



2018 – 2019

Employee Health Benefits Insurance Summary Booklet



Long Beach Unified
School District

Dear Colleagues,

The health and welfare benefits our school district offers are an integral part of the total rewards package you receive in exchange for the important work that you do. Our comprehensive health and wellness offerings support you at work and beyond, helping you maintain and improve your family's health. Each year, our district, in partnership with TALB and CSEA, evaluates your benefit plans, and the vendors that offer them, to ensure we continue to provide comprehensive benefits and choices that meet our employees' diverse needs. That's why we made the move to Aetna as our medical insurance carrier.

Continued Focus on Health Improvement

In addition to efficient benefits administration, Aetna was chosen because it offers enhanced personalized services for our members to help achieve better health outcomes. Some of the services included with your Aetna health plan are described below.

Simple Steps provides digital coaching programs, all online — all personalized to your health goals — whether you're managing a health risk, overcoming an old habit, or just eating healthier.

In Touch Care for members with acute and chronic needs, provides:

- One-on-one phone calls with a nurse who serves as a trusted resource for you and your family
- Digital support that provides a variety of resources to help you better manage your health
- Customized health action plans based on your needs and preferences

Personal Health Record is an online home for your health information that can:

- Help provide better, safer and more cost-effective care
- Scan the information in your personal health record and compare it to thousands of the latest medical guidelines
- Spot potential medical problems, possible drug interactions or gaps in care, and post a message to you. The doctor treating you will also get an alert if it's urgent.

Concierge helps you make sense of the big and complex world of health care by:

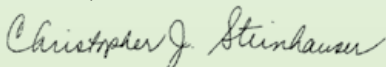
- Walking you through tools to help you make great decisions
- Finding network providers based on your medical needs
- Helping you schedule appointments to save you some stress

In addition to these Aetna health services, we continue to partner with Weight Watchers to help you maintain healthy habits. Enroll through the LBUSD Weight Watchers program to get more than 50% off the cost of membership. Benefit-eligible spouses and medical plan-enrolled retirees and retiree spouses are also eligible for discounted membership.

Visit www.lbusdwellness.com for more information on Aetna and their programs and read monthly updates from our district and Weight Watchers.

Best wishes for continued good health and success here in the Long Beach Unified School District.

Sincerely,



Christopher J. Steinhauser

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.

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. You can find important notices about state and federal laws that affect your benefits on our LBusD Benefit website at **www.lbusdwellness.com**.

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**, option 4. Representatives are available Monday through Friday from 5 a.m. to 5 p.m., Pacific time.

Table of Contents

Benefits Eligibility	4
Employee Eligibility	4
Dependent Eligibility	4 – 5
Your Cost for Benefits	5
When to Enroll	6
Enrolling When You're First Eligible	6
Making Changes During Open Enrollment	6
Making Changes During the Year	7
How to Enroll	8
Employee Service Center	9
An Overview of Your Benefits	10
Medical Coverage Options	10
CSEA — 2018 – 2019 Medical Coverage Options	11
NON-REPRESENTED — 2018 – 2019 Medical Coverage Options	12
TALB — 2018 – 2019 Medical Coverage Options	13
Prescription Drug Benefits	14 – 16
Employee Assistance Program (EASE)	16
Dental Plan Options	17
Vision Coverage	18
Flexible Spending Accounts (FSAs)	19
2018 FSA Contribution Limits	19
Group Life Insurance and Group Accidental Death & Dismemberment Insurance	20
Life Insurance Conversion	20
Retirement Plans	21
Internal Revenue Code (IRC) Section 125 Flexible Fringe Benefits Plan	21
Important Information About Your Benefits	22
Appealing a Claim	22
Filing a Complaint or Grievance	22
Phone Numbers and Websites	23

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 our LBUSD Benefit website, www.lbusdwellness.com.

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.



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, option 4, 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. (Required documentation: a birth certificate.)

- **Your children, stepchildren, or adopted children who are developmentally 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, non-temporary 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 July 1, 2018 – June 30, 2019 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**, option 4, for your cost information.

Tier	July 2018 – June 2019 District Annual Maximum (DAM)	July 2018 – June 2019 Employer Costs	July 2018 – June 2019 Employee Cost
Employee	\$12,204	\$11,950	\$0.00
Employee + 1	\$22,320	\$21,800	\$0.00
Family	\$28,030	\$27,425	\$0.00

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 our LBUSD Benefit website at www.lbusdwellness.com.





