2018

Retiree Benefits Guide

Annual Benefits Open Enrollment
November 1-19, 2017

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About This Guide

This LAUSD 2018 Annual Benefits and Enrollment Guide contains information for retirees, eligible dependents, and individuals who are receiving health care benefits through COBRA or AB528. Although this Guide contains important information for you, certain sections will not apply to you. Please pay particular attention to the health care plan descriptions highlighted on pages 6 to 14.

The District-sponsored benefits described in this Guide are subject to agreement between employee organizations and the Board of Education. The District-sponsored benefits for active employees and retirees may be amended or changed at any time. This Guide is a summary of the benefits provided under the applicable plan documents, including insurance contracts and/or regulatory statutes. If any conflict should arise between the contents of this Guide and any official plan documents, or if any point is not covered in this Guide, the terms of the plan documents will govern in all cases.

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The **Los Angeles Unified School District** is proud to present this 2018 Annual Benefits and Enrollment Guide. We encourage you to read it, share it with your family, and use it as a reference guide during the Open Enrollment period as well as throughout the year.

This enrollment guide contains detailed information on all of the plans. In order to ensure that you have the coverage you want effective January 1, 2018, it is critical that you review your existing plans and available options for the 2018 plan year.

2018 Annual Benefits Open Enrollment Period

This year's Annual Benefits Open Enrollment period is November 1-19, 2017. All benefit-eligible retirees may change plans during the open enrollment period by accessing the Benefits Administration website at benefits.lausd.net. Please see your enrollment packet for the registration code. You will need this registration code to access, view, and/or change your 2018 elections.

Please note that the automated telephone enrollment system will no longer be available.

If you are a COBRA/AB528 participant, please complete and submit the enclosed form to WageWorks, the District's COBRA/AB528 Administrator. For more information, please contact WageWorks at (877) 502-6272.

You must take action during the Annual Benefits Open Enrollment period if...

- You wish to change your medical, dental, and/or vision plan.
- You and/or your spouse/domestic partner have become Medicare-eligible and you want to join a new medical plan; you can choose from Health Net Seniority Plus, Kaiser Senior Advantage, UnitedHealthcare® Group Medicare Advantage (HMO), or Anthem Blue Cross EPO Plans.

You do not need to take any action if you want to remain enrolled in your current medical, dental, and vision plans.

Any changes you make to your benefit elections or coverage levels during the Annual Benefits Open Enrollment period will be effective January 1, 2018.

If you require assistance to complete your enrollment, please contact Benefits Administration at (213) 241-4262.

Mid-Year Plan Changes

Internal Revenue Service (IRS) rules do not allow plan participants to make election changes except during the Annual Benefits Open Enrollment period. However, the IRS does permit a participant to make a change in the middle of a plan year when certain major life events or actions take place as outlined below. No exceptions can be made to this policy.

Election changes MUST be consistent with the event that prompted the change. You MUST appropriately fill out and submit the required documentation, which certifies your event, within 30 days of the event. Forms can be found on the Benefits Administration website at benefits.lausd.net.

Major Life Events/Actions

- Begins/ends full-time employment
- Begins retirement
- Marriage, divorce or death of a spouse
- Birth or adoption
- Death of a covered child
- Spouse gains or loses employer health plan eligibility
- Spouse loses employment
- Retiree or spouse gains eligibility for Medicare
- Retiree or dependent moves in or out of plan's service area

Planning to Move?

It is important that you keep the District informed of your current address. If you have moved recently and are:

- **A retiree**, notify Benefits Administration at (213) 241-4262.
- **A COBRA/AB528 participant**, contact WageWorks, the District's COBRA/AB528 Administrator, at (877) 502-6272.

Please note, out-of-country coverage is not available for retirees. Retirees who resided outside the country prior to 1/1/10 were grandfathered and may continue their coverage.

District-Sponsored Health Plans

The District offers several medical, dental, and vision plans to eligible retirees and their dependents. A general overview of these plans and eligibility requirements begins on page 6. Plan phone numbers and website addresses are provided on page 24.

Medical Plans

The District offers seven medical plan options:

- Health Net HMO*
- Health Net Seniority Plus**
- Kaiser HMO*
- Kaiser Senior Advantage
- Anthem Blue Cross Select HMO*
- Anthem Blue Cross EPO
- UnitedHealthcare® Group Medicare Advantage (HMO)***

For additional details, see the charts on pages 6-11 to compare key benefits of each plan. These charts are a summary of the benefits provided under the applicable plan documents. Copayments and coinsurance may vary in certain areas. Contact your plan for more information.

**Retirees must be under 65.*

***Retirees and spouses/domestic partners who are over 65 must be enrolled in both Medicare Parts A and B.*

****Both retirees and spouses/domestic partners must be age 65 or over and enrolled in Medicare Parts A and B.*

Dental Plans

The District offers four dental plan options:

- DeltaCare® USA DHMO
- United Concordia Dental PPO
- Western Dental DHMO Centers Only
- Western Dental DHMO Plan Plus

Each plan covers a variety of dental services. The plans differ in areas such as specific coverage levels and copayment amounts. For additional details, see the chart on pages 12-13 to compare the key benefits of each plan.

Vision Plans

The District offers two vision plan options:

- EyeMed Vision Care
- VSP® Vision Care

Both vision plans provide similar benefits. However, there are some key differences such as deductibles, non-network benefits and locations. For additional details, refer to the comparison chart on page 14.

Enrolling in a vision plan is a two-year commitment. When choosing a vision plan, remember that the District requires you to remain enrolled in the plan you choose for two full plan years. For example, if you switched from EyeMed Vision Care to VSP® Vision Care for the 2017 plan year, you are not eligible to change vision plan for the 2018 plan year.

Notes

A Closer Look At Your Medical Plan Options

Medical Plan Options	UNITEDHEALTHCARE® GROUP MEDICARE ADVANTAGE (HMO)[1]	HEALTH NET HMO and HEALTH NET SENIORITY PLUS[2]
Who May Enroll	Eligible retirees and their eligible dependents or AB528 participants who live in the UnitedHealthcare service area and who are enrolled in Medicare Parts A & B. Available to most residents in CA and certain areas in NV, AZ, TX, WA, CO, and OR. Please contact plan for service area where plan is available.	Eligible retirees, COBRA and AB528 participants, and their eligible dependents who live in the Health Net service area and who are not eligible for Medicare (Medicare eligible members are covered under Seniority Plus from Health Net). Available to most CA residents only. Please contact plan for service area where plan is available.
Provider Choice	UnitedHealthcare providers only; each family member may select his or her own doctor	Health Net HMO or Seniority Plus (Medicare Advantage) providers only; each family member may select his or her own doctor
Annual Deductible	None	None
Out-of-Pocket Limit	$1,500 per member	$1,500 per member $3,000 per family **Seniority Plus**: $3,400 per member
Maximum Lifetime Benefit	Unlimited	Unlimited
Physician and Routine Services		
Physician Office Visits	CA: $5 copay/visit Non-CA: $10 copay/visit for Primary Care Physician; $15 copay/visit for specialist	$20 copay/visit for primary care physician $30 copay/visit for specialist **Seniority Plus**: $5 copay/visit
Well Baby Care	Not covered	No copay to age 2; $20 copay/visit thereafter **Seniority Plus**: Not covered
Adult Physical Exam	No copay	$20 copay/visit **Seniority Plus**: No copay
Well Woman Exam	No copay	$20 copay/visit **Seniority Plus**: No copay
Prescription Drugs		
Retail Prescription Drugs	CA: $5 copay preferred generic drug; $7.50 copay for preferred brand, non-perferred, or specialty drugs; up to 30-day supply/formulary applies Non-CA: $5 copay Tier 1 preferred generic drug $20 copay Tier 2 preferred brand drug $40 copay Tier 3 non-preferred drug $40 copay Tier 4 specialty drug Up to 30-day supply/formulary applies	$5 copay/fill for generic; $25 copay/fill for brand; $45 copay/fill for non-formulary medications; up to 30-day supply/ formulary applies **Seniority Plus**: $5 copay/fill for generic medications; $7.50 copay/fill for brand name medications; up to 30 day supply/ formulary applies

[1]Both retirees and spouses/domestic partners must be 65 or older and enrolled in both Medicare Parts A and B.

