2016–2017

Retiree 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,

Your health and welfare benefits are an important way we reward you for all of the work you do as a District employee. They're also a key component of your overall health and wellness. We evaluate these benefits each year to make sure we're providing comprehensive plans that offer choice and flexibility for each employee's unique needs.

What's New

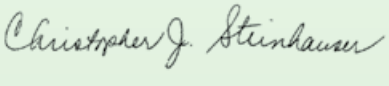
We've made minimal changes to our benefit programs this year. However, the benefits plan year will begin in July instead of January from now on, and Open Enrollment will occur this May. The changes you make during this enrollment period will be effective July 1, 2016 through June 30, 2017. The new plan year aligns more closely with what we consider to be a "new year" here at the District. While our benefit plans will be provided on this new schedule, Flexible Spending Accounts (FSAs) will continue to run on a calendar year. Your current FSA elections will be effective until
Dec. 31, 2016. We'll offer a separate enrollment in November for employees who wish to participate in an FSA for 2017. FSAs allow you to pay for certain health and dependent care expenses with pretax contributions from your paycheck. This means less of your paycheck goes to taxes.

More Wellness Resources

Your wellness is important, and we will continue providing resources to help you feel your best. LBUSD, CSEA and TALB have been working together to promote the health and wellbeing of our employees. In addition to our wellness newsletters, you now have another great informational resource this year. Our new benefits and wellness website, **www.lbusdwellness.com**, is your one-stop shop for benefits information, wellness resources and answers to frequently asked questions. I encourage you to explore the website and to use this guide to fully understand your benefits.

Best wishes for good health and success here at Long Beach Unified School District.

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

Inside this booklet you'll find all the details about your District benefits, including information about enrolling your eligible dependents in your coverage. You'll also find information about how and when to enroll.

We've also included some important information about Medicare. Depending on your situation, you may be required to enroll in Medicare to participate in the District's retiree benefits program. Please review this information carefully.

At the back of the booklet, 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.

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.

Table of Contents

Participating in Your Benefits

Health Care Benefits

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**.

Your Retiree Dental Coverage

If you want to participate in one of the District's retiree dental plans, you must elect this coverage within 31 days of receiving your retirement letter. If you don't, you won't be eligible to elect this coverage at a later date, even if you elect retiree medical coverage when you retire.

Benefits Eligibility

Retiree Eligibility

As a District retiree, you're eligible for medical and dental insurance up to a certain age if, at the time of your retirement, you're age 55 or older and you meet the following service requirements:

- **TALB and CSEA Unit B represented employees:** You have 17 years of credited service with LBUSD;
- **CSEA Unit A represented employees:** You have 15 years of credited service with LBUSD; or
- **Non-represented employees:** You have at least 15 years of credited service with LBUSD (note that if you retire with at least 17 years of credited service, your retiree benefits will continue for a longer period; see page 10 for details).

If you retire from the District after you reach age 55 but you don't meet the service requirements for District-paid benefits, you may participate in retiree coverage by paying the group rates for coverage.

If you want retiree coverage, it's important that you enroll immediately after you retire. You'll lose eligibility to enroll in retiree coverage if any of the following events occurs:

- You don't elect retiree coverage within 31 days after receiving your retirement letter;
- You retire and elect COBRA continuation coverage instead of retiree coverage; or
- You elect retiree coverage and then terminate that coverage.

STRS Disability Retirement

If you're a TALB member on disability, you may be able to apply for disability benefits through STRS. If you began drawing STRS disability payments after June 1, 1979, you're eligible for District-paid health insurance for the term of the disability, up to a maximum of 39 months from the date of approval of the disability or age 67, whichever comes first.

Dependent Eligibility

If you enroll yourself in District benefits, you can also enroll your eligible dependents in certain plans. 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 or the Blue Shield HMO, your dependent children may be enrolled as dependents for one of you only, not both. (Required documentation: a birth certificate.)
- **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 31 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.

