2025 Retiree Health Benefits Guide

Benefits Administration
www.lausd.org/benefits

About This Guide

This Retiree Benefits Guide contains information for Los Angeles Unified School District (LAUSD) retirees, eligible dependents, and individuals who are receiving health 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 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 2025 Retiree Benefits 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, 2025, it is critical that you review your existing plans and available options for the 2025 plan year.

2025 Annual Benefits Open Enrollment Period

This year's Annual Benefits Open Enrollment period is from October 28 - November 19, 2024. All benefit-eligible retirees may change plans during the open enrollment period by calling Benefits Administration at (213) 241-4262.

If you are a COBRA/AB528 participant and need to make a plan change, please complete and submit the provided enrollment form to WageWorks, the District's COBRA/AB528 Administrator. For more information, please contact WageWorks at (888) 678-4881.

Benefits Highlights for 2025

Diabetic Supply Coverage for Anthem Medicare Preferred (PPO) Members

For members enrolled in the Anthem Medicare Preferred (PPO), diabetic supplies will be covered either by your medical or prescription plan. Your Anthem medical plan covers diabetic durable medical equipment (DME) such as insulin pumps, blood glucose monitors, test strips, and related supplies under Medicare Part B Drugs as part of your medical coverage. Your CVS/SilverScript prescription drug plan covers your insulin and certain medical supplies used with injection of insulin under Medicare Part D Drugs. You may have a copayment or out-of-pocket expense depending on which plan covers your diabetic supplies. Please see the table for a summary of diabetic supply coverage.

Anthem Medicare Preferred (PPO) Medicare Part B Drugs	CVS/SilverScript Medicare Part D Drugs
Insulin (if used with an insulin infusion pump)	Insulin (not used with an insulin infusion pump)
Insulin pump (if deemed medically necessary)	Syringes
Supplies to monitor blood glucose:	Needles
• Blood glucose monitor (one every year)	Gauze
• Blood glucose test strips (up to 200 for a 30-day supply)	Alcohol swabs
• Lancet devices and lancets	Inhaled insulin devices
• Glucose control solutions for checking accuracy of test strips and monitors	Anti-diabetic drugs

Note: Subject to change. Benefits may vary for members and/or dependents in non-Medicare Anthem plans.

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 submit the documentation, which certifies your event, within 30 days of the event. Additional information can be found on the Benefits Administration website at lausd.org/benefits.

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**, complete and submit the Retiree Change of Address Form, which is available at lausd.org/benefits/forms.
- **A COBRA/AB528 participant**, contact WageWorks, the District's COBRA/AB528 Administrator, at (888) 678-4881.

Please note, out-of-country coverage is not available for retirees who reside outside of the United States and U.S. territories. 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 medical plan options for the following retiree groups:

Retirees Under 65	Retirees Over 65[1] with Medicare Parts A and B	Retirees Over 65[1] with Medicare Part B Only
Anthem Blue Cross Select HMO	Anthem Medicare Preferred (PPO)[2]	Anthem Blue Cross EPO[2]
Anthem Blue Cross EPO	Health Net Seniority Plus[3]	Kaiser Permanente Senior Advantage[5]
Health Net HMO	Kaiser Permanente Senior Advantage[4]	
Kaiser Permanente HMO		

[1] Retirees, spouses/domestic partners, and dependents who are under 65 and eligible for Medicare Parts A and B due to disability may enroll in these plans by providing Medicare information to Benefits Administration. Retirees, spouses/domestic partners, and their dependents over 65 must enroll into Medicare.

[2] Once a retiree turns 65 or becomes Medicare eligible, the Anthem Blue Cross Select HMO plan is not available to dependents. If the retiree's dependent(s) is under 65 or only has Medicare Part B, then the dependent(s) will be enrolled into the Anthem Blue Cross EPO plan. If dependent is Medicare eligible and has Medicare Parts A and B, then the dependent will enroll in Anthem Medicare Preferred (PPO).