[2] Retirees and spouses/domestic partners who are over 65 and enrolled in Health Net Seniority Plus must be enrolled in both Medicare Parts A and B. The Health Net HMO network is different from the Health Net Seniority Plus network. UCLA Medical Group and Cedars Sinai Health Associates are not included in the Seniority Plus network.

Note: This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-payments, and restrictions may apply. If there is any discrepancy between this chart and the plan documents, the plan documents shall govern. Copies of the plan documents are on file with Benefits Administration.

Note: Benefits and copays may vary in certain areas, please contact the plan for more information.

KAISER PERMANENTE HMO and SENIOR ADVANTAGE	ANTHEM BLUE CROSS SELECT HMO[3]	ANTHEM BLUE CROSS EPO[3]
Eligible retirees, COBRA and AB528 participants, and their eligible dependents who live in the Kaiser service area and who are not eligible for Medicare (Medicare eligible members are covered under Senior Advantage). Available to residents in CA only. HI, OR and WA members may contact Plan for benefits information.[4]	Eligible retirees under age 65, COBRA and AB528 participants, and their eligible dependents who live in the Select HMO service area. Available to most residents in CA only. Please contact plan for service area where plan is available.	Eligible retirees, COBRA and AB528 participants, and their eligible dependents. Available in all U.S. states, however coverage may be limited outside CA. Please contact plan for more information.
Kaiser HMO providers only; each family member may select his or her own doctor	Anthem Blue Cross Select HMO provider; each family member may select his or her own doctor	Any Prudent Buyer PPO provider in California; any National (BlueCard) PPO provider outside of California
None	None	Retired Member: $300; Retired Family: Maximum of 3 separate deductibles
$1,500 per member $3,000 per family	$1,500 per member $3,000 for 2 members $4,500 per family	$7,500 per member
Unlimited	Unlimited	Unlimited
$20 copay/visit **Senior Advantage**: $5 copay/visit	Physician office/LiveHealth online visit: $10 copay/visit	Physician office/LiveHealth online visit: Member pays 20% after deductible*
No charge to 23 months **Senior Advantage**: Not covered	No copay	CA and Non-CA in network - $25 (No deductible) Non-CA out of network - Member pays 50%
$20 copay/visit **Senior Advantage**: No copay	No copay	CA and Non-CA in network - $25 (No deductible) Non-CA out of network - Member pays 50%
$20 copay/visit **Senior Advantage**: No copay	$10 copay	CA and Non-CA in network - Member pays 20% (No deductible) Non-CA out of network - Member pays 50%
$10 copay/fill for generic medications; up to 30-day supply $25 copay/fill for brand name medications; up to 30-day supply **Senior Advantage**: $10 copay/fill for generic medications up to 30-days; $25 copay/fill for brand medications up to 30-day supply	**Non-Medicare members/CVS Caremark:** Fill up to 1-34 day supply: $5 generic; $25 preferred brand; $45 non-preferred brand For maintenance drugs, after 2nd fill at any in-network retail pharmacy, there is a mandatory 90-day supply by mail order or at local CVS/Pharmacy store at mail order copay. **Medicare members, SilverScript®:** At local CVS/Pharmacy Store: 1-34 day supply: $5/$25/$45 35-60 day supply: $10/$50/$90 61-90 day supply: $10/$50/$90 At other retail pharmacies: 1-34 day supply: $5/$25/$45 35-60 day supply: $10/$50/$90 61-90 day supply: $15/$75/$135	**Non-Medicare members/CVS Caremark** Fill up to 1-34-day supply: $10 generic; $30 preferred brand; $50 non-preferred brand **Medicare members, SilverScript®:** At local CVS/Pharmacy Store: 1-34 day supply: $10/$30/$50 35-60 day supply: $20/$60/$100 61-90 day supply: $20/$60/$100 At other retail pharmacies: 1-34 day supply: $10/$30/$50 35-60 day supply: $20/$60/$100 61-90 day supply: $30/$90/$150

[3]Anthem Blue Cross pays the applicable percentage of the Anthem Blue Cross allowed amount for the in-network services. Anthem Blue Cross Select HMO and EPO network providers accept this amount as payment in full, less any deductible and copayment. Non-participating providers may bill you for any amounts that exceed the "allowable" amount, plus any deductible and copayment amounts. Under the EPO plan, members must receive health care services from Anthem Blue Cross PPO network providers, unless they receive authorized referrals or need emergency and/or out-of-area urgent care. Emergency services received from a non-PPO hospital and without an authorized referral are covered only for the first 48 hours. Coverage will continue beyond 48 hours if the member cannot be moved safely.

[4]Copayments & charges may vary in certain areas, such as Northern CA, HI, OR, and WA. Contact Member Services for information.

* In certain states outside of California, members may be required to pay a 50% copay with some limited benefits. Please contact plan for more information.

A Closer Look At Your Medical Plan Options *(continued)*

Medical Plan Options	UNITEDHEALTHCARE® GROUP MEDICARE ADVANTAGE (HMO)	HEALTH NET HMO and HEALTH NET SENIORITY PLUS
Home Delivery (Mail Order) Prescription	CA: $10 copay/fill; up to 90-day supply/ formulary applies Non-CA: $10 copay Tier 1 preferred generic drug $40 copay Tier 2 preferred brand drug $80 copay Tier 3 non-preferred drug $80 copay Tier 4 specialty drug Per prescription unit or up to a 90-day supply/formulary applies	$10 copay/fill for generic; $50 copay/fill for brand/ formulary applies; $90 copay/fill for non-formulary medications; mandatory 90-day supply of maintenance medications either through CVS Caremark Mail Service Pharmacy or at a local CVS/ pharmacy store after the third fill at a retail pharmacy. **Seniority Plus**: $10 copay/fill; up to 90-day supply formulary applies
Hospital or Outpatient Facility		
Inpatient Care, Room and Board, Surgery and Other Hospital Charges	CA: 100% Non-CA: $50 copay per admission	10% coinsurance plus $100 copay per admission **Seniority Plus**: No copay
Outpatient Surgery	CA: 100% Non-CA: $25 copay per surgery	$250 copay per outpatient surgery visit **Seniority Plus**: No copay
Emergency Room Treatment	$50 copay/visit (waived if admitted)	$100 copay/visit (waived if admitted) **Seniority Plus**: $50 copay/visit (waived if admitted)
Mental Health Care and Substance Abuse Treatment (for AB88[5] and Non-AB88 diagnosis)		
Outpatient Mental Health Care	$5 copay/visit as medically necessary with no annual limit Non-CA: $15 copay per individual visit $10 copay per group visit	$20 copay/visit as medically necessary with no annual limit No copay for Applied Behavioral Analysis and Intensive Outpatient Treatment **Seniority Plus:** $5 copay/visit as medically necessary with no annual limit
Inpatient Mental Health Care	CA: 100% per admission, 190 day lifetime maximum Non-CA: $50 copay per admission; 190-day lifetime maximum Partial hospitalization psychiatric program: $55 copay/day	10% coinsurance plus $100 copay per admission with no annual limit No copay for Partial Hospitalization and Day Treatment **Seniority Plus**: No copay

[5] Under California law AB88, LAUSD medical plans cover certain mental health diagnoses the same as other medical conditions. These include schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

Note: This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-payments, and restrictions may apply. If there is any discrepancy between this chart and the plan documents, the plan documents shall govern. Copies of the plan documents are on file with Benefits Administration.