Surviving-Spouse or Domestic Partner Eligibility

If you retire and elect retiree coverage for yourself and your spouse or domestic partner, your surviving spouse or domestic partner may qualify to continue his or her existing coverage by purchasing District medical and dental coverage.

If your surviving spouse or domestic partner elects this coverage, he or she may also elect to continue coverage for any other eligible dependents who were enrolled in your coverage at the time of your death.

To be eligible, your surviving spouse must elect this coverage within 31 days after your death. In addition, your surviving spouse will lose eligibility upon entering into a marriage or domestic partnership with another individual after your death.

More information about this coverage is available when you call the Employee Service Center at (866) 844-9744.

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 (EOC) for more information.

Important!

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

Your Cost for Benefits

As a retiree, you're responsible for the full cost of retiree dental coverage for you and your eligible dependents.

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. Retirees who pay their share of premiums will be billed on a monthly basis. Keep in mind that the lowest cost HMO plan will be free to eligible retirees 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%. These rates will apply to all coverage levels: retiree only, retiree plus one and family.

Paying Your Premiums

If you retire under the State Teachers Retirement System (STRS), you can make arrangements to have the premiums for your District retiree coverage deducted from your STRS monthly allowance. STRS will then automatically forward these premium payments to the District. For more information or to elect this option, you can contact STRS directly.

You can find out your premiums for benefits by reviewing the personalized worksheet you receive during the annual Open Enrollment. If you're making changes to your benefits outside the Open Enrollment period because of a qualifying status change, contact the Employee Service Center at (866) 844-9744 for your cost information.

Upon reaching age 65, District retirees (who retired on or after December 9, 1991) and their dependents are required to apply for Medicare Part A (if you're eligible for premium-free benefits) and Medicare Part B. If you don't apply, benefits for you and your covered dependents will be terminated. See page 17 for more information about Medicare and your District benefits.

When to Enroll

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

- 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 should make your initial benefits enrollment for yourself and your dependents within 31 days of your retirement from the District. However, if you're a TALB member and you complete your contract and retire in June at the end of the school year, your employee benefits will continue through September 30 of that year; you'll receive your retiree benefits enrollment information in August. Enrollment documents should be completed and submitted within 31 days so your retiree benefits can begin on October 1.

If you don't enroll when you're initially eligible, you will lose eligibility for the District's retiree benefits, and you won't be able to enroll in the future. In addition, if you decline retiree dental coverage when you're initially eligible, you will not be able to enroll at a later date, even if you elect retiree medical coverage when you're first eligible.

Enrolling 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. Beginning this Open Enrollment, the elections you make will take effect on July 1 and be effective through June 30 of the following year. Going forward Open Enrollment will usually occur each spring.

Medicare and Your Benefits

Don't forget that you and your covered spouse or domestic partner are required to enroll in Medicare when you're eligible in order to keep your District benefits. See page 17 for more details.

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 31 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 or 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 31 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 31 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 31 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 31 — 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.

How to Enroll

The easiest way to enroll for your benefits is through the District's online enrollment site, **www.benefitenroll.com**.

When you enroll online, you'll be able to review your benefit elections and make sure all 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, 1943, your password would be 05091943.)
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 DHMO 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 dependents.

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.

Steps to Upload Your Benefit Documents Online

1. Save the documentation to a file on your computer in .pdf format
2. Login to **www.benefitenroll.com**
3. Enter your login information
   - Your login is your unique user name and the password you created
4. Select the 'Upload Document' tab on the blue tool bar
5. Select 'Upload'
6. Select 'Browse'
7. Locate the saved documentation on your computer and select 'Open'
8. Select 'Save'

To view what documents have been uploaded, click the 'Upload Document' link

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 to participate in the coverage; it DOES NOT mean that you will continue with the same coverage you currently have. If you waive coverage during your enrollment, you will not be able to re-enroll in the District's retiree benefits program.

When Coverage Ends

If you're eligible for retiree coverage, as specified on page 4, the date your retiree benefits end depends on your bargaining unit and, in some cases, your years of credited service with the District.

