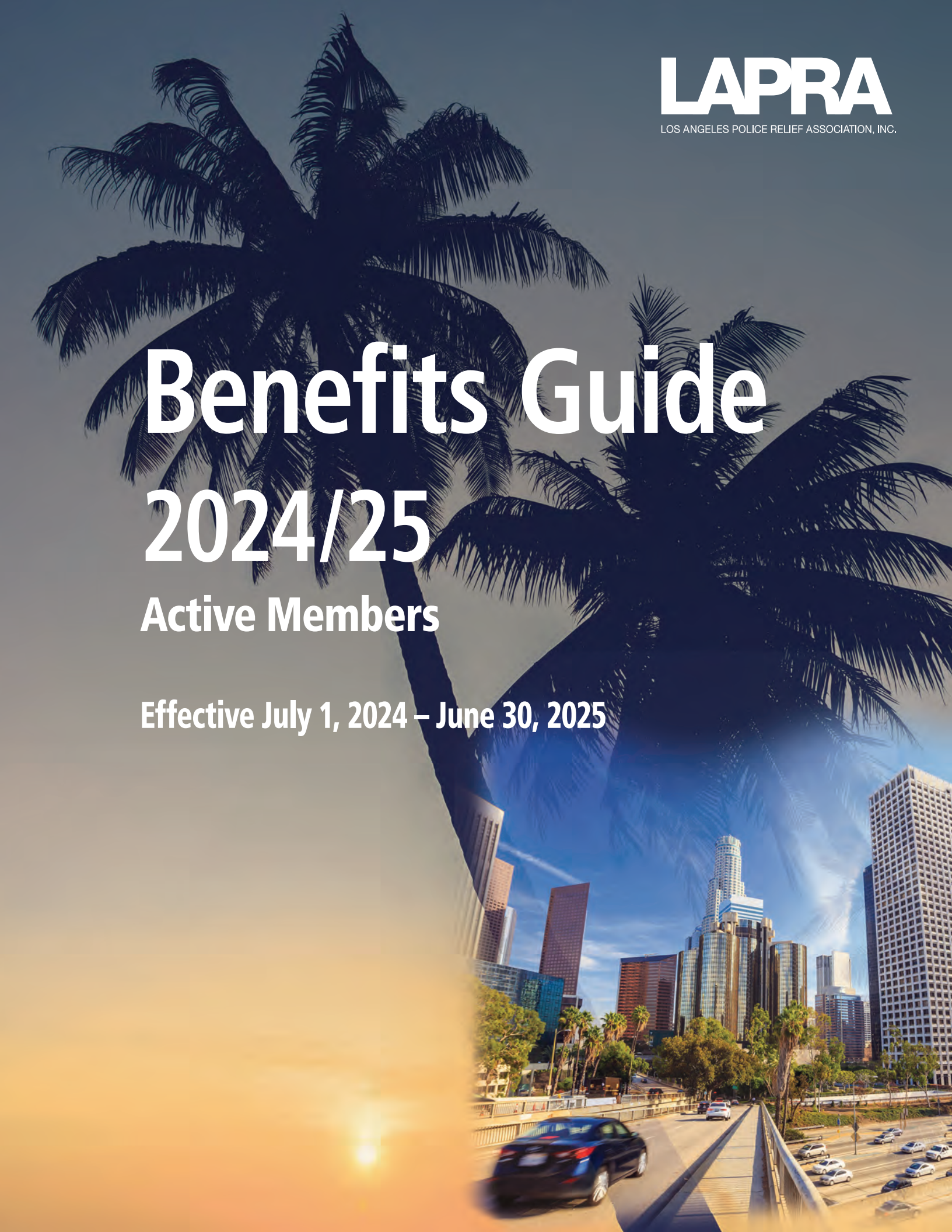
LAPRA

LOS ANGELES POLICE RELIEF ASSOCIATION, INC.

Benefits Guide 2024/25

Active Members

Effective July 1, 2024 – June 30, 2025



LAPRA Benefits

Security. Protection. Choice.

At the Los Angeles Police Relief Association (LAPRA), maintaining a quality benefits program for our members and their families is our priority. Our goal is to promote security, protection and choice while keeping our members strong and healthy. We know you have a choice when it comes to insurance and we take pride in offering medical, dental and vision protection to meet your needs. You can count on the LAPRA benefits program for superior coverage and value.

Inside

Legally Required Notices

Each year there are legally required notices and disclosures that LAPRA is required to make available to participants in LAPRA's benefit plans which are available at **www.lapra.org**. You can also send an email to **benefits@lapra.org** or call LAPRA at 213-674-3701 to request a printed copy of any legal notices or disclosures be mailed to you at no charge.

Get Started on www.LAPRALive.org

Access www.LAPRALive.org to enroll or make changes to your benefits, update personal information, update beneficiary designations and more.

1) Open your web browser and delete your browser history/cookies. Then go to www.LAPRALive.org.
2) The first time you log in, click on the **REGISTER** button.
3) For Company Key, enter **LAPRA**. Then enter your **Social Security Number** and **date of birth**.
4) Click the **CONTINUE** button.
5) Fill in the information requested to create your account including a **user name** and **password**. Complete the three security questions and click the **CONTINUE** button.
6) On the Confirm screen, click the **CONTINUE** button.
7) Enter your user name and password and click on the **LOGIN** button.
8) Follow the onscreen instructions and complete the information requested.

Annual Enrollment

To enroll in or change medical or dental coverage or add or drop coverage for eligible dependents during Annual Enrollment, log in to www.LAPRALive.org (see instructions above). You can also call LAPRA at 213-674-3701 or 888-252-7721 and speak to a Benefits Representative who can assist you with registering and logging into the www.LAPRALive.org website. Any required forms or documents such as proof of dependent status if you add a dependent to your coverage can be uploaded to www.LAPRALive.org by clicking the Help button or submitted to LAPRA by email to benefits@lapra.org or regular mail by May 31, 2024.

Changes Limited

Once you submit your benefit elections, they must remain in effect for the full plan year (July 1 through June 30) unless you experience a qualifying event as provided under Section 125 of the IRS Code.

To make changes due to a qualifying event (such as a dependent losing other coverage), complete your benefit changes on www.LAPRALive.org within 31 days of the qualifying event (60 days for loss of eligibility for Medi-Cal or Healthy Families Program coverage). **If more than 31 days (or 60 days, as applicable) have lapsed since the qualifying event took place, you must wait until the next Annual Enrollment to make the change.** The change in election will generally be effective the first day of the month following the effective date of the qualifying event. Proof of the qualifying event, such as birth/adoption certificate, marriage certificate, divorce decree, or letter verifying the change is required.

If You're Not Making Any Changes During Annual Enrollment

If you do not wish to make changes to your current medical or dental coverage and you have no changes to dependents, there is no need to re-enroll during Annual Enrollment. Your current medical and/or dental coverage will automatically continue. You can make changes to your beneficiary designation(s) on www.LAPRALive.org at any time during the year.

As a reminder, LAPRA does not provide coverage for ineligible dependents, including former spouses, former domestic partners or children who do not qualify as dependents under the plans.

Who Is Eligible?

Employees

All full-time employees working 30 or more hours per week who are:

- Recruits employed by the City of Los Angeles to become sworn police officers;
- Sworn police officers of the LAPD; or
- Employees of the Los Angeles Police Relief Association, the Los Angeles Retired Fire and Police Association or the Los Angeles Police Protective League.