KAISER PERMANENTE HMO and SENIOR ADVANTAGE	ANTHEM BLUE CROSS SELECT HMO[6]	ANTHEM BLUE CROSS EPO[6]
$10 copay/fill for generic medications up to 30-day supply or $20 for a 31 to 100 day supply; $25 copay/fill for brand name medications up to 30-day supply or $50 for a 31 to 100 day supply **Senior Advantage**: $10 copay/fill for generic medications up to 30-day supply or $20 for a 31 to 100 day supply; $25 copay/fill for brand name medications up to 30-day supply or $50 for a 31 to 100 day supply	$10 copay/fill for generic; $50 copay/fill for brand/formulary applies; $90 copay/fill for non-formulary medications For maintenance drugs, after 2nd fill at any in-network retail pharmacy, there is a mandatory 90-day supply by mail order or at local CVS/pharmacy store at mail order copay.	$20 generic; $60 preferred brand; $100 non-preferred brand For maintenance drugs, after 2nd fill at any in-network retail pharmacy, there is a mandatory 90-day supply by mail order or at local CVS/pharmacy store at mail order copay.
$100 per admission **Senior Advantage**: 100%	No copay	Member pays 20% after deductible (subject to utilization review) *
$100 per procedure **Senior Advantage**: $5 copay/procedure	$10 copay/visit	Member pays 20% after deductible *
$100 copay/visit (waived if admitted) **Senior Advantage**: $50 copay/visit (waived if admitted)	$50 copay/visit (waived if admitted)	$100 deductible per visit (waived if admitted), then member pays 20%
$20 per individual visit; $10 per group visit (no annual limit) **Senior Advantage**: $5 copay/visit $2 copay/group visit	$10 copay per visit	Member pays 20% after deductible
$100 per admission (no limit) **Senior Advantage**: 100%	No copay (no day limit)	Member pays 20% after deductible (no day limit) *

[6]Anthem Blue Cross pays the applicable percentage of the Anthem Blue Cross allowed amount for the in-network services. Anthem Blue Cross Select HMO and EPO network providers accept this amount as payment in full, less any deductible and copayment. Non-participating providers may bill you for any amounts that exceed the "allowable" amount, plus any deductible and copayment amounts.

Under the EPO plan, members must receive health care services from Anthem Blue Cross PPO network providers, unless they receive authorized referrals or need emergency and/or out-of-area urgent care. Emergency services received from a non-PPO hospital and without an authorized referral are covered only for the first 48 hours. Coverage will continue beyond 48 hours if the member cannot be moved safely.

* In certain states outside of California, members may be required to pay a 50% copay with some limited benefits. Please contact plan for more information.

A Closer Look At Your Medical Plan Options *(continued)*

Medical Plan Options	UNITEDHEALTHCARE® GROUP MEDICARE ADVANTAGE (HMO)	HEALTH NET HMO and HEALTH NET SENIORITY PLUS
Substance Abuse Treatment	CA: Inpatient treatment - Paid in full Outpatient treatment - $5 copay/session Non-CA: Inpatient treatment -$50 copay per admittance Outpatient treatment - $15 copay per individual visit or $10 copay per group visit	Inpatient treatment: 10% coinsurance plus $100 copay per admission with no annual limit Outpatient treatment: $20 copay per individual visit; $10 per group visit (unlimited visits/days each calendar year) **Seniority Plus:** Inpatient - No copay Outpatient - $5 copay/session
Other Medical Care		
Chiropractic Care	CA: $5 copay per visit (up to 12 visits/year) - no referral needed Non-CA: $15 copay per visit (up to 12 visits/year) - no referral needed	$10 copay/visit; up to 20 visits/year through American Specialty Health Plan (ASHP) network. No referral needed **Seniority Plus:** $5 copay/visit (up to 12 visits/year) through ASHP network. No referral needed.
Durable Medical Equipment	Paid in full for CA members 20% coinsurance for Non-CA members	No copay ($5,000 annual benefit maximum per calendar year, except for orthotics, diabetic supplies and pediatric asthma supplies) **Seniority Plus:** No copay
Hearing Aids[7]	CA: 100% of covered hearing aid expenses; replacement of one pair every 3 years Non-CA: up to a $500 hearing aid allowance every 36 months	No copay of covered hearing aid expenses; replacement once every 3 years (one pair) **Seniority Plus:** No copay for covered hearing aid expenses; replacement once every 3 years (one pair)

[7]Consult your plan regarding the procedures for obtaining hearing aids and for information regarding limitations and exclusions.

Note: This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-payments, and restrictions may apply. If there is any discrepancy between this chart and the plan documents, the plan documents shall govern. Copies of the plan documents are on file with Benefits Administration.

KAISER PERMANENTE HMO and SENIOR ADVANTAGE	ANTHEM BLUE CROSS SELECT HMO[8]	ANTHEM BLUE CROSS EPO[8]
Inpatient Detoxification: $100 per admission; Residential rehabilitation: $100 per admission (no limit); **Senior Advantage**: 100% Outpatient therapy $20/individual session; $5/group session; **Senior Advantage**: $5/individual session, $2/group session	Inpatient: No copay (no day limit) Outpatient: $10 copay per visit	Inpatient: Member pays 20% after deductible (no day limit) * Outpatient: Member pays 20% after deductible
Not covered **Senior Advantage**: $5 copay per visit in accordance with Medicare guidelines. Limited to manual manipulation of the spine to correct a subluxation	$10 copay per visit (covered under Rehabilitative Care benefit limited to 60 combined visits per injury or illness; additional visits available when approved by the medical group or Anthem Blue Cross)	Member pays 20% after deductible (covered under Rehabilitative Care benefit limited to 24 visits per calendar year; additional visits may be authorized) *
Member pays 10% **Senior Advantage**: Covered in full	Member pays 20%	CA and Non-CA in network - member pays 20% after deductible Non-CA out of network - member pays 50% after deductible. Benefits limited to $5000 per calendar year.
Not covered **Senior Advantage**: $2,500 allowance for each device every 36 months; one device per ear	Member pays 20% (limited to one pair every 3 years; batteries and repairs not covered)	

[8]Anthem Blue Cross pays the applicable percentage of the Anthem Blue Cross allowed amount for the in-network services. Anthem Blue Cross Select HMO and EPO network providers accept this amount as payment in full, less any deductible and copayment. Non-participating providers may bill you for any amounts that exceed the "allowable" amount, plus any deductible and copayment amounts.

Under the EPO plan, members must receive health care services from Anthem Blue Cross PPO network providers, unless they receive authorized referrals or need emergency and/or out-of-area urgent care. Emergency services received from a non-PPO hospital and without an authorized referral are covered only for the first 48 hours. Coverage will continue beyond 48 hours if the member cannot be moved safely.

* In certain states outside of California, members may be required to pay a 50% copay with some limited benefits. Please contact plan for more information.