- **TALB and CSEA Unit B represented employees:** Your District-paid retiree benefits will end at the end of the month you turn age 67.
- **CSEA Unit A represented employees:** Your District-paid retiree benefits will end at the end of the month you turn age 65.
- **Non-represented employees:** If you retired with at least 15 years, but less than 17 years, of credited service with LBUSD, your benefits will continue until the end of the month you turn age 65. If you completed 17 years of credited service with LBUSD, your retiree benefits will end at the end of the month you turn age 67.

Medical Coverage Options

Your medical benefits are designed to help maintain wellness and protect your family. The District offers two types of medical plan options: HMO and PPO.

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. The **PPO** plan gives you the flexibility to receive care from any provider; however, your benefits will be higher if you receive care from a provider in the plan's network.

The following charts summarize your various plan options. Please note that certain columns are for plans available only to retirees who were non-represented or were represented by CSEA when they were District employees, while other columns are for plans available only to retirees who were represented by TALB.

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 (or Kaiser Senior Advantage HMO, available to retirees who are age 65 and over and enrolled in Medicare) • Blue Shield of California HMO (or Blue Shield of California 65 Plus HMO, available to retirees who are age 65 and over and enrolled in Medicare) The District also offers the following PPO plan: • Blue Shield of California PPO All medical plans include prescription drug coverage. A summary of these benefits is provided on pages 12 – 16.
Dental	The District offers two dental plans: • Delta PPO Plus Premier • Delta Care DHMO You can find a summary of your dental benefits on pages 19 – 20.

Blue Shield of California PPO

AVAILABLE TO ALL RETIREES

Please check the website for a copy of the Evidence of Coverage (EOC): **www.benefitenroll.com**.

	In-Network	Out-of-Network
Plan Year Deductible	$300/person; $600/family	$500/person; $1,000/family
Coinsurance	80% of allowable amounts	60% of allowable amounts
Plan Year Out-of-Pocket Maximum (includes deductible)	$1,300/person; $2,600/family	$5,500/person; $11,000/family
Lifetime Maximum	Unlimited	Unlimited
Inpatient Hospital	80% of allowable amounts	Plan pays 60% up to $600 per day or $360
Surgeon	80% of allowable amounts	60% of allowable amounts
Outpatient Surgery	80% of allowable amounts	Plan pays up to 60% of $350 claim, or $210
Ambulatory Surgery Center and Outpatient Services	80% of allowable amounts	Plan pays up to 60% of $350 per claim, or $210
Emergency Room	80% of allowable amounts	80% of allowable amounts
Physician Visits	80% of allowable amounts	60% of allowable amounts
Prenatal and Postnatal	80% of allowable amounts	60% of allowable amounts
X-ray and Laboratory	80% of allowable amounts[1]	60% of allowable amounts
Chiropractic	80% of allowable amounts	60% of allowable amounts
Ambulance	80% of allowable amounts	80% of allowable amounts
Dental	No coverage	No coverage
Vision	No coverage	No coverage
Routine Physicals	No charge	60% of allowable amounts
Mental Health Inpatient Outpatient	 80% of allowable amounts 80% of allowable amounts	 Plan pays up to 60% of $600 per day, or $360 60% of allowable amounts

	CSEA & Non-represented		TALB	
Prescription Drug Out-of-Pocket Maximum Individual/Family	$5,550/$11,100		$5,550/$11,100	
Prescription Drugs (in-network only)[2]	**Retail**	**Mail Order**	**Retail**	**Mail Order**
Generic	$0 copay	$0 copay	$0 copay	$0 copay
Brand	$20 copay	$20 copay	$20 copay	$20 copay
Non-formulary	$50 copay	$50 copay	$50 copay	$50 copay
Maximum Supply	30 days	90 days	30 days	90 days

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 actively 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.

[1] Women's preventive care and some routine tests and screenings for women are 100% covered in-network with no deductible required.