[3] A group enrollment form is required.

[4] Applicable to CA and certain areas of Hawaii and the Northwest (OR and WA).

[5] Exclusive to CA members.

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.

Dental Plans

The District offers three dental plan options:

- Aetna Dental PPO
- DeltaCare® USA DHMO
- Western Dental DHMO

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 2024 plan year, you are not eligible to change vision plans for the 2025 plan year.

Notes

A Closer Look At Your Medical Plan Options

Medical Plan Options	KAISER PERMANENTE HMO and SENIOR ADVANTAGE	HEALTH NET HMO and HEALTH NET SENIORITY PLUS[2]
Who May Enroll	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 most residents in CA and certain areas in HI, OR, and WA. Members may contact Plan for information.[1]	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	Kaiser HMO 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 $3,000 per family **Senior Advantage**: $1,000 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	$20 copay/Office visit; $0 copay/Telehealth visit **Senior Advantage**: $5 copay/Office visit; $0 copay/Telehealth visit	**HMO:** $20 copay for primary care physician visit/call; $30 for Specialist visit/call; **Seniority Plus:** $5 copay for visit/call; no copay for Telehealth services **through preferred vendor**
Well Baby Care	No charge to 23 months **Senior Advantage**: Not covered	No copay to age 2; $20 copay/visit thereafter **Seniority Plus**: Not covered
Adult Physical Exam	$20 copay/visit **Senior Advantage**: No copay	$20 copay/visit **Seniority Plus**: No copay
Well Woman Exam	$20 copay/visit **Senior Advantage**: No copay	$20 copay/visit **Seniority Plus**: No copay
Prescription Drugs		
Retail Prescription Drugs	$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	$5 copay/fill for generic; $25 copay/fill for brand; $45 copay/fill for non-preferred medications; up to 30-day supply/formulary applies **Seniority Plus**: No copay/fill for preferred generic medications; $5 copay/fill for generic medications; $7.50 copay/fill for brand name medications; up to 30 day supply/formulary applies

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

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

[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.

ANTHEM BLUE CROSS SELECT HMO[3]	ANTHEM BLUE CROSS EPO[3]	ANTHEM MEDICARE PREFERRED (PPO) In & Out-of-Network
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 under age 65, retirees with Medicare Part B only, 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.	Eligible retirees and dependents with Medicare Parts A and B. Eligible dependents under age 65 will be enrolled in Anthem Blue Cross EPO. Available in all 50 states and U.S. territories.
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	You may see any provider who accepts Medicare and the plan.
None	Retired Member: $300; Retired Family: Maximum of 3 separate deductibles	$0 combined in-network and out-of-network
$1,500 per member $3,000 for 2 members $4,500 per family	$7,500 per member	$0 combined in-network and out-of-network
Unlimited	Unlimited	Unlimited
Physician office/LiveHealth online visit: $10 copay/visit	Physician office/LiveHealth online visit: Member pays 20% after deductible*	No copay
No copay	CA and Non-CA in network - $25 (No deductible) Non-CA out of network - Member pays 50%	N/A
No copay	CA and Non-CA in network - $25 (No deductible) Non-CA out of network - Member pays 50%	No copay
$10 copay	CA and Non-CA in network - Member pays 20% (No deductible) Non-CA out of network - Member pays 50%	No copay
Non-Medicare members/CVS Caremark: Fill up to 1-34 day supply: $5 generic; $25 preferred brand; $45 non-preferred brand	**Non-Medicare members/CVS Caremark:** Fill up to 1-34-day supply: $10 generic; $30 preferred brand; $50 non-preferred brand	**Non-Medicare members/CVS Caremark:** Fill up to 1-34-day supply: $10 generic; $30 preferred brand; $50 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 with your 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	**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	**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 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	KAISER PERMANENTE HMO and SENIOR ADVANTAGE	HEALTH NET HMO and HEALTH NET SENIORITY PLUS
Home Delivery (Mail Order) Prescription	$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-preferred 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**: No copay/fill for generic medications; $10 copay/fill for brand name medications; up to 90-day supply formulary applies
Hospital or Outpatient Facility		
Inpatient Care, Room and Board, Surgery and Other Hospital Charges	$100 per admission **Senior Advantage**: No copay	10% coinsurance plus $100 copay per admission **Seniority Plus**: No copay
Outpatient Surgery	$100 per procedure **Senior Advantage**: $5 copay/procedure	$250 copay per outpatient surgery visit **Seniority Plus**: No copay
Emergency Room Treatment	$100 copay/visit (waived if admitted) **Senior Advantage**: $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[4] and Non-AB88 diagnosis)		
Outpatient Mental Health Care	$20 per individual visit; $10 per group visit (no annual limit) **Senior Advantage**: $5 copay/visit $2 copay/group visit	$20 copay/Telehealth or in-person 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	$100 per admission (no limit) **Senior Advantage**: No copay	10% coinsurance plus $100 copay per admission with no annual limit No copay for Partial Hospitalization and Day Treatment **Seniority Plus**: No copay