A Closer Look At Your Dental Plan Options

Dental Plan Option	Western Dental DHMO Plan Plus	Western Dental DHMO Centers Only
Who May Enroll	Eligible retirees, COBRA and AB528 participants, and their eligible dependents residing in California	Eligible retirees, COBRA and AB528 participants, and their eligible dependents residing in California
Annual Deductible	None	None
Maximum Annual Benefit	None	None
Provider Choice	Participants have the flexibility of visiting any Western Dental Center only (Open Access) without the worry of being appointed to a specific office or an affiliated private practice dentists. Family members may each select their own primary care dentist.	Participants have the flexibility of visiting any Western Dental Center (Open Access) without the worry of being appointed to a specific office.
Specialist Referral	Pre-Authorization Required	Pre-Authorization Required
Preventative Services	Member Pays	Member Pays
Includes Teeth Cleaning, Panoramic or Full Mouth X-rays and Fluoride Treatment	No Cost (for cleaning - up to 3 per year)	No Cost (for cleaning - up to 3 per year)
Therapeutic Services	Member Pays	Member Pays
Extractions, Simple (Single Tooth)	No Cost	No Cost
Extractions for Orthodontic Reasons	Not Covered	Not Covered
Fillings (Amalgam)	No Cost	No Cost
Fillings (Composite for Molars)	Up to $140	Up to $140
Root Canal - Molar	$40	$40
Periodontics (Scaling and Root Planning; per Quadrant)	No Cost	No Cost
Osseous Surgery - 4 or More Contiguous Teeth per Quadrant	No Cost (once every 36 months)	No Cost (once every 36 months)
Major Services	Member Pays	Member Pays
Crown	$20–$165 (Cost varies based on metal chosen. No cost for Clinical Crown Lengthening)	$20–$165 (Cost varies based on metal chosen. No cost for Clinical Crown Lengthening)
Full Denture, Upper or Lower	$50	$50
Partial Denture, Upper or Lower	$50–$63	$50–$63
Bridge (3 Unit)	$40-$165 per unit (Includes high noble and noble metal charge) Limitations may apply	$40-$165 per unit (Includes high noble and noble metal charge) Limitations may apply
Dental Implants	Cost varies based on dental implant treatment plan (available only at Western Dental Implant Centers)	
Orthodontia - 24 Month Treatment Plan	Member Pays	Member Pays
Children (to age 19) / Adults	$1,000 copay—comprehensive treatment only for both children and adults	$1,000 copay—comprehensive treatment only for both children and adults
Additional Benefits	Member Pays	Member Pays
Deep Sedation/General Anesthesia - First 15 Minutes	$75	$75
External Bleaching, per Arch	$125	$125
Occlusal Guards	$85	$85

Note: This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-payments, and restrictions may apply. If there is any discrepancy between this chart and the plan documents, the plan documents shall govern. Copies of the plan documents are on file with Benefits Administration.

DeltaCare® USA DHMO	United Concordia Dental (PPO)[5]	
	In-Network	Out-of-Network
Eligible retirees, COBRA and AB528 participants, and their eligible dependents residing in all 50 states & Washington D.C.[1,2,3,4]	Eligible retirees, COBRA and AB528 participants, and their eligible dependents	Eligible retirees, COBRA and AB528 participants, and their eligible dependents
None	$100 for the following Covered Services Combined: Basic Restorative; Major Restorative	
None	$2,000 for the following Covered Services: Preventive and Diagnostic; Basic Restorative; Major Restorative (excludes most in-network preventive services).	
Participants must use their assigned DeltaCare® USA DHMO primary care dentist. Family members have the ability to select separate network dentists.	Participants must use a United Concordia Dental PPO dentist; family members may each select their own network dentist.	Participants and family members may use any licensed dental provider.
Direct referral from Primary Care Dentist	No Authorization Required	
Member Pays	**Member Pays**	**Member Pays**
No Cost (for cleaning - up to 3 per year)	No Cost. Subject to procedure limitations. Teeth cleanings up to 2 per year in and out of network combined.	20% based on the reasonable and customary charge. Subject to procedure limitations. Teeth cleanings up to 2 per year in and out of network combined.
Member Pays	**Member Pays**	**Member Pays**
No Cost	20% of the maximum allowed charge	40% based on the reasonable and customary charge
Not Covered		
No Cost		
from $85 to $140		
$40		
No Cost		
No Cost (once every 36 months)		
Member Pays	**Member Pays**	**Member Pays**
$20–$165 (Cost varies based on metal chosen. No cost for Clinical Crown Lengthening)	50% of the maximum allowed charge	50% based on the reasonable and customary charge
$50		
$50–$63		
Up to 6 units with an additional $125 per unit after the 6th unit. (Includes high noble and noble metal charge) Limitations may apply		
Not Covered	Not Covered	Not Covered
Member Pays	**Member Pays**	**Member Pays**
$1,000 copay (children)/ $1,250 copay (adults) - comprehensive treatment only	50% up to the $750 individual lifetime maximum, then you pay 100% for both children and adults	
Member Pays	**Member Pays**	**Member Pays**
$68	20% of the maximum allowed charge	40% based on the reasonable and customary charge
$125	Not Covered	Not Covered
$85	50% of the maximum allowed charge	50% based on the reasonable and customary charge

[1] Subject to regulatory approval.
[2] Based on applicable state laws. Benefits may vary by location.
[3] In the states of California and Texas, the pre-paid dental plan is referred to as DeltaCare® USA DHMO. For all other states, the pre-paid dental plan is referred to as DeltaCare® USA.
[4] For states other than California, DeltaCare® USA is underwritten through Alpha Dental of the respective state and administered by Delta Dental of California.
[5] In certain states outside of California, state regulations mandate that the benefit levels be the same in and out of network. Contact United Concordia Dental for more information.

A Closer Look At Your Vision Plan Options

Vision Plan Options	EyeMed Vision Care		VSP® Vision Care	
	EyeMed Provider	Non-EyeMed Provider	Choice Network Provider[1]	Non-VSP Provider[2]
Who May Enroll	Eligible U.S.-based retirees, COBRA and AB528 participants, and their eligible dependents		Eligible retirees, COBRA and AB528 participants, and their eligible dependents	
Office Locations	More than 88,000 providers nationwide, including Lens Crafters, Pearle Vision, Sears, Target and JC Penney optical locations; call EyeMed directly for locations	Not applicable	Choose from 86,000 provider access points including independent doctors and retail chain locations like Costco Optical, VisionWorks and Pearle Vision[3].	Freedom to see any provider including the out-of-network provider of your choice.
Annual Deductible	None	None	$25	$25
Examination (1 every 12 months)	Plan pays 100%	Plan pays up to $20	Plan pays 100%	Plan pays up to $55
Lenses (1 pair every 12 months):				
Single Vision	Plan pays 100%	Plan pays up to $20	Plan pays 100%	Plan pays up to $40
Lined Bifocal	Plan pays 100%	Plan pays up to $30	Plan pays 100%	Plan pays up to $60
Lined Trifocal	Plan pays 100%	Plan pays up to $40	Plan pays 100%	Plan pays up to $80
Lenticular	Plan pays 100%	Plan pays up to $50	Plan pays 100%	Plan pays up to $125
Standard Progressive	$65 copay	Plan pays up to $30	$55 copay	Plan pays up to $80
Frames: (1 every 24 months)	Plan pays up to $100, plus 20% off the balance over $100	Plan pays up to $40	Plan pays up to $100 · 20% off the balance over $100 · $120 allowance on featured frame brands · $70 allowance at Costco	Plan pays up to $45
Contact Lenses: EyeMed - In lieu of lenses VSP[4] - In lieu of lenses and frames; available once every year	Plan pays 100% for medically necessary contact lenses. Plan pays up to $105 for elective contact lenses; standard contact lens fitting, plan pays 100%.	Plan pays up to $50 for elective contacts and up to $40 for contact lens fitting/follow-up	Plans pays 100% for medically necessary contact lenses after deductible. Plan pays up to $105 for elective contact lenses, plus 15% off your contact lens exam.	Plan pays up to $210 for medically necessary contact lenses after deductible and up to $105 for elective contact lenses
Optional Features: (tinted lenses, scratch-resistant, ultra-violet coatings, retinal imaging, polycarbonate, photochromatic glass and standard progressive lenses)	Plan pays 100% for tint and scratch-resistant coating; you pay $15 to $65 for additional features	Tinted lenses Plan pays up to $5 Standard scratch-resistant Plan pays up to $5	Standard lens enhancements are covered after a copay ranging from $15-$70. Premium options are available for an additional cost. You can expect an average savings of 20-25%. Visit vsp.com for details or ask your VSP provider.	Not Covered
Laser Vision Correction	Discounts on PRK or LASIK; please call (877)-5LASER6	Not Covered	Discounts on PRK, LASIK, and Custom LASIK surgery at contracted VSP centers; contact VSP directly for information	Not Covered

