benefits period
Private Duty Nurses	No charge in service area	No charge if authorized	Not covered	Not covered
Home Health Care	No charge in service area	No charge if authorized	No charge if authorized	No charge; unlimited visits
Hospice Care	No charge (only home-based hospice care)	No charge	No charge if authorized	No charge
Emergency Benefits				
Inpatient	$50 copay (waived if admitted)	$50 copay (waived if admitted)	$50 per visit	$50 copay (waived if admitted)
Outpatient	$50 copay	$50 copay (waived if admitted)	$50 per visit	$50 copay (waived if admitted)
Ambulance	20% copay; max. of $500 per trip	$100 copay	No charge	$50 copay
Outpatient Benefits				
Doctor's Office Visits	$5 copay ($15 copay for specialist visit)*	$15 copay	$15 copay	$5 copay
Preadmission Diagnostic X-ray and Lab Tests	Included in office visit copay	Copay varies	No charge	No charge
Routine Checkups				
– Adults	No charge	No charge	No charge	No charge
– Children Under 17	No charge	No charge	No charge	Not covered
Immunizations	$5 copay; no charge if preventive	$15 copay; no charge if preventive	No charge	No charge
Outpatient Surgical Services	$50 copay	$100 copay	$15 copay	$5 copay
Physical Therapy	$250 copay inpatient; $5 copay outpatient	$15 copay outpatient	$15 copay	$5 copay; unlimited visits
Speech Therapy	$250 copay inpatient; $5 copay outpatient	$15 copay outpatient	$15 copay	$5 copay; unlimited visits
Maternity	No charge	No charge	No charge (after confirmation of pregnancy)	No charge
Prescription Drug Benefits				
Prescription Drugs	$10 copay for up to 60-day supply	$15 generic/$30 brand copay for up to 30-day supply at Kaiser Permanente; $25 generic/$40 brand copay for 30-day supply at Rite Aid or Walgreens	$10 copay for up to 30-day supply	$5 copay for a 30-day supply
Mental Health Benefits				
Inpatient	$250 per admission	$250 per admission	$50/day**	No charge
Outpatient	$5 copay	$15 copay	$15 copay**	$5 copay
Substance Abuse Benefits				
Inpatient	$250 per admission	$250 per admission; detox and rehab	$50/day	No charge
Outpatient	$5 copay	$15 copay	$15 copay	$5 copay
Vision/Hearing Care Benefits				
Eye Exams	$5 copay	$15 copay	$15 copay	$5 copay
Lenses	$150 credit toward lenses, contact lenses or frames combined every 2 years	$100 credit toward lenses and/or frames combined every 2 years	Not covered	$150 credit toward the purchase of lenses, frames, and/or contact lenses every 24 months
Frames			Not covered	
Hearing Exam	$5 copay	$15 copay	$15 copay	$5 copay (adults/children)
Hearing Aids	Not covered	Not covered	$500 allowance to purchase hearing aids; provided every 3 years	Not covered

*All office-administered prescription drugs covered by Medicare Part B (except preventive immunizations and diagnostic drugs) will be subject to 20% coinsurance. This coinsurance will apply to the annual maximum out-of-pocket expenses.

**When prescribed by a physician, services for serious mental illness will be provided in accordance with state law.

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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