2016

Employee Health Benefits

Insurance Summary Booklet

Long Beach Unified
School District

OFFICE OF THE SUPERINTENDENT
1515 Hughes Way, Long Beach, CA 90810-1839
www.lbschools.net

Dear Colleagues,

The health and welfare benefits described in this guide are one way we invest in our most valuable asset — you. All of the benefits available are evaluated each year to ensure we're continuing to provide comprehensive benefits that offer choices for our diverse employee needs.

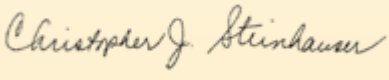
This year, we're again making very minimal changes to our benefit programs. However, we are switching to a plan year that will begin in July, which is more in line with the school year. Your benefits will be effective from January 1 – June 30, 2016. I hope you find this change to be advantageous for you as you plan for the year to come.

In addition, LBUSD, CSEA, and TALB are partnering together this year to focus on wellness and to help you reach your health-related goals. I hope you will engage in this effort and make use of the resources available to you. After all, feeling good — whether it is physically or mentally — is an integral part of your success at work and in your everyday life. You will receive newsletters throughout the school year with tips, tools and information to help you build healthy habits so you can move more, eat healthy and feel great. I encourage you to read those newsletters for personal inspiration and also work together to build a healthy community where you can share information and motivate one another.

Creating healthy habits also helps you (and the school district) to keep health care costs down in the long-term. Please take advantage of this guide as a tool to understand your benefits and use them wisely throughout the year.

Best wishes for a healthy and successful school year.

Sincerely,



Christopher J. Steinhauser

Superintendent of Schools

Our Mission:

To support the personal and intellectual success of every student, every day.

Our Vision:

Every student a responsible, productive citizen in a diverse and competitive world.

What's Inside

This booklet includes important details about your District benefits, including which benefits you can enroll your eligible dependents in, details about your plans, and the steps you need to take to enroll. You'll also find information about how and when to enroll.

At the back, we've included some important notices about state and federal laws that affect your benefits, as well as the contact details for each of the plans.

We encourage you to keep this booklet for your reference throughout the year. If you still have questions after reviewing the booklet, feel free to contact the Employee Service Center.

The Employee Service Center

The District's Employee Service Center is ready to help if you have any benefits-related questions. Need detailed information about your medical benefits? Want to know if your dependent is eligible for coverage? Have a question about enrollment? Just give the Employee Service Center a call at (866) 844-9744. Representatives are available Monday through Friday from 5 a.m. to 5 p.m., Pacific time.

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General Information

This booklet is intended to provide highlights of your benefits only; it is not an Evidence of Coverage (EOC) plan document. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including a complete list of exclusions and limitations, please refer to each carrier's EOC. The EOCs are available on the Employee Service Center's website, **www.benefitenroll.com**.

Benefits Eligibility

Employee Eligibility

In general, you're eligible for medical, dental, vision, and life and AD&D insurance benefits
if you're:

- A probationary or permanent employee; and
- You work 50% or more of a full-time assignment (at least 80 hours every four weeks).

In addition, job share participants may enroll in District plans under certain conditions.

If you're a represented employee, we encourage you to review your collective bargaining contract each year to verify your specific eligibility requirements. You may also call the Employee Service Center at (866) 844-9744 for more information.

Dependent Eligibility

If you enroll yourself in District benefits, you can also enroll your eligible dependents in certain plans (vision coverage, life insurance and AD&D insurance are available to employees only). You must provide appropriate proof of the dependent relationship when you enroll your dependent.

Eligible dependents include:

- **Your legal spouse.** (Required documentation: a marriage certificate in English.)
- **Your California-registered domestic partner.** A California-registered domestic partner is the same gender as you or may be opposite-gender only if at least one partner is over age 62. (Required documentation: a certified copy of the Declaration of Domestic Partnership filed with the Secretary of State.) *Please note: Domestic partners do not receive the same tax benefits as legal spouses. You and your domestic partner must become legal spouses to receive tax benefits.*
- **Your natural children or stepchildren up to age 26.**
  — Adopted children must have been placed by a recognized county or private agency and must be in the physical control of you or your spouse or domestic partner, and you must have the right to control the health care of the child. Note: If you and your spouse or domestic partner are both District employees who are eligible for District coverage, and you both select the Blue Shield PPO, Blue Shield HMO, or Blue Shield PPO $aver Plan (for non-represented employees only), your dependent children may be enrolled as dependents for one of you only, not both. (Required documentation: a birth certificate.)

Residency Requirements

Some plans have residency requirements. If you're going to be covering a dependent out of state, please contact your plan's member services or refer to the Evidence of Coverage for more information.

Important!

The District reserves the right to require evidence of the disability status at any time.

- **Your children, stepchildren, or adopted children who are mentally retarded or physically disabled.** Your dependent must also:
  - — Be chiefly dependent on you or your spouse or domestic partner for support and maintenance;
  - — Have been disabled continuously prior to reaching limiting age;
  - — Have been enrolled as a dependent under your coverage before reaching limiting age; and
  - — The proof of disability must be submitted to the Employee Service Center within 30 days after the onset of the disability, the attainment of the limiting age, or the time of initial enrollment. (Required documentation: a birth certificate and a physician's written certification of the disability.)
- **Any children for whom you are the legal guardian (excluding foster children) or whom you are required to support as part of a Qualified Medical Child Support Order (QMCSO)** (Required documentation: court or administrative orders from the District Attorneys' office, State Department of Health Services, or the courts). Children who meet these requirements are eligible for coverage as long as they don't have access to medical coverage through their employer.

Your Cost for Benefits

Each year, the District will pay a maximum contribution toward medical coverage premiums for you and your dependents. If the District's maximum medical contribution does not cover the full cost of the premium (based on the plan and coverage level you elected), you will pay the remaining amount through payroll deductions. Keep in mind that the lowest cost HMO plan will be free to eligible employees each year. The lowest cost plan may change on an annual basis.