[1]Based on applicable state laws. Benefits may vary by location.
[2]When services are received from a non-VSP Provider, the $25 copayment is deducted from the reimbursement amount.
[3]Coverage with a participating retail chain may be different. Visit vsp.com for details.
[4]Contact lenses are in lieu of standard lenses and frames with VSP. If you select contact lenses, you are not eligible for standard lenses and frames for 12 and 24 months, respectively, from your last date of service.

Note: This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-payments, and restrictions may apply. If there is any discrepancy between this chart and the plan documents, the plan documents shall govern. Copies of the plan documents are on file with Benefits Administration.

Important Information About Your Prescription Drug Benefits

If I choose a new medical plan, does that mean I have a new pharmacy benefit provider?
Yes, each medical plan has a different pharmacy benefit manager. For more information regarding the network of pharmacies, covered drugs and transition of care available under each plan, visit the plan website or contact the customer service number noted on page 24.

What is a formulary drug?
A formulary, sometimes called a recommended drug list, is a list of preferred generic and brand name drugs. This list includes a wide selection of medications and offers you a choice while helping to keep the cost of your prescription drug benefits affordable. Every drug on the formulary has been approved by the Food and Drug Administration (FDA) and reviewed by an independent group of doctors and pharmacists for safety and efficacy. The list can be obtained by contacting the plan.

What is the Primary/Preferred drug list and what is a preferred drug?
The Primary/Preferred Drug List is a list of commonly prescribed drugs in select drug classes, or grouping of drugs that are used to treat the same condition. There are preferred brand drugs as well as generic drugs on the drug list. The drugs listed are considered preferred drug choices as they provide the greatest economic value in the drug class. It is important to note that preferred medications are not chosen for inclusion on the Primary/Preferred Drug List based on price alone; they are selected based on comparable clinical efficacy to other products in the same drug classes. The Primary/Preferred Drug List is reviewed and updated on a quarterly basis. Medical specialists (physicians and pharmacists) conduct a rigorous clinical and economic review and evaluate any proposed changes to ensure they are consistent with the most recent and relevant clinical findings.

What is a maintenance medication?
A maintenance medication is one that you take on a daily and ongoing basis to maintain your health and most likely no dosage changes are required. Examples of this type of medication are those that you take to manage blood pressure or cholesterol.

Is prior authorization ever required?
Yes, some medications are covered by your plan only under certain circumstances or in certain quantities.

Why do some drugs require prior authorization?
Prior authorization is a patient safety process that ensures members get the safest medications with the best value and are approved by the Food and Drug Administration (FDA). Medications selected for prior authorization are based on at least one of the following criteria:

- have a high potential for abuse;
- require laboratory tests/monitoring for safety reasons;
- are part of a step-care guideline;
- are used for indications not approved by the FDA or the plan;
- have a high potential for "off-label" or experimental use;
- are excluded or limited by benefit coverage.

How do I obtain prior authorization for medication on the Formulary or Primary/Preferred Drug List?
The pharmacy will let you know if additional information is required. You or the pharmacy can then ask your doctor to call a special toll-free number. This call will initiate a review that typically takes one to three business days. This is a common practice for pharmacies and physicians.

Contact the plan either by visiting the website or calling the phone number noted on page 24.

What happens in the Coverage Gap Stage?

Los Angeles Unified School District provides additional coverage for your prescriptions. As a result, your copayments remain the same when you are in the Coverage Gap Stage of your Medicare Part D benefit with SilverScript®.

What if I refill a prescription at a non-participating pharmacy?
For some plans there may be limitations on filling prescriptions at non-participating pharmacies. For example, you may only be able to receive reimbursement for drugs purchased at non-participating pharmacies in an emergency or urgent situation or when you are traveling. Check with the plan to determine any limitations. Plan phone numbers and website addresses are provided on page 24.

Compound drug coverage for Anthem Blue Cross EPO and HMO plan members

What is a compound drug?
A compound drug is a medication made by combining, mixing, or altering ingredients (some of which may not be subject to approval by the FDA), in response to a prescription, to create a customized drug that is not otherwise commercially available.

Are compound medications covered?
Due to the lack of U.S. Food and Drug Administration (FDA) approval for many ingredients included in compounds and the high cost of these compounded medications, most compounds may not be covered by your prescription plan or may require a prior authorization.

What if my compound is not covered?
If the compound ingredients are not covered, you will be responsible for the full cost of those ingredients.

How much will I pay if my compound is covered?
In situations where the compound ingredients are covered through prior authorization, you will pay the cost share specified by your prescription benefit.

What if my compound is not covered and I am unable to pay the full cost?
If you do not wish to or are unable to cover the costs of your compounded prescription, please speak with your doctor about the use of FDA-approved medications that may be used for treatment of your condition.

How do I know if my compound is covered?
Please ask your doctor to call CVS Caremark's toll-free at 1-800-294-5979 to see if your compounded drug is covered or to request a prior authorization.

Medicare Eligibility and your District-Sponsored Medical Coverage

While your retiree health care coverage is available after you become eligible for Medicare, you should understand how Medicare affects health care coverage. Medicare is the national health care program for individuals who are age 65 and older (and certain other individuals). There are three main parts: Part A, which provides coverage for hospitalization, Part B, which provides coverage for outpatient care, and Part D, which provides prescription drug coverage (all LAUSD plans include prescription drug coverage). To retain your District-sponsored retiree medical coverage after you and/or your spouse/domestic partner become eligible for Medicare for any reason, **you must enroll and remain enrolled in Medicare Parts A and B**. It is recommended that you apply for Medicare 90 days prior to your 65th birthday; contact your local Social Security office for information.

Eligibility for Medicare is considered a major life event, therefore you are eligible to change plans. However, you must send a written request to Benefits Administration for your plan change 30 days before you become eligible for Medicare.

Lack of Medicare coverage will not affect your dental or vision benefits.

LAUSD Medicare Requirements

All retirees/spouses/domestic partners age 75 and older as of January 1, 2010 (retirees born prior to January 1, 1935), were grandfathered-in at their current Medicare Parts A and B enrollment levels. All other retirees/spouses/domestic partners must comply with all District Medicare Parts A, B, & D requirements as listed below.