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:**
 - Aetna Choice POS II (Open Access) 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 DHMO 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.

The elections you make during Open Enrollment will take effect on July 1 and be effective through June 30 of the following year. Open Enrollment will occur each spring, generally in May.

Please note, Flexible Spending Accounts (FSAs) are now part of the regular plan year and are effective July 1 – June 30 each year. If you don't use your whole balance by June 30, 2019, you'll have a grace period to use the funds and submit claims. **If you don't use your balance by September 15, 2019 and submit claims by September 28, 2019 you'll forfeit any remaining funds.**



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 the event. You must 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**, option 4.



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.lbusdbenefits.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

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.lbusdbenefits.com**.

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.lbusdbenefits.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 Aetna 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 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, option 4. (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 July 1, 2018 through June 30, 2019. 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.

NOTE: Your Enrollment communication contains a worksheet that you can use to plan your elections. **Do not submit this form to the Employee Service Center or Risk Management.**



An Overview of Your Benefits

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

Health Care Benefits	
Medical	<p>The District offers two HMO Plans:</p> <ul style="list-style-type: none"> • Kaiser Permanente HMO • Aetna HMO <p>The District also offers the following plans:</p> <ul style="list-style-type: none"> • Aetna Choice POS II (Open Access) • Aetna Choice POS II (Open Access) HDHP (for Non-represented employees) <p>All medical plans include prescription drug coverage. A summary of these benefits is provided on pages 11 – 16.</p>
Dental	<p>The District offers two dental plans:</p> <ul style="list-style-type: none"> • Delta PPO Plus Premier • Delta Care DHMO <p>You can find a summary of your dental benefits on page 17.</p>
Vision	<p>The Medical Eye Services (MES) vision plan is available to employees only. More information about this plan is available on page 18.</p>
Employee Assistance Program (EASE)	<p>The District provides EASE to assist employees with personal and work/life issues. You can find additional information about EASE on page 16.</p>
Financial Savings & Security	
Flexible Spending Accounts (FSAs)	<p>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 19.</p>
Group Life and Group Accidental Death & Dismemberment (AD&D) Insurance	<p>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 20.</p>
Deferred Compensation (IRC 457) Retirement Plan	<p>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 21.</p>
IRC Section 125 Flexible Fringe Benefits Plan	<p>This plan allows you to pay premiums for certain District benefits and potentially reduce your taxes at the same time. Details about this plan can be found on page 21.</p>

Teladoc — A Great Resource for Aetna Members

If you are a Aetna member, you will have access to telemedicine services through your District medical benefits. These programs give you **24/7/365** access to a doctor through the convenience of your smartphone, tablet, or computer.

You can connect with doctors using the video chat function on your computer, smartphone or tablet, or you can speak with a provider over the phone. Doctors can assess and diagnose conditions such as bronchitis and even fill prescriptions (depending on your location) during your digital consultation. It's an affordable option for quality medical care. Call **(855) 835-2362**.

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.
- **Choice POS II (Open Access) Plan:** With this 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.
- **Choice POS II (Open Access) HDHP Plan:** With this plan, you have the coverage of a POS plan, and 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.lbusdbenefits.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.

CSEA — 2018 – 2019 Medical Coverage Options

This chart 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.

	Kaiser HMO ¹	Aetna HMO ¹	Aetna Choice POS II	
			In-Network	Out-of-Network
Plan Year Deductible Individual/Family	None	None	\$300/\$600	\$500/\$1,000
Plan Year 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	
Member Cost for Covered Services				
Inpatient Hospital	No charge	No charge	20%	40%
Outpatient Surgery	\$10 copay	No charge	20%	40%
Ambulatory Surgery Center and Outpatient Services	\$10 copay	No charge	20%	40%
Emergency Room Facility	\$100 copay (waived if admitted) ²	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)
Emergency Room Physician	No charge	No charge	20% after deductible	20% after deductible
Physician Office Visit	\$10 copay	\$10 copay	20%	40%
Routine Physical	No charge	No charge	No charge ³	40%
Well-Baby & Well-Child Care	No charge	No charge	No charge ³	40%
Well-Woman Exams	No charge	No charge	No charge ³	40%
Maternity Care	No charge	No charge	No charge ³	40%
Lab and X-ray	No charge	No charge	20%	40%
Physical or Occupational Therapy	\$10 copay	\$10 copay	20%	40%
Chiropractic Care	\$5 copay (Up to 30 visits/year)	\$5 copay (Up to 30 visits/year)	20%	40%
Durable Medical Equipment	No charge	No charge	20%	40%
Mental Health				
Inpatient	No charge	No charge	20%	40%
Outpatient	\$10 copay	\$10 copay	20%	40%
Prescription Drugs ⁴	Kaiser	Aetna	Express Scripts	
Out-of-Pocket Maximum Individual/Family	None	Combined with medical	\$5,550/\$11,100	
Retail	100 day supply Generic: \$5 copay Brand: \$10 copay Non-formulary: \$10 copay ⁵	30 day supply Generic: \$5 copay Brand: \$10 copay Non-formulary: \$35 copay	30 day supply ⁶ Generic: \$5 copay Brand: \$20 copay Non-formulary: \$50 copay	Not covered
Mail Order	100 day supply Generic: \$5 copay Brand: \$10 copay Non-formulary: \$10 copay ⁵	90 day supply Generic: \$5 copay Brand: \$10 copay Non-formulary: \$35 copay	90 day supply Generic: \$0 copay Brand: \$20 copay Non-formulary: \$50 copay	