Dependents

The following dependents of enrolled plan members:

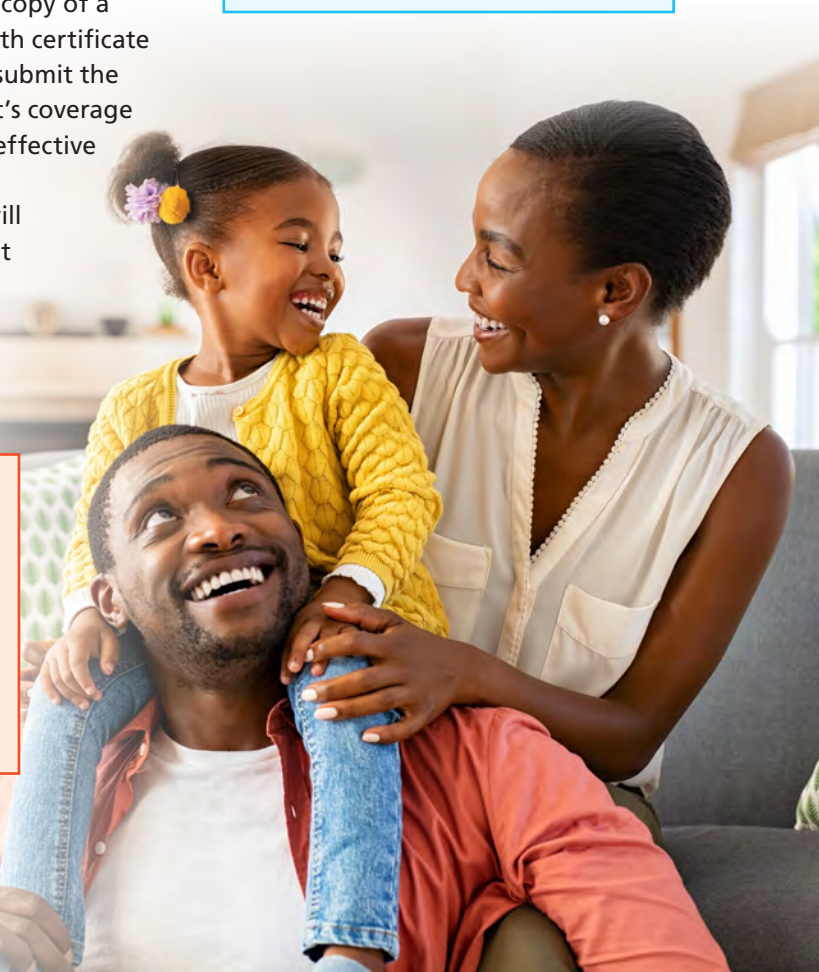
- Legal spouse or legally registered domestic partner or City-approved domestic partner.
- Children under age 26, and children of any age who are incapable of sustaining employment due to a physical or mental disability who became disabled before age 26.

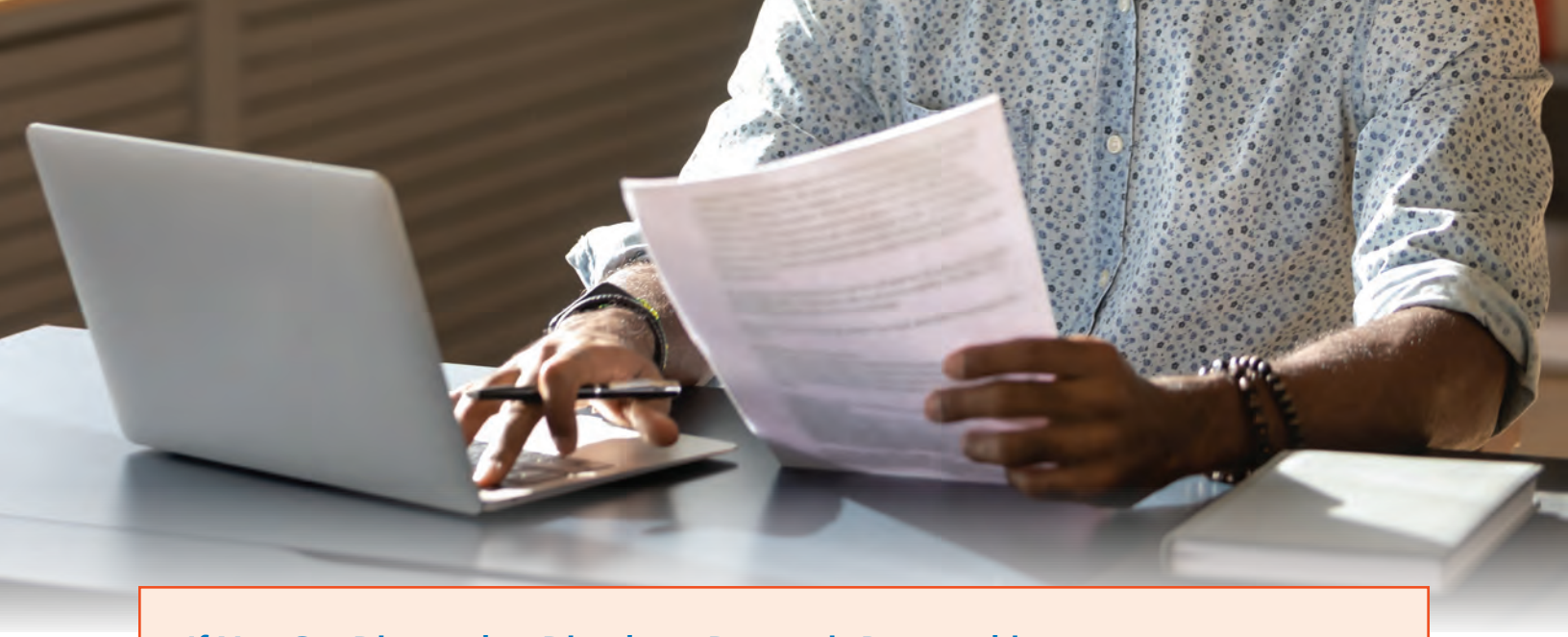
If you enroll an eligible dependent when you are first eligible to enroll in the program or within 31 days following an event or during each year's Annual Enrollment period, you must provide a valid Social Security number for your dependent. Also, you will have 60 days from the dependent's effective date of coverage to submit proof of dependent status, such as a copy of a certified marriage certificate, copy of a certified birth certificate, or commemorative hospital birth certificate that lists the names of one or both parents. If you fail to submit the required proof within the 60-day period, your dependent's coverage will automatically be canceled retroactively to the initial effective date of coverage. You may be responsible to pay for any services incurred prior to coverage being canceled. You will then be required to wait until the next Annual Enrollment period to re-enroll your dependent and submit proof of dependent status. Any medical or dental expenses your dependent incurs after coverage is canceled will be your responsibility.

You may add a domestic partner when you are first eligible to enroll in the program or by completing your enrollment on www.LAPRALive.org within 31 days of the legal and valid registration of a domestic partnership or approval of a domestic partnership application by the City of Los Angeles, whichever is applicable, or during each year's Annual Enrollment period. Written proof of the legal registration of a domestic partnership or the written approval of the domestic partnership application by the City of Los Angeles must also be submitted.