Please mail/fax copies of Medicare cards and letters to LAUSD Benefits Administration at the address listed on page 24 and include retiree's name, employee ID, or Social Security number on all correspondence.

Medicare Part A

All retirees/spouses/domestic partners must enroll and remain enrolled in Medicare Part A premium free, if eligible. To be eligible for Part A premium free, an individual must have 40 quarters of Medicare-covered employment. These earnings can be based on his/her own earnings or the earnings of a spouse or former spouse. Contact your local Social Security office for eligibility information.

If you are not eligible for Medicare Part A premium free, to continue your District benefits you must provide to LAUSD Benefits Administration a confirmation letter of ineligibility from the Centers of Medicare and Medicaid Services (CMS). By submitting the ineligibility letter, you will only be eligible to enroll in Kaiser Senior Advantage or Anthem Blue Cross EPO plan. Health Net Seniority Plus and UnitedHealthcare® Group Medicare Advantage (HMO) plans require eligibility and enrollment in Medicare Parts A and B.

Medicare Part B

All retirees/spouses/domestic partners must enroll and remain enrolled in Medicare Part B and remit the applicable premium to Social Security in order to maintain District-sponsored medical benefits. If you don't enroll or you stop paying for your Medicare Part B premium at any time for yourself and/or your spouse/domestic partner, your District-sponsored medical benefits will terminate. For Medicare Part B premium, contact your local Social Security office.

Medicare Part D

The Medicare Prescription Drug Plan (PDP), also known as Medicare Part D, became available January 1, 2006. Although you have the option of enrolling in a Medicare PDP, in most cases these plans will not provide you with any additional advantages. The LAUSD prescription drug plan is at least as good as the standard Medicare Part D benefit for most Medicare-eligible participants. LAUSD will continue to provide your current prescription drug coverage through Kaiser Senior Advantage, UnitedHealthcare® Group Medicare Advantage (HMO), Health Net Seniority Plus, or SilverScript®, a CVS/Caremark company the prescription drug provider for the Anthem Blue Cross EPO and HMO plans. **If you elect to enroll in a PDP outside your current District-sponsored plan, the District will cancel your medical and prescription coverage.**

2018 Medicare Part D Monthly Adjustment Amounts

Higher income Medicare members will be subject to a Medicare Part D income-related monthly adjustment amount (Part D - IRMAA) if their gross adjusted income exceeds the threshold amounts listed below.

Monthly Part D Premium Adjustment*	Individual's Annual Income	Married Couples Filing Jointly Annual Income	Married Couples Filing Separately Annual Income
$0	$85,000 or less	$170,000 or less	$85,000 or less
$13.00	$85,001 - $107,000	$170,001 - $214,000	n/a
$33.60	$107,001 - $133,500	$214,001 - $267,000	n/a
$54.20	$133,501 - $160,000	$267,001 - $320,000	n/a
$74.80	Above $160,000	Above $320,000	Above $85,000

**Premiums are subject to change.*

The Medicare Part D premium will not be paid by the District or your medical plan. You are required to remit the specified payment to Medicare to maintain your District-sponsored coverage. If you fail to pay your Part D - IRMAA, your District medical and prescription coverage will be canceled.

Medicare Enrollment Period

There are three (3) timeframes in which eligible individuals can enroll in Medicare:

1. Initial Enrollment Period. This is when individuals who become eligible can enroll in Medicare: three months prior to their 65th birthday, during the month of their 65th birthday, or within three months after their 65th birthday;
2. Special Enrollment Period. This is when those who are 65 and older who were previously covered as an active employee under their employer's plan or under their working spouse's plan and are no longer covered. These individuals are eligible to enroll in Medicare before they lose this coverage (e.g. they retire or their spouse/domestic partner retires);
3. General Enrollment Period. This Open Enrollment period is from January through March for coverage effective July 1 of the same year (coverage would start on July 1).

How to Enroll in Medicare

To enroll in Medicare and maintain your District-sponsored medical benefits, contact the nearest Social Security office three months before the first of the month in which you, and/or your eligible dependent, reach age 65. For more information, you may contact Medicare directly by calling (800) 633-4227 (800-MEDICARE) or (877) 486-2048 (TTY for the hearing impaired) or by visiting medicare.gov. You may also contact the Social Security department by calling (800) 772-1213 or by visiting ssa.gov.

Enrolling in Medicare Advantage Plans

As a Medicare-eligible retiree, you have to enroll in a Medicare Advantage plan. Medicare Advantage plans include Kaiser Senior Advantage, Health Net Seniority Plus, and UnitedHealthCare® Group Medicare Advantage (HMO). With these Medicare Advantage plans, you will be responsible for paying a small copayment for most outpatient services, and the plan generally pays 100% of hospitalization. For services that are covered by Medicare, the plans will file a claim with Medicare on your behalf and will coordinate benefit payments directly with Medicare. Some providers and services may vary with Medicare Advantage plans. Please contact your plan for details.

Once you have completed the enrollment process for Medicare, there are additional requirements by some providers as listed below:

- For Kaiser HMO, you must complete and submit a Kaiser Advantage group enrollment form in the month prior to your 65th birthday or you can also enroll in Kaiser Senior Advantage by calling (877) 425-0717. You will then be enrolled in Kaiser Senior Advantage once the form is received and approved by Kaiser and Medicare.
- For Health Net HMO, you must complete and submit a Health Net Seniority Plus group enrollment form in the month prior to your 65th birthday. You will be enrolled in Health Net Seniority Plus once the form is received and approved by Health Net and Medicare. You must be eligible and enrolled in Medicare Parts A and B to enroll in this plan. The Health Net Seniority Plus network is different than the Health Net HMO network.

  Health Net Seniority Plus is a Medicare Advantage HMO Plan. When you become a member, you agree to receive all your routine medical services from a Health Net Seniority Plus Participating Physician Group. Please be aware that the Health Net HMO physician group network, that is available to active employees, and early (pre-Medicare) retirees are not the same as the Health Net Seniority Plus network. Certain medical groups, such as **UCLA Medical Group and Cedars Sinai Health Associates**, are not included in the Health Net Seniority Plus network. You may need to select a new provider if you choose to enroll in Health Net Seniority Plus and your current doctor does not participate in the Health Net Seniority Plus network. If you have any questions regarding Health Net Seniority Plus or the physician network, please call (844) 542-0102 (TDD/TTY (800) 929-9955) during office hours of 8:00 am to 8:00 pm, 7 days a week. You can also visit Health Net's website at healthnet.com/lausd and use the "provider search" tool to confirm if your primary care physician and physician group is in the Health Net Seniority Plus network.

- For UnitedHealthcare® Group Medicare Advantage (HMO), you must notify the District and submit **two** UnitedHealthcare® group enrollment forms (Medicare Advantage Enrollment form and Outpatient Prescription Drug Enrollment form) to UnitedHealthcare in the month prior to your 65th birthday. You will be enrolled in UnitedHealthcare® Group Medicare Advantage (HMO) once the forms are received and approved by UnitedHealthcare and Medicare. Retiree and spouse/domestic partner both must be over 65, eligible, and enrolled in both Medicare Parts A and B to qualify for this plan.

Enrolling in Anthem Blue Cross EPO

When you turn 65, Anthem Blue Cross HMO will convert your plan to the Anthem Blue Cross EPO plan. For the Anthem Blue Cross EPO plan, there is no Medicare enrollment form.