¹ If you enroll in an HMO plan, you can obtain services only within the plan's geographic service area, except for urgent and emergency services.

² The Emergency Room Copay does apply if you are admitted for observation but are not admitted as an inpatient.

³ 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.

⁴ Some contraceptive prescriptions for women are 100% covered in-network with no copay or deductible required. Age limits may apply. Contact the plan for details.

⁵ For Kaiser plans, non-formulary brand-name drugs are not listed on the drug formulary and aren't covered unless approved through an exception process initiated by the members plan physician. If approved, non-preferred (non formulary) brand-name drugs are covered at the brand copay.

⁶ Diabetic medications are available in 90 day supplies at select retail pharmacies.

NON-REPRESENTED — 2018 – 2019 Medical Coverage Options

This chart 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.

	Kaiser HMO ¹	Aetna HMO ¹	Aetna Choice POS II		Aetna Choice POS II HDHP	
			In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible Individual/Family	None	None	\$300/\$600	\$500/\$1,000	\$1,500/\$3,000 (For family coverage, full family deductible must be met before plan pays benefits)	
Plan Year Out-of-Pocket (includes deductible) Maximum Individual/Family	\$1,500/\$3,000	\$250/\$500	\$1,300/\$2,600	\$5,500/\$11,000	\$3,275/\$6,550 (For family coverage, full family out-of-pocket maximum must be met before plan pays benefits)	
Lifetime Maximum	Unlimited	Unlimited	Unlimited		Unlimited	
Health Savings Account (HSA)	None	None	None		Available (includes District contribution)	
Member Cost for Covered Services						
Inpatient Hospital	No charge	No charge	20%	40%	10%	40%
Outpatient Surgery	\$10 copay	No charge	20%	40%	10%	40%
Ambulatory Surgery Center and Outpatient Services	\$10 copay	No charge	20%	40%	10%	40%
Emergency Room Facility	\$100 copay (waived if admitted) ²	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)	\$100 copay (waived if admitted), then 10%	\$100 copay (waived if admitted), then 10%
Emergency Room Physician	No charge	No charge	20% after deductible	20% after deductible	10% after deductible	10% after deductible
Physician Office Visit	\$10 copay	\$10 copay	20%	40%	10%	40%
Routine Physical	No charge	No charge	No charge ³	40%	No charge ³	Not covered
Well-Baby & Well-Child Care	No charge	No charge	No charge ³	40%	No charge ³	Not covered
Well-Woman Exams	No charge	No charge	No charge ³	40%	No charge ³	Not covered
Maternity Care	No charge	No charge	No charge ³	40%	No charge ³	40%
Lab and X-ray	No charge	No charge	20%	40%	\$25 then you pay 10%	40%
Physical or Occupational Therapy	\$10 copay	\$10 copay	20%	40%	No charge	40%
Chiropractic Care	\$5 copay (Up to 30 visits/year)	\$5 copay (Up to 30 visits/year)	20%	40%	10% (Up to 20 visits/year)	40% (Up to 20 visits/year)
Durable Medical Equipment	No charge	No charge	20%	40%	10%	40%
Mental Health						
Inpatient	No charge	No charge	20%	40%	10%	40%
Outpatient	\$10 copay	\$10 copay	20%	40%	10%	40%
Prescription Drugs ⁴	Kaiser	Aetna	Express Scripts		Aetna ⁵	
Out-of-Pocket Maximum Individual/Family	None	Combined with medical	\$5,550/\$11,100		Combined with medical	
Retail	100 day supply Generic: \$5 copay Brand: \$10 copay Non-formulary: \$10 copay ⁷	30 day supply Generic: \$5 copay Brand: \$10 copay Non-formulary: \$35 copay	30 day supply ⁷ Generic: \$5 copay Brand: \$20 copay Non-formulary: \$50 copay	Not covered	30 day supply Generic: \$5 copay Brand: \$10 copay Non-formulary: \$35 copay	Not covered
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² The Emergency Room Copay does apply if you are admitted for observation but are not admitted as an inpatient.