Dual Coverage

If your parent, spouse or domestic partner is also a sworn active or retired LAPD officer, you each must choose to enroll either as a member or as a dependent, but not both under the same plan. Contact LAPRA for more information.





If You Get Divorced or Dissolve a Domestic Partnership

LAPRA does not provide coverage for ineligible dependents, including former spouses, former domestic partners or children who do not qualify as dependents under the plans. You must notify LAPRA within 31 days of the date of divorce or the date your domestic partnership dissolution is final. To remove your former spouse or former domestic partner or any children who no longer qualify as dependents, login to **www.LAPRALive.org**. For instructions, click on **Divorce or Ending a Domestic Partnership** in the Life Event Changes section.

You may not cover a divorced spouse, even if the divorce decree states that coverage must be provided. If the court orders you to provide coverage for your divorced spouse, you must arrange for coverage on your own.

In the case of divorce, COBRA continuation will not be offered to your former spouse and any stepchildren who cease to be your dependents, if LAPRA does not receive notification within 60 days following the date your divorce is final.

If you miss the 31-day deadline noted above:

1. Coverage for your ineligible dependents will be retroactively terminated to the first of the month following the date your divorce or domestic partnership dissolution is final, up to a maximum of 6 months.
2. You may be financially and legally responsible for the cost of medical, dental and vision services provided to your former spouse, former domestic partner and any stepchildren who cease to be your dependents during the period of ineligibility.
3. You may be financially and legally responsible for the cost of any subsidy paid to LAPRA, on your behalf, by either the City of Los Angeles or LAFPP.

To remove ineligible dependents from your coverage, login to **www.LAPRALive.org**. For instructions, click on **Divorce or Ending a Domestic Partnership** in the Life Event Changes section.

If you are currently covering dependents who do not meet the eligibility requirements of the plans, you must notify LAPRA within the time frames listed above. Failure to do so will result in the penalties listed above. Send an email to benefits@lapra.org or call LAPRA at 213-674-3701 for more information.

Medical

LAPRA offers you and your family three medical options:

- Anthem PPO
- Anthem HMO
- Kaiser HMO

All three plans provide coverage for preventive care, office visits, hospitalization, surgery and prescription drugs. The plans differ in co-payments, coinsurance, out-of-pocket costs, and provider choice.

Anthem PPO Plan

www.anthem.com/ca

The Anthem PPO Plan is a Preferred Provider Organization (PPO) that gives you the option to see any provider (participating providers or non-participating providers) whenever you need care. If saving health care dollars is important to you, you will want to stay in-network by using only PPO doctors and hospitals. The Prudent Buyer PPO network is the largest provider network in California.

PPO Network Providers

PPO network providers are doctors, hospitals, pharmacies, labs, etc. that participate in the Anthem Blue Cross Prudent Buyer PPO network and have agreed to provide services at pre-negotiated reduced rates. When you use PPO network providers, you receive the highest level of benefits at the lowest possible cost. You are not required to choose a primary care physician and you can see doctors and specialists within the network without a referral. PPO providers file all claims for you.

See **page 9** for instructions on how to find Anthem PPO network providers.

How It Works

After the applicable calendar year deductible is met, the plan pays 90% of most covered services.

When the deductible and other out-of-pocket expenses for covered services total the applicable calendar year out-of-pocket maximum, the plan begins to pay covered charges at the 100% level for the remainder of the year. There are separate out-of-pocket maximums for medical charges and for prescription drug expenses.

As shown in the comparison charts on **pages 6** and **7**, deductible amounts and out-of-pocket maximums differ for individual or family coverage, and are higher for non-network providers than for network providers.

IMPORTANT: If services are received from a non-participating provider, you may be billed by the provider for the difference between their charges and your plan's maximum allowed amount. The maximum allowed amount is the total reimbursement payable under your plan for covered services you receive from providers.

Need Help?

Want to change doctors? Need an ID card? Call Anthem at the toll-free number listed on the back cover of this Guide if you want to change doctors, request a new ID card, or have your claim or benefit questions answered. For questions regarding eligibility, send an email to benefits@lapra.org or call 213-674-3701. If you are new to the plan, you will receive an identification card shortly after you enroll. If you need care before your card arrives, make an appointment and explain that you are a new plan member.

Anthem HMO

www.anthem.com/ca

The Anthem HMO offers comprehensive coverage for a wide range of health care services. Benefits are payable only when you use Anthem HMO providers and facilities.* There are no deductibles and no claim forms. You pay a $20 co-pay for most services. The calendar year out-of-pocket co-pay maximum is $1,000 per person and $3,000 per family.

You must choose a primary care physician (PCP) from a Participating Medical Group or Independent Practice Association (IPA) in the Anthem HMO network. See **page 9** for instructions on how to search for a PCP on the Anthem website. You have the right to designate any PCP who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP. You do not need authorization to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. Your PCP manages all of your medical care, refers you to specialists as needed, and can help you take advantage of special wellness programs. If you do not list a PCP when you enroll on your enrollment form, Anthem Blue Cross will automatically assign one to you within 30 miles from your home address. You can change your PCP at anytime by calling Anthem Blue Cross Customer Service at 800-289-2250.

This plan is only available to California residents.

Anthem Blue Cross Guest Membership Program

Your eligible dependents living outside of California may be eligible to enroll in HMO coverage with a partner Blue Cross and Blue Shield plan under the Guest Membership Program. The program is for members who will be temporarily residing outside of California for a minimum of 90 days.

Call 800-827-6422 for a list of states that participate in the program, verify provider availability and request a Guest Membership application.

