

The LACCD Joint Labor/Management
Benefits Committee presents

Health Benefits Highlights Booklet



PART-TIME FACULTY
MEMBERS

2009



**You MUST re-enroll
during the annual
enrollment period to
participate in the LACCD
health insurance plans!**

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JOINT LABOR-MANAGEMENT
BENEFITS COMMITTEE

IMPORTANT CONTACT INFORMATION

Medical Plans

Blue Shield

P.O. Box 272540
Chico, CA 95927-2540
(800) 443-5005
www.blueshieldca.com

U.S. Behavioral Health Plan
(mental health services administrator)
(877) 263-8827
www.unitedbehavioralhealth.com

Kaiser Permanente

(800) 464-4000
www.kp.org

Dental Plans

Delta Dental

P.O. Box 997330
Sacramento, CA 95899-7330
(800) 765-6003
www.deltadentalins.com

SafeGuard

P.O. Box 3594
Laguna Hills, CA 92654
(800) 880-1800
www.safeguard.net
(plan code SGC1028)

Vision Plan

VSP

P.O. Box 997100
Sacramento, CA 95899-7105
(800) 877-7195
www.vsp.com

Employee Assistance Program (EAP)

Horizon Health

(800) 342-8111
www.horizoncarelink.com
login code: laccd
password: eap

Other Benefits & COBRA Information

LACCD Health Benefits

Call Center

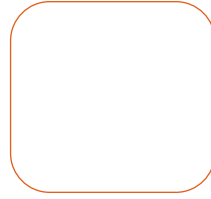
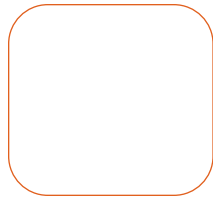
770 Wilshire Blvd., 6th Floor
Los Angeles, CA 90017
(888) 428-2980
www.laccd.edu/health



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This summary describes the key features of the benefits available to retirees and survivors. It is only intended to provide the highlights of your benefits; see your Evidence of Coverage or plan document for full details. If any conflict ever arises between this summary and the actual Evidence of Coverage or other plan document, the terms of the plan document will govern in all cases. LACCD reserves the right to change, modify, or terminate the benefit plans at any time. This summary is not a contract for payment of benefits.



LACCD's Part-Time Faculty Health Benefits Program

The Los Angeles Community College District is proud to make comprehensive medical, dental, vision, and EAP benefits available to eligible part-time faculty members.

Your eligibility for benefits depends on how many semesters you have taught for LACCD and how many hours you're scheduled to teach during the current semester. Your full-time equivalent (FTE) teaching load also determines the cost of your benefits and whether you pay for your coverage through the Premium Only Plan (POP) or the Access-Only Plan.

The key differences between the POP and Access-Only Plan are shown in the chart below. Please keep in mind that these "plans" only refer to the financial and administrative rules that apply to your coverage—all eligible part-time faculty members have the same benefit plan options, no matter how you pay your premiums.

	Premium Only Plan (POP)	Access-Only Plan
You are eligible if...	You are assigned to teach a .33 (or higher) FTE load in the upcoming semester and you are not eligible for coverage under another group health insurance plan (through another employer or your spouse's employer)	Your current teaching load is at least a .2 FTE but less than a .33 FTE
	You must have completed a .2 FTE or higher part-time faculty position in the District during at least three of the previous eight consecutive Spring or Fall semesters	
Who pays for your health insurance coverage...	The District contributes toward the cost of your medical coverage; you pay the full cost of your dental and vision coverage	You pay the full cost of your medical, dental, and vision coverage
How you pay your premiums...	Your premium payments will automatically be deducted from your paycheck on a before-tax basis	Your premium payments will automatically be deducted from your paycheck on an after-tax basis
You may cancel or change your coverage...	Only at the start of each plan year on March 1, unless you have a "qualified life event" as defined by the IRS	With 30 days' written notice to the LACCD Health Benefits Call Center; cancellation notices received by the 10th of the month will be effective the first of the following month



For more information about eligibility, including information on enrolling your dependents for coverage, please see the enclosed summary of your rights under the plans (or visit www.laccd.edu/health).

