FLU SEASON IS IN FULL SWING!

As flu season approaches, it's time to consider getting a flu shot. It's never fun to be sick, but the flu is more serious than the common cold. Protect yourself and your loved ones from serious health risks with a yearly flu shot.

WHERE CAN I GET A FLU VACCINE?

Flu vaccines can be obtained at your providers office, most large retail pharmacy chains (including CVS, Walgreen's, Wal-Mart, Costco, etc.) as well as many retail grocery stores (Ralph's, Von's, Safeway, etc.).

HOW MUCH WILL THE RELIEF'S PPO MEDICAL PLAN REIMBURSE?

The LAFRA PPO Medical Plan will cover flu vaccines for PPO Members and their covered dependents, with no copays, deductibles or coinsurance fees when administered at an in-network doctor's office. Chargers over UCR (usual, customary and reasonable) from an out-of-network provider are the Member's responsibility.

The PPO Medical Plan will reimburse 100% of UCR (usual, customary and reasonable), per flu vaccine, for you and each of your covered depen-dents, if your vaccination is administered outside of a physician's office visit.

HOW DO I GET REIMBURSED IF I PAY FOR MY FLU SHOT?

Reimbursement is easy! Simply complete the claim form and send your form, along with your receipt(s), to HealthComp via **fax**: (559) 499-2464, **mail:** P.O. Box 45018, Fresno, CA 93718-5018 or **email:** scanform@healthcomp.com.

WHAT IF I AM RETIRED AND COVERED BY MEDICARE PART B?

Medicare Part B covers one flu shot per flu season. If you have Medicare Part B and get your flu shot from a Medicare provider, you typically pay no coinsurance or deductible.

WHAT IF I HAVE QUESTIONS?

If you have questions, please contact HealthComp, our Third Party Administrator, at 866-995-2372.

LOS ANGELES FIREMEN'S RELIEF ASSOCIATION - FLU VACCINATION CLAIM FORM

(IMPORTANT: YOU MUST ATTACH YOUR RECEIPT(S) IN ORDER TO RECEIVE REIMBURSEMENT)

RELIEF MEMBER INFORMATION

Full Name *(Primary Subscriber, Surviving Spouse or Surviving Domestic Partner)*	**Subscriber #** *(on PPO Medical Plan ID Card)*	**DOB**	**Email**

Who is this claim for?	Full Name	Date of Service	Location of Service	Amount Billed	Amount Paid
☐ Member				$	$
☐ Spouse				$	$
☐ DP				$	$
☐ Surviving Spouse				$	$
☐ Surviving DP				$	$
☐ Child				$	$
☐ Child				$	$
☐ Child				$	$