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

[4] 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.

ANTHEM BLUE CROSS SELECT HMO[5]	ANTHEM BLUE CROSS EPO[5]	ANTHEM MEDICARE PREFERRED (PPO) In & Out-of-Network
$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 with your 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. Note: Certain diabetic supplies, as detailed on page 2, will be provided through the Anthem plan for retail and mail orders.
No copay	Member pays 20% after deductible (subject to utilization review) *	For Medicare-covered hospital stays: No copay per admission; No copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay
$10 copay/visit	Member pays 20% after deductible *	No copay for Medicare-covered outpatient hospital facility or ambulatory surgical center visit; No copay for Medicare-covered outpatient observation room visit
$50 copay/visit (waived if admitted)	$100 deductible per visit (waived if admitted), then member pays 20%	No copay
$10 copay per visit	Member pays 20% after deductible	No copay for individual therapy visit; No copay for group therapy visit; No copay for partial hospitalization visit
No copay (no day limit)	Member pays 20% after deductible (no day limit) *	No copay per admission with no limit to the number of days covered by the plan; No copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay.

[5]Anthem Blue Cross pays the applicable percentage of the Anthem Blue Cross allowed amount for 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	KAISER PERMANENTE HMO and SENIOR ADVANTAGE	HEALTH NET HMO and HEALTH NET SENIORITY PLUS
Substance Abuse Treatment	Inpatient Detoxification: $100 per admission; Residential rehabilitation: $100 per admission (no limit); **Senior Advantage**: No copay Outpatient therapy: $20/individual session; $5/group session; **Senior Advantage**: $5/individual session, $2/group session	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	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/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	Member pays 10% **Senior Advantage**: No copay	No copay **Seniority Plus:** No copay
Hearing Aids[6]	Not covered **Senior Advantage**: $2,500 allowance for each device every 36 months; one device per ear	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 year (one pair)

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

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

ANTHEM BLUE CROSS SELECT HMO[7]	ANTHEM BLUE CROSS EPO[7]	ANTHEM MEDICARE PREFERRED (PPO) In & Out-of-Network
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	No copay for individual therapy visit; No copay for group therapy visit; No copay for partial hospitalization visit
$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) *	No copay for Medicare non-covered chiropractic services; limited to 25 visits per year combined in-network and out-of-network. No copay for Medicare non-covered acupuncture services; limited to 12 visits per year combined in-network and out-of-network.
Member pays 20%	CA and Non-CA in-network: member pays 20% after deductible Non-CA out-of-network: member pays 50% after deductible.	No copay for Medicare-covered durable medical equipment
Member pays 20% (limited to one pair every 3 years; batteries and repairs not covered)	Benefits limited to $5,000 per calendar year. Covered under durable medical equipment; batteries and repairs not covered.	No copay for routine hearing exams, fittings and evaluation; hearing aids are limited to a $2,000 per ear maximum benefit every 3 years combined in-network and out-of-network