Paying for Your Coverage

Premium Only Plan (POP). The District will contribute \$180 per month (\$2,160 annually) to the cost of your medical coverage. You will pay your share of the medical plan premium — as well as the full cost of any dental or vision coverage you elect — through automatic before-tax payroll deductions. Your payments will be deducted from your paycheck as follows:

Payroll Deductions	Period of Coverage
February 2009 – June 2009	March 1, 2009 – August 31, 2009
September 2009 – January 2010	September 1, 2009 – February 28, 2010

Access-Only Plan. You will have monthly payroll deductions from September through June, as long as you remain eligible.



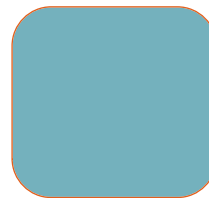
Enrollment

You must enroll while you are eligible (Spring or Fall semester only) and have a current teaching assignment. Your coverage will become effective after your eligibility is verified. You will be notified of your effective date of coverage.

Spring Semester. Enrollment in the POP or Access-Only Plan is permitted during the annual enrollment period that is held from mid-January to mid-February. Your coverage for the Spring semester begins in March and ends in August.

Fall Semester. All eligible faculty members may enroll in the Access-Only Plan during the fall. However, only newly eligible faculty members may join the POP in the fall. The enrollment period begins mid-July and ends mid-August. Coverage for the Fall semester begins in September and ends in February.

Please see your application form and instruction letter for more information on enrolling for benefits. The 2009 premiums are shown on the next page.



ALL part-time faculty members must re-enroll in the POP or Access-Only Plan during each annual enrollment period.

Access-Only Plan participants must submit a new application each semester.

Verifying Your Teaching Load

Your eligibility for health benefits is verified only through the District's employee database. Before the start of each semester, the District will notify you by e-mail of your eligibility status. If your work assignment for the semester does not qualify you for the POP but is at least a .2 FTE, you will receive an enrollment offer for the Access-Only Plan.



Please contact your campus Academic Affairs Office or SPOC (single point of contact) if you have any questions about your teaching assignment or FTE load.

2009 Premium Rates

Premium Only Plan

	Single	Two-Party	Family
Medical Plans			
Blue Shield PPO	\$ 457.22	\$ 1,193.76	\$ 1,797.47
Blue Shield HMO	\$ 229.73	\$ 715.60	\$ 1,121.21
Kaiser Permanente HMO	\$ 229.66	\$ 715.43	\$ 1,120.98
Dental Plans			
Delta Dental PPO	\$ 55.24	\$ 110.51	\$ 155.71
SafeGuard HMO	\$ 23.95	\$ 45.49	\$ 57.46
Vision Plan			
Vision Service Plan	\$ 12.16	\$ 17.63	\$ 20.60

NOTE: The rates above are tenths, for 12 months of coverage. The medical plan rates reflect the District's 2009 medical plan contribution of \$180 per month (\$2,160 annually); the District does not contribute toward the dental or vision plan premiums.

Access-Only Plan

	Single	Two-Party	Family
Medical Plans			
Blue Shield PPO	\$ 673.22	\$ 1,409.76	\$ 2,013.47
Blue Shield HMO	\$ 445.73	\$ 931.60	\$ 1,337.21
Kaiser Permanente HMO	\$ 445.66	\$ 931.43	\$ 1,336.98
Dental Plans			
Delta Dental PPO	\$ 55.24	\$ 110.51	\$ 155.71
SafeGuard HMO	\$ 23.95	\$ 45.49	\$ 57.46
Vision Plan			
Vision Service Plan	\$ 12.16	\$ 17.63	\$ 20.60

NOTE: The rates above are tenths, for 12 months of coverage. The District does not contribute toward the medical, dental, or vision plan premiums.

