



# 2012 Annual Benefits and Enrollment Guide

## Los Angeles Unified School District



# RETIREE BENEFITS

**BENEFITS  
ADMINISTRATION**

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# About This Guide

This LAUSD 2012 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 6–14.

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 summary and any official Plan documents, or if any point is not covered in this summary, 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 2012 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.

To make sure you receive the coverage you need, take the time to read this Guide and your other benefits materials.

## **2012 Annual Benefits Open Enrollment Period**

This year's Annual Benefits Open Enrollment period is November 1-20, 2011. All benefit-eligible retirees have two ways to change plans during the open enrollment period:

1. Access the Benefits Administration website at <http://benefits.lausd.net>.
2. Use our automated telephone enrollment system (IVR) at (800) 527-1482.

If you are a COBRA/AB528 participant, please complete and submit the enclosed form to Fringe Benefits Management Company, a Division of WageWorks (FBMC). For more information, please contact FBMC at (800) 342-8017.

## **What's New for 2012**

There are no significant benefits modifications to your medical and dental plans for the 2012 plan year.

As of January 1, 2012:

- SecureHorizons plan will have a new name and will be known as UnitedHealthcare® Group Medicare Advantage HMO. The name change will not impact the benefits. Members will receive a new ID card with the UnitedHealthcare® plan name.
- The VSP Plan will change from the Value Plan to the VSP Choice Plan. The Choice Plan includes the following member benefits not currently available under the Value Plan.
  - Polycarbonate lenses fully covered for dependent children.
  - Discounted pricing on polycarbonate lenses for adults averaging 20-25% off doctor's usual and customary charges.
  - 20% off any amount above the \$100 retail frame allowance.
  - 20% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses.
- There will be no co-payment for most preventive services under Kaiser Senior Advantage plan. Other Medicare Advantage plans such as Health Net Seniority Plus Plan and UnitedHealthcare® Group Medicare Advantage HMO (formerly known as SecureHorizons) also provide most preventive services with no co-payment.

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, 2012, it is critical that you review your existing plans and available options for the 2012 plan year.

### **You must take action during 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 (formerly known as Secure Horizons) 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, 2012.

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

## Mid-Year Plan Changes

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 in the list below. No exceptions can be made to this policy per IRS rules.

Election changes **MUST** be consistent with the event that prompted the change. You must also submit your changes within 31 days of the event. You **MUST** appropriately fill out and submit the required documentation, which certifies your event. Forms can be found on the Benefits Administration website at <http://benefits.lausd.net>.

### Major Life Event:

- 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
- Gains/loses eligibility for Medicare
- Employee 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. Be sure to include your employee number or Social Security Number on all correspondence.
- **A COBRA/AB528 participant**—contact FBMC, a Division of WageWorks, the COBRA/AB528 Administrator, at (800) 342-8017 for instructions on how to update your address.

**Please note:** There is no out of country coverage for retirees. Retirees who resided outside the country prior to 1/1/10 were grandfathered and may continue their coverage.

## District Sponsored Plans

The District offers several medical, dental and vision plans to eligible retirees and dependents. A general overview of these plans and eligibility requirements begins on page 6. Provider directories are available, at no cost, by calling the plan directly. Plan phone numbers and website addresses are provided on page 24.

### Medical Plans

The District offers seven medical plan options, including:

- 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 (formerly known as SecureHorizons)\*

*\*Retirees and spouse/domestic partner must be age 65 or over and enrolled in Medicare Parts A and B to enroll in this plan.*

### Dental Plans

The District offers four dental plan options, including:

- MetLife affiliated Dental Health Care Service Plan (SafeGuard DHMO)
- MetLife Preferred Dentist Program (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 co-payment amounts (the amount you must pay when you receive services). For additional details, see the chart on pages 12-13 to compare key benefits of each plan.

### Vision Plans

The District offers two vision plan options, including:

- EyeMed Vision Care
- VSP

Both vision plans provide similar benefits. However, there are some key differences such as deductibles, non-network benefits, and locations. For more information about the vision plan benefits, 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 for the 2011 plan year, you are not eligible to change vision plans for the 2012 plan year.