[7]Anthem Blue Cross pays the applicable percentage of the Anthem Blue Cross allowed amount for 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	DeltaCare® USA DHMO
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 all 50 states & Washington D.C.[1,2,3,4]
Annual Deductible	None	None
Maximum Annual Benefit	None	None
Provider Choice	Participants must use their assigned Western Dental Plan-DHMO network providers. Family members have the ability to select separate network dentists.	Participants must use their assigned DeltaCare® USA DHMO primary care dentist. Family members have the ability to select separate network dentists.
Specialist Referral	Pre-Authorization Required	Direct referral from Primary Care Dentist
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/Basic 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)	No Cost	from $85 to $140
Root Canal - Molar	No Cost	$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	No Cost	$20–$165 (Cost varies based on metal chosen. No cost for Clinical Crown Lengthening)
Full Denture, Upper or Lower	No Cost	$50
Partial Denture, Upper or Lower	No Cost	$50-$63
Bridge (3 Unit)	No cost per unit. Limitations may apply.	$40 - $165 per unit. Up to 6 units with an additional $125 per unit after the 6th unit. (includes high noble and noble metal charge). Limitations may apply.
Dental Implants	Cost varies based on dental implant treatment	Not Covered
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 (children)/ $1,250 copay (adults) - comprehensive treatment only
Additional Benefits	Member Pays	Member Pays
Deep Sedation/General Anesthesia	No cost	$68 each 15 minutes
External Bleaching, per Arch	No cost	$125
Occlusal Guards	No cost	$85

[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.

Aetna Dental PPO[1]	
In-Network	Out-of-Network
Eligible retirees, COBRA and AB528 participants, and their eligible dependents	Eligible retirees, COBRA and AB528 participants, and their eligible dependents
$100 per person per calendar year; applies to Basic & Major Services	
$3,000 combined In-Network and Out-of-Network; applies to all Basic and Major Services only.	
Participants must use an Aetna Dental PPO dentist; family members may each select their own network dentist.	Participants and family members may use any licensed dental provider.
No Authorization Required	
Member Pays	Member Pays
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
20% of the maximum allowed charge; Composite fillings for molars will be covered at the amalgam level.	40% based on the reasonable and customary charge; Composite fillings for molars will be covered at the amalgam level.
Member Pays	Member Pays
50% of the maximum allowed charge	50% based on the reasonable and customary charge
Not Covered	Not Covered
Member Pays	Member Pays
50% up to $750 individual lifetime ortho maximum per person, then you pay 100% for both children and adults	
Member Pays	Member Pays
20% of the maximum allowed charge	40% based on the reasonable and customary charge
Not Covered	Not Covered
50% of the maximum allowed charge	50% based on the reasonable and customary charge

[1] In certain states outside of California, state regulations mandate that the benefit levels be the same in and out of network. Contact Aetna Dental PPO for more information.

Note: This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, 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.