MEDICAL PLANS

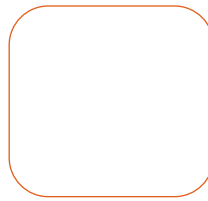
LACCD offers you three medical plan options:

- Blue Shield Spectrum PPO
- Blue Shield Access+ HMO
- Kaiser Permanente HMO

How a PPO works. A preferred provider organization (PPO) is a network of doctors and health care facilities that provide services to plan members at special discounted rates. You can go directly to any doctor you like within the PPO network. You also have the option of going to a doctor or health care facility that does not belong to the PPO network, but you will pay more for your care if you do.

How an HMO works. A health maintenance organization (HMO) is a network of doctors and health care facilities that closely manage your medical care to control your out-of-pocket costs. There are no deductibles to pay and no claim forms to fill out. You'll make a small copayment for certain services, like routine visits to your doctor; other services, such as hospitalization, are covered at no charge to you. If you enroll in an HMO, you must receive all of your non-emergency care within the HMO network, or the plan will not pay benefits.

The main differences between these medical plan options are how much flexibility you have in choosing a provider and how much you spend on out-of-pocket health care expenses.



Blue Shield Spectrum PPO

You can go to any doctor you like within the Blue Shield PPO network, including specialists. You do not have to select a personal physician, as you do with an HMO. You also have the option of going to a doctor or health care facility that does not belong to the PPO network, although your out-of-pocket expenses will be higher.

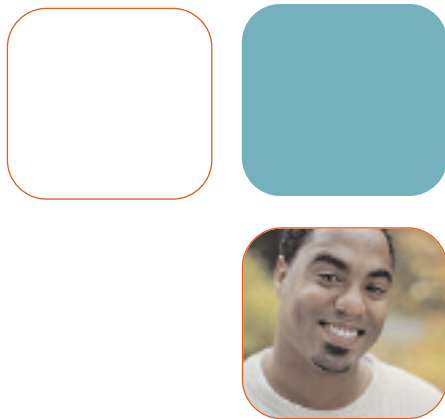
In the PPO network. When you go to a provider within the PPO network, most services are provided at no cost to you after you pay an annual deductible of \$200 per person (to a maximum benefit of \$600 per family). You will pay only a copayment for physician office visits, preventive care, and prescription drugs. There are no claim forms to fill out when you go to a network provider.

Outside the PPO network. If you go to a doctor or health care facility that does not belong to the PPO network, you will pay 20% of your covered medical expenses after meeting the deductible. If your share of the medical expenses reaches an amount called the **copayment maximum**, you will not have to make any more copayments for the rest of the calendar year. Your copayment maximum for out-of-network care is \$1,000 per person (or \$2,000 per family).

When you receive services from an out-of-network provider, the plan pays benefits based on what Blue Shield has determined is an appropriate charge for a particular service in your area. Blue Shield calls this the **allowable amount**. If your doctor charges more than the allowable amount covered by the plan, you will have to pay the difference.

If you go to an out-of-network provider, you will pay the provider directly for the full cost of your care. You will then submit a claim to Blue Shield to be reimbursed for the covered portion of your bill. Claim forms are available at www.laccd.edu/health.

The chart on page 8 shows the highlights of the PPO plan. Please see your Evidence of Coverage (available at www.laccd.edu/health) for complete information on the plan's benefits, limitations, and exclusions.



Health & Wellness Programs

Blue Shield offers a number of resources to help you manage your health.

- **Health education programs** teach you how to maintain a healthy lifestyle.
- **Health management programs** help you live with chronic conditions like diabetes or asthma.
- **Healthy Lifestyle Rewards** is an interactive, online program that helps you adopt and maintain healthy lifestyle habits.
- **Lifepath Advisers** gives you a confidential 24-hour resource for personal issues and nurse line services.
- **Lifepath Decision Guide** is a collection of tools to help you compare hospitals, evaluate treatment options, and research drugs on the Blue Shield formulary.
- **The health library** contains a wealth of information on health care topics.