## A Closer Look At Your Medical Plan Options

Medical Plan Options	UnitedHealthcare® Group Medicare Advantage HMO (formerly known as SecureHorizons)	HEALTH NET HMO <sup>1</sup>
<b>Who May Enroll</b>	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, 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.
<b>Provider Choice</b>	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
<b>Annual Deductible</b>	None	None
<b>Out-of-Pocket Limit</b>	\$1,500 per member	\$1,500 per member (\$3,000 per family) <b>Seniority Plus:</b> \$3,400 per member
<b>Maximum Lifetime Benefit</b>	Unlimited	Unlimited
<b>Physician and Routine Services</b>		
<b>Physician Office Visits</b>	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 <b>Seniority Plus:</b> \$5 copay/visit
<b>Well Baby Care</b>	Not covered	No copay to age 2; \$20 copay/visit thereafter <b>Seniority Plus:</b> No copay
<b>Adult Physical Exam</b>	No copay	\$20 copay/visit <b>Seniority Plus:</b> No copay
<b>Well Woman Exam</b>	No copay	\$20 copay/visit <b>Seniority Plus:</b> No copay
<b>Prescription Drugs</b>		
<b>Retail Prescription Drugs</b>	CA: \$5 generic/\$7.50 brand; up to 31-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 31-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 <b>Seniority Plus:</b> \$5 copay/fill for generic medications; \$7.50 copay/fill for brand name medications; up to 30-day supply/formulary applies

<sup>1</sup>The Health Net HMO network is different than the network available under the Health Net Seniority Plus plan.

If there is any discrepancy between this chart and the Plan documents, the Plan documents will govern. Copies of the Plan documents are on file in Benefits Administration.

Note: Benefits and copays vary from state to state, please contact the plan for more information.

KAISER PERMANENTE HMO	ANTHEM BLUE CROSS SELECT HMO <sup>2</sup>	ANTHEM BLUE CROSS EPO <sup>2</sup>
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, HI, OR and WA. Please contact plan for service area where plan is available.	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 <b>Senior Advantage:</b> \$5 copay/visit	\$10 copay/visit	Member pays 20% after deductible *
No charge to 23 months <b>Senior Advantage:</b> Not covered	100% (up to age 7)	CA and Non-CA in network - \$25 (deductible waived) Non-CA out of network - Member pays 50%
\$20 copay/visit <b>Senior Advantage:</b> \$5 copay/visit	No copay	CA and Non-CA in network - \$25 (deductible waived) Non-CA out of network - Member pays 50%
\$20 copay/visit <b>Senior Advantage:</b> \$5 copay/visit	\$10 per exam (limited to 2 exams per year)	CA and Non-CA in network - 20% (deductible waived) Non-CA out of network - Member pays 50%
	CVS Caremark: Prescription drug coverage for all Anthem Blue Cross plans is provided through CVS Caremark	
\$10 copay/fill for generic medications; up to 30-day supply \$25 copay/fill for brand name medications; up to 30-day supply <b>Senior Advantage:</b> \$10 copay/fill for generic medications up to 30-days; \$25 copay/fill for brand medications up to 30-day supply	For up to 30-day supply: \$5 generic/ \$25 preferred brand / \$45 non-preferred brand  For maintenance drugs there is a mandatory 90-day supply at local CVS/ pharmacy store after the second fill at a retail pharmacy at mail order copay.	For up to 30-day supply: \$10 generic/ \$30 preferred brand/ \$50 non-preferred brand  For maintenance drugs there is a mandatory 90-day supply at local CVS/ pharmacy store after the second fill at a retail pharmacy at mail order copay.