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	Non-VSP Provider
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 164,200 access points nationwide, including Pearle Vision, LensCrafters, Target Optical and online providers such as ContactsDirect.com, Glasses.com, Oakley.com, TargetOptical.com, RayBan.com and LensCrafters.com.	Freedom to receive services at the provider of your choice.	Choose from 121,000 provider access points including Independent Doctors, Costco Optical, Walmart, Visionworks, Linden Optometry A P.C., and VSP's online eyewear store, Eyeconic.com	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	$0 copay[1]	Plan pays up to $30	$0 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, plus 20% off the balance over $100. $150 allowance on featured frame brands.	Plan pays up to $45
Contact Lenses: EyeMed - In lieu of lenses VSP - In lieu of lenses (every 12 months).	Plan pays 100% for medically necessary contact lenses. Plan pays up to $105 for elective lenses; standard contact lens fitting covered with $0 copay.	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 or 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 or up to $105 for elective contact lenses
Optional Features: (tinted lenses, scratch-resistant, ultra-violet coatings, retinal imaging, polycarbonate, photochromatic lenses and standard progressive lenses)	Plan pays 100% for tint and scratch-resistant coating; you pay $15 to $75 for additional features	Tinted lenses: Plan pays up to $5 Standard scratch-resistant: Plan pays up to $5	Plan pays 100% for Standard Progressive Lenses, Tinted Lenses, and Scratch Resistant Coatings. VSP also saves you 30% on non-covered lens enhancements.	Plan pays up to $5 for tinted lenses
Laser Vision Correction	Discounts on PRK or LASIK; please call (877)-5LASER6	Not Covered	Discounts on PRK, LASIK, SMILE, Bladeless, Contoura. Please call VSP at (800) 877-7195.	Not Covered

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.

[1]Premium progressive tiers 1 - 4: $85, $95, $110, $175 copay

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, prior authorization may be required as 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 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; or
- 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 Catastrophic Coverage Stage?
If you are enrolled in Medicare, once you've spent $2,000 on your prescriptions in 2025, you will enter the Catastrophic Coverage Stage. At this point, you will not have any out-of-pocket costs for the drugs covered by Medicare. For drugs not covered by Medicare but covered by the District, your copays will remain the same.

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

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 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.

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 stated.

Please email/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, and/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 quarters 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 the Kaiser Senior Advantage or Anthem Blue Cross EPO plan. Health Net Seniority Plus and Anthem Medicare Preferred (PPO) require eligibility and enrollment in Medicare Parts A and B.

Medicare Part B

All retirees/spouses/domestic partners/Medicare eligible dependents 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 Medicare eligible dependent(s), your/their District-sponsored medical benefits will terminate. For Medicare Part B premium information and questions, 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. The LAUSD prescription drug plan is at least as good as the standard Medicare Part D benefit for most Medicare-eligible participants. LAUSD provides prescription drug coverage through Kaiser Senior Advantage and Health Net Seniority Plus. For Anthem Blue Cross Select HMO, Anthem Blue Cross EPO, and Anthem Medicare Preferred (PPO), prescription drug coverage will be provided by CVS/SilverScript, a Caremark company. **If you elect to enroll in a PDP outside your current District-sponsored plan, the District will terminate your medical and prescription coverage.**

2024 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
$0.00	$103,000 or less	$206,000 or less	$103,000 or less
$12.90	$103,001 - $129,000	$206,001 - $258,000	n/a
$33.30	$129,001 - $161,000	$258,001 - $322,000	n/a
$53.80	$161,001 - $193,000	$322,001 - $386,000	n/a
$74.20	$193,001 - $499,999	$386,001 - $749,999	$103,001 - $396,999
$81.00	$500,000 and above	$750,000 and above	$397,000 and above

**Premiums are subject to change. Visit medicare.gov for the latest Part D - IRMAA rates. 2025 rates were not available at the time of this guide's publishing.*

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-sponsored medical and prescription coverage will be terminated.

Medicare Enrollment Period

There are three 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 for those who are 65 and older and 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) MEDICARE / (800) 633-4227 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 District Medicare-eligible retiree, you have to enroll in a Medicare Advantage plan. Medicare Advantage plans offered through LAUSD include Kaiser Senior Advantage, Health Net Seniority Plus, and Anthem Medicare Preferred (PPO). With these Medicare Advantage plans, you will be responsible for paying a small copayment or no copay 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 Senior Advantage plan, you must be enrolled in Medicare Parts A and B or Medicare Part B only. You must notify the District and submit proof of enrollment in Medicare in the month(s) prior to your 65th birthday. Once your verification of Medicare enrollment is received by the District, you will be enrolled in the Kaiser Senior Advantage plan. All Kaiser HMO plan members who have Medicare will be enrolled in the Kaiser Permanente Senior Advantage plan unless they select another plan.