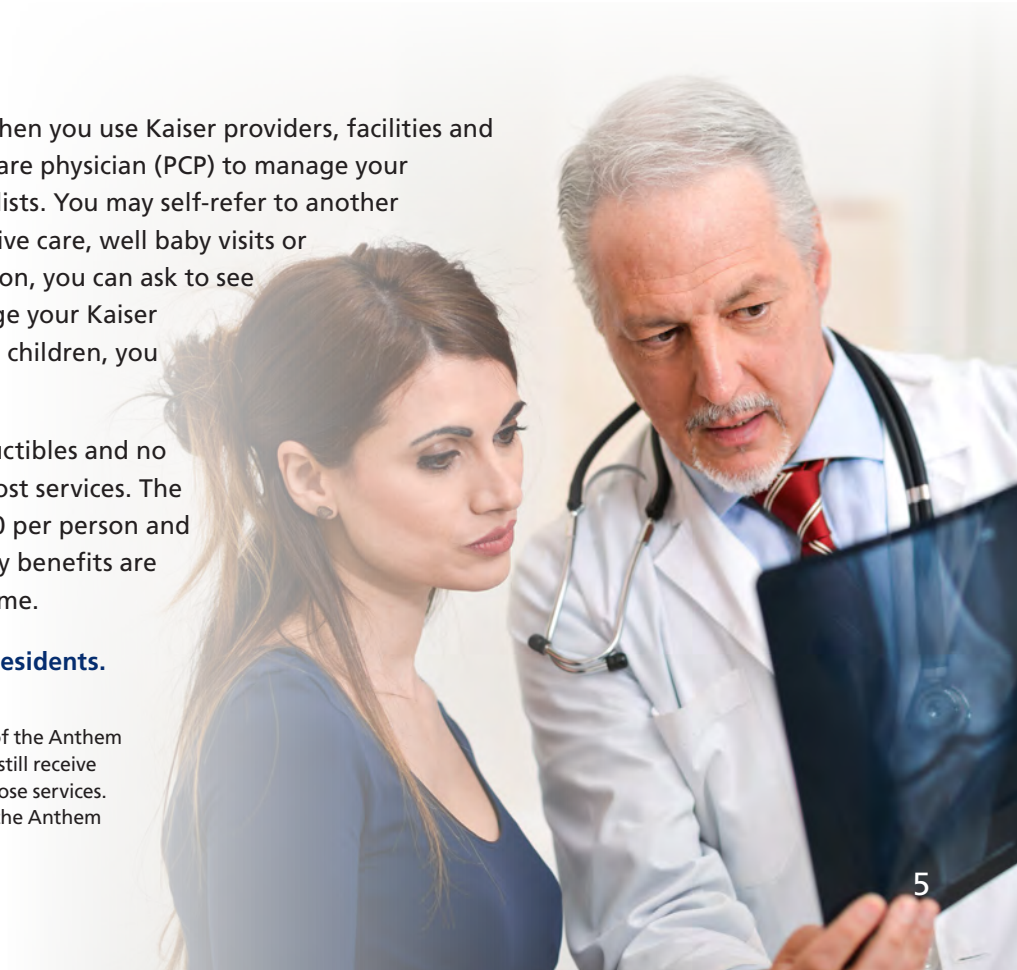
Kaiser HMO

www.kp.org

Kaiser HMO benefits are payable only when you use Kaiser providers, facilities and pharmacies. You must select a primary care physician (PCP) to manage your health care, including referrals to specialists. You may self-refer to another Kaiser physician for routine and preventive care, well baby visits or OB/Gyn care. If you'd like a second opinion, you can ask to see another Kaiser physician. You may change your Kaiser physician at any time for any reason. For children, you may designate a pediatrician as the PCP.

With the Kaiser HMO, there are no deductibles and no claim forms. You pay a $15 co-pay for most services. The annual out-of-pocket maximum is $1,500 per person and $3,000 per family. Worldwide emergency benefits are available when you travel away from home.

This plan is only available to California residents.



* You have the option to choose providers outside of the Anthem HMO network for certain outpatient services and still receive limited benefits up to a maximum of $1,000 for those services. Refer to the section titled "Your Plus Benefits" in the Anthem HMO Evidence of Coverage for details.

2024/25 LAPRA Medical Plans At-a-Glance

The table below provides an overview of the key benefits provided through the LAPRA medical plans. Please refer to the Anthem PPO or HMO, or Kaiser HMO materials on the LAPRA website (**www.lapra.org**) for a complete description of benefits including terms of coverage, exclusions and limitations.

Benefit Feature	Anthem PPO		Anthem HMO (California Residents Only)	Kaiser HMO (California Residents Only)
Providers	**PPO Network**	**Non-PPO Network[1]**	**HMO Providers Only[3]**	**HMO Providers Only**
Calendar Year Deductible	$350 per person $700 per family	$750 per person $1,500 per family	N/A	N/A
Calendar Year Out-of-Pocket Maximum (includes deductibles and co-pays; excludes co-pays for infertility benefits)	**Medical Charges:** $2,000 per person $6,000 per family (not to exceed $2,000 for any one person) See page 7 for prescription drug out-of-pocket maximum.	**Medical Charges:** $4,000 per person $12,000 per family (not to exceed $4,000 for any one person) See page 7 for prescription drug out-of-pocket maximum.	**Medical and Prescription Drug Charges:** $1,000 per person $3,000 per family	**Medical and Prescription Drug Charges:** $1,500 per person $3,000 per family
Lifetime Max	Unlimited		Unlimited	Unlimited
Office Visit	90%[2]	70%[2]	$20 co-pay	$15 co-pay
Hospitalization	90%[2]	70%[2,4,5]	100%	100%
Emergency Room	90%[2] after a $150 co-pay (waived if admitted)		$150 co-pay (waived if admitted)	$150 co-pay (waived if admitted)
Urgent Care	90%[2]	70%[2]	$20 co-pay	$15 co-pay
Maternity Care	90%[2]	70%[2]	Doctor visits: $20 co-pay (initial visit only) Facility charges: 100%	Doctor visits: 100% Facility charges: 100%
Well Baby/ Child Care	100% (up to age 7; not subject to deductible)	70%[2] (up to age 7; not subject to deductible)	100% (up to age 7)	100% (up to age 2)
Routine Physical	100% (adults & children over age 7; not subject to deductible)	70%[2]	100% (adults & children over age 7)	100%
Diagnostic X-ray & Lab Tests	90%[2]	70%[2]	100%	100%
Body Scans (not subject to deductible)	100% (no co-pay) up to $500 every 2 years for enrollee and spouse or registered domestic partner		Not Covered	Not Covered
Physical & Occupational Therapy and Chiropractic Services (additional services may be authorized)	90%[2] (24 visits per calendar yr combined PPO Network & Non-PPO Network)	70%[2] (24 visits per calendar yr combined PPO Network & Non-PPO Network)	$20 co-pay (limited to a 60-day period of care after illness or injury; additional visits available when approved by the medical group)	$15 co-pay (Chiropractic up to 40 visits per year)
Acupuncture	90%[2] (24 visits per calendar yr combined PPO Network & Non-PPO Network)	70%[2] (24 visits per calendar yr combined PPO Network & Non-PPO Network)	$20 co-pay	$15 co-pay (Must be referred by your primary care physician)
Mental Health/ Chemical Dependency • Outpatient	90%[2]	70%[2]	$20 co-pay	$15 co-pay individual therapy/ group therapy: $7 co-pay mental health, $5 co-pay chem dep
• Inpatient	90%[2]	70%[2,4,5]	100%	100%

[1] You may be responsible for paying the difference between the maximum allowed amount and the amount the non-participating provider or other health care provider charges. This amount can be significant. Choosing a participating provider will likely result in lower out of pocket costs to you.

[2] Subject to calendar year deductible.

[3] Your primary care physician can refer you to a specialist when necessary and must approve all care you receive except in the event of an emergency.

[4] Failure to obtain pre-service authorization may result in a $350 penalty.

[5] Covered expense is reduced by 25% for services and supplies provided by a non-contracting hospital.

When You Need a Prescription

When you enroll in a LAPRA medical plan, you automatically receive prescription drug coverage as shown in the table below. Note that prescription drug co-pays count towards your medical plan calendar year out-of-pocket maximum in the Anthem HMO and the Kaiser HMO, but there is a separate prescription drug out-of-pocket maximum for the Anthem PPO.

To save money on prescription drugs, request that your doctor write your prescriptions for "generic" drugs whenever possible. Generic drugs are often the therapeutic equivalent of their brand-name counterparts, but cost significantly less. Under the Anthem PPO and HMO plans, if a generic drug is available and a brand-name drug is dispensed because your physician specifies "dispense as written," you will pay the applicable co-pay for the brand name drug you receive. See footnote #2 below if your physician does not specify "dispense as written."

You can purchase up to a 90-day supply of most maintenance drugs at a retail pharmacy under the Anthem PPO and HMO and up to a 100-day supply under the Kaiser HMO. Maintenance drugs are those used to treat chronic conditions and are typically taken on a regular basis.