<sup>2</sup>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 (formerly known as SecureHorizons)	HEALTH NET HMO
<b>Home Delivery (Mail Order) Prescription</b>	<p>CA: \$10 copay/fill; up to 90-day supply/formulary applies</p> <p>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</p>	<p>\$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.</p> <p><b>Seniority Plus:</b> \$10 copay/fill; up to 90-day supply formulary applies</p>
<b>Hospital or Outpatient Facility</b>		
<b>Inpatient Care, Room and Board, Surgery and Other Hospital Charges</b>	<p>CA: 100%</p> <p>Non-CA: \$50 copay per admission</p>	<p>10% coinsurance plus \$100 copay per admission</p> <p><b>Seniority Plus:</b> No copay</p>
<b>Outpatient Surgery</b>	<p>CA: 100%</p> <p>Non-CA: \$25 copay per surgery</p>	<p>\$250 copay per outpatient surgery visit</p> <p><b>Seniority Plus:</b> No copay</p>
<b>Emergency Room Treatment</b>	<p>\$50 copay/visit (waived if admitted)</p>	<p>\$100 copay/visit (waived if admitted)</p> <p><b>Seniority Plus:</b> \$50 copay/visit (waived if admitted)</p>
<b>Mental Health Care and Substance Abuse Treatment (for AB88<sup>3</sup> and Non-AB88 diagnosis)</b>		
<b>Outpatient Mental Health Care</b>	<p>\$5 copay/visit as medically necessary with no annual limit</p> <p>Non-CA:            \$15 copay per individual visit            \$10 copay per group visit</p>	<p>All diagnoses: \$20 copay/visit as medically necessary with no annual limit</p> <p><b>Seniority Plus:</b>            \$5 copay/visit as medically necessary with no annual limit.</p>
<b>Inpatient Mental Health Care</b>	<p>CA: 100% per admission, 190 day lifetime maximum.</p> <p>Non-CA: \$50 copay per admission, 190-day lifetime maximum</p> <p><u>Partial hospitalization psychiatric program:</u>            \$60 copay/day</p>	<p>All diagnoses: 10% coinsurance plus \$100 copay per admission with no annual limit</p> <p><b>Seniority Plus:</b> No copay</p> <p>Partial Hospitalization: No copay</p>

<sup>3</sup> 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.

If there is any discrepancy between this chart and the Plan documents, the Plan documents will govern. Copies of the Plan documents are on file in Benefits Administration.

KAISER PERMANENTE HMO	ANTHEM BLUE CROSS SELECT HMO <sup>2</sup>	ANTHEM BLUE CROSS EPO <sup>2</sup>
<p>\$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</p> <p><b>Senior Advantage:</b> \$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</p>	<p>\$10 copay/fill for generic; \$50 copay/fill for brand/formulary applies; \$90 copay/fill for non-formulary medications; mandatory up to 90-day supply of maintenance medications either through CVS Caremark Mail Service Pharmacy or a 90-day mandatory supply at local CVS/pharmacy store after the second fill at a retail pharmacy.</p>	<p>\$20 generic/\$60 preferred brand/\$100 non-preferred brand; mandatory up to 90-day supply of maintenance medications either through CVS Caremark Mail Service Pharmacy or a 90-day mandatory supply at local CVS/pharmacy store after the second fill at a retail pharmacy.</p>
<p>\$100 per admission</p> <p><b>Senior Advantage:</b> 100%</p>	<p>No copay</p>	<p>Member pays 20% after deductible (subject to utilization review) *</p>
<p>\$100 per procedure</p> <p><b>Senior Advantage:</b> \$5 copay/procedure</p>	<p>\$10 copay/visit</p>	<p>Member pays 20% after deductible *</p>
<p>\$100 copay/visit (waived if admitted)</p> <p><b>Senior Advantage:</b> \$50 copay/visit (waived if admitted)</p>	<p>\$50 copay/visit (waived if admitted)</p>	<p>\$100 deductible per visit (waived if admitted), then member pays 20%</p>
<p>\$20 per individual visit; \$10 per group visit (no annual limit)</p> <p><b>Senior Advantage:</b> \$5 copay/visit \$2 copay/group visit</p>	<p>\$10 copay per visit</p>	<p>Member pays 20% after deductible</p>
<p>\$100 per admission (no limit)</p> <p><b>Senior Advantage:</b> 100%</p>	<p>No copay (no day limit)</p>	<p>Member pays 20% after deductible (no day limit) *</p>