  Both Medicare Parts A and B are required for Kaiser Permanente Senior Advantage regional areas of Hawaii and the Northwest (OR and WA).

  Medicare Part B is required at the minimum for CA residents. Medicare Part A is required unless you are not eligible for Medicare Part A without a cost. If this is the case a letter from the Centers for Medicare and Medicaid Services (CMS), stating you are ineligible to enroll in a premium-free Medicare Part A, must be provided to the District.

  CMS requires Medicare participants to confirm they reside in the service area by providing a physical address if they have a P.O. Box address on file with the District. You must submit a P.O. Box Address form to enroll in a Kaiser Senior Advantage plan, otherwise your medical and prescription coverage will terminate. Medicare participants with a P.O. Box address will be sent a P.O. Box Address form.
- For Health Net HMO, you must complete and submit a Health Net Seniority Plus group enrollment form in the month(s) 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 and your spouse/domestic partner who are over 65 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 is 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: 711) 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 "Find Doctors and Services" tool to confirm if your primary care physician and physician group is in the Health Net Seniority Plus network.

- For Anthem Medicare Preferred (PPO), you must be enrolled in Medicare Parts A and B. You must notify the District and submit proof of enrollment in Medicare Parts A and B in the month(s) prior to your 65th birthday. Once your verification of Medicare enrollment is received by the District, you will be enrolled in the Anthem Medicare Preferred (PPO) the first of the following month. You and your dependents must be enrolled in both Medicare Parts A and B to qualify for this plan. Any dependents who are over the age of 65 with Medicare Part B only or who are under the age of 65 will be enrolled/remain in Anthem Blue Cross EPO.

  Most people qualify for Medicare at age 65. If you, your spouse/domestic partner, or dependent have certain disabilities and/or have end-stage renal disease (ESRD), you may qualify for Medicare before age 65. If you have Medicare Parts A and B before age 65, you are eligible to enroll in the Anthem Medicare Preferred (PPO).

  The Centers for Medicare and Medicaid Services (CMS) requires Medicare participants to attest that they reside in the service area or provide a physical address if they have a P.O. Box address on file. The service area is defined as any physical address within the United States or certain U.S. territories. You must submit an attestation form to enroll in a Medicare Advantage plan, otherwise your medical and prescription coverage will terminate. Medicare participants with a P.O. Box address will be sent a P.O. Box Attestation Form.

  Once you are enrolled in the Anthem Medicare Preferred (PPO), Anthem coordinates all of your care. You must use a provider who accepts Medicare and the Anthem Medicare Preferred (PPO) in order for services to be covered by the plan. The plan will not pay for services from a provider who does not accept Medicare or has opted out of Medicare. So, if you receive care from one of these providers, you'll have to pay the full medical bill without reimbursement.

  If you fail to enroll and provide Medicare information to the District at least 30 days prior to your 65th birthday, you may have a lapse in coverage. In accordance with CMS guidelines, you can only enroll in one Medicare Advantage plan.

Enrolling in Anthem Blue Cross EPO

If you are 65 or older and only have Medicare Part B, you will have the option of enrolling in Anthem Blue Cross EPO.

Prescription drug coverage for Medicare eligible retirees and dependents in all Anthem Blue Cross plans is provided by SilverScript, a CVS/SilverScript Caremark company.

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/or 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); or
- your death.

The notice must be faxed to (213) 241-4247, emailed to benefits@lausd.net or mailed 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 (888) 678-4881.

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. Employees who retire and are not eligible for lifetime benefits are also eligible for AB528. Dependent children are not eligible for coverage under AB528. AB528 coverage will continue as long as you make the premium payments.

Cal-COBRA Coverage

When the 18 months of Federal COBRA ends, you and your spouse/dependent(s) may be able to continue medical coverage under Cal-COBRA. Cal-COBRA allows medical coverage to continue 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 (888) 678-4881.