These resources are available to Blue Shield members at no cost. To find out more, go to www.blueshieldca.com and click on the *Health & Wellness* tab.

Blue Shield Access+ HMO

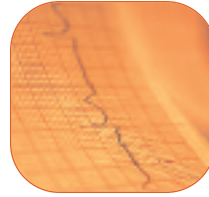
If you enroll in the Blue Shield HMO, you (and each of your enrolled dependents) must choose a **personal physician** to be your primary health care provider. Your personal physician must be in the Blue Shield HMO network and belong to one of these groups: family practice, general practice, internal medicine, obstetrics/gynecology, or pediatrics.

Your personal physician will coordinate all of your medical care. You and your dependents may each have your own personal physician, and you may change your personal physician whenever you wish by contacting Blue Shield.

Seeing a specialist. Generally, you need to get a referral from your personal physician before you can go to a specialist. Under the Access+ HMO, there are several exceptions to this rule:

- Women may go directly to a gynecologist or family practice physician in their personal physician's medical group or practice association without a referral.

Unless it's an emergency, you must receive all of your medical care within the HMO network — and under your personal physician's direction. You do not have the option of going to an out-of-network provider, as you do with the PPO plan.



- You have the option of selecting your own specialist, as long as your personal physician is part of a provider group that offers the Access+*Specialist* feature. You must choose a specialist in the same medical group or practice association as your personal physician. If you choose to go to a specialist without a referral from your personal physician, you will pay a \$30 copayment for each office visit. If you have a referral from your personal physician, visits to that specialist will only cost you a \$5 copayment.
- Non-emergency mental health or substance abuse services must be arranged directly through U.S. Behavioral Health, which administers Blue Shield's mental health/substance abuse benefits.

Kaiser Permanente HMO

Kaiser Permanente is an HMO that provides medical care through its own hospitals and health care facilities. All Kaiser members are encouraged to select a personal physician for preventive care, treatment of illness, and referral to a specialist when needed. You may change or choose your personal physician at any time.

To learn more about selecting a physician, go to www.kp.org.

The chart on page 7 compares the key benefits under both HMO plans. Please see your Evidence of Coverage (available at www.laccd.edu/health) for complete information on each plan's benefits, limitations, and exclusions.

You must go to a Kaiser facility and see only Kaiser doctors whenever you need medical care. Except in the case of an emergency, out-of-network care is not covered.

