MEDICAL PLANS OVERVIEW

LACERA is proud to offer comprehensive medical plans to Los Angeles County retirees and their eligible dependents. Eligibility for some plans depends on whether the person being insured is eligible for Medicare coverage. The following chart shows the plans, availability based on Medicare eligibility, and where in this brochure to get more information.

Plan	Available to Those who ARE Medicare Eligible	Available to Those who ARE NOT Medicare Eligible	More Information on Page
Health Maintenance Organizations (HMOs)			
Kaiser Permanente HMO	Yes	Yes	4
UnitedHealthcare HMO	No, unless under age 65	Yes, if under age 65	4
Cigna Network Model Plan HMO	In California: Yes In Arizona: Yes, if under age 65	In California: Yes In Arizona: Yes, if under age 65	5
Indemnity Medical Plans			
Anthem Blue Cross Prudent Buyer	Yes	Yes	7
Anthem Blue Cross Plan I	Yes	Yes	7
Anthem Blue Cross Plan II	Yes	Yes	7
Medicare Supplement Plan *(Must be currently enrolled in Medicare Part A and B)*			
Anthem Blue Cross Plan III	Yes	No	9
Medicare Advantage-Prescription Drug (MA-PD) HMOs (with Medicare Part D) *(Must be currently enrolled in Medicare Part A and B)*			
Kaiser Permanente Senior Advantage	Yes	No	14
UnitedHealthcare Medicare Advantage	Yes	No	14
Cigna Preferred with Rx (HMO)(available in Maricopa County and Apache Junction, Pinal County, Arizona only)	Yes	No	15
SCAN Health Plan serves retirees with Medicare Parts A and B entitlements in the following California counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, Ventura, Fresno, Madera, Santa Clara, San Francisco, Stanislaus, Alameda, and San Mateo. SCAN Desert Health Plan - Arizona. Available in the following counties: SCAN Health Plan Nevada - Nevada. Available in Clark and Nye County)	Yes	No	15

MEDICAL PLANS OVERVIEW

Medicare Enrollees:
Prescription Drug Benefits

LACERA members do not have to enroll in any separate Medicare Part D plans because all LACERA-administered medical plans have prescription drug coverage that is at least as good as the standard Medicare Part D plan.

As a LACERA member, you should not enroll in a separate Medicare Part D plan. Enrollment in a separate Medicare Part D plan may jeopardize your LACERA-administered coverage. In addition, if you later decide to disenroll from the separate Medicare Part D plan, your reenrollment into a LACERA plan may be delayed.

All individuals who have medical coverage through LACERA are provided with a Notice of Creditable Coverage (NOCC), an official statement that your LACERA-administered medical plan provides you with prescription drug coverage that is, on average, as good as or better than that offered by the standard Medicare Part D plan. Anyone who enrolls in a separate Medicare Part D plan at a later date and shows the NOCC will not have to pay a higher premium for late enrollment.

If you are thinking about enrolling in a separate Medicare Part D Plan, contact LACERA first:

- **please visit LACERA's website at www.lacera.com to download a copy of the NOCC, or**
- **call LACERA's Retiree Healthcare Division at (800) 786-6464.**
- **Log in or register to myLACERA at lacera.com**

Health Maintenance Organizations (HMOs)

A health maintenance organization (HMO) is a healthcare plan that requires you to use certain providers specified by the plan.

HMOs offer:

- Coverage for most expenses, including those for preventive care.
- No deductibles.
- No claim forms.
- Small copayments for office visits.
- No paperwork.
- No restrictions on coverage for pre-existing conditions.

The two types of HMOs:

1. Group model – The HMO owns and/or operates the facility and the physician is an HMO employee. Services are provided at the facility.
2. Independent Physicians Association (IPA) model – Physicians in private practice or physicians in medical groups contract with the HMO to provide services to its members. Services are provided either at a facility or at the physician's office.

LACERA offers the following HMOs:

- Kaiser Permanente (Group model).
- UnitedHealthcare* (IPA model).
- Cinga Network Model Plan (IPA model).

* *Available to eligible LACERA members and dependents who are under age 65.*

All of the LACERA-administered medical plans have voluntary Disease Management features and/or programs to help LACERA members who have chronic conditions stay as healthy as possible for as long as possible. Details are on page 16.