Each year, the District will increase the prior year's District annual maximum contribution toward insurance premiums by 3.5%. The rates for January 1 – June 30 will apply to all coverage levels: employee only, employee plus one and family, as shown below.

Your premiums for benefits can be found on the personalized worksheet you receive when you first become eligible for District benefits. You'll also receive a personalized worksheet every year during the annual Open Enrollment. If you're making changes to your benefits outside the Open Enrollment period because of a qualifying change in status, contact the Employee Service Center at (866) 844-9744 for your cost information.

Tier	January – June 2016 District Annual Maximum (DAM)	January – June 2016 Employer Costs	January – June 2016 Employee Cost
Employee	$11,196	$10,373	$0.00
Employee + 1	$20,478	$18,887	$0.00
Family	$25,716	$23,728	$0.00

When to Enroll

You're allowed to enroll in benefits and make changes to your benefits only:

- When you're initially eligible;
- During the annual Open Enrollment period; or
- If you experience a qualifying status change.

Enrolling When You're First Eligible

You must enroll yourself and your dependents within 30 days of becoming eligible for District benefits. You can enroll eligible dependents at the same time you enroll yourself. If you don't enroll, you'll receive the default coverage shown below.

Default Coverage

If you're eligible for 100% District-paid benefits and you don't elect or waive coverage within the 30-day window, you'll automatically be enrolled as follows:

- **TALB and Non-represented employees:**
  - Blue Shield PPO medical plan;
  - Delta PPO Plus Premier dental plan;
  - Vision;
  - Life and accidental death & dismemberment insurance; and
  - Employee Assistance Program (EASE).
- **CSEA:**
  - Kaiser HMO medical plan;
  - DeltaCare/PMI dental plan;
  - Vision;
  - Life and accidental death & dismemberment insurance; and
  - Employee Assistance Program (EASE).

Your dependents will not be covered under default coverage.

Making Changes During Open Enrollment

Once you've enrolled in benefits, you generally aren't allowed to make changes until the next Open Enrollment. Open Enrollment is your one chance each year to review your coverage and make changes to your benefits. It's also your chance to enroll if you declined coverage when you first became eligible.

For this Open Enrollment period, the changes you make will take effect on January 1 and be effective through June 30. There will be an additional enrollment period in May 2016 for benefits effective from July 1, 2016 – June 30, 2017. Open Enrollment for benefits will usually occur each spring going forward.

Please note, Flexible Spending Accounts (FSAs) will continue on a calendar year basis and will be effective January 1 – December 31 each year. There will be a special enrollment period during the fall each year to elect your FSA contribution amounts.

Making Changes During the Year

Other than during Open Enrollment, you can make changes to your benefits during the year only if you experience a qualifying status change. *Any changes must be made within 30 days of the qualifying status change*. A qualifying status change can include:

- **A change in family status,** such as your marriage or registration of a domestic partnership, the birth or adoption of a child, divorce or dissolution of a domestic partnership, or the death of a dependent. You must provide the Employee Service Center with proof of the event (such as a marriage certificate, birth certificate, divorce order, or court order).
- **The loss of existing coverage** for you and/or your eligible dependents (for example, the termination of coverage that was provided through your spouse's employer).
- **A qualified court or administrative order** that requires you to provide coverage for an eligible dependent.

Any benefit changes must be consistent with the qualifying status change. Provided you make changes within 30 days of the event, the change will take effect on the date of the event for a birth, adoption, or placement for adoption; changes you make as a result of other qualifying status changes will take effect the first day of the month after you submit the appropriate documentation to the Employee Service Center.

Notice of Special Enrollment Rights for Medical Plan Coverage

If you've declined enrollment in a District medical plan for yourself or your dependents (including your spouse or same-sex domestic partner) because of other medical plan coverages, you and/or your dependents may be able to enroll in a District medical plan without waiting for the next Open Enrollment period, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

The District will also recognize and allow a special enrollment opportunity in a medical plan if you or your eligible dependents:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you're no longer eligible; or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these new enrollment opportunities only, you'll have 60 days — instead of 30 — from the date of the Medicaid/CHIP eligibility change to request enrollment in a District medical plan.

For more information or to request a special enrollment after a qualifying status change, contact the Employee Service Center at (866) 844-9744.

Make Sure You're Up-to-Date!

If you use the online enrollment system, make sure you're using a recent version of your web browser; you may have problems if you're using an older version of Internet Explorer or an older Macintosh browser.

How to Enroll

Once you've decided which benefits you'd like, the easiest way to enroll is through the District's online enrollment site, **www.benefitenroll.com**. You can enroll for all your benefits except flexible spending accounts through this site.

When you enroll online, you'll be able to review your benefit elections and make sure your dependent information is correct. The online enrollment site also has all the details about each plan, right at your fingertips.

Here are the steps to take to click your way through online enrollment:

1. Go to **www.benefitenroll.com**.
2. Log-in to the site. Your user ID is the last six digits of your Social Security number, and the first time you Log-in, your password is your date of birth in MMDDYYYY format. (For example, if you were born May 9, 1970, your password would be 05091970.)
3. After you log-in to the site for the first time, you'll be prompted to change your password.
4. Click "Enrollment" under the "Steps to Enroll" heading.
5. You can review your current benefits by selecting "Review Employee Coverage."
6. To enroll for your benefits, select "Open Enrollment" at the top of the page.
7. For each benefit, select the plan and coverage level you want, then click "Next" to move to the next benefit.
8. Once you've completed the enrollment process, you'll be directed to a confirmation page, at which point you can print a confirmation statement. You'll also receive a paper confirmation statement in the mail once your enrollment is complete.