	Kaiser Permanente HMO	Blue Shield Access+ HMO
	Kaiser Network Only	Blue Shield Network Only
Where You Go for Care	All care must be received at a Kaiser health care facility	All care must be coordinated by your primary care physician
Calendar Year Deductible	None	None
Calendar Copayment Maximum	\$1,500/person; \$3,000/family	\$500/person; \$1,500/family
Lifetime Maximum Benefit	Unlimited	Unlimited
Covered Services	What You Pay	
Physician Office Visits	\$10 per visit	\$5 per visit
Preventive Care (includes routine physicals and well-woman exams)	\$10 per visit	No copayment
Well-Child Care (includes routine exams and immunizations)	No copayment	No copayment
Maternity (pre- and post-natal office visits)	No charge for pre-natal visits and first post-natal visit; \$10 copayment for subsequent post-natal visits	No copayment
Inpatient Hospital Services	No copayment	No copayment
Outpatient Surgery	\$10 per procedure	No copayment
Emergency Room Services	\$50 per visit (waived if admitted directly to the hospital)	No copayment
Physical, Occupational, or Speech Therapy	\$10 per visit	\$5 per visit
Chiropractic Care	Not covered	\$10 per visit; limited to 30 visits per calendar year (combined with acupuncture)
Acupuncture	Not covered	\$10 per visit; limited to 30 visits per calendar year (combined with chiropractic care)
Durable Medical Equipment	No copayment	No copayment
Hearing Aids	No copayment; limited to \$500 allowance every 36 months	20%; benefit limited to \$2,000 every 24 months
Home Health Care	No copayment; limited to 100 2-hour visits per calendar year	\$5 per visit; limited to 100 visits per calendar year
Skilled Nursing Facility	No copayment; limited to 100 days per calendar year	No copayment; limited to 100 days per calendar year
Mental Health Services*		
▪ Inpatient Care	No copayment; limited to 45 days per calendar year	No copayment
▪ Outpatient Care	\$10 copayment/private visit; \$5 copayment/group visit No limit on visits	\$25 per visit for non-severe conditions; limited to 20 visits per calendar year (combined with outpatient substance abuse care) \$5 per visit for severe conditions; no limit on visits
Substance Abuse Services		
▪ Inpatient Care	No copayment for detoxification only; \$100 copayment per admission for transitional residential recovery services (up to 60 days per calendar year)	No copayment for detoxification only; \$50 per day for additional inpatient care and \$25 per day for partial hospitalization/day treatment (at a U.S. Behavioral Health network facility)
▪ Outpatient care	\$10 copayment/private visit; \$5 copayment/group visit No limit on visits	\$25 per visit; limited to 20 visits per calendar year (combined with non-severe mental health visits)
Prescription Drugs		
▪ Participating Network Pharmacy	Up to a 100-day supply Generic: \$5; Brand-name formulary: \$15	Up to a 30-day supply Generic: \$5; Brand-name formulary: \$15; Non-formulary: \$35; Home self-injectables: \$30
▪ Mail-Order Drug Service	Up to a 100-day supply Generic: \$5; Brand-name formulary: \$15	Up to a 90-day supply Generic: \$5; Brand-name formulary: \$15; Non-formulary: \$35

* Limits and benefits maximums do not apply to severe mental illness or serious emotional disturbances of children.

Blue Shield Spectrum PPO

	PPO Network	Out of Network**
Where You Go for Care	You may go to any provider in the Blue Shield PPO Network	
	You may go to any provider you choose	
Calendar Year Deductible	\$200/person; \$600/family	
Calendar Copayment Maximum	\$1,000/person; \$3,000/family	
Lifetime Maximum Benefit	\$6,000,000/person	
Covered Services	What You Pay	
Physician Office Visits	\$15 per visit	20% after deductible
Preventive Care (includes routine physicals and well-woman exams)	No copayment	20% after deductible
Well-Child Care (includes routine exams and immunizations)	No copayment	20% after deductible
Maternity (pre- and post-natal office visits)	No copayment after deductible	20% after deductible
Inpatient Hospital Services	No copayment after deductible	20% after deductible
Outpatient Surgery	No copayment after deductible	20% after deductible
Emergency Room Services	\$50 per visit (waived if admitted directly to the hospital)	
Physical, Occupational, or Speech Therapy	No copayment after deductible	20% after deductible
Chiropractic Care	No copayment after deductible Benefit limited to 24 combined visits per calendar year	20% after deductible
Acupuncture	No copayment after deductible Benefit limited to 24 combined visits per calendar year	20% after deductible
Durable Medical Equipment	No copayment after deductible	20% after deductible
Hearing Aids	20% after deductible; benefit limited to \$2,000 every 24 months	
Home Health Care	No copayment after deductible (prior authorization required); benefit limited to 100 combined visits per calendar year	
Skilled Nursing Facility	No copayment after deductible	No copayment after deductible in a freestanding facility (prior authorization required) Benefit limited to 100 combined visits per calendar year
Mental Health Services*		
▪ Inpatient Care	No copayment after deductible	20% after deductible
▪ Outpatient Care	\$25 per visit for non-severe conditions; \$10 per visit for severe conditions (no limit on visits) Benefit for outpatient non-severe mental health care limited to 20 visits per calendar year (combined with outpatient substance abuse visits)	20% after deductible; no limit on visits for severe conditions
Substance Abuse Services		
▪ Inpatient Care	Detoxification: no copayment after deductible; other inpatient care: 10% after deductible Hospital benefit limited to 30 days per calendar year	20% after deductible
▪ Outpatient care	\$25 per visit Benefit for outpatient substance abuse care limited to 20 visits per calendar year (combined with outpatient non-severe mental health visits)	20% after deductible
Prescription Drugs		
▪ Participating Network Pharmacy Up to a 30-day supply	Generic: \$5; Brand-name formulary: \$15; Non-formulary: \$45; Home self-injectables: \$30	Regular copayment plus 25% of the reasonable charge (as determined by Blue Shield) and any amounts exceeding the reasonable charge
▪ Mail-Order Drug Service Up to a 90-day supply	Generic: \$10; Brand-name formulary: \$30; Non-formulary: \$90	Not covered