³ 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.

⁴ Some contraceptive prescriptions for women are 100% covered in-network with no copay or deductible required. Age limits may apply. Contact the plan for details.

⁵ For the Choice POS II HDHP, prescription drugs count towards annual deductible.

⁶ For Kaiser plans, non-formulary brand-name drugs are not listed on the drug formulary and aren't covered unless approved through an exception process initiated by the members plan physician. If approved, non-preferred (non formulary) brand-name drugs are covered at the brand copay.

⁷ Diabetic medications are available in 90 day supplies at select retail pharmacies.

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: Aetna Choice POS II medical plan, Delta PPO Plus Premier plan, vision coverage, life and accidental death & dismemberment insurance, and the employee assistance program.

TALB — 2018 – 2019 Medical Coverage Options

This chart 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.

	Kaiser HMO ¹	Aetna HMO ¹	Aetna Choice POS II	
			In-Network	Out-of-Network
Plan Year Deductible Individual/Family	None	None	\$300/\$600	\$500/\$1,000
Plan Year 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	
Member Cost for Covered Services				
Inpatient Hospital	No charge	No charge	20%	40%
Outpatient Surgery	\$10 copay	No charge	20%	40%
Ambulatory Surgery Center and Outpatient Services	\$10 copay	No charge	20%	40%
Emergency Room Facility	\$100 copay (waived if admitted) ²	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)
Emergency Room Physician			20% after deductible	20% after deductible
Physician Office Visit	\$10 copay	\$10 copay	20%	40%
Routine Physical	No charge	No charge	No charge ³	40%
Well-Baby & Well-Child Care	No charge	No charge	No charge ³	40%
Well-Woman Exams	No charge	No charge	No charge ³	40%
Maternity Care	No charge	No charge	No charge ³	40%
Lab and X-ray	No charge	No charge	20%	40%
Physical or Occupational Therapy	\$10 copay	\$10 copay	20%	40%
Chiropractic Care	\$5 copay (Up to 30 visits/year)	\$5 copay (Up to 30 visits/year)	20%	40%
Durable Medical Equipment	No charge	No charge	20%	40%
Mental Health				
Inpatient	No charge	No charge	20%	40%
Outpatient	\$10 copay	\$10 copay	20%	40%
Prescription Drugs ⁴	Kaiser	Aetna	Express Scripts	
Out-of-Pocket Maximum Individual/Family	None	Combined with medical	\$5,550/\$11,100	
Retail	100 day supply Generic: \$5 copay Brand: \$10 copay Non-formulary: \$10 copay ⁵	30 day supply Generic: \$5 copay Brand: \$10 copay Non-formulary: \$35 copay	30 day supply ⁶ Generic: \$5 copay Brand: \$20 copay Non-formulary: \$50 copay	Not covered
Mail Order	100 day supply Generic: \$5 copay Brand: \$10 copay Non-formulary: \$10 copay ⁵	90 day supply Generic: \$5 copay Brand: \$10 copay Non-formulary: \$35 copay	90 day supply Generic: \$0 copay Brand: \$20 copay Non-formulary: \$50 copay	

¹ If you enroll in an HMO plan, you can obtain services only within the plan's geographic service area, except for urgent and emergency services.

² The Emergency Room Copay does apply if you are admitted for observation but are not admitted as an inpatient.

³ 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.

⁴ Some contraceptive prescriptions for women are 100% covered in-network with no copay or deductible required. Age limits may apply. Contact the plan for details.

⁵ For Kaiser plans, non-formulary brand-name drugs are not listed on the drug formulary and aren't covered unless approved through an exception process initiated by the members plan physician. If approved, non-preferred (non formulary) brand-name drugs are covered at the brand copay.

⁶ Diabetic medications are available in 90 day supplies at select retail pharmacies.