<sup>2</sup>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 (formerly known as SecureHorizons)	HEALTH NET HMO
<b>Substance Abuse Treatment</b>	CA: <u>Inpatient treatment</u> - Paid in full <u>Outpatient treatment</u> - \$5 copay/session  Non-CA: <u>Inpatient treatment</u> -\$50 copay per admittance <u>Outpatient treatment</u> - \$15 copay per individual visit or \$10 copay per group visit	<u>Inpatient treatment</u> : 10% coinsurance plus \$100 copay per admission with no annual limit <u>Outpatient treatment</u> : \$20 copay per individual visit; \$10 per group visit (unlimited visits/days each calendar year) <b>Seniority Plus:</b> Inpatient—No copay; Outpatient \$5 copay/session.
<b>Other Medical Care</b>		
<b>Chiropractic Care</b>	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 ASHP <sup>4</sup> network). No referral needed. <b>Seniority Plus:</b> \$5 copay/visit (up to 12 visits/year) through ASHP network. No referral needed.
<b>Durable Medical Equipment</b>	Paid in full	No copay (\$5,000 annual benefit maximum per calendar year, except for orthotics, diabetic supplies and pediatric asthma supplies) <b>Seniority Plus:</b> No copay
<b>Hearing Aids</b>	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) <b>Seniority Plus:</b> No copay for covered hearing aid expenses; replacement once every 3 years (one pair)

<sup>4</sup>American Specialty Health Plan

If there is any discrepancy between this chart and the Plan documents, the Plan documents will govern. Copies of the Plan documents are on file in Benefits Administration.

Consult your Plan regarding the procedures for obtaining hearing aids and for information regarding limitations and exclusions.

KAISER PERMANENTE HMO	ANTHEM BLUE CROSS SELECT HMO <sup>1</sup>	ANTHEM BLUE CROSS EPO <sup>1</sup>
<u>Inpatient Detoxification:</u> \$100 per admission; Residential rehabilitation: \$100 per admission (no limit); <b>Senior Advantage:</b> 100% <u>Outpatient therapy</u> \$20/individual session; \$5/group session; <b>Senior Advantage:</b> \$5/individual session, \$2/group session	Inpatient: No copay (no day limit)  Outpatient: \$10 copay per visit (pre-service review required after 12th visit)	Inpatient: Member pays 20% after deductible (no day limit) *  Outpatient: Member pays 20% after deductible (pre-service review required after the 12th visit) *
Not covered  <b>Senior Advantage</b> \$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 24 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%  <b>Senior Advantage:</b> 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.
Not covered <b>Senior Advantage:</b> \$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)	Benefits limited to \$5000 per calendar year.