Prescription Drugs	Anthem PPO	Anthem HMO (California Residents Only)	Kaiser HMO (California Residents Only)
Prescription Benefit Manager (PBM)	IngenioRx	IngenioRx	Kaiser Permanente
Calendar Year Prescription Drug Out-of-Pocket Maximum	$4,850 per person $7,700 per family (not to exceed $4,850 for any one person)	N/A	N/A
Retail Pharmacy			
• Generic	$15 co-pay[1]	$15 co-pay[1]	$15 co-pay[1]
• Brand	$25 co-pay[1,2]	$25 co-pay[1,2]	$30 co-pay
• Non-formulary	$40 co-pay	$40 co-pay	$30 co-pay
• Maintenance Drugs[3]	2 co-pays (90-day supply)	2 co-pays (90-day supply)	N/A
• Specialty Drugs[4]	20% co-pay, max $150/prescription	20% co-pay, max $150/prescription	N/A
• Retail Supply	Up to 30 days (90 days for maintenance drugs[3])	Up to 30 days (90 days for maintenance drugs[3])	Up to 30 days
Mail Order	**1-30 day supply / 31-90 day supply**	**1-30 day supply / 31-90 day supply**	**1-30 day supply / 31-90 day supply**
• Generic	$15 co-pay[1] / $30 co-pay[1]	$15 co-pay[1] / $30 co-pay[1]	$15 co-pay / $30 co-pay[1]
• Brand	$25 co-pay[1,2] / $50 co-pay[1,2]	$25 co-pay[1,2] / $50 co-pay[1,2]	$30 co-pay / $60 co-pay
• Non-formulary	$40 co-pay / $80 co-pay	$40 co-pay / $80 co-pay	$30 co-pay / $60 co-pay
• Specialty Drugs[4]	20% co-pay, max $150/prescription / 20% co-pay, max $300/prescription	20% co-pay, max $150/prescription / 20% co-pay, max $300/prescription	N/A
• Mail Order Supply	Up to 90 days	Up to 90 days	Up to 100 days

[1] $0 co-pay for women's prescription contraceptives.

[2] Under the Anthem PPO and HMO plans, you will have to pay the co-pay for the generic drug plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug, but not more than 50% of the average cost for the tier that the brand name drug is in.

[3] Maintenance drugs are those used to treat chronic conditions and are typically taken on a regular basis. To determine if your medication qualifies as a maintenance drug, contact IngenioRx at the telephone number on the back of your Anthem medical ID card. Maintenance drugs do not include any controlled substances, smoking cessation or weight management medications.

[4] 20% co-pay does not apply to insulin. Regular co-pays apply.

Your Cost for Medical Per Pay Period

Your cost for Medical is based on your selected plan and coverage category as well as the amount of the City of Los Angeles subsidy. The table below reflects the member cost per pay period effective July 1, 2024.

Coverage Category	Anthem PPO	Anthem HMO (California Residents Only)	Kaiser HMO (California Residents Only)
Lieutenants and Below			
Single	$0.00	$0.00	$0.00
2-Party	$0.00	$0.00	$0.00
Family	$76.62	$126.08	$0.00
Captains and Above			
Single	$0.00	$0.00	$0.00
2-Party	$66.23	$0.00	$0.00
Family	$163.33	$212.69	$30.86

Pre-service Review Requirements

Pre-service review establishes in advance the medical necessity of certain care and services covered under the Anthem HMO or PPO medical plans. Not all services which require pre-service review are listed here. For a complete list of services requiring pre-service review, contact Anthem Blue Cross at the telephone number listed on the back of your ID card. **Pre-service review is required under both the HMO and PPO medical plans for facility-based care for the treatment of mental or nervous disorders, severe mental disorders, and substance abuse.**

Anthem PPO

Pre-service review is also required for the following services under the Anthem PPO:

- Scheduled, non-emergency inpatient hospital stays and residential treatment center admissions (except inpatient hospital stays for maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section and mastectomy and lymph node dissection)
- Transplant services
- Visits for physical therapy, physical medicine, occupational therapy and chiropractic care beyond 24 combined visits per calendar year
- Home health care; home infusion therapy
- Admission to a skilled nursing facility
- Surgical treatment for morbid obesity performed at a Centers of Expertise facility
- Select imaging procedures including MRI, CAT scan, PET scan, MRS scan, MRA scan and Nuclear Cardiac Imaging
- Certain types of Durable Medical Equipment including ultra lightweight wheelchairs, motorized/power wheelchairs, power operated vehicles and related accessories

HMO and PPO providers will initiate a pre-service review on your behalf. Non-PPO providers may initiate the review for you, or you may call Anthem Blue Cross directly at the toll-free telephone number for pre-service review printed on your ID card.

It is your responsibility to confirm that the review has been performed. Failure to obtain pre-service authorization for an inpatient hospital or residential treatment center admission or the facility-based care for the treatment of mental or nervous disorders and substance abuse with a non-Anthem PPO provider will be subject to a $350 non-certification penalty.

How to Find an Anthem Blue Cross Medical and/or Dental Provider

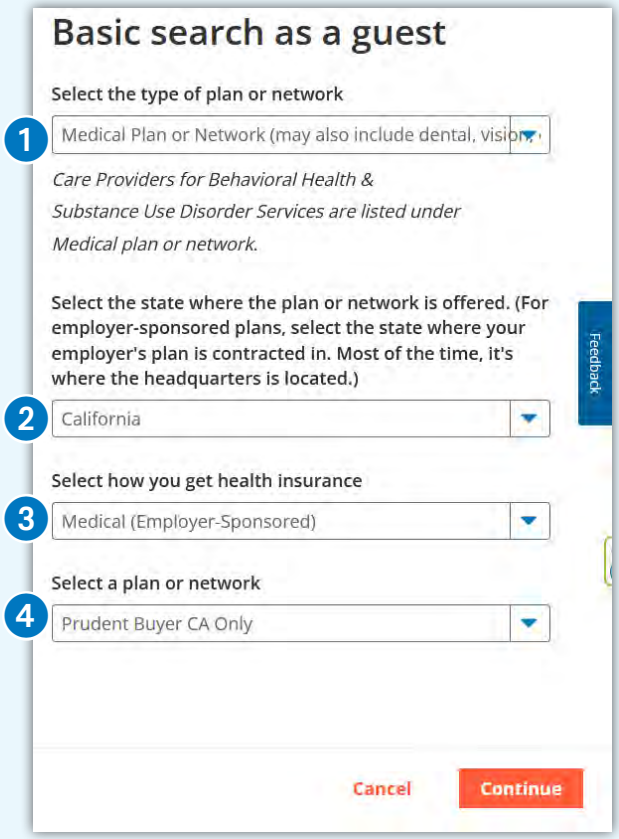
Go to **www.anthem.com/ca** in your web browser and click on **FIND CARE**. For a **personalized search**, click on Log In to Find Care. For a **basic search** without logging in, enter your **ID number or Prefix** from your Member ID card under **Use Member ID** for Basic Search. To **search as a guest**, click on Basic search as a guest, then follow the steps below to find a PPO or HMO medical provider.