MEDICAL PLANS OVERVIEW

HMO	Features
Kaiser Permanente HMO The Kaiser plan is a group model HMO available to all eligible LACERA members and their dependents. Those who are eligible for Medicare may be eligible for Kaiser Senior Advantage, described on page 14.	■ You must receive **ALL** medical care from a Kaiser physician at a Kaiser facility, except in the case of a life-threatening emergency. ■ Kaiser has numerous major medical centers and many smaller medical clinics located throughout California, as well as several other states. ■ If you are covered under Kaiser and move out of California to a state where a LACERA-administered Kaiser plan is also available (i.e., Oregon, Washington, Hawaii, Colorado and Georgia), you may contact LACERA to enroll.
UnitedHealthcare HMO The UnitedHealthcare HMO is an IPA HMO available to all eligible LACERA members and their dependents who are under age 65, regardless of Medicare eligibility.	■ You must receive **ALL** care through UnitedHealthcare providers, except in the case of a life-threatening emergency. ■ UnitedHealthcare contracts with physicians and hospitals throughout Northern and Southern California.

MEDICAL PLANS OVERVIEW

HMO	Features
Cigna Network Model Plan HMO The Cigna Network Model Plan is an IPA HMO available to all eligible LACERA members and their dependents.	■ You select a primary care physician (PCP) from either the Cigna Medical Group or a private practice physician. Each family member is allowed to select a separate PCP. ■ In Arizona, if the PCP is in the Cigna Medical Group, the covered family member must receive **ALL** medical care at a Cigna Healthcare Center, unless an emergency occurs and the patient is outside of the service area. ■ If the PCP is in private practice, you must receive all covered health care or referral care from that physician, except in the event of an emergency. ■ Each covered person selects a PCP from the Cigna Medical Group or Cigna's network of participating private practice physicians. The PCP will direct **ALL** of that person's non-emergency medical care. In Arizona, if the PCP is part of the Cigna Medical Group, the person must receive all care at a Cigna Healthcare Center. ■ Cigna offers this plan in certain areas of California and Arizona. In Arizona, only retirees under age 65 or dependents of retirees who elect Cigna Preferred with Rx (HMO) (available in Maricopa County and Apache Junction, Pinal County, Arizona only) may enroll in this plan.

Indemnity Medical Plans

An indemnity medical plan is fee-for-service health insurance. With this type of plan, you pay a certain amount in medical expenses each year (called the annual deductible) before the plan pays benefits. After you meet your annual deductible, you pay for services at the time you receive care from the provider or hospital of your choice. You then submit a claim and are reimbursed a portion of covered expenses by the plan. If you use network providers, no claim forms are required.

These plans allow you to use any provider you choose. But, you will pay less when you see a provider who is part of the Prudent Buyer Network. That's because these providers have negotiated to limit their fees to a contracted rate and you pay less in coinsurance. The negotiated rate will vary depending on where you live.

When you see a provider who is not in the Prudent Buyer network, you may end up paying more because that provider hasn't agreed to limit his or her charges to a negotiated rate. That means you not only pay the deductible and your coinsurance, but also pay any amount over the reasonable and customary charge. A reasonable and customary charge is the maximum amount the plan will pay for a service, based on what providers in that geographic area charge for similar services or supplies.

The following plans use the Anthem Blue Cross Prudent Buyer provider network:

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

You should contact Anthem Blue Cross at 1-800-284-1110 to find out if a physician or hospital is in the Prudent Buyer Network.

Indemnity medical plans require:

- Annual deductibles.
- Coinsurance (you pay a percentage of all medical services).
- Claim forms for reimbursement of services.*
- Utilization Review which determines medical necessity and length of stay of all hospital admissions.

**If you use network providers, no claim forms are required.*

Indemnity medical plans currently offered by LACERA are:

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

Lifetime Benefit Maximum

The Lifetime Benefit Maximum for the Anthem Blue Cross Prudent Buyer Plan, Anthem Blue Cross I, and Anthem Blue Cross II combined is $1 million per member. The benefit amount available is reduced by any amount paid previously from another LACERA-administered Anthem Blue Cross Plan (except Anthem Blue Cross III). For Lifetime Benefit Maximum information, call Anthem Blue Cross at 1-800-284-1110. To enroll in LACERA-administered medical plans,contact LACERA's Retiree Healthcare Division at 1-800-786-6464, log in or register to myLACERA at lacera.com.