Before You Enroll!

Before you begin enrollment, make sure you have:

- Your dependent's Social Security numbers; and
- Your primary care provider's (PCP's) name and PCP ID, if you're enrolling in the Blue Shield HMO plan and/or the DeltaCare/PMI dental plan. (If you don't provide a PCP ID, you'll automatically be assigned a PCP.)

Once you enroll, you'll also be required to send the Employee Service Center the required documentation for your newly added dependents.

Employee Service Center

In addition to using the online enrollment system, you may enroll through the Employee Service Center. Speak with an Employee Service Center representative by calling (866) 844-9744. (Employee Service Center representatives are available Monday through Friday from 5 a.m. to 5 p.m., Pacific time.)

Waiving Coverage

When you enroll online, you may choose to waive, or decline, enrollment in one or more benefit plans by selecting the "Waive" button. Keep in mind that if you choose to waive coverage, it means that you are declining coverage from January 1 through June 30, 2016. It DOES NOT mean that you will continue with the same coverage you currently have. If you waive coverage during this enrollment, you will not be able to re-enroll for coverage during this period unless you experience a qualifying status change. If you elect to waive health coverage, you will be required to complete and sign a waiver form. If this form is not completed within 30 days, you only (and not your dependents) will be placed in the default coverage.

Reimbursement for Hearing Aids

Employees who are insured in one of the District's medical plans may request reimbursement from the District for the costs of hearing aids. The maximum amount of reimbursement shall be $1,000 within any three-year period. The cost of hardware, fitting tests, and other tests related to the hearing aids is included for reimbursement purposes.

To obtain a reimbursement form, visit the Employee Service Center website at **www.benefitenroll.com**.

Medical Coverage Options

Your medical benefits are designed to help maintain the wellness and health of you and your family. The District offers three types of medical plan options.

HMO Plans: With the HMO options, you must receive care from providers in the plan's network; the plan won't pay any benefits for care received outside the network except in an emergency.

PPO Plan: With the PPO plan, you have the flexibility to receive care from any provider; however, the plan will pay a higher level of benefits when you receive care from a provider who participates in the plan's network.

PPO $aver Plan: With the PPO $aver Plan, you can establish an account that allows you to save for health care expenses tax-free (known as a Health Savings Account, or HSA). More information about the HSA is available at **www.benefitenroll.com**.

Keep in mind that certain benefits in each plan may vary, depending on your bargaining unit. For employees represented by CSEA, a summary of your benefits is provided on page 11. Employees represented by TALB can find a summary of their benefits on page 13, while a summary of the benefits for Non-represented employees can be found on page 12.

An Overview of Your Benefits

The District offers you and your eligible dependents a comprehensive selection of health and welfare benefits.

Health Care Benefits	
Medical	The District offers two HMO Plans: • Kaiser Permanente HMO • Blue Shield of California HMO The District also offers the following plans: • Blue Shield of California PPO • PPO $aver Plan (for Non-represented employees) All medical plans include prescription drug coverage. A summary of these benefits is provided on pages 11 – 17.
Dental	The District offers two dental plans: • Delta PPO Plus Premier • Delta Care/PMI You can find a summary of your dental benefits on page 16.
Vision	The Medical Eye Services (MES) vision plan is available to employees only. More information about this plan is available on page 17.
Employee Assistance Program (EAP)	The District provides an EAP to assist employees with personal and work/life issues. You can find additional information about the EAP on page 15.
Financial Savings & Security	
Flexible Spending Accounts (FSAs)	FSAs give you the option to set aside pre-tax funds to pay for certain eligible health care and dependent care expenses. You can find more details about FSAs on page 18.
Group Life and Group Accidental Death & Dismemberment (AD&D) Insurance	The District provides eligible employees with life and AD&D insurance coverage to help provide financial protection. More details about these coverages are available on page 19.
Deferred Compensation (IRC 457) Retirement Plan	So you can set aside pre-tax money for retirement, the District offers you the opportunity to participate in a Deferred Compensation Plan. Details about this plan can be found on page 20.
IRC Section 125 Flexible Fringe Benefits Plan	This plan allows you to pay premiums for certain District benefits and potentially reduce your taxes at the same time. See page 20 for more information.

CSEA — 2016 Medical Coverage Options

The chart below summarizes the main features of the medical plans available to employees represented by CSEA. For the full details of each plan, including exclusions, refer to the Evidence of Coverage plan documents.

	Kaiser HMO[1]	Blue Shield HMO[1]	Blue Shield PPO	
			In-Network	Out-of-Network
Calendar-Year Deductible Individual/Family	None	None	$300/$600	$500/$1,000
Annual Out-of-Pocket Maximum (including deductible) Individual/Family	$1,500/$3,000	$250/$500	$1,300/$2,600	$5,500/$11,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	
Covered Services				
Inpatient Hospital	No charge	No charge	80%	Plan pays up to 60% of $350 per claim, or $210
Outpatient Surgery	$5 copay	No charge	80%	60%
Ambulatory Surgery Center and Outpatient Services	$5 copay	No charge	80%	Plan pays up to 60% of $350 per claim, or $210
Emergency Room	$100 copay (waived if admitted)	$100 copay (waived if admitted)	80%	80%
Physician Office Visit	$5 copay	$5 copay	80%	60%
Routine Physical	No charge	No charge	No charge[2]	60%
Well-Baby & Well-Child Care	No charge	No charge	No charge[2]	60%
Well-Woman Exams	No charge	No charge	No charge[2]	60%
Maternity Care	No charge	$5 copay	80%	60%
Lab and X-ray	No charge	No charge	80%[3]	60%
Physical or Occupational Therapy	$5 copay	$5 copay	80%	60%
Chiropractic Care	$5 copay (Up to 30 visits/year)	$5 copay (Up to 30 visits/year)	80%	60%
Durable Medical Equipment	No charge	No charge	80%	60%
Mental Health – Inpatient	**Kaiser**	**Blue Shield**	**Blue Shield**	
	No charge	No charge	80%	Plan pays up to 60% of $600 per day, or $360
Mental Health – Outpatient	**Kaiser**	**Blue Shield**	**Blue Shield**	
	$5 copay	$5 copay	80%	60%
Prescription Drugs[3]	**Kaiser**	**Blue Shield**	**Express Scripts**	
Out-of-Pocket Maximum Individual/Family	None	None	$5,550/$11,100	
Retail				Not covered
Generic	$5 copay	$5 copay	$0 copay	
Brand	$5 copay	$10 copay	$20 copay	
Non-formulary	$5 copay	$35 copay	$50 copay	
Retail Supply	100 days	30 days	30 days	
Mail Order				
Generic	$5 copay	$5 copay	$0 copay	
Brand	$5 copay	$10 copay	$20 copay	
Non-formulary	N/A	$35 copay	$50 copay	
Mail-Order Supply	100 days	90 days	90 days	