[2] Prescription drug coverage provided through Express Scripts. Some contraceptive prescriptions for women are 100% covered in-network with no copay or deductible required. Contact the plan for details.

Blue Shield of California HMOs

Please check the website for a copy of the Evidence of Coverage (EOC): **www.benefitenroll.com**.

	HMO CSEA and Non-Represented	HMO TALB	65 Plus (Available to retirees age 65 and over)
Plan Year Deductible	None	None	None
Coinsurance	N/A	N/A	Must pledge Medicare
Plan Year Out-of-Pocket Maximum	$250/person; $500/family	$250/person; $500/family	$250/person
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Inpatient Hospital	No charge	No charge	No charge
Surgeon	No charge	No charge	No charge
Outpatient Surgery	No charge	No charge	No charge
Ambulatory Surgery Center and Outpatient Services	No charge	No charge	$5 copay per procedure
Emergency Room	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$25 copay (waived if admitted)
Physician Visits	$5 copay ($30 access + specialist)	$5 copay ($30 access + specialist)	$5 copay
Prenatal and Postnatal	$5 copay	$5 copay	$5 copay
X-ray and Laboratory	No charge	No charge	No charge
Chiropractic	$5 copay (up to 30 visits/year)	$5 copay (up to 30 visits/year)	$5 copay
Ambulance	No charge	No charge	No charge
Dental	Not covered	Not covered	Not covered
Vision	Not covered	Not covered	Not covered
Routine Physicals	No charge	No charge	No charge
Mental Health[1]			
Inpatient[1]	No charge	No charge	No charge
Outpatient	$5 copay	$5 copay	$5 copay

	CSEA and Non-represented		TALB			
Prescription Drugs[2]	**Retail**	**Mail Order**	**Retail**	**Mail Order**	**Retail**	**Mail Order**
Generic	$5 copay	$5 copay	$5 copay	$5 copay	$5 copay	$5 copay
Brand	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay
Non-formulary	$35 copay	$35 copay	$35 copay	$35 copay	$35 copay	$35 copay
Maximum Supply	30 days	90 days	30 days	90 days	30 days	90 days

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[1] Severe Mental Illness of adults and children and emotional disturbances of children are treated like any other illness.
[2] Some contraceptive prescriptions for women are 100% covered in-network with no copay required. Contact the plan for details.

Kaiser Permanente and Kaiser Permanente Senior Advantage

Please check the website for a copy of the Evidence of Coverage (EOC): **www.benefitenroll.com**.

	Kaiser[1]	Kaiser Senior Advantage[1]
Plan Year Deductible	None	None
Coinsurance	N/A	**Must pledge Medicare**
Plan Year Out-of-Pocket Maximum[1]	$1,500/person; $3,000/family	$1,500/person; $3,000/family
Lifetime Maximum	Unlimited	Unlimited
Inpatient Hospital	No charge	No charge
Surgeon	No charge	No charge
Outpatient Surgery	$5 copay	No charge
Ambulatory Surgery Center and Outpatient Services	$5 copay	No charge
Emergency Room	$100 copay (waived if admitted)	No charge
Physician Visits	$5 copay	No charge
Prenatal and Postnatal	No charge	No charge
X-ray and Laboratory	No charge	No charge
Chiropractic	$5 copay (up to 30 visits/year)	$5 copay (up to 30 visits/year)
Ambulance	No charge	No charge
Dental	None	DeltaCare DHMO
Vision	Eye exam only	Eyewear purchased from Plan optical sales offices every 24 months $150 allowance
Routine Physicals	No charge	No charge
Mental Health[2] Inpatient	No charge	First 190 days per lifetime as covered by Medicare. Thereafter up to 45 days per calendar year no charge
Outpatient	$5 copay	No charge
Prescription Drugs	$5 copay (up to 100-day supply)	$5 copay (up to 100-day supply)

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 actively 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.

[1] If you are enrolled in an HMO plan, you can obtain services only within the plan's geographic service area, except emergency services may be obtained outside the plan's geographic service area as needed.