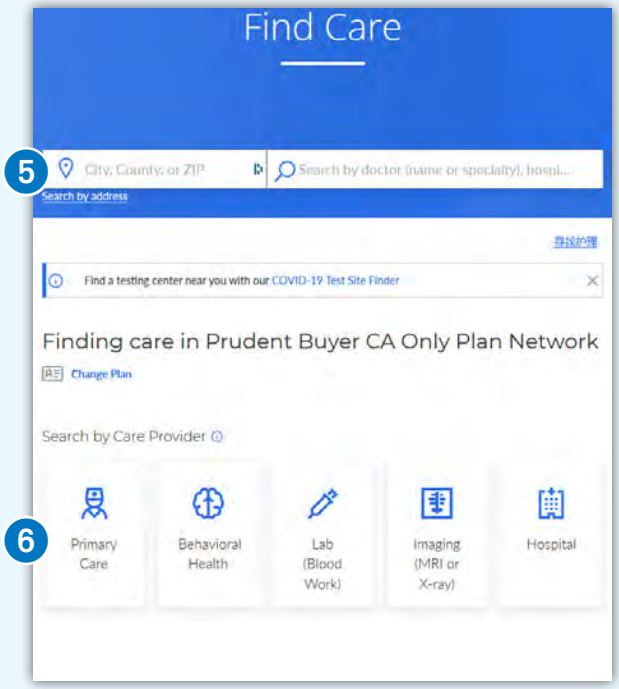
1. Under "Select the type of plan or network," select **Medical Plan or Network or Dental Plan or Network**.
2. Under "Select the state where the plan or network is offered.", choose **your state from the dropdown list**.
3. Under "Select how you get health insurance", select Medical (Employer Sponsored).
4. Under "Select a plan or network", choose one of the **LAPRA medical or dental plan networks** listed below and click **Continue**.

Medical Plans
Prudent Buyer CA Only *California residents*
National PPO (BlueCard PPO) *if you live outside of California*
Blue Cross HMO (CACare) – Large Group *if you live in California*
Dental Plans
Dental Blue Complete *PPO Dental except for Idaho residents*
Dental PPO *PPO Dental for Idaho residents*
Dental Net HMO *HMO Dental for California residents*

5. Under "Find Care", **enter your city, county or zip code**. If you know the provider's name or specialty, enter the information in the Search box and press **Enter** to search.
6. Your can also search by type of care provider. Click on the **type of care provider you are looking for** (Primary Care, Behavioral Health, Lab, Imaging or Hospital).

   For more information on a provider, such as skills and training, **click on the care provider's name**.





LiveHealth Online: 24/7/365 Access to Health Care

Anthem PPO and HMO members have access to LiveHealth Online—a service that lets you see a doctor without appointments or waiting rooms via two-way online video conferencing. It's available for you when you need it—24 hours a day, 365 days a year.

How much does it cost to use LiveHealth Online? LiveHealth Online is a part of your health plan. The cost of a LiveHealth Online visit is the same or less than a primary care office visit. To find out how much your visit will cost, enter your member ID on LiveHealth Online and the cost will be shown before you visit with a doctor.

LiveHealth Online Mobile App

Download the free LiveHealth Online mobile app to your web-enabled smart phone. Search "LiveHealth Online" from the App Store or on Google Play.

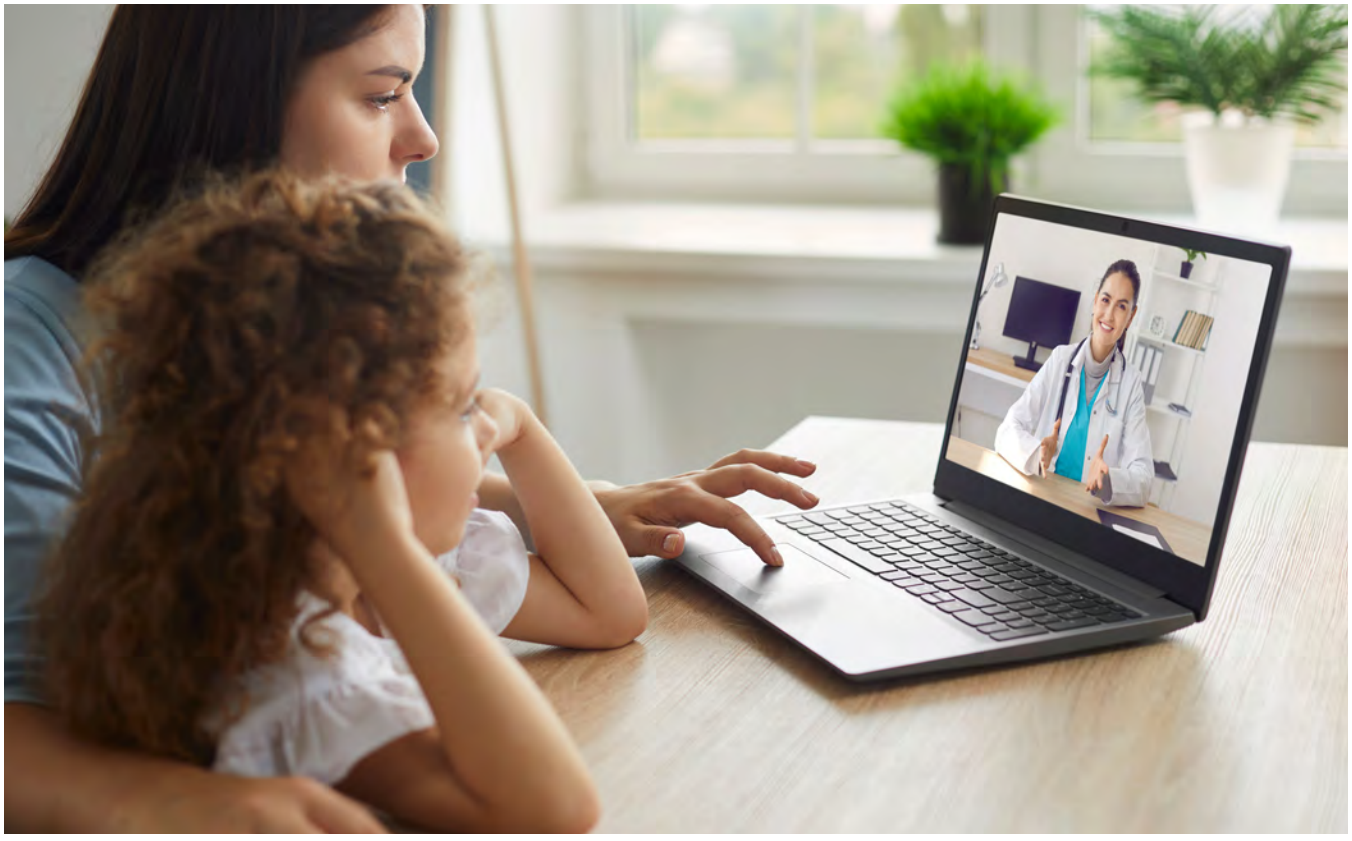
Get Started Using LiveHealth Online

To get started using LiveHealth Online, you'll need to set up an account and complete your profile at **www.livehealthonline.com**.

If you have questions or need assistance setting up an account, call LiveHealth Online at 855-603-7985.

Video Visits with a Kaiser Doctor

If you are enrolled in the Kaiser HMO, you can see a doctor face-to-face with a video visit. Video visits are easy, secure, and part of your coordinated care. For health matters that need urgent attention, you can have a video visit with an emergency medicine doctor. You can also have video visits with your personal physician during office hours. There is no co-pay for a video visit. Register at **kp.org** to schedule a video visit.