1 If you enroll in an HMO plan, you can obtain services only within the plan's geographic service area, except for emergency services.
2 Preventive care is 100% covered in-network with no deductible required. Routine tests and screenings are free to you when you use in-network providers, too.
3 Some contraceptive prescriptions for women are 100% covered in-network with no copay or deductible required. Contact the plan for details.

If you don't enroll for coverage when you're first eligible, you'll be automatically enrolled in the CSEA default coverage for yourself only: Kaiser HMO medical plan, DeltaCare/PMI dental plan, vision coverage, life and accidental death & dismemberment insurance, and the employee assistance program.

NON-REPRESENTED — 2016 Medical Coverage Options

The chart below summarizes the main features of the medical plans available to Non-represented employees. For the full details of each plan, including exclusions, refer to the Evidence of Coverage plan documents.

	Kaiser HMO[1]	Blue Shield HMO[1]	PPO $aver Plan		Blue Shield PPO	
			In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar-Year Deductible Individual/Family	None	None	$1,500/$3,000 (For family coverage, full calendar-year deducible must be met before plan pays benefits)		$300/$600	$500/$1,000
Annual Out-of-Pocket (includes deductible) Maximum Individual/Family	$1,500/$3,000	$250/$500	$3,275/$6,550 (For family coverage, full annual out-of-pocket maximum must be met before plan pays benefits)		$1,300/ $2,600	$5,500/$11,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited		Unlimited	
Health Savings Account (HSA)	None	None	Available		None	
Covered Services						
Inpatient Hospital	No charge	No charge	90%	Plan pays 40% up to $600 per day or $360	80%	Plan pays 60% up to $600 per day or $360
Outpatient Surgery	$5 copay	No charge	90%	Plan pays up to 60% of $350 per claim, or $210	80%	Plan pays up to 60% of $350 per claim, or $210
Ambulatory Surgery Center and Outpatient Services	$5 copay	No charge	90%	Plan pays up to 40% of $350 per claim, or $210	80%	Plan pays up to 60% of $350 per claim, or $210
Emergency Room	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted), then 90%	$100 copay (waived if admitted), then 90%	80%	80%
Physician Office Visit	$5 copay	$5 copay	90%	60%	80%	60%
Routine Physical	No charge	No charge	No charge[2]	Not covered	No charge[2]	60%
Well-Baby & Well-Child Care	No charge	No charge	No charge[2]	Not covered	No charge[2]	60%
Well-Woman Exams	No charge	No charge	No charge[2]	Not covered	No charge[2]	60%
Maternity Care	No charge	$5 copay	90%	60%	80%	60%
Lab and X-ray	No charge	No charge	90%	60%	80%	60%
Physical or Occupational Therapy	$5 copay	$5 copay	90%	60%	80%	60%
Chiropractic Care	$5 copay (Up to 30 visits/year)	$5 copay (Up to 30 visits/year)	90% (Up to 20 visits/year)	60% (Up to 20 visits/year)	80%	60%
Durable Medical Equipment	No charge	No charge	90%	60%	80%	60%
Mental Health – Inpatient	**Kaiser**	**Blue Shield**	**Blue Shield**		**Blue Shield**	
	No charge	No charge	90%	Plan pays up to 60% of $600 per day, or $360	80%	Plan pays up to 60% of $600 per day, or $360
Mental Health – Outpatient	**Kaiser**	**Blue Shield**	**Blue Shield**		**Blue Shield**	
	$5 copay	$5 copay	90%	60%	80%	60%
Prescription Drugs[3]	**Kaiser**	**Blue Shield**	**Blue Shield[4]**		**Express Scripts**	
Out-of-Pocket Maximum Individual/Family	None	None	None		$5,550/$11,100	
Retail						Not covered
Generic	$5 copay	$5 copay	$5 copay	Not covered	$0 copay	
Brand	$5 copay	$10 copay	$10 copay	Not covered	$20 copay	
Non-formulary	$5 copay	$35 copay	$35 copay	Not covered	$50 copay	
Retail Supply	100 days	30 days	30 days	Not covered	30 days	
Mail Order						
Generic	$5 copay	$5 copay	$5 copay	Not covered	$0 copay	
Brand	$5 copay	$10 copay	$10 copay	Not covered	$20 copay	
Non-formulary	N/A	$35 copay	$35 copay	Not covered	$50 copay	
Mail-Order Supply	100 days	90 days	90 days	Not covered	90 days	

[1] If you enroll in an HMO plan, you can obtain services only within the plan's geographic service area, except for emergency services.
[2] Preventive care is 100% covered in-network with no deductible required. Routine tests and screenings are free to you when you use in-network providers, too.
[3] Some contraceptive prescriptions for women are 100% covered in-network with no copay or deductible required. Contact the plan for details.
[4] Subject to calendar-year deductible.

