A Closer Look At Your Medical Plan Options

Medical Plan Options	Health Net HMO	Kaiser Permanente HMO	Anthem Blue Cross Select HMO[1]	Anthem Blue Cross EPO[1]
Provider Choice	Health Net HMO or Seniority Plus (Medicare Advantage) providers only; each family member may select his or her own doctor.	Kaiser HMO providers only; each family member may select his or her own doctor.	Anthem Blue Cross Select HMO providers only; 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.
Annual Deductible	None	None	None	0.5% of gross fiscal earnings per active member, rounded down to the next higher $50 increment ($100 Minimum per member - $800 Maximum per member). Family: 3x member deductible
Out-of-Pocket Limit	$1,500 per member ($3,000 per family)	$1,500 per member ($3,000 per family)	$1,500 per member $3,000 for 2 members $4,500 per family	$7,500
Maximum Lifetime Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Physician and Routine Services				
Physician Office Visits	$20 copay/visit for primary care physician; $30 copay/visit for specialist	$20 copay/visit	$10 copay/visit	Member pays 20% after deductible*
Well Baby Care	No copay to age 2; $20 copay/visit thereafter	No charge to 23 months	100% (up to age 7)	No copay
Adult Physical Exam	$20 copay/visit	$20 copay/visit	No copay	No copay
Well Woman Exam	$20 copay/visit	$20 copay/visit	$10 per exam (limited to 2 exams per year)	No copay
Prescription Drugs			Prescription for all Anthem Blue Cross plans is provided through CVS Caremark	
Retail Prescription Drugs	$5 copay/fill for generic up to 30-day supply; $25 copay/fill for brand up to 30-day supply; $45 copay/fill for non-formulary medications up to 30-day supply/ formulary applies.	$10 copay/fill for generic medications up to 30-day supply. $25 copay/fill for brand name 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.
Home Delivery (Mail Order) Prescription	$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.	$10 copay/fill for generic medications up to 30-day supply or $20 for a 31 to 100 day supply; $25 copay/fill for brand name medications up to 30-day supply or $50 for a 31 to 100 day supply.	$10 copay/fill for generic; $50 copay/fill for brand/formulary applies; $90 copay/fill for non-formulary medications; 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.	$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.
Hospital or Outpatient Facility				
Inpatient Care, Room and Board, Surgery and Other Hospital Charges	10% coinsurance plus $100 copay per admission.	$100 per admission.	No copay.	Member pays 20% after deductible (subject to utilization review).*
Outpatient Surgery	$250 copay per outpatient surgery visit.	$100 per procedure.	$10 copay/visit.	Member pays 20% after deductible.*
Emergency Room Treatment	$100 copay/visit (waived if admitted).	$100 copay/visit (waived if admitted).	$50 copay/visit (waived if admitted).	$100 deductible per visit (waived if admitted), then member pays 20%.
Mental Health Care and Substance Abuse Treatment (for AB88[2] and Non-AB88 diagnosis)				
Outpatient Mental Health Care	All diagnosis: $20 copay/visit as medically necessary with no annual limit.	$20 per individual visit; $10 per group visit (no annual limit).	$10 copay per visit.	Member pays 20% after deductible.
Inpatient Mental Health Care	All diagnoses: 10% coinsurance plus $100 copay per admission with no annual limit. Partial Hospitalization: No copay.	$100 per admission.	No copay (no day limit).	Member pays 20% ater deductible (no day limit).*
Substance Abuse Treatment	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).	Inpatient Detoxification: $100 per admission Residential Rehabilitation: $100 per admission (no limit). Outpatient treatment: $20 copay per individual visit; $10 per group visit (unlimited visits/ days each calendar year).	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).*
Other Medical Care				
Chiropractic Care	$10 copay/visit (up to 20 visits/year through ASHP[3] network). No referral needed.	Not covered.	$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).*
Durable Medical Equipment	No copay ($5,000 annual benefit maximum per calendar year, except for orthotics, diabetic supplies and pediatric asthma supplies).	Member pays 10%.	Member pays 20%.	Member pays 20% after deductible.
Hearing Aids[4]	No copay of covered hearing aid expenses; replacement once every 3 years (one pair).	Not covered.	Member pays 20% (limited to one pair every 3 years; batteries and repairs not covered).	Member pays 20% after deductible; one hearing aid per ear every three years.