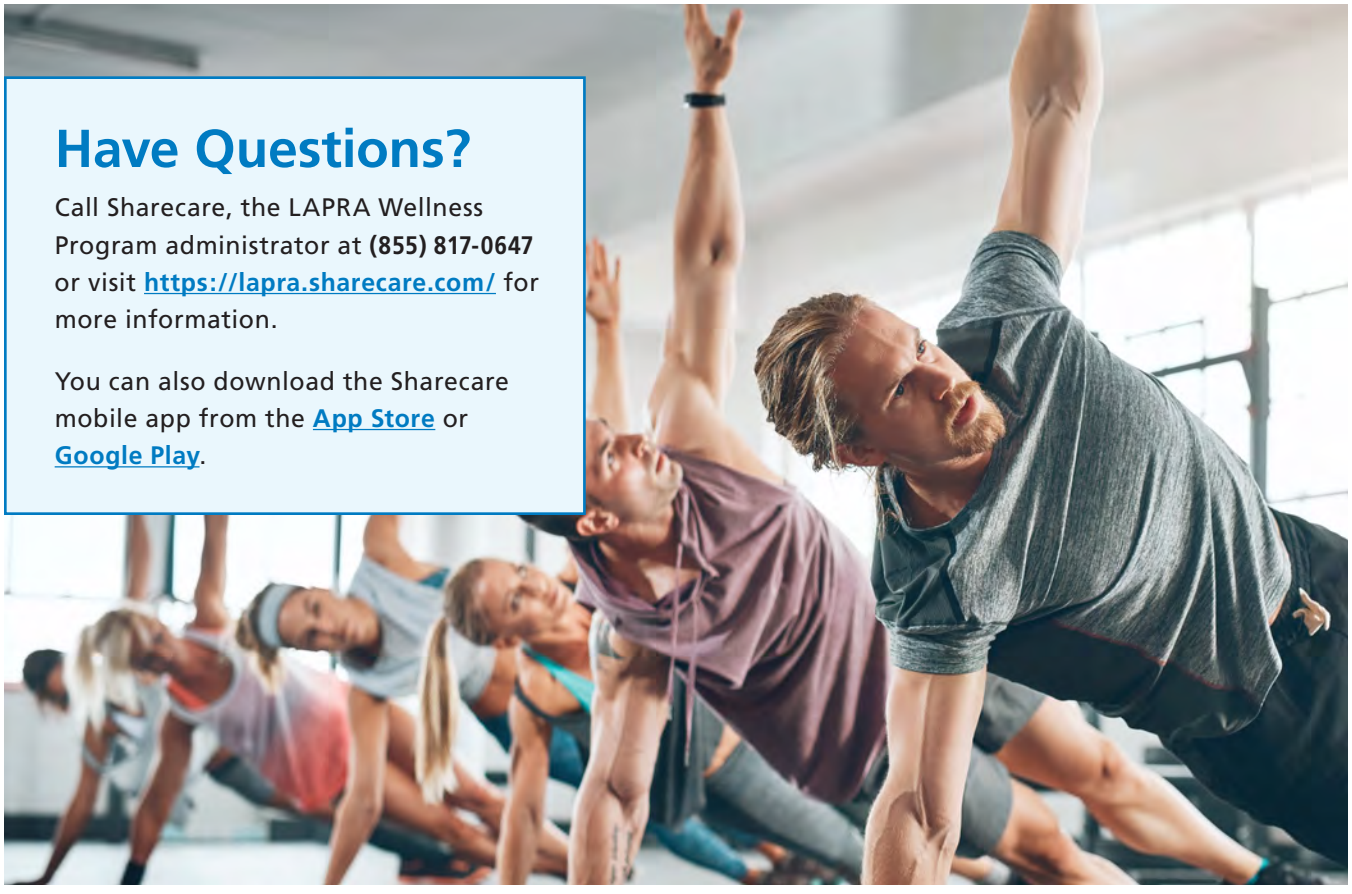


LAPRA Wellness Program

We want you to be healthy in all aspects of your life! The LAPRA Wellness Program is free for active and retired members and their adult dependents who are enrolled in a LAPRA medical plan. The program is administered by Sharecare and is designed to help you develop healthy habits for a lifetime.

Check out some of these great tools on the Sharecare platform for living your healthiest, happiest and most productive life:

- **A free gym membership at more than 11,000 Prime fitness centers across the country.** Go to lapra.org/laprawellness.html and click on the LAPRA Wellness Program banner on the left side of your web browser to register or log in to Sharecare. From there you can access your membership card and find a participating gym near you.
- **Reveal your RealAge**. Take the RealAge® test to find out your body's "actual" age and how your lifestyle choices help you stay young - or make you age faster - than your calendar age.
- **Connect with a health coach**. A health coach can help you lose weight, be more active, quit smling, manage your stress and more.
- **Take your health to the next level**. Once you register for Sharecare, you'll unlock highly personalized content and resources basd on your health and well-being.
- **Quarterly wellness challenges**. The LAPRA Wellness Program offers quarterly challenges to motivate and help you to create healthy habits.
- **Unlock your rewards**. Earn points by visiting a gym, participating in health coaching or completing a wellness challenge.



Have Questions?

Call Sharecare, the LAPRA Wellness Program administrator at **(855) 817-0647** or visit https://lapra.sharecare.com/ for more information.

You can also download the Sharecare mobile app from the App Store or Google Play.

Vision

www.vsp.com

LAPRA members who enroll in the Anthem PPO or the Anthem HMO automatically receive vision coverage through Vision Service Plan (VSP) Choice Plan.

You may use any vision provider for vision care; however, when you use a VSP Choice provider, you'll save money on exams and eyewear and there are no claim forms. VSP also offers discounts on glasses and sunglasses, contact lenses, and laser vision correction. Most services are provided every 12 months. For more information and to find a member doctor, visit the VSP website at **www.vsp.com**.

2024/25 LAPRA Vision Plan At-a-Glance

Benefit Feature	Coverage from VSP Choice Network Provider	Non-VSP Choice Network Reimbursement Amounts[1]
Eye Exam Once every 12 months	$20 co-pay	$45 reimbursement
Frames Once every 12 months	Plan pays up to $115 (20% discount on out-of-pocket expense above $115)	$47 reimbursement
Lenses Once every 12 months • Single vision lens • Lined bifocal lens • Lined trifocal lens	 Plan pays 100% Plan pays 100% Plan pays 100%	 $45 reimbursement $65 reimbursement $85 reimbursement
Contact Lenses & Fitting Exam Once every 12 months (in lieu of lenses and frames)	$120 allowance	$105 reimbursement

[1] You must submit claim forms when you use non-VSP Choice Network providers.

Vision Benefits for Kaiser HMO Members

www.kp2020.org

If you enroll in the Kaiser HMO, vision care is provided through Kaiser. You can only use your optical benefit at a Kaiser Permanente Optical Center.

Benefit Feature	Coverage
Eye Exam No limit on frequency	Covered in full
Eyeglasses and Contact Lenses Once every 24 months	$350 allowance toward the purchase price of any of the following: • Prescription eyeglasses. At least one of the two lenses requires a prescription • Contact lenses, fitting and dispensing

Dental

The Dental Plans cover preventive, basic, and major services, as well as orthodontia. Two options are available:

- Anthem PPO Dental Plan
- Anthem HMO Dental Plan (for California residents only)

Anthem PPO Dental Plan

www.anthem.com/ca

With the Anthem PPO Dental Plan you can visit any dentist and receive benefits; however, you will receive the greatest value for your dollar when you use network dentists. All dentists nationwide participating in the Anthem Blue Cross Dental Blue Complete Network 100, 200 or 300 are considered Network dentists* under the Anthem PPO Dental Plan. Network dentists have contracted with the plan to provide services at reduced rates, so using these dentists will save you money. Plus, deductibles do not apply when you use in-network dentists.