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: Aetna Choice POS II medical plan, Delta PPO Plus Premier plan, vision coverage, life and accidental death & dismemberment insurance, and the employee assistance program.

Reimbursement for Hearing Aids

Active 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. Dependents covered by District medical plans are not eligible for this benefit.

To obtain a reimbursement form, visit our LBUSD Benefit website at www.lbusdwellness.com.

Prescription Drug Costs

Keep in mind, prescription drug 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 Choice POS II plan. (\$5,550 individual/\$11,100 family, in-network only)

Prescription Drug Benefits

Each of our medical plans has a 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 or brand, part of your plan's drug formulary (a list of drugs the insurance company considers "preferred choices" based on their effectiveness and cost), or not (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, or 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.

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 the same 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.

SafeGuard RX Diabetes Care Value Program

Express Scripts works to help reduce the costs of medicine commonly used to treat diabetes. If you use diabetes-related prescription drugs and are enrolled in the Choice POS II (Open Access) plan, you will need to fill your prescriptions through a new network of pharmacies in the Diabetes Care Value Program. These pharmacies help to control costs by giving you 3-month supplies of diabetes medicine with each refill. The network includes select pharmacies near you or delivery from the Express Scripts Pharmacies network. For more information, call (866) 662-0297 or go to www.express-scripts.com.

Advanced Utilization Step Therapy Program

Step Therapy is a program designed exclusively for employees who have certain conditions—arthritis, high blood pressure and high cholesterol, for example—that require them to take medications regularly.

In Step Therapy, medications are grouped in categories, based on cost:

- **Front-line medications — the first step** — are generic medications proven safe, effective and affordable. These medications should be tried first because they can provide the same health benefit as more expensive medications, at a lower cost.
- **Back-up medications — Step 2 and Step 3 medications** — are brand-name medications such as those you see advertised on TV. There are lower-cost brand medications (Step 2) and higher-cost brand medications (Step 3). Back-up medications always cost more than front-line medications.

HOW IT WORKS

When your doctor writes you a prescription:

- Ask your doctor if a generic medication — listed by your plan as a front-line medication — is right for you.
- If you've already tried a front-line medication, or your doctor decides one of these medications isn't appropriate for you, then your doctor can prescribe a back-up medication. Ask your doctor if one of the lower-cost brands (Step 2 medications) listed by your plan is appropriate.
- You can get a higher-cost brand-name medication at a higher copay if the front-line or Step 2 back-up medications aren't right for you.

For more information, call **(888) 290-6620** or go to **www.aetna.com** if you are enrolled in the HMO or HDHP plan. If you are enrolled in the Aetna Choice POSII plan call **(866) 662-0297** or go to **www.express-scripts.com**.

A Special Note about Express Scripts

Your prescription drug coverage is provided through Express Scripts if you select the Aetna Choice POSII 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**.

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.





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).

Is Your Drug on the Formulary?

If you’re enrolled in the Aetna Choice POS II plan, 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 national preferred formulary. Keep in mind that your benefits will be highest if you receive a generic drug.

Employee Assistance Program (EASE)

EASE 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. EASE 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 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.

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 (EOC) plan documents.

MAJOR COVERAGE	Delta PPO Plus Premier Plan		DeltaCare DHMO Plan
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
	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	<p>What the plan pays:</p> <ul style="list-style-type: none">• Pays 70% – 1st year of participation• Pays 80% – 2nd year of participation• Pays 90% – 3rd year of participation• Pays 100% thereafter <p>Levels increase each year if employee visits dentist at least once a year</p>		Per copay schedule shown in the EOC available on our Benefit website at www.lbusdwellness.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 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.

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 benefits. 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 Benefits Summary, available on our LBUUSD Benefit website at www.lbusdwellness.com.

MAJOR COVERAGE	Participating Provider	Non-participating Provider
First, you pay an annual deductible...		
Annual deductible	\$10	
Then, the plan pays for the following benefits...		
Exams		
Ophthalmic Examination (with or without refraction, once every 12 months)	Plan pays 100%	Plan pays \$60
Optometric Examination (with or without refraction, once every 12 months)		Plan pays \$50
Frames		
Two every 24 months	Plan pays 100% ¹	Plan pays \$40/frame
Lenses (per pair, up to two pairs every 24 months)		
Single Vision (plastic)	Plan pays 100% for two pairs of standard lenses ²	Plan pays \$43
Bifocal (plastic)		Plan pays \$60
Trifocal (plastic)		Plan pays \$75
Aphakic Monofocal		Plan pays \$120
Aphakic Multifocal		Plan pays \$200
Tints (Pink or Rose #1 or #2) Single vision Bifocals Trifocals		Plan pays \$10 Plan pays \$15 Plan pays \$20
Tints (other than Pink or Rose #1 or #2)	Not covered	Not covered
Contact Lenses (in lieu of frames and lenses, once every 24 months)		
Medically Necessary	Plan pays 100% ³	Plan pays \$250
Cosmetic	Plan pays 100%, up to a \$100 maximum	Plan pays \$100