<sup>1</sup>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
<b>Who May Enroll</b>	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
<b>Annual Deductible</b>	None	None
<b>Maximum Annual Benefit</b>	None	None
<b>Provider Choice</b>	Participants may select a Western Dental DHMO primary care dentist, or an affiliated private practice primary care dentist. Family members may each select their own primary care dentist	Participants must use a Western Dental DHMO primary care dentist within a Western Dental Center; family members may each select their own Western Dental Office
<b>Specialist Referral</b>	Pre-Authorization Required	Pre-Authorization Required
<b>Preventative Services</b>	Member Pays	Member Pays
<b>Includes Teeth Cleaning, Panoramic or Full Mouth X-rays and Fluoride Treatment</b>	No Cost (for cleaning - up to 3 per year)	No Cost (for cleaning - up to 3 per year)
<b>Therapeutic Services</b>	Member Pays	Member Pays
<b>Extractions, Simple (Single Tooth)</b>	No Cost	No Cost
<b>Extractions for Orthodontic Reasons</b>	Not Covered	Not Covered
<b>Fillings (Amalgam)</b>	No Cost	No Cost
<b>Fillings (Composite for Molars)</b>	Up to \$140	Up to \$140
<b>Root Canal - Molar</b>	\$40	\$40
<b>Periodontics (Scaling and Root Planning; per Quadrant)</b>	No Cost	No Cost
<b>Osseous Surgery - 4 or More Contiguous Teeth per Quadrant</b>	No Cost (once every 36 months)	No Cost (once every 36 months)
<b>Major Services</b>	Member Pays	Member Pays
<b>Crown</b>	\$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)
<b>Full Denture, Upper or Lower</b>	\$50	\$50
<b>Partial Denture, Upper or Lower</b>	\$50–\$63	\$50–\$63
<b>Bridge (3 Unit)</b>	\$165 per unit (Includes high noble and noble metal charge) Limitations may apply	\$165 per unit (Includes high noble and noble metal charge) Limitations may apply
<b>Dental Implants</b>	Cost varies based on dental implant treatment plan (available only at Western Dental Implant Centers.)	
<b>Orthodontia - 24 Month Treatment Plan</b>	Member Pays	Member Pays
<b>Children (to age 19) / Adults</b>	\$1,000 copay—comprehensive treatment only for both Children and Adults	\$1,000 copay—comprehensive treatment only for both Children and Adults
<b>Additional Benefits</b>	Member Pays	Member Pays
<b>Deep Sedation/General Anesthesia - First 30 Minutes</b>	\$160	\$160
<b>External Bleaching, per Arch</b>	\$125	\$125
<b>Occlusal Guards</b>	\$85	\$85

If there is any discrepancy between this chart and the Plan documents, the Plan documents will govern. Copies of the Plan documents are on file in Benefits Administration.

MetLife affiliated Dental Health Care Service Plan (SafeGuard DHMO)	MetLife Preferred Dentist Program (PPO)	
	In-Network	Out-of-Network
Eligible retirees, COBRA, and AB528 participants and their eligible dependents residing in California, Texas or Florida	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	\$1,000 for the following Covered Services: Preventive and Diagnostic; Basic Restorative; Major Restorative	
Participants must use a MetLife affiliated Dental Health Care Service Plan (SafeGuard DHMO) primary care dentist; family members may each select their own network dentist	Participants must use a MetLife PPO dentist; family members may each select their own network dentist	Participants and family members may use any licensed dental provider
Pre-Authorization Required	No Authorization Required	
<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
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.
<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
No Cost	20% of the maximum allowed charge	40% based on the reasonable and customary charge
Not Covered		
No Cost		
Up to \$140		
\$40		
No Cost		
No Cost (once every 36 months)		
<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
\$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		
\$40-\$165 per unit (Includes high noble and noble metal charge) Limitations may apply		
Not Covered	Not Covered	Not Covered
<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
\$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	
<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
\$160	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

## A Closer Look At Your Vision Plan Options

Vision Plan Options	EyeMed Vision Care		VSP	
	EyeMed Provider	Non-EyeMed Provider	Choice Network Provider	Non-VSP Provider <sup>1</sup>
<b>Who May Enroll</b>	Eligible U.S.-based retirees, COBRA, and AB528 participants		Eligible retirees, COBRA, and AB528 participants	
<b>Office Locations</b>	More than 45,000 providers nationwide, including Lens Crafters, Pearle Vision, Sears, Target and JC Penney optical locations; call EyeMed directly for locations	Not applicable	More than 42,000 providers nationwide; retail chain affiliate providers - including Costco and Eyecare Center of America retail stores <sup>3</sup> ; call VSP directly for locations.	Not applicable
<b>Annual Deductible</b>	None	None	\$25	\$25
<b>Examination (1 every 12 months)</b>	Plan pays 100%	Plan pays up to \$20	Plan pays 100%	Plan pays up to \$55
<b>Lenses (1 pair every 12 months):</b>				
<b>Single Vision</b>	Plan pays 100%	Plan pays up to \$20	Plan pays 100%	Plan pays up to \$40
<b>Lined Bifocal</b>	Plan pays 100%	Plan pays up to \$30	Plan pays 100%	Plan pays up to \$60
<b>Lined Trifocal</b>	Plan pays 100%	Plan pays up to \$40	Plan pays 100%	Plan pays up to \$80
<b>Lenticular</b>	Plan pays 100%	Plan pays up to \$50	Plan pays 100%	Plan pays up to \$125
<b>Standard Progressive</b>	\$65 copay	Plan pays up to \$30	\$55 copay	Plan pays up to \$80
<b>Frames: (1 every 24 months)</b>	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	Plan pays up to \$45
<b>Contact Lenses<sup>2</sup> EyeMed - In lieu of lenses VSP - In lieu of lenses and frames</b>	Plan pays 100% for medically necessary contact lenses; Plan pays up to \$105 for elective contact lenses	Plan pays up to \$50	Available once every year; Plan covers 100% of doctor's reasonable and customary fee for medically necessary contact lenses with prior authorization; Plan pays up to \$105 for elective contact lenses	Available once every year; Plan pays up to \$210 for medically necessary contact lenses, and up to \$105 for elective contact lenses
<b>Optional Features: (tinted lenses, scratch-resistant, ultra-violet coatings, retinal imaging, polycarbonate, standard photochromatic glass and progressive lenses)</b>	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	You pay \$15 to \$55 for these additional features. Premium options may vary	Not covered
<b>Laser Vision Correction</b>	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