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

[1]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

[2]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.

[3]American Specialty Health Plan.

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

*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.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) are voluntary plans that enable you to save money by paying for certain health care and dependent care expenses using pre-tax pay. The District offers two special tax-savings accounts to eligible employees:

- Health Care FSA
- Dependent Care FSA

How the Accounts Work

When you enroll, you decide how much of your pay to set aside in the Health Care FSA and/or Dependent Care FSA. The money you elect to set aside is deducted throughout the year from your pay before federal income, state income, and Social Security taxes are calculated.

When you have an eligible expense, you pay for the expense and file for reimbursement from your FSA. You are reimbursed with your own money from the appropriate account, and the money remains untaxed. In other words, you never pay taxes on the money that flows through your FSA(s).

Eligible expenses for the Health Care FSA include deductibles or co-pays; prescription drug co-pays; co-pays for orthodontia, prescription eyewear, and contact lenses. For a guide to eligible and ineligible health care expenses, visit http://www.irs.gov to retrieve the most current edition of the IRS publication 502.

Eligible expenses for the Dependent Care FSA include child or adult daycare services provided in your home, someone else's home (see IRS Publication 503 for exclusions); expenses for a licensed daycare center including annual registration fees. To qualify daycare as an eligible expense, the IRS says your qualified dependent must either be under age 13, or physically or mentally disabled (regardless of age) and unable to be self reliant while you are working.
If you are paying for adult daycare outside your home, your dependent must live with you at least eight hours a day. Daycare providers must claim the income on their tax return, and you will be required to include their Social Security number on your reimbursement request. For the most current guide of eligible and ineligible dependent care expenses, visit http://www.irs.gov and retrieve IRS Publication 503.

Enrollment in the Health Care FSA and/or Dependent Care FSA is not automatic! You must enroll every year during Open Enrollment in order to participate.

457(b) and 403(b) Retirement Savings Plans

As an employee of the Los Angeles Unified School District you have the opportunity to accumulate savings for your future. The District sponsors a 457(b) Deferred Compensation Plan and offers a 403(b) Plan providing you an excellent opportunity to contribute pre-tax dollars via automatic payroll deductions, which may lower your current income taxes. You are immediately eligible to begin contributing to the 457(b) and/or the 403(b) plans. For more information, please visit the http://benefits.lausd.net website, click on "Active Employees" and then click on the "For Your Wealth" section.

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[1]
Office Locations	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[3]; call VSP directly for locations.	Not Applicable
Annual Deductible	None	None	$25	$25
Examination *(1 every 12 months)*	Plan pays 100%.	Plan pays up to $20.	Plan pays 100%.	Plan pays up to $55.
Lenses *(1 pair every 12 months)*:				
Single Vision	Plan pays 100%.	Plan pays up to $20.	Plan pays 100%.	Plan pays up to $40.
Lined Bifocal	Plan pays 100%.	Plan pays up to $30.	Plan pays 100%.	Plan pays up to $60.
Lined Trifocal	Plan pays 100%.	Plan pays up to $40.	Plan pays 100%.	Plan pays up to $80.
Lenticular	Plan pays 100%.	Plan pays up to $50.	Plan pays 100%.	Plan pays up to $125.
Standard Progressive	$65 copay.	Plan pays up to $30.	$55 copay.	Plan pays up to $80.
Frames: *(1 every 24 months)*	Plan pays up to $100, plus 20% off the balance over $100.	Plan pays up to $40.	Plan pays up to $100, plus 20% off the balance over $100.	Plan pays up to $45.
Contact Lenses[2] **EyeMed** - *In lieu of lenses.* **VSP** - *In lieu of lenses and frames.*	Plan pays up to $100 for medically necessary contact lenses; Plan pays up to $105 for elective 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.
Optional Features: (Tinted lenses, scratch resistant, ultra-violet coatings, retinal imaging, polycarbonate, standard photochromatic glass and progressive lenses.)	Plan pays 100% for tint and scratch-resistant coating; you pay $15 to $65 for additional features.	Tinted lenses Plan pays up to $5. Standard scratch resistant Plan pays up to $5	You pay $15 to $55 for these additional features. Premium options may vary.	Not covered.
Laser Vision Correction	Discounts on PRK or LASIK; Please call (877) 5LASER6	Not covered.	Discounts on PRK, LASIK and Custom LASIK surgery at contracted VSP centers; contact VSP directly for information.	No Covereed