If you don't enroll for coverage when you're first eligible, you'll be automatically enrolled in the Non-represented default coverage for yourself only: Blue Shield PPO medical plan, Delta PPO Plus Premier plan, vision coverage, life and accidental death & dismemberment insurance, and the employee assistance program.

TALB — 2016 Medical Coverage Options

The chart below summarizes the main features of the medical plans available to employees represented by TALB. For the full details of each plan, including exclusions, refer to the Evidence of Coverage plan documents.

	Kaiser HMO[1]	Blue Shield HMO[1]	Blue Shield PPO	
			In-Network	Out-of-Network
Calendar-Year Deductible Individual/Family	None	None	$300/$600	$500/$1,000
Annual Out-of-Pocket Maximum (includes deductible) Individual/Family	$1,500/$3,000	$250/$500	$1,300/$2,600	$5,500/$11,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	
Covered Services				
Inpatient Hospital	No charge	No charge	80%	Plan pays 60% up to $600 per day or $360
Outpatient Surgery	$5 copay	No charge	80%	Plan pays up to 60% of $350 per claim, or $210
Ambulatory Surgery Center and Outpatient Services	$5 copay	No charge	80%	Plan pays up to 60% of $350 per claim, or $210
Emergency Room	$100 copay (waived if admitted)	$100 copay (waived if admitted)	80%	80%
Physician Office Visit	$5 copay	$5 copay	80%	60%
Routine Physical	No charge	No charge	No charge[2]	60%
Well-Baby & Well-Child Care	No charge	No charge	No charge[2]	60%
Well-Woman Exams	No charge	No charge	No charge[2]	60%
Maternity Care	No charge	$5 copay	80%	60%
Lab and X-ray	No charge	No charge	80%	60%
Physical or Occupational Therapy	$5 copay	$5 copay	80%	60%
Chiropractic Care	$5 copay (Up to 30 visits/year)	$5 copay (Up to 30 visits/year)	80%	60%
Durable Medical Equipment	No charge	No charge	80%	60%
Mental Health – Inpatient	**Kaiser**	**Blue Shield**	**Blue Shield**	
	No charge	No charge	80%	Plan pays up to 60% of $350 per claim, or $210
Mental Health – Outpatient	**Kaiser**	**Blue Shield**	**Blue Shield**	
	$5 copay	$5 copay	80%	60%
Prescription Drugs[3]	**Kaiser**	**Blue Shield**	**Express Scripts**	
Out-of-Pocket Maximum Individual/Family	None	None	$5,550/$11,100	
Retail Generic Brand Non-formulary Retail Supply	 $5 copay $5 copay $5 copay 100 days	 $5 copay $10 copay $35 copay 30 days	 $0 copay $20 copay $50 copay 30 days	Not covered
Mail Order Generic Brand Non-formulary Mail-Order Supply	 $5 copay $5 copay N/A 100 days	 $5 copay $10 copay $35 copay 90 days	 $0 copay $20 copay $50 copay 90 days	Not covered

[1] If you enroll in an HMO plan, you can obtain services only within the plan's geographic service area, except for emergency services.
[2] Preventive care is 100% covered in-network with no deductible required. Routine tests and screenings are free to you when you use in-network providers, too.
[3] Some contraceptive prescriptions for women are 100% covered in-network with no copay or deductible required. Contact the plan for details.

If you don't enroll for coverage when you're first eligible, you'll be automatically enrolled in the TALB default coverage for yourself only: Blue Shield PPO medical plan, Delta PPO Plus Premier plan, vision coverage, life and accidental death & dismemberment insurance, and the employee assistance program.

Prescription Drug Benefits

Depending on the medical plan you select, you may have a two- or three-tiered prescription drug benefit. With this type of plan, the amount you pay for prescriptions depends on:

- The type of drug you choose;
- Whether the drug is a generic drug, part of your plan's drug formulary (a list of drugs the insurance company considers "preferred choices" based on their effectiveness and cost), or neither (non-formulary); and
- Whether you fill your prescription at a retail pharmacy or through the mail-order program.

Generally:

- **Generic drugs** are in the plan's first tier and are your lowest copay option;
- **Brand-name drugs that are on your plan's drug formulary** are in the second tier for most plans, and are your mid-range copay option; and
- **Brand-name drugs that are not on your plan's drug formulary (non-formulary)** are in the third tier for some plans, and may not be covered under certain plans; if they're covered under your plan, these are generally your highest copay option.

Generic drugs are the cheaper equivalent of many brand-name drugs. In fact, they have to prove that they're just as effective as the brand-name drug before they're approved. In addition, many brand-name drugs that aren't on the formulary have similar equivalents that are. So if your doctor prescribes a drug that's not on the formulary, ask whether a generic or formulary brand drug would work just as well.

Prescription Drug Costs

Keep in mind, prescription drugs copays accrue towards the out-of-pocket maximum for all medical plans. Note there is a separate prescription drug out-of-pocket maximum for the PPO plan. ($5,550 individual/$11,100 family, in-network only)

Using the Mail-Order Pharmacy

If you're taking a medication on an ongoing basis for a chronic condition such as diabetes or heart disease, you may want to consider using your plan's prescription drug mail-order service. The mail-order service usually saves you money, because you can order a larger supply of your medication for a smaller copay. When you use the mail-order pharmacy, you generally receive about a three-month supply of the medication.

Prior Authorization and Specialty Drugs

Depending on your pharmacy plan, you may be required to receive prior authorization before you can fill prescriptions for certain drugs. In addition, you may need to use a Specialty Pharmacy designated by your plan to fill prescriptions for certain drugs. For more information, contact your plan's member services or visit the plan's website.