MEDICAL PLANS OVERVIEW

Plan	Features
Anthem Blue Cross Prudent Buyer Plan Anthem Blue Cross Prudent Buyer Plan is a PPO plan that allows you to use preferred providers. Both Medicare-eligible and non-Medicare-eligible members can join this plan.	■ This plan has a California-based preferred provider network of physicians and hospitals that have negotiated with Anthem Blue Cross to provide discounted services to participants. ■ You decide at the time you need healthcare services whether to see a network provider or a non-network provider. ■ Retail prescription drug benefits are provided through CarelonRx. If you have any prescription drug questions you can call 1-800-284-1110.
Anthem Blue Cross I Anthem Blue Cross I is a traditional indemnity plan available to all eligible LACERA members and dependents. Both Medicare-eligible and non-Medicare-eligible members can join this plan. ***Hospital benefits***, however, are ***very limited***.	■ The plan has very limited hospital room and board benefits—an important consideration if you or your dependents do not have Medicare Part A (hospital benefits).
Anthem Blue Cross II Anthem Blue Cross II is a traditional indemnity plan available to all eligible LACERA members and dependents. Both Medicare-eligible and non-Medicare-eligible members can join this plan.	■ This plan offers more comprehensive hospitalization benefits than Anthem Blue Cross I. Anthem Blue Cross II offers a hospital PPO that provides reduced hospital fees to participants who are admitted as inpatients. ■ The most an Anthem Blue Cross II participant will have to pay out-of-pocket for covered medical expenses is $2,500 a year. You will remain responsible for costs in excess of the *maximum allowed amount.*

Plan	Features
Anthem Blue Cross I and II	Both plans offer: ■ Caremark Prescription Drug Program, including retail and mail-order prescription drug benefits. For details, see pages 10 – 12. ■ Coordination with Medicare. ■ "Centers of Medical Excellence"—a unique program that consists of facilities that provide case management and high-quality care for specific medical conditions and transplants.
Anthem Blue Cross Prudent Buyer Plan, Anthem Blue Cross I, Anthem Blue Cross II	■ There is a $1 million Lifetime Benefit Maximum from all three Anthem Blue Cross plans combined (except Anthem Blue Cross III).

Plan	Features
Utilization Review Program (for Anthem Blue Cross I , II and Prudent Buyer — non-Medicare members only) The Utilization Review (UR) program is an important benefit for members and eligible dependents who enroll in Anthem Blue Cross I, Anthem Blue Cross II, or Anthem Blue Cross Prudent Buyer. The program provides pre-admission review to determine medical necessity and appropriate length of stay for all hospital admissions. When you use UR, the plan will pay your regular benefits. If you do not use UR, your hospital benefits may be reduced.	The following is a brief summary of how Utilization Review (UR) works: ■ Your identification card will have the UR toll-free telephone number. ■ Submit a request for admission to UR. UR will review the details of the proposed admission and treatment, and determine, based on UR criteria, whether the admission is medically necessary: – If UR determines that the proposed admission is medically necessary, UR will tell you how long you should be hospitalized. UR will also establish a time frame for continued stay review. – If a proposed admission is determined not to be medically necessary, and you elect to stay at the hospital, hospital charges will not be covered. – If a proposed non-emergency admission is not submitted for review—or if an emergency admission is not submitted for review on the first business day following the admission—the first $200 of covered expenses will not be covered.

Medicare Supplement Plan

A Medicare supplement plan is a plan that requires you to pay for services at the time you receive care.

This plan is for members enrolled in **both** Medicare Part A and Part B. The plan supplements Medicare coverage by:

- Paying Medicare Part A deductibles and copayments.
- Paying the annual Medicare Part B deductible and 20% of Medicare-approved amounts for covered services and supplies.
- Providing prescription drug benefits *instead of* Medicare Part D.

The only Medicare supplement plan currently offered by LACERA is:

- Anthem Blue Cross III.