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[1]When services are received from a non-VSP Provider, the $25 copayment is deducted from the reimbursement amount.

[2]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.

[3]Coverage with a retail chain affiliate may be different. Visit vsp.com for details.

Life Insurance

Basic Life Insurance

As an eligible District employee, you automatically recieve Basic Life Insurance coverage up to $20,000. MetLife underwrites this life insurance coverage.

The District pays the full cost of your Basic Life Insurance, which provides a lump sum payment to your designated beneficiary if you die while employed with the District.The District will pay the premiums for your Basic Life Insurance coverage for up to 12 months if you are on an approved unpaid illness or industrial injury leave. It is your responsibility to keep your beneficiary designation up to date.

Optional Life

You may use the optional life insurance plan (paid for through your payroll deduction) to obtain:

- a greater level of life insurance for yourself;
- life insurance for your eligible dependents (spouse/domestic partner and children);
- accident protection for you and/or your dependents.

Filing a Claim

If you or a dependent dies while covered under the life insurance plan(s), the designated beneficiary should contact MetLife, who will assist the beneficiary with filing a claim for benefits under the plan.

For additional information about the District's Life Insurance programs visit http://metlife.com/mybenefits or contact MetLife at (866) 492-6983.

A Closer Look At Your Dental Plan Options

Dental Plan Option	Western Dental DHMO Plan Plus	Western Dental DHMO Centers Only	MetLife Dental DHMO	MetLife Dental (PPO)	
				In-Network	Out-of-Network
Annual Deductible	None	None	None	$100 for the following Covered Services Combined: Basic Restorative; Major Restorative.	
Maximum Annual Benefit	None	None	None	$1,000 for the following Covered Services: Preventative and Diagnostic; Basic Restorative; Major Restorative.	
Provider Choice	Western Dental DHMO primary care dentist, or an affiliated private practice 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.	Participants must use a MetLife Dental DHMO primary care dentist; family members may each select their own network dentist.	Participants must use a MetLife Dental (PPO) dentist; family members may each select their own network dentist.	Participants and family members nay use any licensed dental provider.
Specialist Referral	Pre-Authorization Required	Pre-Authorization Required	Pre-Authorization Required	No Authorization Required	
Preventative Services	Member Pays	Member Pays	Member Pays	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).	No Cost (for cleaning - up to 3 per year).	No Cost. Subject to procedure limitations; teeth cleaning up to 2 per year in and out of network.	20% based on the reasonable and customary charge. Subject to procedure limitations; teeth cleaning up to 2 per year in and out of network.
Therapeutic Services	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Extractions, Simple (Single tooth)	No Cost.	No Cost.	No Cost.	20% of the maximum allowed charge.	40% based on the reasonable and customary charge.
Extractions for Orthodontic Reasons	Not Covered.	Not Covered.	Not Covered.		
Fillings (Amalgam)	No Cost.	No Cost.	No Cost.		
Fillings (Composite for Molars)	Up to $140	Up to $140	Up to $140		
Root Canal - Molar	$40	$40	$40		
Periodontics (Scaling and Root Planning; per Quadrant)	No Cost.	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).	No Cost (once every 36 months).		
Major Services	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Crown	$20-$165 (Cost varies based on metal chosen. No cost for Clinical Crown Lengthening).	$20-$165 (Cost varies based on metal chosen. No cost for Clinical Crown Lengthening).	$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.
Full Denture, Upper or Lower	$50	$50	$50		
Partial Denture, Upper or Lower	$50-$63	$50-$63	$50-$63		
Bridge (3 unit)	$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.	$40-$165 per unit (In-cludes high noble and noble metal charge). Limitations may apply.		
Dental Implants	Cost varies based on dental implant treatment (available only at Western Dental Implant Centers)	Cost varies based on dental implant treatment (available only at Western Dental Implant Centers)	Not Covered.	Not Covered.	Not Covered.
Additional Benefits	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Deep Sedation/ General Anesthesia - First 30 Minutes	$160	$160	$160	20% of the maximum al-lowed charge.	40% based on the reasonable and customary charge.
External Bleaching, per Arch	$125	$125	$125	Not Covered.	Not Covered.
Occlusal Guards	$85	$85	$85	50% of the maximum allowed.	50% based on the reasonable and customary charge.