<sup>1</sup> When services are received from a non-VSP Provider, the \$25 copayment is deducted from the reimbursement amount.

<sup>2</sup> 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.

<sup>3</sup> Coverage with a retail chain affiliate may be different. Visit vsp.com for details.

If there is any discrepancy between this chart and the Plan documents, the Plan documents will govern. Copies of the Plan documents are on file in Benefits Administration.

## Important Information about your Prescription Drugs 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. To find out more about 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 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 or by visiting the Benefits Administration website at <http://benefits.lausd.net>.

### ***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;
- used for indications not approved by the FDA or the plan;
- have a high potential for "off-label" or experimental use;
- benefit exclusions or limitations may apply.

### ***How do I obtain a prior authorization for medication on the Formulary or Recommended 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 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.

## **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 within 30 days of the life event.

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

### **Medicare Part A**

All retirees/spouses/domestic partners must enroll and remain enrolled in Medicare Part A if eligible premium free. If not eligible for Medicare Part A premium free, you must provide ineligibility letters in order to maintain District-sponsored medical benefits.

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 or her own earnings or the earnings of a spouse or former spouse. Contact your local Social Security office for eligibility information.

For retirees who are not eligible for Part A premium free, they may be eligible for the CalSTRS Medicare Premium Payment Plan (MPPP). Contact CalSTRS for eligibility requirements.

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

For Spouses/Domestic partners who are not eligible for Medicare Part A premium free, they must submit to LAUSD Benefits Administration a confirmation letter of ineligibility from CMS only.

### **Medicare Part B**

All retirees/spouses/domestic partners must enroll and remain enrolled in Medicare Part B and remit the applicable premium to CMS in order to maintain District-sponsored medical benefits. If 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 CVS Caremark the prescription drug provider for Anthem Blue Cross EPO plan. **If you elect to enroll in a PDP outside your current plan, the District will cancel your medical and prescription coverage.**

### Medicare Part D monthly adjustment amounts

Effective January 1, 2011, higher income Medicare beneficiaries who are enrolled in Medicare Advantage Plan (Kaiser Senior Advantage, Health Net Seniority Plus and UnitedHealthcare® Group Medicare Advantage HMO) will be subject to a Medicare Part D premium 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
\$12.00	\$85,001 - \$107,000	\$170,001 - \$214,000	n/a
\$31.10	\$107,001 - \$160,000	\$214,001 - \$320,000	n/a
\$50.10	\$160,001 - \$214,000	\$320,001 - \$428,000	\$85,001 - \$129,000
\$69.10	Above \$214,000	Above \$428,000	Above \$129,000

\*Premiums are subject to change.

The 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.