Once you are enrolled in Medicare Parts A and B as required, Medicare becomes your primary coverage and the Anthem Blue Cross EPO plan will pay your coverage as secondary. This means you or your provider must submit a claim to Medicare and Anthem Blue Cross EPO. Anthem Blue Cross EPO for Medicare-eligible retirees and dependents will provide full integration with Medicare for allowable expenses and covered services. **The plan requires that you must use an Anthem Blue Cross provider who is also a Medicare provider for covered services to receive any benefits from the plan**. Anthem Blue Cross and Medicare will not pay for any services from a non-Medicare provider. After a retiree or their dependent satisfies the $300 deductible, Anthem Blue Cross will pay the difference between what Medicare pays and cost of services up to 100% of allowable Medicare charges (but not more than the amount at 80% if Medicare was not present). **Retirees/dependents that are not eligible for Medicare Part A may be responsible for additional costs.**

Prescription drug coverage for Medicare eligible retirees in Anthem Blue Cross is provided by SilverScript.

Survivor Health Benefits

The District will **not** pay for the health plan coverage of a surviving spouse or other dependents of a deceased retiree. However, surviving spouses may continue coverage at their own expense under the District's AB528 Continuation Plan and may also be eligible for COBRA coverage for a limited time. Other dependents are eligible for COBRA only.

To continue medical, dental, and/or vision coverage, the surviving spouse/dependent(s) **must** contact the District to report the retiree's death within 60 days. **Failure to notify the District within 60 days of the death of the retiree will forfeit the surviving spouse's/dependent's right to elect continuation coverage**.

The District will notify the COBRA/AB528 Administrator and the Administrator will mail the surviving spouse/dependent(s) an enrollment packet. If the COBRA/AB528 Administrator is not notified by the surviving spouse/dependent of his or her decision to continue coverage within 60 days following the retiree's death, coverage will be cancelled retroactive to the date of the end of the month in which the retiree passed away.

Information About the COBRA and AB528 Programs

COBRA Continuation Coverage

Under the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, you and your covered dependents may be eligible to temporarily continue your medical, dental, and vision coverage at your own expense after your District-sponsored coverage ends. To continue coverage under COBRA, you must pay a monthly premium. The actual premium amount is determined annually and will not exceed 102% of the applicable premium paid by the District for retired employees and/or dependents in a comparable status, except in certain circumstances, such as an extension of COBRA for disability. Applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries. Both you and the District have responsibilities regarding COBRA coverage.

In order to be able to elect COBRA in a timely manner, you or a family member must notify the District within 60 days in the event of:

- your divorce;
- your child ceasing to qualify as a dependent under the District's plan(s);
- your death.

The notice must be in writing and sent by first-class mail to Benefits Administration, P.O. Box 513307, Los Angeles, CA 90051-1307 and must include the employee's name, employee number, the event that qualifies you to elect COBRA, the date of the event, and appropriate documentation in support of the event, such as final divorce documents. Upon receipt of notification, you and/or your dependent will be mailed a COBRA election packet. Failure to notify the District within 60 days of the event will **forfeit** your rights to elect COBRA/AB528.

In general, employees may continue coverage under COBRA for 18 months, while dependents may continue for 36 months. For more information about your rights under COBRA, contact WageWorks, the COBRA/AB528 Administrator, at (877) 502-6272.

AB528 Coverage

Your surviving spouse and dependent children may continue their coverage under COBRA, as previously explained, by paying the required premium. Once COBRA eligibility ends, your surviving spouse may be able to continue coverage through AB528. Dependent children are not eligible for coverage under AB528.

Cal-COBRA Coverage

When the 18 months of Federal COBRA ends, your spouse/dependent(s) may be able to continue medical coverage under Cal-COBRA. Cal-COBRA allows them to keep their medical coverage for up to a total of 36 months. For information regarding Cal-COBRA benefits for Kaiser and Health Net, contact the plans directly. For Anthem Blue Cross Select HMO and Anthem Blue Cross EPO plans, contact WageWorks at (877) 502-6272.

Please Note

- If you retire but are not eligible for LAUSD retiree health care coverage, continuation of coverage may be available first through COBRA for you and your dependent(s), then through AB528 for you and your spouse. The COBRA/AB528 Administrator, WageWorks, will notify you if you become eligible for COBRA.
- There is no reinstatement of coverage after cancellation of COBRA/AB528 coverage.
- You must adhere to the specific time frames for enrolling in your coverage. You have 60 days to notify the Administrator of your intent to enroll in the COBRA or AB528 coverage. If you miss this deadline, you will lose your right to enroll in benefits.
- You may also be eligible to obtain affordable and quality heath care coverage through the Health Care Exchange. Visit coveredca.com for more information and coverage options.

Dependent Eligibility

When you enroll in the District's retiree health care plans, you may also enroll your eligible dependents in the same plans. Proof of dependent status will be required. For health care plan purposes, eligible dependents include your:

- legal spouse (includes spouses of the same or opposite gender) or qualified domestic partner;
- dependent children up to age 19. Dependent children age 19 to 25 are required to be full-time students in order to continue medical, dental, and vision coverage. You will be required to provide the District with verification of your dependent's full-time student status in April and September of each year;

- dependent children age 19 to 26 who are not full time students are eligible for medical plan only (under the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010). This is **only** applicable for retirees who are enrolled in Anthem Blue Cross Select HMO, Anthem Blue Cross EPO, Health Net HMO, or Kaiser HMO plans. This is not applicable to dependent children of retirees enrolled in Kaiser Senior Advantage and Health Net Seniority Plus Plans;
- dependent children of any age who are permanently disabled and who were continuously enrolled in the District's plans before age 19; or who were first enrolled as eligible full-time students prior to the disabling condition;
- your domestic partner's child, only if you have adopted the child or have been declared the child's legal guardian, **and** you are registered with the **State of California**;
- court-ordered child;
- stepchild, only if the child is included in your tax return.

To enroll or add a dependent to your coverage, you must provide necessary documentation, so the District can verify the dependent's eligibility for coverage. Visit benefits.lausd.net for details on required documentation. See page 22 under section "HIPPA Special Enrollment Rights".

Dual Coverage

If you and your spouse/domestic partner and/or dependent child are District employees or retirees of the District and eligible for District-sponsored health care benefits, you may each enroll in a District-sponsored medical, dental, and vision plan.

- If you enroll in the same or different plans, you may cover each other as dependent spouses and both of you may cover your eligible children. This does not apply to retirees over age 65. Such retirees may not cover spouses enrolled in a different plan, and may not be dependents under the coverage of a spouse. Dual coverage is not available under all plans.

State and Federally Mandated Benefits

The District is required to provide certain protections for its employees, retirees, and for all those enrolled in its health plans.

Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, health plan providers may not require that a provider obtain authorization for prescribing a hospital length of stay of less than 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

Federal law requires group health plans to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Each group health plan must determine the manner of coverage in consultation with the attending physician and patient. Benefits for breast reconstruction and related services must be consistent with the deductibles and coinsurance

amounts that apply to other similar services covered under the plan.

Qualified Medical Child Support Order
A Qualified Medical Child Support Order (QMCSO) is an order or a judgment from a court or administrative body directing the plan to cover a child of a participant under the group health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child (or child's representative) covered by the order will be given notice of the receipt of the order and a copy of the plan's procedures for determining if the order is valid. Coverage under the plan pursuant to a QMCSO will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions about the procedure for determining if the order is valid, please contact Benefits Administration at (213) 241-4262.