Important Contact Information

Plan Name	Address	Web Address	Phone
Anthem Blue Cross	P.O. Box 60007 Los Angeles, CA 90060-0007	www.anthem.com/ca	(800) 700-3739
CVS Caremark (prescription drug provider for Anthem Blue Cross Plans only)	Caremark Research Team P.O. Box 832407 Richardson, TX 75083	www.caremark.com	(888) 752-7229
Health Net HMO	P.O. Box 10348 Van Nuys, CA 91409-10348	www.healthnet.com/lausd	(800) 654-9821
Health Net Seniority Plus	P.O. Box 10198 Van Nuys, CA 91410-0198	www.healthnet.com/lausd	Enrollment Info (800) 596-6565 After Enrollment (800) 275-4737
Kaiser Permanente HMO and Kaiser Senior Advantage	393 E. Walnut St. Pasadena, CA 91188	www.kp.org	(800) 464-4000
MetLife Dental PPO	MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282	www.metlife.com/mybenefits	(866) 576-9121
MetLife Dental DHMO	SafeGuard Dental HMO Claims P.O. Box 981987 El Paso, TX 79998-1987	www.metlife.com/mybenefits	(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	www.westerndentalbenefits.com	(866) 901-4416
EyeMed Vision Care	4000 Luxottica Place Mason, OH 45040	www.eyemedvisioncare.com	Inquiries (866) 723-0514 LASIK - (877) 5LASER6
VSP	P.O. Box 997100 Sacramento, CA 95899-7100	www.vsp.com	(800) 877-7195
UniAccount - FSA Plans	P.O. Box 4381 Woodland Hills, CA 91365	www.anthem.com/ca	(888) 209-7976
457(b) Savings Plans		www.myretirementmanager.com	Effective through 1/31/12 (800) 448-2542
457(b) Savings Plan	TIAA-CREF Processing P.O. Box 1259 Charlotte, NC 28201	http://457b.lausd.net	Effective as of 2/1/12 (800) 842-2776 (800) 914-8922 (fax)
403(b) Savings Plan	TSA Consulting Group 28 Ferry Rd. SE, Fort Walton Beach, FL 32548	http://403b.lausd.net	Effective as of 2/1/12 (888) 796-3786 (866) 741-0645 (fax)
MetLife - Life Insurance	MetLife Recordkeeping Center P.O. Box 14401 Lexington, KY 40512-4401	www.metlife.com/mybenefits	(866) 492-6983
OTHER RESOURCES			
LAUSD COBRA/AB528 Administrator, FBMC	FBMC P.O. Box 730561 Ormond Beach, FL 32173-0561	www.myFBMC.com	(800) 342-8017
Social Security Administration		http://www.ssa.gov	(800) 772-1213
Medicare		http://www.medicare.gov	(800) 633-4227
Public Employees Retirement System (PERS)			(888) 225-7377
State Teachers Retirement System (STRS)			(800) 228-5453 Sacramento (562) 922-6838 Los Angeles
LAUSD Benefits Administration	P.O. Box 513307 Los Angeles, CA 90051	http://benefits.lausd.net	(213) 241-4262 (213) 241-4247 (fax)