## 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 as soon as 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 (or your eligible dependent) reach age 65. For more information you may contact Medicare directly at (800) 633-4227 (800-MEDICARE) or at (877) 486-2048 (TTY) for the hearing impaired. You may also visit the Medicare website at <http://www.medicare.gov> or the Social Security website at <http://www.socialsecurity.gov> or (800) 772-1213.

## **LAUSD Medicare Requirements**

Retirees and/or their 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.

For all other retirees and/or their spouse/domestic partner, in order to continue your District-sponsored benefits:

- Mail or fax a photocopy of your Medicare card or letter from CMS which provide proof of eligibility for Medicare Parts A and B, in the month prior to your 65th birthday. If you are only eligible for Medicare Part B, provide the ineligibility letters for Medicare Part A as described on page 16. Please include retiree's name, employee ID or Social Security number to LAUSD Benefits Administration at the address listed on page 24.

### **Enrolling in Medicare Advantage Plans**

As a Medicare eligible retiree, you have to enroll in the Medicare Advantage plan. Medicare Advantage plans include Kaiser Senior Advantage, Health Net Seniority Plus and UnitedHealthcare® Group Medicare Advantage HMO (formerly known as SecureHorizons). 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:

- For Kaiser HMO, you must complete and submit a Kaiser Advantage group enrollment form in the month prior to your 65th birthday. You will then be enrolled in Kaiser Senior Advantage once the form is received and approved by Kaiser.
- 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. The Health Net Seniority Plus network is different than the Health Net HMO network. Please contact Health Net for provider information.
- If you wish to enroll in UnitedHealthcare® Group Medicare Advantage HMO (formerly known as SecureHorizons), you must notify the District and submit a UnitedHealthcare® group enrollment form to United Healthcare in the month prior to your 65th birthday. You will be enrolled in UnitedHealthcare® Group Medicare Advantage HMO once the form is received and approved by UnitedHealthcare® Group Medicare Advantage HMO. Retiree and spouse/domestic partner must both be over 65 and eligible for Medicare Parts A and B to qualify for this plan.

### **Enrolling in Anthem Blue Cross EPO**

When you turn 65, Anthem Blue Cross HMO plan will change to Anthem Blue Cross EPO plan. For 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 were not present). Retirees/dependents that are not eligible for Medicare Part A may be responsible for additional costs.

## **Survivor 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 only for COBRA.

To continue medical, dental, and/or vision coverage, your surviving spouse must contact the District to report your death within 60 days. The District will notify the COBRA/AB528 Administrator to mail your surviving spouse an enrollment packet. If the COBRA/AB528 Administrator is not notified by the surviving spouse 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 retiree's death.

## **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 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. LAUSD will notify the COBRA Administrator in the event of your loss of benefits due to lack of Medicare Parts A or B. Upon receipt of notification, you will be mailed a COBRA election packet. Failure to notify the COBRA/AB528 administrator within 60 days will forfeit your right to elect COBRA.

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 FBMC, a Division of WageWorks, the COBRA/AB528 Administrator, at (800) 342-8017.

### **AB528 Coverage**

Your surviving spouse and dependent children may continue their coverage under COBRA, as explained previously, 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 your 18 months of Federal COBRA ends, you may be able to continue medical coverage under Cal-COBRA. Cal-COBRA allows you to keep your 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 & Anthem Blue Cross EPO plans, contact FBMC at (800) 342-8017.

## **Please Note**

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- 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 dependents, then through AB528 for you and your spouse. The COBRA/AB528 Administrator, FBMC, a Division of 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.

## **Dependent Eligibility**

When you enroll in the District's 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. 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 plan.
- 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, 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 <http://benefits.lausd.net> for details on required documentation.

## **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 both enroll in the same plan(s), you may not cover each other as dependents; similarly, only one of you may cover your eligible children under the plan(s). In instances of dual coverage, your eligible children will be enrolled as a dependent under the plans in which the older parent is enrolled, unless otherwise specified by the employee/retiree.
- If you enroll in 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.