[2] Severe mental illnesses of adults and children and emotional disturbances of children are treated like any other illness.

Prescription Drug Benefits

Depending on the medical plan you select, your prescription drug benefit may have different tiers of coverage. 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.

The prescription drug benefits offered under each plan are included in the plan comparison charts on the previous pages.

Prescription Drug Costs

Keep in mind, costs for Prescription Drugs apply to the deductible and out-of-pocket maximum for all medical plans.
Note: there is a separate prescription drug out-of-pocket maximum for the PPO plans ($5,550 individual/$11,100 family, in-network only).

Your Prescription Drug Benefits

Your prescription drug benefits depend on your medical plan and may depend on whether, as a District employee, you were represented by TALB, represented by CSEA, or were Non-represented. You can find more details on the following pages:

- Blue Shield PPO plan: page 12
- Blue Shield HMO plans: page 13
- Kaiser HMO plans: page 14

Is Your Drug on the Formulary?

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

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 at (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).

Medicare Coverage and Your District Medical Benefits

Medicare Parts A and B

Upon reaching age 65, District retirees (who retire on or after December 9, 1991) are required to apply for Medicare Part A (if you're eligible for premium-free benefits) and Medicare Part B. If you don't apply, you won't be eligible to receive medical benefits through age 67. All retirees are eligible for Medicare Part B and are required to purchase this coverage in order to remain eligible for District benefits.

You're required to assign your Medicare Part A (if you're eligible for this coverage) and Part B benefits to the District medical plan that you're enrolled in if, as a District employee, you:

- Were non-represented or represented by CSEA; and
- Retired on or after November 4, 2005.

If you don't assign your Medicare benefits, you won't be eligible for District-paid benefits.

You should apply for Medicare coverage (Parts A and B) at least 3 months before your 65th birthday. If you don't enroll when you first become eligible, you may have to pay a penalty if you enroll at a later date, and neither you nor your dependents will be eligible for coverage.

If you're eligible for Medicare Parts A and B coverage and don't apply for it, the District won't contribute to the cost of your health insurance premiums from age 65 to age 67. If you're a Medicare-eligible retiree, Medicare coverage will be primary and the District's plan will provide secondary coverage.

Enrolling in Medicare

If you don't enroll for Medicare when you first become eligible, you'll have to enroll during Medicare's general Open Enrollment period, which runs each year from January through March. If you enroll during this period, your Medicare coverage will begin on the following July 1.

Types of Medicare Coverage

Medicare Part A

Part A is a hospital insurance benefit that helps cover your inpatient care in hospitals, critical access hospitals, and skilled nursing facilities. It also covers hospice care and some home health care if you meet certain conditions.

Medicare Part B

Part B is a medical insurance benefit that helps cover your doctors' services and outpatient hospital care. It also covers some other medically necessary services that Part A does not cover, such as some physical therapy, occupational therapy, and home health care services.

Medicare Part D

Part D is a prescription drug coverage benefit, which helps cover the cost of filling your prescriptions. It's open to individuals who are enrolled in or eligible for Medicare Parts A and B.

Important!

If you're in a plan that offers prescription drug coverage through Express Scripts, it is not recommended that you sign up for Medicare Part D, as the Express Scripts Plan and Medicare will not coordinate benefits. If you do enroll in Part D, you may jeopardize your coverage.

Medicare Part D

Kaiser Senior Advantage Plan

If you're currently enrolled in the Kaiser Senior Advantage plan, you'll automatically be enrolled into Medicare Part D through the plan. The prescription benefits you receive through the Senior Advantage plan provides benefits that are equal to or are better than the government-designed Medicare Part D prescription coverage. **If you elect one of these plans, you should not enroll for Medicare Part D on your own or you may jeopardize your coverage.**

Blue Shield PPO Plan and Blue Shield HMO Plan

If you're enrolled in the Blue Shield PPO plan you receive your prescription drug coverage through the Express Scripts program. If you're enrolled in the Blue Shield HMO plan you receive your prescription drug coverage through the Blue Shield program. With this coverage, you do not need to enroll in individual Medicare Part D. Because the prescription drug coverage you receive through Express Scripts or Blue Shield is equal to or better than the government-designed Part D coverage, you're not required to sign up for individual Part D coverage. In addition, you'll receive a "Notice of Creditable Coverage" from the District confirming that your coverage is equal to or better than coverage offered through Part D. It's important to keep this notice because it will enable you to avoid paying a higher premium if you sign up for Part D coverage in the future.