A Special Note about Express Scripts

Your prescription drug coverage is provided through Express Scripts if you select the Blue Shield PPO plan.

If you participate in any of the other medical plans, your prescription drug coverage is provided through your medical plan.

If your prescription drug coverage is provided through Express Scripts, you'll receive a separate ID card for prescription drug coverage. You should be prepared to present your Express Scripts ID card whenever you have a prescription filled at a retail pharmacy. If you don't, you may be denied benefits and have to pay for your prescription up front.

To receive benefits, you must fill your prescription by using either the mail-order pharmacy or a participating retail pharmacy. To find a participating pharmacy, you can call Express Scripts Member Services at (866) 662-0297 or visit **www.express-scripts.com**.

The Specialty Pharmacy

Certain drugs covered by the Express Scripts plan require you to purchase them through Accredo, Express Scripts' Specialty Pharmacy program. These drugs include growth hormone medications as well as drugs to treat cystic fibrosis, multiple sclerosis, and viral hepatitis. These drugs may be dispensed through mail-order only. For more information or to enroll in the Specialty Pharmacy program, call Express Scripts Member Services (866) 662-0297.

Clinical Prior Authorization

With the Express Scripts plan, certain prescriptions require approval from the plan, or "clinical prior authorization," before they'll be covered. These include, but aren't limited to, biological response modifiers and anti-obesity, insomnia, and migraine medications. To request approval, you, your pharmacy, or your physician should call (866) 662-0297. When you call, you'll need to have the name of the medication, your physician's name and phone number, and your member ID and group number (which are printed on your Express Scripts ID card).

Your Prescription Drug Benefits

Your prescription drug benefits depend on your medical plan. You can find more details on the following pages:

- CSEA: page 11
- Non-Represented: page 12
- TALB: page 13

Keep in mind that to receive those benefits, you'll need to use a pharmacy that's part of your plan's network.

Is Your Drug on the Formulary?

If your drug is on the plan's preferred drug list (or formulary), your benefits will probably be better. You can contact Express Scripts Member Services, (866) 662-0297, or visit the Express Scripts website, **www.express-scripts.com**, for information about which drugs are on the plan's formulary. Keep in mind that your benefits will be highest if you receive a generic drug.

Employee Assistance Program (EAP)

The EAP is an additional benefit and specialized program provided by Employee Assistance Service for Education (EASE), which is part of the Los Angeles County Office of Education. The EAP is available to you and your immediate family members.

EASE provides professional and confidential counseling to help you with:

- Family troubles with spouse or children;
- Emotional distress;
- Drug or alcohol abuse;
- On-the-job anxieties and stress;
- Grief, loss, and transitions;
- Legal or financial referrals; and
- Worksite and phone consultations.

Access to all of the EASE services is just a phone call away — (800) 882-1341.

Dental Plan Options

Because regular dental care is vital to your overall health well being, your dental benefits are an important part of your health care package.

With the DeltaCare/PMI plan, you must receive care from a provider in the plan's network or no benefits will be paid. For the Delta PPO Plus Premier plan, you have the flexibility to receive care from any provider; however, you may pay less if you receive care from a Delta Dental contracted provider, because Delta Dental negotiates lower fees for Delta plan members.

The chart below summarizes the main features of the dental plans available to all District employees. For the full details of each plan, including exclusions, refer to the Evidence of Coverage plan documents.

MAJOR COVERAGE	Delta PPO Plus Premier Plan		DeltaCare/PMI
Eligibility	Employee only; dependent coverage at employee's expense		Employee and dependents
Choice of Dentist	For highest level of benefits, you must use In-Network dentists. Enrollees also have the flexibility to see any licensed dentist		You must use a dentist on the panel of primary care dentists
	In-Network Dentist	**Any Licensed Out-of-Network Dentist**	
Covered Fees	Contracted fees	U&C[1]	All services provided by contract
Annual Maximum	$2,200	$2,000	No maximum
Deductible	None		None
Coinsurance/Copay	What the plan pays • Pays 70% – 1st year of participation • Pays 80% – 2nd year of participation • Pays 90% – 3rd year of participation • Pays 100% thereafter Levels increase each calendar year if employee visits dentist at least once a year		Per copay schedule shown in the Evidence of Coverage available on the Benefits website at **www.benefitenroll.com** and the LBUSD website at **www.lbschools.net**
Preventive Services			
Teeth Cleaning	Covered – 2 per year		Covered in full – 2 per year
Full Mouth X-rays	Covered – every 5 years		Covered in full – every 2 years
Bite-Wing X-rays	Covered – 2 per year		Covered in full – 2 per year
Fluoride Treatments	Covered[2]		Covered in full – to age 18
Therapeutic Services			
Extractions	Covered[2]		Covered in full (uncomplicated)
Fillings	Covered[2]		Covered in full (amalgam, acrylic)
Root Canals/Periodontics	Covered[2]		Covered subject to copay
Crowns, Dentures, Bridges			
Crown	Covered[2]		Covered subject to copay
Denture/Bridge	Paid at 50%		Covered subject to copay
Orthodontia			
Children/Adults	Not covered		Covered subject to $350 start-up fee, $1,200 copay

[1] If a covered individual uses a Delta PPO Plus Premier dentist, reimbursement under the plan is based on the plan's allowed fees. All other dentists are subject to reimbursements based on the usual & customary (U&C) amount for the service.

[2] Covered at applicable coinsurance level.

Vision Coverage

With the Medical Eye Services (MES) vision plan, you have coverage for a wide range of vision services. Vision coverage is available to employees only.

After you've met the annual deductible, the plan begins to pay benefit. The amount the plan pays depends on whether or not you visit a participating provider. When you go to a participating provider, the plan provides full coverage for many covered services and materials. When you go to a non-participating provider, charges will be paid on the basis of prevailing fees, but not to exceed the schedule of allowances in the right column of the following chart.