Notice of Prescription Drug Creditable Coverage
Medicare prescription drug coverage ("Medicare Part D") became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan (PDP) or join a Medicare Advantage Plan (like an HMO or EPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The prescription drug coverage offered through District-sponsored medical plans is creditable coverage. Creditable coverage means that, on an average for all plan participants, our Plan is expected to pay out as much as the standard Medicare Part D prescription drug coverage will pay. It also means that if you keep the District-sponsored plan's coverage and do not enroll in an individual non-District-sponsored Medicare prescription drug plan, you will not pay a higher premium (a penalty) if you later decide to join a Medicare prescription drug plan. If you join a PDP that is not offered through the District, you will lose your District-sponsored medical & prescription coverage for yourself and your dependents.

For more information about Medicare prescription drug coverage:

- visit medicare.gov;
- call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048;
- visit socialsecurity.gov;
- call the Social Security Administration at 1-800-772-1213.

HIPAA Special Enrollment Rights
If you or your dependents decline coverage because you or they have medical coverage elsewhere and one of the following events occurs, you have 30 days from the date of the event to request enrollment for yourself and/or your dependents:

- You and/or your dependent(s) lose the other health coverage because eligibility was lost for reasons including legal separation, divorce, death, termination of employment or reduced work hours (but not due to failure to pay premiums on a timely basis, voluntary cancellation, or termination for cause);
- The employer contributions to the other coverage have stopped;
- The other coverage was COBRA and the maximum COBRA coverage period ends.

As a retiree, you must enroll your new spouse within 45 days of your marriage and a new child within 30 days of his/her birth, or legal adoption in order for coverage to be effective as of the date of marriage, date of birth, or legal adoption. In addition, if you are not enrolled in the plans as a retiree, you must also enroll in the plan when you enroll any of your dependents. If the dependent enrollment application is not received in a timely manner, the coverage becomes effective the first of the following month in which the completed enrollment form with necessary documentations are received.

Private Health Information
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule establishes national standards to

protect individuals' medical records and other personal health information. The Rule applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections. For more information, visit the Department of Health and Human Services (HHS) web site at hhs.gov.

Grandfathered Health Plan

The District-sponsored health and welfare plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

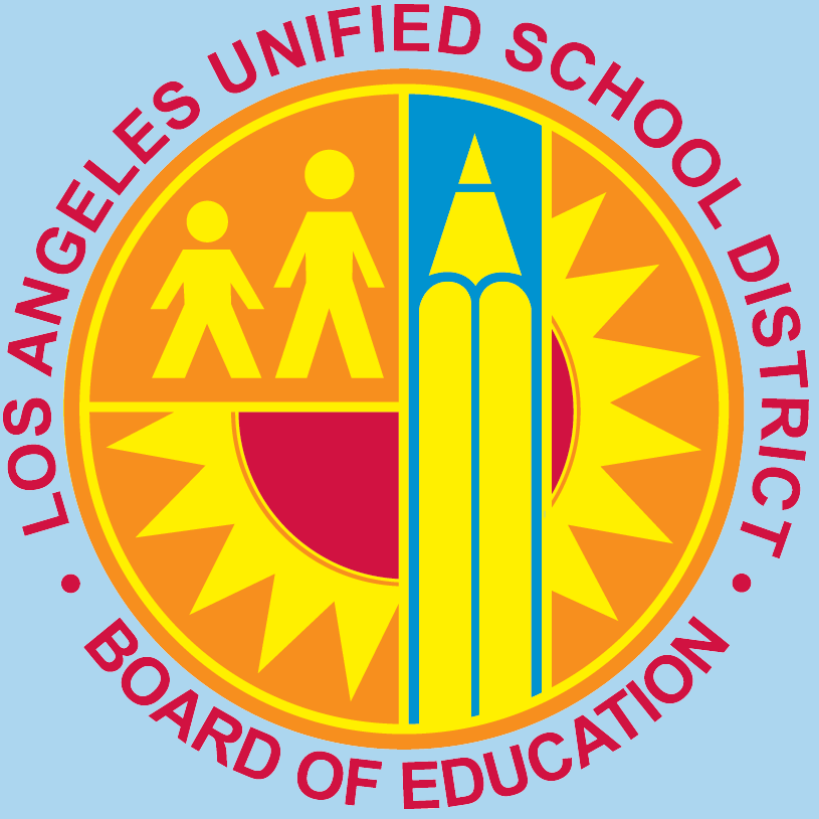
Dependent Coverage Extension

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in District-sponsored health insurance coverage (unless or until they become eligible for other employer-sponsored health benefits other than from another parent). To ensure compliance with the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010, the District will extend the coverage for dependent children up to age 26. This requirement applies to qualified dependents of active and certain retired employees who are eligible for District-sponsored health benefits.

Notes

Important Contact Information

Plan Name	Address	Web Address	Phone
Anthem Blue Cross	P.O. Box 60007 Los Angeles, CA 90060-0007	anthem.com/ca	(800) 700-3739
CVS Caremark	P.O. Box 6590 Lees Summit, MO 64064-6590	caremark.com	(888) 752-7229
SilverScript® (prescription drug providers for Anthem Blue Cross plans only)	P.O. Box 53991 Phoenix, AZ 85072-3991	lausd.silverscript.com	(844) 819-3075
Health Net HMO	P.O. Box 10348 Van Nuys, CA 91409-10348	healthnet.com/lausd	(800) 654-9821
Health Net Seniority Plus	P.O. Box 10198 Van Nuys, CA 91410-0198	healthnet.com/lausd	Enrollment Info (800) 596-6565 After Enrollment (844) 542-0102 (800) 929-9955 (TTY)
Kaiser Permanente HMO and Kaiser Senior Advantage	Kaiser Foundation Health Plan, Inc. 1950 Franklin Street Oakland, CA 94612	kp.org	(800) 464-4000 (877) 425-0717
UnitedHealthCare® Group Medicare Advantage (HMO)	P.O. Box 29650 Hot Springs, AR 71903-9973	uhcretiree.com	Enrollment Info (877) 714-0178 After Enrollment (800) 457-8506
DeltaCare® USA DHMO	P.O. Box 1810 Alpharetta, GA 30023	deltadentalins.com/lausd	(844) 697-0580
United Concordia Dental PPO	P.O. Box 69425 Harrisburg, PA 17106-9425	unitedconcordia.com	(844) 397-4176
Western Dental DHMO Centers Only and Western Dental Plan Plus	Western Dental Services Attn: Customer Service 530 South Main Street Orange, CA 92868	westerndental.com	(866) 901-4416
EyeMed Vision Care	4000 Luxottica Place Mason, OH 45040	eyemedvisioncare.com	Inquiries (866) 723-0514 LASIK (877) 5LASER6
VSP® Vision Care	P.O. Box 997100 Sacramento, CA 95899-7100	vsp.com	(800)877-7195
ReliaStar Life Insurance Company, a member of the Voya® family of companies	20 Washington Avenue South, Mail Stop 2-N Minneapolis, MN 55401	voya.com	(877) 236-6564
Other Resources			
LAUSD COBRA/AB528 Administrator - WageWorks	P.O. Box 14055 Lexington, KY 40512-4055	wageworks.com	(877) 502-6272
Social Security Administration		ssa.gov	(800) 772-1213
Medicare		medicare.gov	(800) 633-4227 (877) 486-2048 (TTY)
Public Employees Retirement System (PERS)		calpers.ca.gov	(888) 225-7377
State Teachers Retirement System (STRS)		calstrs.com	(800) 228-5453 Sacramento
LAUSD Benefits Administration	P.O. Box 513307 Los Angeles, CA 90051	benefits.lausd.net	(213) 241-4262 (213) 241-4247 (fax)


LOS ANGELES UNIFIED SCHOOL DISTRICT
BOARD OF EDUCATION