If you enroll in Anthem Blue Cross III, your premiums for Medicare Part B are reimbursed (base rate) by the County on a tax-free basis provided you meet all the conditions outlined in the *Decision Guide* insert in your *RHC Enrollment Packet*, subject to annual approval by the L.A. County Board of Supervisors.

All of the LACERA-administered medical plans have voluntary Disease Management features and/or programs to help LACERA members who have chronic conditions stay as healthy as possible for as long as possible. Details are on page 16.

Plan	Features
Anthem Blue Cross III Medicare Supplement Plan Anthem Blue Cross III supplements Medicare coverage by paying many of the costs that Medicare doesn't cover, such as copayments or annual deductibles. Anthem Blue Cross III also covers prescription drugs through CVS, so participants should not enroll in a separate Medicare Part D plan as it may jeopardize these benefits.	▪ You may select the doctor or hospital of your choice. However, to obtain the maximum benefit, **you must choose a physician who accepts assignment of benefits from Medicare**. If the provider does not accept assignment, you must pay the difference between what the provider charges and what Medicare and the Anthem Blue Cross III plan both pay. ▪ Anthem Blue Cross III includes the Caremark Prescription Drug Program, described in detail on pages 10 – 12, including retail and mail-order prescription drug benefits. These benefits are provided instead of Medicare Part D's prescription drug coverage. ▪ Anthem Blue Cross III provides certain emergency benefits for sudden and unexpected life threatening conditions when participants are traveling in a foreign country. Medicare does not offer coverage outside of the United States.

Prescription Drug Benefits for Anthem Blue Cross Plans I, II, and III

Anthem Blue Cross Plans I, II, and III provide prescription drug benefits through CVS Caremark, the pharmacy benefits manager contracted through Anthem Blue Cross. Detailed charts showing these prescription drug benefits are on pages 11 and 12.

Plan	Features
CVS Caremark Network Pharmacies (for Anthem Blue Cross Plans I, II and III only) Use a network retail pharmacy for 30-day non-maintenance prescriptions. CVS Caremark's network includes more than 68,000 pharmacies nationwide, including chain pharmacies, 20,000 independent pharmacies and 9,600 CVS Pharmacy locations, many which are now at Target stores. ■ Call Caremark for a listing of pharmacies in your area. ■ Receive an ID card from Anthem Blue Cross with Caremark information on the back that identifies you as a participant in the program. This card must be presented to a pharmacist along with each prescription to ensure correct claims processing.	Here are the steps for using the program: ■ You pay for your prescription when you receive your medication. ■ When you use a network retail pharmacy for non-maintenance prescriptions, the pharmacy will calculate the 20 percent coinsurance at the time of purchase (after applying your deductible) and that is all you will need to pay*. ■ If you use a Non-Network Pharmacy: – You submit a claim form directly to Caremark for reimbursement. – Anthem Blue Cross reimburses you for 60% of reasonable and customary charges (after you meet your annual deductible*). – If you do not live within the Caremark service area, you will be reimbursed for 80% of reasonable and customary charges (after you meet your annual deductible*). ** No deductible is required by the Anthem Blue Cross III plan.*

Plan	Features
CVS Caremark Mail-Order Drug Program for Anthem Blue Cross I, II and III only This program is important for participants who take maintenance prescriptions for chronic medical conditions and specialty drugs. The Mail Order Program provides exceptional value for participants who take prescription drugs on an ongoing basis. You receive up to a 90-day supply of maintenance medications for one small copayment, instead of paying 20% of the cost for a 30-day supply at a network pharmacy (or 40% at a non-network pharmacy). We encourage you to consider purchasing generic drugs when possible. They are typically as effective as brand-name drugs and you will pay only $10 for each 90-day supply. The program also offers specialty drugs for a fraction of the cost you would pay if you purchased them from other sources. And, with mail order, your prescription drugs are delivered right to your door – you don't have to make a trip to the pharmacy, stand in line, or wait for reimbursement! ■ You may order up to a 90-day supply of long-term maintenance prescription drugs by mail.	■ There is no deductible required. For up to a 90-day supply you pay a: – $10 copay for each authorized generic prescription – $30 copay for each authorized preferred brand-name prescription – $50 copay for each authorized non-preferred brand-name prescription ■ Caremark will mail your prescriptions to your home approximately 10 to 14 days ***after*** receiving your order. ■ To request refills and check which are preferred drugs, call Caremark's toll-free telephone number (800) 450-3755 or log on to www.caremark.com. ■ **Maintenance Choice**®: – 30-day fills of maintenance medications can be filled (no fill limits) at any participating CVS network pharmacy. You will pay the 20% retail coinsurance, after you meet the annual deductible. – 90-day fills of maintenance medications can be filled at CVS pharmacies (including those inside Target stores) or through Mail Order service. Using these options, you pay the copay amounts ($10 – Generic Drugs, $30 Preferred brand drugs, $50 Non-preferred brand drugs). This remains unchanged. ■ The chart on the next page shows the summary of options, including your coinsurance/copays, available to fill your maintenance prescription medications:

Maintenance Prescription Medications - Summary of Options			
	Any Network Retail Pharmacy Up to a 30-day supply	**Maintenance Choice (Filled at CVS/ pharmacy) Up to a 90-day supply**	**Mail Order Service Up to a 90-day supply**
Generic Drugs	20% coinsurance*	$10 copay	$10 copay
Preferred Brand Drugs	20% coinsurance*	$30 copay	$30 copay
Non-preferred Brand Drugs	20% coinsurance*	$50 copay	$50 copay
Fill Limit for Long-term Medications	No Limit	No Limit	No Limit

*After you meet the annual deductible. Note: Anthem Blue Cross Plan III does not have deductibles.

With using the Maintenance Choice option, you can save time and money for your maintenance medications. All you need to do is obtain a 90-day supply maintenance prescription from your doctor and have it filled through Mail Order or at CVS pharmacies (including those inside Target stores). For questions, please contact CVS Caremark at (800) 450-3755 or visit their website at www.caremark.com.

Specialty Drugs

Specialty drugs are available only by mail through Caremark Specialty Pharmacy Services, unless they are dispensed in your physician's office.

Specialty drug copayments are:

- $50 for up to a 30-day supply.
- $100 for a 31-60-day supply.
- $150 for a 90-day supply.

You must register with Caremark Specialty Pharmacy Services by calling 1-800-237-2767, Monday through Friday, 4:30 AM to 6 PM (Pacific Time). For TDD, call 1-800-231-4403. For refills, call 1-800-237-2767.

What is a specialty drug?

While there is no single accepted definition, all descriptions agree that specialty drugs:

- often use biotechnology and genetic coding
- are used to treat complex or rare conditions, such as rheumatoid arthritis, osteoporosis, cancer, anemia and multiple sclerosis
- are delicate and difficult to produce
- are typically self-injected or administered by a health care professional
- are typically very expensive because of their complexity and narrow therapeutic range.

Specialty drugs are available only by mail through Caremark Specialty Pharmacy Services, unless they are dispensed in your physician's office. You must register with Caremark Specialty Pharmacy Services by calling the phone number listed above.

Medicare Advantage Prescription Drug (MA-PD) HMOs (with Medicare Part D)

A Medicare Advantage Prescription Drug (MA-PD) HMO Plan is an HMO that has a contract with the federal government to provide healthcare services to those with Medicare Part A and Part B coverage. Medicare (the federal government) in turn, pays the HMO a monthly fee for each member.

MA-PD HMOs offer:

- Coverage for most expenses, including those for preventive care and prescription drugs.
- No deductibles.
- No claim forms.
- Small copayment for office visits.
- No paperwork.
- No restrictions on coverage for pre-existing conditions.

Premiums for Medicare Part B (base rate) are reimbursed by the County on a tax-free basis provided you meet all the conditions outlined in the *Decision Guide* insert in your *RHC Enrollment Packet*, subject to annual approval by the Los Angeles County Board of Supervisors. To participate in this plan, you must:

- agree to receive **ALL** medical services and prescription drugs from plan providers (except emergency care while traveling outside the HMO's service area).
- assign all Medicare benefits to the MA-PD HMO.