For a complete list of covered services and limitations/exclusions, refer to the Evidence of Coverage plan document for Limitations and Exclusions.

<table>
<tr><th>MAJOR COVERAGE</th><th>Participating Provider</th><th>Non-participating Provider</th></tr>
<tr><td colspan="3">First, you pay an annual deductible…</td></tr>
<tr><td>Annual deductible</td><td colspan="2">$10</td></tr>
<tr><td colspan="3">Then, the plan pays for the following benefits…</td></tr>
<tr><td colspan="3">Exams</td></tr>
<tr><td>Ophthalmic Examination
(with or without refraction, once every 12 months)</td><td rowspan="2">Plan pays 100%</td><td>Plan pays $60</td></tr>
<tr><td>Optometric Examination
(with or without refraction, once every 12 months)</td><td>Plan pays $50</td></tr>
<tr><td colspan="3">Frames</td></tr>
<tr><td>Two every 24 months</td><td>Plan pays 100%[1]</td><td>Plan pays $40/frame</td></tr>
<tr><td colspan="3">Lenses (per pair, up to two pairs every 24 months)</td></tr>
<tr><td>Single Vision (glass or plastic)</td><td rowspan="8">Plan pays 100% for two pairs of standard lenses[2]</td><td>Plan pays $43</td></tr>
<tr><td>Bifocal (glass or plastic)</td><td>Plan pays $60</td></tr>
<tr><td>Trifocal (glass or plastic)</td><td>Plan pays $75</td></tr>
<tr><td>Aphakic Monofocal</td><td>Plan pays $120</td></tr>
<tr><td>Aphakic Multifocal</td><td>Plan pays $200</td></tr>
<tr><td>Tints (Pink or Rose #1 or #2)</td><td>Plan pays 100%</td></tr>
<tr><td>Tints (other than Pink or Rose #1 or #2)
Single vision
Bifocals
Trifocals</td><td>Plan pays $10
Plan pays $15
Plan pays $20</td></tr>
<tr><td colspan="3">Contact Lenses (in lieu of frames and lenses, once every 24 months)</td></tr>
<tr><td>Medically Necessary</td><td>Plan pays 100%[3]</td><td>Plan pays $250</td></tr>
<tr><td>Cosmetic</td><td>Plan pays 100%, up to a $100 maximum</td><td>Plan pays $100</td></tr>
</table>

[1] A standard frame is any frame that has a retail value of $60 or less; you are responsible for any charges above $60.
[2] Standard lenses fit any frame with an eye size less than 56 mm.
[3] Contact lenses are medically necessary if they are prescribed following cataract surgery, when they are the only means to correct visual acuity to 20/70 in the better eye, or when necessitated by anisometropia or certain conditions of keratoconus. **Prior authorization from Medical Eye Services is required before contact lenses will be considered medically necessary.** treated like any other illness.

Flexible Spending Accounts (FSAs)

The District gives all eligible employees access to two flexible spending accounts (FSAs) — a Health Care FSA and a Dependent Care FSA. Non-represented employees who enroll in the PPO $aver Plan will have access to the Limited Purpose FSA. These accounts let you pay for certain expenses using pre-tax contributions — that means less of your paycheck goes to taxes and you take home more money! The FSAs are administered by WageWorks, and you can enroll in FSAs through the Employee Service Center.

FSAs will continue to stay on the calendar year and are effective through December 31, 2016. When you take advantage of the FSAs, you can:

- Put more money in your pocket;
- Reduce your income tax liability;
- Budget for non-covered health care expenses; and
- Set aside dollars for day care and other dependent care costs — so you have the money when you need it.

With FSAs, you can also save for expected out-of-pocket costs, such as:

- **Health care expenses** — vision exams and eyeglasses, hearing aids, orthodontia, medical and dental deductibles, even laser vision surgery and other services not covered by your medical benefits plan; and
- **Work-related dependent care expenses** — nursery schools and day care centers for your children, or for an adult dependent.

More information about eligible expenses is available at **www.benefitenroll.com**.

When you enroll in an FSA, you elect how much money you want to contribute for 2016. The District then takes that amount out of your paychecks in equal installments — before taxes are taken out. You can then submit a claim for reimbursement from these accounts whenever you have eligible expenses.

However, it's important to budget carefully, because any money that's left over at the end of the year will be forfeited. And keep in mind that once you've elected a contribution amount, you're not allowed to change it during the year unless you have a qualifying status change (although not all status changes allow you to change your contribution amount).

2016 FSA Contribution Limits

For 2016, you can contribute the following amounts to your FSA:

- Health Care FSA: $2,550
- Limited Purpose FSA: $2,550
- Dependent Care FSA: $5,000 (if you are single or married and filing taxes jointly) or $2,500 (if you are married and filing taxes separately)

Limited Purpose FSA — for Non-Represented Employees Enrolled in the PPO $aver Plan

If you enroll in the PPO $aver Plan, you cannot enroll in the regular Health Care Flexible Spending Account (FSA). However, you can enroll in a Limited Purpose FSA. You can only use a Limited Purpose FSA to pay certain non-medical expenses, such as eligible dental or vision care.

Important! *If you currently participate in a Health Care FSA and want to enroll in the PPO $aver Plan for 2016, IRS regulations require that you use up your FSA balance by December 31, 2015. If you don't use your FSA balance, you won't be eligible to open an HSA until April 1, 2016.*

FSAs, HSAs, and Your Domestic Partner

You can use the funds in your Health Care FSA and PPO $aver Plan HSA to pay for expenses for your eligible dependents. However, because of IRS regulations, your California-registered domestic partner is not considered an eligible dependent for purposes of the FSA or HSA unless he or she is an IRS tax dependent. Also, you cannot spend funds from your Dependent Care FSA on the children of your domestic partner, unless the children qualify as your IRS tax dependents.