* Limits and benefits maximums do not apply to severe mental illness or serious emotional disturbances of children.

**Out-of-network benefits will be based on Blue Shield's allowable amount; you will be responsible for any charges above the allowable amount.

PRESCRIPTION DRUG BENEFITS

Blue Shield Pharmacy Benefits

The Blue Shield HMO and PPO plans provide prescription drug benefits at three different levels. Your copayment will vary depending on which category your prescription drug falls into: generic, formulary brand-name, or non-formulary brand-name. When you buy your drugs at a participating retail pharmacy, you'll get up to a 30-day supply for the copayments shown below.

- **Generic drugs** have the same active chemical ingredients and therapeutic effect as their brand-name counterparts. Although a generic drug may have a different color or shape, the Food and Drug Administration requires that it meet the same quality standards as the brand-name version. Generic drugs are your best value.
- **Formulary brand-name drugs** are medications included on Blue Shield's list of preferred drugs. (This list is called a **formulary**.) These drugs are more expensive than generic drugs.
- **Non-formulary brand-name drugs** are medications that are not included on Blue Shield's formulary. Many of the new drugs on the market—such as the ones you see advertised on television—would fall into this category.

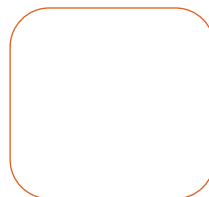
If you decide you want a brand-name drug when a generic equivalent is available, you will have to pay the difference between Blue Shield's cost for the generic drug and the cost of the brand-name drug. However, if your doctor indicates that you must be given a brand-name drug (by writing "dispense as written" on your prescription), you will only have to pay the regular brand-name drug copayment.

Self-administered injectable medications. Blue Shield dispenses these drugs through two specialty pharmacy networks, Caremark and Curascript. These drugs may require prior authorization from Blue Shield Pharmacy Services.



Kaiser Pharmacy Benefits

If you are a Kaiser member, you will have your prescriptions filled at a Kaiser pharmacy or through Kaiser's mail-order service. Either way, Kaiser provides up to a 100-day supply of generic or brand-name drugs.



Blue Shield Mail-Order Drug Service

If you take maintenance medication — that is, drugs you take every day, like blood pressure or asthma medication — you can save time and money by filling your prescriptions through the mail. When you order your drugs through the mail, you'll pay only two times the regular monthly copayment for a 90-day supply.

DENTAL PLANS



New for 2009!

LACCD offers you the choice of two dental plans:

- Delta Dental PPO dental plan
- SafeGuard HMO dental plan

Delta Dental PPO

Like a medical PPO, this plan gives you the option of going to any licensed provider you choose. If you go to a dentist who is a member of Delta Dental's PPO network, you can take advantage of the PPO provider's discounted rates and reduce your out-of-pocket costs. Whenever you need dental care, you have three options, as shown below.