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 are plastic and 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.**

FSAs, HSAs, and Your Domestic Partner

You can use the funds in your Health Care FSA and Choice POS II HDHP 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.

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 Choice POS II (Open Access) HDHP 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.

FSAs are now on the plan year and are effective from July 2018 through June 2019. Enrollment for FSA participation will take place in April.

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 on our LBUSD Benefit website at www.lbusdwellness.com.

When you enroll in an FSA, you elect how much money you want to contribute for the calendar year. 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).

2018 FSA Contribution Limits

For 2018, you can contribute the following amounts to your FSA:

- Health Care FSA: \$2,650
- Limited Purpose FSA: \$2,650
- 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)

Note: Enrollment for FSAs is now concurrent with the regular plan year, July 2018-June 2019.

Contribution amounts may change each year, based on IRS regulations, and will be communicated during the enrollment period in the fall. If you don't use your whole balance by the end of June 2019, you'll have a grace period to use the funds and submit claims. **If you don't use your balance by September 15, 2019 and submit claims by September 28, 2019 you'll forfeit any remaining funds.**

Limited Purpose FSA — for Non-Represented Employees Enrolled in the Choice POS II (Open Access) HDHP

If you enroll in the CPOSII HDHP, 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 an FSA and want to enroll in the CPOSII HDHP for 2018 – 2019, IRS regulations require that you use up your FSA balance before contributing. If you have no balance (\$0.00) in your FSA on June 30, 2018, you can contribute to the HSA beginning July 1, 2018. If you don't use your full FSA balance by June 30, 2018, you won't be eligible to open an HSA until July 1, 2019.

Group Life Insurance and Group Accidental Death & Dismemberment Insurance

If you're eligible, the District automatically provides you with group life and basic 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	<ul style="list-style-type: none">• Life insurance benefit equal to one times annual salary, but not less than \$15,000 or more than \$50,000.• AD&D coverage is provided in the same amount.
Management, Supervisory, and Confidential Employees	<ul style="list-style-type: none">• Life insurance benefit of \$50,000.• AD&D coverage is provided in the same amount.

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.

For more information on your District retirement plans, please call the plan contacts.

Plan	Plan Contact	Phone Number
403(b)	SchoolsFirst FCU	(800) 462-8328 x4116
457	Morgan Stanley	(562) 901-4378 (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**, option 4.

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 23 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 23 of this booklet.



Phone Numbers and Websites

		Phone Number	Website
	LBUSD Employee Resources		
	LBUSD Risk Management – Health Benefits	(562) 997-8234	www.lbschools.net (Click "R" for Risk Management)
	LBUSD Employee Service Center (Member Services)	(866) 844-9744	www.lbusdbenefits.com
	LBUSD Benefit Website	(562) 997-8234	www.LBUSDWellness.com
	Morneau-Shepell		
	COBRA Benefit Billing Center	(855) 274-8493	https://msbenefitscontinuation.morneaushepell.com
	Aetna		
	Concierge Member Services (HMO, Choice POS II Plan and Choice POS II HDHP)	(888) 290-6620	www.aetna.com
	HMO and HDHP Rx	(888) 792-3862	www.aetna.com
	Teladoc services	(855) 835-2362	www.Teladoc.com/Aetna
	Kaiser		
	Member Services (HMO)	(800) 464-4000	https://my.kp.org/lbusd/
	Express Scripts		
	Member Services	(866) 662-0297	www.express-scripts.com
	EASE		
	Member Services	(800) 882-1341	www.lacoe.edu/ease
	Delta Dental		
	Member Services (PPO & Premier) Member Services (DHMO)	(866) 499-3001 (800) 422-4234	www.deltadentalins.com
	Medical Eye Services		
	Member Services	(800) 877-6372	www.mesvision.com
	WageWorks		
	Member Services	(855) 774-7441	www.wageworks.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
	Reliance Standard		
	Member Services	(800) 644-1103	