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/AB528.
- 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 health care coverage through the Health Care Exchange. Visit coveredca.com for more information and coverage options.
- The Anthem Medicare Preferred (PPO) and SilverScript plans are not available to COBRA/AB528 members.

Dependent Eligibility

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

- legal spouse (includes spouse 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 25 who are not full time students are eligible for medical plan only. This is **only** applicable for non-Medicare 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 Medicare retirees enrolled in Kaiser Senior Advantage, Health Net Seniority Plus, Anthem Medicare Preferred (PPO), and Anthem Blue Cross EPO plans;
- dependent disabled children must meet the disability standards your medical plan and must be enrolled prior to age 26;
- 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 lausd.org/benefits for details on required documentation. See page 22 under section "HIPAA Special Enrollment Rights".

Dual Coverage

If you and your spouse/domestic partner and/or dependent child are District employees or retirees 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 medical plans for Medicare eligible retirees. Such retirees may not cover spouses enrolled in the same or different medical 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 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 LAUSD 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; or
- call (800) MEDICARE / (800) 633-4227; TTY: (877) 486-2048;
- visit socialsecurity.gov; or
- call the Social Security Administration at (800) 772-1213.

Health Insurance Portability and Accountability Act (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; or
- 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 documentation is 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 (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website summarizes 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 HMO and EPO Plans	P.O. Box 60007 Los Angeles, CA 90060-0007	anthem.com/ca	(800) 700-3739
Anthem Medicare Preferred (PPO)	P.O. Box 173605 Denver, CO 80217-3605	anthem.com/ca	Enrollment Info (833) 277-5221 After Enrollment (833) 277-5222
CVS Caremark SilverScript® (prescription drug providers for Anthem Blue Cross plans only)	P.O. Box 6590 Lees Summit, MO 64064-6590	caremark.com	(888) 752-7229 CVS (844) 819-3075 SilverScript®
Health Net HMO	P.O. Box 10348 Van Nuys, CA 91410-0348	healthnet.com/lausd	(800) 654-9821
Health Net Seniority Plus	P.O. Box 10344 Van Nuys, CA 91410-0344	healthnet.com/lausd	(844) 542-0102 TDD/TTY: 711
Kaiser Permanente HMO and Kaiser Senior Advantage	Kaiser Foundation Health Plan, Inc. 1950 Franklin Street Oakland, CA 94612	kp.org	(800) 464-4000 (800) 443-0815
Aetna Dental PPO	P.O. Box 14094 Lexington, KY 40512-4094	aetnaresource.com/p/lausd	(877) 338-1579
DeltaCare® USA DHMO	P.O. Box 1810 Alpharetta, GA 30023	deltadentalins.com/lausd	(844) 697-0580
Western Dental DHMO	Western Dental Services Attn: Customer Service 101 Park Lane Boulevard, Ste 301 Sugar Land, TX 77478	westerndentalbenefits.com	(866) 901-4416
EyeMed Vision Care	4000 Luxottica Place Mason, OH 45040	eyemed.com	Inquiries (866) 723-0514 LASIK (877) 5LASER6
VSP® Vision Care	P.O. Box 997100 Sacramento, CA 95899-7100	vsp.com	(800) 877-7195
Securian Financial (Life Insurance)	400 Robert Street North St. Paul, MN 55101-2098	lifebenefits.com	(866) 293-6047
Other Resources			
WageWorks, LAUSD COBRA/AB528 Administrator	Payments: P.O. Box 660212 Dallas, TX 75266 Forms: P.O. Box 223684 Dallas, TX 75222	mybenefits.wageworks.com	(888) 678-4881 (866) 450-5634 (fax)
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
LAUSD Benefits Administration	P.O. Box 513307 Los Angeles, CA 90051	web: lausd.org/benefits email: benefits@lausd.net	(213) 241-4262 (213) 241-4247 (fax)


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