If you have any questions about how Medicare and your medical plan work together, please contact the individual insurance carrier or call Medicare directly at (800) 633-4227, or (877) 486-2048 (TTY) for the hearing impaired. You can also visit Medicare's website at **www.medicare.gov**.

Helpful Sources of Information on Retiree Eligibility and Coverage

For more information on what Medicare covers, how to enroll, and the premiums, call 1-800-MEDICARE (1-800-633-4227), or (877) 486-2048 (TTY) for the hearing impaired, or visit **www.medicare.gov**.

- To enroll in Medicare or to learn if you are already eligible for premium-free Medicare Part A coverage, call the Social Security Administration office at (800) 772-1213 or visit their website at **www.ssa.gov**.
- For information about the CalSTRS Medicare Benefit program and how the program might help you qualify and pay for Plan A coverage, call the CalSTRS office at (800) 228-5453 or visit their website at **www.calstrs.ca.gov**.

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 DHMO 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.

Keep in mind that as a retiree, you pay the full cost of District dental premiums for you and your eligible dependents. In addition, if you decline retiree dental coverage when you're initially eligible, you won't be able to enroll at a later date, even if you elect retiree medical coverage when you retire.

The chart on the following page summarizes the main features of the dental plans available to all District retirees. For the full details of each plan, including exclusions, refer to the Evidence of Coverage (EOC) plan documents.

Dental Benefits

MAJOR COVERAGE	Delta PPO Plus Premier Plan		DeltaCare DHMO Plan
Eligibility	Retiree and dependent coverage is at retiree's expense		Retiree and dependent coverage is at retiree's expense
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
	Delta Dental PPO Dentist	**Any Licensed non-PPO 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 to age 18; 1 per year ages 18 and up		Covered in full – 2 per year
Fluoride Treatments	Covered – 2 per calendar year[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.

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 22 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 25 of this booklet.

Phone Numbers and Websites			
		Phone Number	Website
	LBUSD Employee Resources		
	LBUSD Risk Management	N/A	www.lbschools.net (Click "R" for Risk Management)
	LBUSD Employee Service Center (Member Services)	(866) 844-9744	www.benefitenroll.com
	LBUSD Wellness Microsite	N/A	www.LBUSDWellness.com
	Morneau-Shepell		
	COBRA Benefit Billing Center	(855) 274-8493	https://msbenefitscontinuation. morneaushepell.com
	Blue Shield of California		
	Member Services (HMO & PPO)	(855) 256-9404	www.blueshieldca.com/lbusd
	Kaiser & Kaiser Senior Advantage		
	Member Services (HMO)	(800) 464-4000	http://my.kp.org/lbusd/
	Express Scripts (Blue Shield PPO for all retirees)		
	Express Scripts	(866) 662-0297	www.express-scripts.com
	Delta Dental		
	Member Services (PPO Plus Premier) Member Services (DHMO)	(866) 499-3001 (800) 422-4234	www.deltadentalins.com
	California Public Employees' Retirement System		
	Member Services	(888) 225-7377	www.calpers.ca.gov
	State Teachers' Retirement System		
	Member Services	(800) 228-5453	www.calstrs.ca.gov
	Medicare & Medicare Part D		
	Main Hearing Impaired	(800) 633-4227 (877) 486-2048 (TTY)	www.medicare.gov
	Social Security		
	Main	(800) 772-1213	www.ssa.gov