## **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 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 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 plan's coverage and do not enroll in a Medicare prescription plan now, you will not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

For more information about Medicare prescription drug coverage:

- visit <http://www.medicare.gov>;
- call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048;
- visit <http://www.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 an employee, you must enroll your new spouse within 30 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 or the date of birth, or legal adoption. In addition, if you are not enrolled in the plans as an employee, you must also enroll in the plan when you enroll any of your dependents. If the dependent enrollment application is not received within 30 days of the event, 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 and 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 <http://www.hhs.gov/>.

## **Grandfathered Health Plan**

The District believes that 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](http://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.

## **Notice about the Early Retiree Reinsurance Program**

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

## Important Contact Information

Plan Name	Address	Web Address	Phone
Anthem Blue Cross	P.O. Box 60007 Los Angeles, CA 90060-007	<a href="http://www.anthem.com/ca">www.anthem.com/ca</a>	(800) 700-3739
CVS Caremark (prescription drug provider for Anthem Blue Cross Plans only)	Caremark Research Team P.O. Box 832407 Richardson, TX 75083	<a href="http://www.caremark.com">www.caremark.com</a>	(888) 752-7229
Health Net HMO	P.O. Box 10348 Van Nuys, CA 91409-10348	<a href="http://www.healthnet.com/lausd">www.healthnet.com/lausd</a>	(800) 654-9821
Health Net Seniority Plus	P.O. Box 10198 Van Nuys, CA 91410-0198	<a href="http://www.healthnet.com/lausd">www.healthnet.com/lausd</a>	Enrollment Info (800) 596-6565 After Enrollment (800) 275-4737
Kaiser Permanente HMO and Kaiser Senior Advantage	393 E. Walnut St. Pasadena, CA 91188	<a href="http://www.kp.org">www.kp.org</a>	(800) 464-4000
UnitedHealthCare® Group Medicare Advantage HMO	P.O. Box 29650 Hot Springs, AR 71903-9973	<a href="http://www.uhcretiree.com">www.uhcretiree.com</a>	Enrollment Info (877) 714-0178 After Enrollment (800) 457-8506
MetLife Dental PPO	MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282	<a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a>	(866) 576-9121
MetLife Dental DHMO	SafeGuard Dental HMO Claims P.O. Box 981987 El Paso, TX 79998-1987	<a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a>	(866) 576-9121
Western Dental DHMO Centers Only and Western Dental Plan Plus	Western Dental Services Attn: Customer Service 530 South Main Street Orange, CA 92868	<a href="http://www.westerndentalbenefits.com">www.westerndentalbenefits.com</a>	(866) 901-4416
EyeMed Vision Care	4000 Luxottica Place Mason, OH 45040	<a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a>	Inquiries (866) 723-0514 LASIK (877) 5LASER6
VSP	P.O. Box 997100 Sacramento, CA 95899-7100	<a href="http://www.vsp.com">www.vsp.com</a>	(800)877-7195
MetLife - Life Insurance	MetLife Recordkeeping Center P.O. Box 14401 Lexington, KY 40512-4401	<a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a>	(866) 492-6983
Other Resources			
LAUSD COBRA/AB528 Administrator, FBMC - A Division of WageWorks	FBMC P.O. Box 730561 Ormond Beach, FL 32173-0561	<a href="http://www.myFBMC.com">www.myFBMC.com</a>	(800) 342-8017
Social Security Administration		<a href="http://www.ssa.gov">http://www.ssa.gov</a>	(800) 772-1213
Medicare		<a href="http://www.medicare.gov">http://www.medicare.gov</a>	(800) 633-4227
Public Employees Retirement System (PERS)		<a href="http://www.calpers.ca.gov">http://www.calpers.ca.gov</a>	(888) 225-7377
State Teachers Retirement System (STRS)		<a href="http://www.calstrs.com">http://www.calstrs.com</a>	(800) 228-5453 Sacramento (562) 922-6838 Los Angeles
LAUSD Benefits Administration	P.O. Box 513307 Los Angeles, CA 90051	<a href="http://benefits.lausd.net">http://benefits.lausd.net</a>	(213) 241-4262 (213) 241-4247 (fax)