Group Life Insurance and Group Accidental Death & Dismemberment Insurance

If you're eligible, the District automatically provides you with life and AD&D insurance:

- **Group life insurance** pays a benefit to your beneficiary in the event of your death.
- **Group basic AD&D insurance** provides an additional benefit if you die as the result of an accident. It also provides a benefit if you have certain injuries as the result of an accident — the benefit you receive is a percentage of the total benefit, depending on the extent of your injury.

Your coverage level is shown in the chart below.

Employee Group	Level of Coverage
Bargaining and Non-bargaining Unit Employees	• Life insurance benefit equal to one times annual salary, but not less that $15,000 or more than $50,000. • AD&D coverage is provided in the same amount.
Management, Supervisory, and Confidential Employees	• Life insurance benefit of $50,000. • AD&D coverage is provided in the same amount.

Although the District pays the full cost of coverage for most employees, certain job share and management employees who work less than full time may be required to pay a portion of the premium for this benefit. **If you do not want to pay these premiums, you must elect to waive this benefit during your enrollment.**

If you're a collective bargaining employee, please refer to your collective bargaining agreement to determine District-paid premiums. You can find the full details of the plans in the Certificate of Insurance, which is available on the Employee Service Center website at **www.benefitenroll.com**.

Life Insurance Conversion

Your life insurance coverage will terminate at the end of the month in which you are no longer eligible for District benefits. However, you may be eligible to convert to an individual life insurance policy at that time. For more information, please call the life insurance carrier, Reliance Standard, at (800) 644-1103.

Retirement Plans

In addition to your pension benefits, the District is pleased to offer you two additional plans to help you save for retirement.

The District offers 403(b) and 457 plans in accordance with the Internal Revenue Code to allow participants to save for retirement with pre-tax dollars. These plans offer the following benefits:

- Contributions are made on a salary-reduction basis;
- Variety of investment choices; and
- Easy payroll deduction.

Under current law, before age 59½, a 10% federal tax penalty may apply to amounts distributed from your plan (and certain deemed distributions) which are attributable to an IRA or another qualified plan. Withdrawals are subject to ordinary income tax.

The 403(b) plan is administered by SchoolsFirst Federal Credit Union, while the 457 is administered by the Hartford.

For more information on your District retirement plans, please call the plans' administrator.

Plan	Plan Administrator	Phone Number
403(b)	SchoolsFirst FCU	(800) 462-8328 x4116
457	Morgan Stanley	(800) 755-5721 (Barbara Fleming)

Internal Revenue Code (IRC) Section 125 Flexible Fringe Benefits Plan

The Long Beach Unified School District is pleased to provide our IRC Section 125 Flexible Fringe Benefits plan. This plan will be available for all employees, including the Long Beach Unified School District's Board of Education and Personnel Commission, Teachers Association of Long Beach, California Schools Employee Association Chapter #2, Management, Supervisors, and Confidential and Non-represented Employees.

If you pay premiums for certain District benefits, the Section 125 plan allows you to reduce your taxes by paying certain qualified expenses through payroll deductions on a pre-tax basis (for example, if you pay premiums for Delta Dental coverage for your dependents, or you're a job-share employee who pays medical premiums). By participating in a Section 125 plan, you will lower your taxable income, which can result in lower federal and state taxes.

If you pay premiums for your eligible benefits, you'll have the option to enroll in the Section 125 plan.

Important Information About Your Benefits

This section includes some important notices about your rights and responsibilities as a participant in the District's plans. It also includes details about how to appeal a claim or file a grievance. If you have any additional questions about this information, feel free to contact the Employee Service Center at (866) 844-9744.

Appealing a Claim

If a claim has been denied for you or your eligible family members, you may appeal the claim. Each carrier has its specific appeal process to follow. Please call your insurance carrier member services for the specific grievance and appeals process. See page 21 of this booklet for insurance carrier phone numbers.

Filing a Complaint or Grievance

Each insurance carrier has a specific process for effectively handling complaints and grievances. Please call your insurance carrier member services for details. Insurance carrier phone numbers are listed on page 21 of this booklet.

Phone Numbers and Websites

		Phone Number	Website
Benefit Service Center	**LBUSD Employee Service Center**		
	Member Services COBRA Benefit Billing Center	(866) 844-9744 (800) 877-7994 (800) 995-9935	www.benefitenroll.com www.Ceridian-Benefits.com
blue of california	**Blue Shield of California**		
	Member Services (HMO, PPO, and PPO $aver Plan)	(855) 256-9404	www.blueshieldca.com/lbusd
KAISER PERMANENTE®	**Kaiser**		
	Member Services (HMO)	(800) 464-4000	www.kp.org
EXPRESS SCRIPTS®	**Express Scripts**		
	Member Services	(866) 662-0297	www.express-scripts.com
ease	**EASE**		
	Member Services	(800) 882-1341	www.lacoe.edu/ease
DELTA DENTAL	**Delta Dental**		
	Member Services (PPO & Premier) Member Services (PMI)	(866) 499-3001 (800) 422-4234	www.deltadentalins.com
MES Vision	**Medical Eye Services**		
	Member Services	(800) 877-6372	www.mesvision.com
WageWorks	**WageWorks**		
	Member Services	(855) 774-7441	www.wageworks.com
CalPERS	**California Public Employees' Retirement System**		
	Member Services	(888) 225-7377	www.calpers.ca.gov
CALSTRS	**State Teachers' Retirement System**		
	Member Services	(800) 228-5453	www.calstrs.ca.gov
RELIANCE STANDARD	**Reliance Standard and Risk Management**		
	Member Services	(800) 644-1103	
long beach unified school district	**LBUSD Risk Management**		
	Click "R" for Risk Management		www.lbschools.net