If you choose a non-network dentist, the plan will still provide benefits, but your out-of-pocket expenses may be higher, because the Anthem Blue Cross negotiated fees do not apply to non-network dentists. There is no deductible for non-network preventive and diagnostic services.

IMPORTANT: When using a non-network provider under the Anthem PPO Dental Plan, the maximum allowable charge is based on the customary and reasonable charge for professional services as determined by Anthem. Members are responsible for any difference between the non-network provider's actual charge and the maximum allowable charge, as well as any deductible and/or coinsurance percentage.

Anthem HMO Dental Plan

www.anthem.com/ca

The HMO Dental Plan offers comprehensive coverage designed to fit your family's budget. All services must be performed by an Anthem HMO Dental provider in order to be covered. Many services are covered at 100%, while others require a co-pay. Deductibles and calendar year maximums do not apply. Each family member may choose a different primary dentist and should be listed on your enrollment form. If you do not list a primary dentist on your enrollment form, Anthem will automatically assign one to you within 30 miles from your home address. If you're not satisfied with Anthem's selection, you should call Anthem at 866-527-5801 to request a change in primary dentist.

This plan is only available to California residents.

* All claims incurred in Idaho or Montana will be paid as in-network.

To find an Anthem Blue Cross dental provider in your area, follow the instructions on page 9.

Something to Smile About

The Anthem PPO Dental Plan is designed for individuals and families to promote good oral hygiene and offer convenient, affordable dental coverage. Highlights of the plan include:

- **Higher calendar year maximum benefit for 2024/25 of $2,500**
- **Higher orthodontia lifetime maximum benefit for 2024/25 of $2,500**
- **Access to a broad nationwide network of preferred dentists with in-network coverage available in most geographic locations**
- **No deductible with network providers**
- **No deductible for Preventive and Diagnostic services (network and non-network)**
- **Three cleanings per calendar year covered at 100% (one additional cleaning per calendar year for pregnant women)**
- **Freedom to choose any dentist**

2024/25 LAPRA Dental Plans At-a-Glance

The table below provides an overview of the key benefits and bi-weekly contributions provided through the LAPRA Dental Plans. Refer to the Anthem PPO Dental Plan or HMO Dental Plan materials on the LAPRA website at **www.lapra.org** for a complete description of the LAPRA dental benefits including terms of coverage, exclusions and limitations.

Benefit Feature	Anthem PPO Dental Plan		Anthem HMO Dental Plan (California Residents Only)
Providers	**Network Providers**	**Non-Network Providers***	**HMO Dental Providers Only**
Calendar Year Deductible	None	$25 per person $50 per family (waived for Preventive & Diagnostic)	None
Calendar Year Maximum	$2,500 per person (excluding Orthodontia)		None
Preventive & Diagnostic • Cleanings • Exams • X-rays • Sealants	 100% (3/year) 100% 100% 100%	 100% (3/year) 100% 100% 100%	 No Charge No Charge No Charge $10 co-pay per tooth
Basic • Extractions • Fillings • Root Canal • Oral Surgery	 90% 90% 90% 90%	 80% 80% 80% 80%	 No Charge No Charge $0-$180 co-pay per tooth $0-$200 co-pay per tooth
Major • Crowns & Bridges • Dentures • Implants • Night Guards ($2,000 max benefit)	 60% 60% 60% 60%	 60% 60% 60% 60%	 $100-$200 co-pay per tooth $150-$200 co-pay per tooth N/A N/A
Orthodontia (including adults and children)	50%	50%	$1,750 co-pay (child or adult) (Services exceeding a 24-month treatment period will require additional co-pays.)
Orthodontia Lifetime Maximum	$2,500 per person (Includes $300 for pre-orthodontic visit and treatment plan)		Up to 24 months for standard orthodontic care

* For **non-network providers**, benefits are based on the customary and reasonable charge. You are responsible for any difference between the amount charged and the customary and reasonable charge, plus any deductible and/or coinsurance amount.

Your Cost for Dental Per Pay Period

Your cost for Dental is based on your selected plan and coverage category as well as the amount of the City of Los Angeles subsidy. The table below reflects the member cost per pay period effective July 1, 2024.

Coverage Category	Anthem PPO Dental Plan	Anthem HMO Dental Plan (California Residents Only)
Lieutenants and Below		
Single	$3.29	$0.00
2-Party	$19.87	$0.00
Family	$22.55	$1.20
Captains and Above		
Single	$6.29	$0.00
2-Party	$22.87	$0.00
Family	$25.55	$4.20

Enroll or Make Changes to Your Benefits on www.LAPRALive.org

To enroll or make changes to your benefits, go to **www.LAPRALive.org**. Follow the instructions on **page 1** for information on how to get started using the website.

Say Hello to Sydney, Anthem's Mobile App

The Sydney Health mobile app is all about you, your Anthem medical benefits and your health care needs. Sydney connects you to everything you need to know about your medical plan all in one place. With Sydney, you can:

* Find care and check costs
* View claims
* View and use digital ID cards
* And more

Download the Sydney Health mobile app from the App Store or Google Play.

Key Contacts

Key Contact	Telephone	Website/Email
Los Angeles Police Relief Association, Inc. (LAPRA)	213-674-3701 888-252-7721	www.lapra.org www.lapralive.org benefits@lapra.org
Department of Fire & Police Pensions (LAFPP)	844-885-2377	www.lafpp.com
Anthem Medical Plans • Anthem PPO Plan • Anthem HMO Plan (available in CA only) • Pharmacy/Prescription Drugs/Home Delivery • Pharmacy/Prescription Drugs Medicare Part D • Home Delivery Prescriptions Medicare Part D • Guest Membership Program • Away From Home (urgent care when traveling in the U.S.) • LiveHealth Online	 800-289-2250 800-289-2250 833-284-7514 855-871-5489 833-272-9775 800-827-6422 800-810-2583 855-603-7985	www.anthem.com/ca www.livehealthonline.com
Kaiser Permanente (available in CA only) • Member Services • Appointment Center • Select a Physician • Away From Home Travel Line	 800-464-4000 800-464-4000 800-464-4000 951-268-3900	www.kp.org
Anthem Dental Plans • PPO Dental Plan • HMO Dental Plan (available in CA only)	 866-527-5801 866-527-5801	www.anthem.com/ca
Vision Service Plan	800-877-7195	www.vsp.com
LAPRA Wellness Program	855-817-0647	https://lapra.sharecare.com

About This Guide

This Enrollment Guide provides an overview of the LAPRA medical, dental and vision plans effective July 1, 2024, and tells you how and when you can enroll or make changes to your coverage. It also describes how life changes can affect your benefits and eligibility. While every effort has been made to accurately summarize these benefit plans, discrepancies or errors are always possible. In case of any discrepancy between this Guide and the actual plan documents, the actual plan documents will prevail. If you have any questions about the information presented in this Guide, please contact a LAPRA Benefits Representative.