- 1. Delta Dental PPO dentists** — PPO dentists are a select group of dentists within the Delta Dental network, and they have agreed to charge plan members significantly reduced rates. *Delta Dental PPO dentists are your best value!*
- 2. Delta Dental Premier dentists** — These dentists belong to Delta Dental's extensive national network. Premier dentists accept Delta Dental's approved fee as payment in full, and your share of the cost (if any) will be based on the approved fee. This means they won't "balance bill" you for charges that Delta Dental doesn't cover.
- 3. Out-of-network dentists** — These dentists do not offer discounted rates to Delta Dental plan members. If you go to an out-of-network dentist, the plan will only pay benefits up to Delta Dental's approved fee. If your out-of-network dentist charges you more than the approved fee, you will have to pay the difference between their cost and the approved fee.



Let's Do the Math

Suppose you need a root canal, which the plan covers at 80%. Let's also assume that Delta Dental's approved fee for the root canal is \$500.* Here's an example of what you might pay for this service with each kind of dentist.

Delta Dental PPO Dentists. These dentists' fees have been set by Delta Dental, so their charge for this service is probably lower than the approved fee. Let's say your PPO dentist charges \$400 for a root canal.

- You would pay 20% of \$400, or \$80.

Delta Dental Premier Dentists. These dentists have agreed to accept Delta Dental's approved fee. This means they won't charge a Delta Dental member more than \$500 for this service, no matter what they might charge their non-Delta Dental patients.

- You would pay 20% of \$500, or \$100.

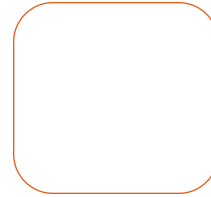
Out-of-Network Dentists. These dentists are not under contract with Delta Dental, so they're free to charge whatever they want. Let's say your out-of-network dentist charges \$700 for a root canal—Delta Dental's benefits will still be based on the approved fee of \$500. You will be responsible for the entire portion of the bill that exceeds Delta Dental's approved fee.

- You would pay 20% of \$500 (\$100), plus the \$200 above the approved fee, for a total of \$300.

As you see, a Delta Dental dentist (either Delta Dental PPO or Delta Dental Premier) is always your best bet—but you can save the most by going to a Delta Dental PPO dentist. Also, there are no claim forms to fill out when you go to a Delta Dental dentist. If you go to an out-of-network dentist, you may have to pay the entire cost up front, then submit a claim to Delta Dental to be reimbursed for the covered portion of your bill.

* The prices in this example do not reflect the actual costs for the procedure. Costs vary based on location and type of procedure performed. See your Evidence of Coverage for more information.

Remember, when you make an appointment with a Delta Dental dentist, be sure to ask if he or she is a Delta Dental PPO dentist — there is a difference!



Safeguard HMO Plan

This plan provides services at little or no cost to you when you go to a dentist who is a member of the Safeguard HMO network. Similar to a medical HMO, the HMO dental plan requires you (and each of your enrolled dependents) to select a primary care dentist to coordinate your care. Out-of-network treatment is not an option.

The chart below shows the key benefits under your dental plans. Please refer to your Evidence of Coverage (available at www.laccd.edu/health) for complete information on the plan's benefits, limitations, and exclusions.

SafeGuard HMO Dental Plan		Delta Dental PPO Plan
Calendar Year Deductible	None	None
Calendar Year Maximum Benefit	Unlimited	Your maximum benefit is based on how long you have worked for LACCD: <ul style="list-style-type: none"> • Less than 5 years of service = \$1,000 • 5 years of service, but less than 10 = \$1,500 • 10 years of service, but less than 15 = \$2,000 • 15 years of service, but less than 20 = \$2,500 • 20 or more years of service = \$3,000
Covered Services	What You Pay	
Diagnostic & Preventive Services (includes oral exams and cleanings 4 times per year, X-rays, fluoride treatments, and space maintainers)	No charge for most services; \$45 copayment for third and fourth cleanings	20%
Basic Services (includes fillings, extractions, root canals, oral surgery, and periodontic treatment)	No charge	20%
Prosthodontics (includes crowns, bridgework, and dentures)	No charge	20%
Orthodontia	Children under age 19: \$1,300 Adults: \$1,400	50% Lifetime maximum orthodontia benefit = \$2,000/person

VISION PLAN

LACCD offers vision coverage through Vision Service Plan (VSP), the nation's largest provider of eye care coverage.