MA-PD HMOs currently offered by LACERA are:

- Kaiser Permanente Senior Advantage.
- UnitedHealthcare Medicare Advantage

MEDICAL PLANS OVERVIEW

- Cigna Preferred with Rx (HMO) (available in Maricopa County and Apache Junction, Pinal County, Arizona only)
- SCAN Health Plan, SCAN Desert Plan Health Plan - Arizona, SCAN Health Plan Nevada - Nevada.

All of the LACERA-administered medical plans have voluntary Disease Management features and/or programs to help LACERA members who have chronic conditions stay as healthy as possible for as long as possible. Details are on page 16.

For details about Medicare eligibility and coverage, you may:

- read *Medicare & You*, a booklet sent every fall by the Centers for Medicare and Medicaid Services (CMS)
- log on to the Medicare website at www.medicare.gov
- call Medicare at 1-800-MEDICARE (1-800-633-4227).

Plan	Features
Kaiser Permanente Senior Advantage This plan is an MA-PD HMO that is available to eligible LACERA members and their dependents who are enrolled in Medicare Parts A and B. All non-Medicare-eligible members who want Kaiser coverage must enroll in the Kaiser HMO, described on page 4.	■ You must receive **ALL** medical care and prescription drugs from a Kaiser physician at a Kaiser facility, except in the case of a life-threatening emergency. ■ Kaiser has numerous major medical centers and many smaller medical clinics located throughout California, as well as several other states. ■ If you are covered under Kaiser and move out of California to a state where a LACERA-administered Kaiser plan is also available (i.e., Oregon, Washington, Hawaii, Colorado and Georgia), you may continue with Kaiser by enrolling in that state's Kaiser plan. **You must contact LACERA immediately for enrollment forms.**
UnitedHealthcare Medicare Advantage This plan is an MA-PD HMO that is available to eligible LACERA members and their dependents who are enrolled in Medicare Parts A and B. If you have Medicare coverage and wish to enroll in UnitedHealthcare Medicare Advantage, all eligible family members who are under age 65, and therefore not eligible for Medicare, ***must*** enroll in the UnitedHealthcare HMO, described on page 4.	■ UnitedHealthcare Medicare Advantage allows you to receive care from its many network providers and provides comprehensive prescription drug coverage.

MEDICAL PLANS OVERVIEW

Plan	Features
Cigna Preferred with Rx (HMO) (available in Maricopa County and Apache Junction, Pinal County, Arizona only) This plan is an MA-PD HMO that is available to eligible LACERA members and their dependents who are age 65 or over and enrolled in Medicare Parts A and B. (Available only in Maricopa County, Arizona.)	■ Cigna Preferred with Rx (HMO) allows you to receive care from its network providers and provides comprehensive prescription drug coverage.
SCAN Health Plan This plan is an MA-PD HMO available to eligible LACERA members and their dependents who are age 65 or over and enrolled in Medicare Parts A and B. SCAN Health Plan is not available to family members who are under age 65 unless enrolled in Medicare Parts A and B.	■ In addition to comprehensive healthcare benefits, SCAN Health Plan offers the“safety net” of Independent Living Power, In-Home Care services, which include personal care services, homemaker/housekeeper services, home delivered meals, emergency response systems and adult day care, in the five (5) core counties only.

Disease Management Programs

Disease Management Programs help LACERA members with certain chronic conditions (such as hypertension, asthma, congestive heart failure, diabetes, etc.) take advantage of support, tools and information to better manage their diseases. Disease Management Programs help LACERA fulfill one of its long-standing objectives to its members: to help you enjoy the best possible quality of life. All of LACERA's medical plans have Disease Management as part of their benefits.

If you have a chronic disease, call the plan(s) in which you are interested to learn about the Disease Management features available to you.

- **An HMO (Cigna, Kaiser Permanente, UnitedHealthcare/UnitedHealthcare Medicare Advantage, SCAN Health Plan):** Call the HMO at the number listed on the "Contact Information" insert.
- **Anthem Blue Cross Plans I, II or III:** Call Accordant at
  - (844) 393-0864
  - Call Pharmacy Advisor Counseling at 866-624-1481
- **Anthem Blue Cross Prudent Buyer Plan:** Call Condition Care, Anthem Blue Cross' Health Improvement Program, at 1-800-522-5560.

These programs are voluntary and exist for your health. We urge you to take advantage of them. Remember, your health is in your hands!

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