Under the vision plan, you can choose between network and out-of-network providers. You will receive a higher level of benefits, and enjoy greater convenience, if you go to a provider in the VSP network. VSP contracts with thousands of doctors across the country, so you should have no problem finding a network provider near you. There are no claim forms to fill out when you go to a VSP network provider.



If you decide to go to an out-of-network provider, you will have to pay your entire bill up front, then file a claim with VSP. You will be reimbursed for your out-of-network services up to the allowances shown in the chart below.

	VSP Network Provider	Out-of-Network Provider
Copayments ▪ Office visits	\$10	None
Examination	Covered in full	Plan reimburses up to \$45
Prescription Lenses ▪ Single vision ▪ Lined bifocal ▪ Lined trifocal ▪ Lenticular	Covered in full, including anti-reflective coating	Plan reimburses up to \$45 Plan reimburses up to \$65 Plan reimburses up to \$85 Plan reimburses up to \$125
Frame	Covered in full up to \$120*	Plan reimburses up to \$47
Contact Lenses (instead of glasses)** ▪ Elective ▪ Medically necessary	Covered in full up to \$150 Covered in full	Plan reimburses up to \$150 Plan reimburses up to \$210
Covered Services	Examinations: once every 12 months; Lenses: once every 12 months Frame: once every 24 months; Contact Lenses: once every 12 months	

*If the frame you choose costs more than the allowance, you will receive a 20% discount on your out-of-pocket costs.

**Contact lenses are available once every 12 months in lieu of all other lens and frame benefits. When you get contact lenses, you will not be eligible for lenses or a frame for 12 months.



In addition, VSP members can receive a number of lens options (such as scratch-resistant coating and an additional pair of glasses) at a discounted price when using a VSP network provider. VSP has also arranged for members to receive PRK, LASIK, and custom LASIK using wavefront technology through contracted laser centers. Discounts vary by location (but average 15%). Contact VSP for details.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Everyone needs help now and then. If a difficult situation is affecting your quality of life, the employee assistance program (EAP) is there for you and all members of your household 24 hours a day. The EAP is provided by LACCD at no cost to you and is administered by Horizon Health.

The EAP provides *strictly confidential* counseling through outside professionals to help you manage stress and resolve personal issues that may be affecting your daily life. The EAP can help you with:

- Emotional well-being
- Marriage and family issues
- Child care and elder care referrals
- Stress/anxiety
- Grief counseling
- Depression
- Alcohol or drug abuse
- Workplace conflict
- Legal assistance
- Educational referrals
- Financial consultation



Call the EAP at the number shown below whenever you need help. Your call will be handled confidentially by a professional counselor, who will either work with you over the phone or arrange an appointment for you to have an in-person session. The EAP will cover up to five free face-to-face counseling sessions for each issue per year.

For 24-Hour EAP Help, Call (800) 342-8111





Joint Labor/Management Benefits Committee

Dr. Susan Aminoff

Chair, JLMBC

Robert Garber

*Management Representative
President, Pierce College*

Dawn Bastin

Director, LACCD Business Services

Velma J. Butler

*President
AFT College Staff Guild
Local 1521A*

Frank Torres

SEIU Local 99

Royston Thomas

Teamsters Local 911

Galen Bullock

SEIU Local 721

Ted Strinz

*Building & Construction
Trade Council*

Carolyn Widener

L.A. College Faculty Guild

Kenneth B. Takeda

Administrator's Representative

District Resources to the JLMBC

Katrelia C. Walker

Human Resources

Retiree Resources to the JLMBC

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General Counsel

OUR MISSION

The mission of the Joint Labor/Management Benefits Committee is to select and review the District's health benefit plans and providers to contain costs while maintaining the quality of the benefits available to employees. The cooperation between representatives of labor and management has resulted in the ability of our employees to enjoy an outstanding benefits program.