

2016

Active Employee Benefits Overview



CITY OF
LONG BEACH

Annual Open Enrollment: October 12-30, 2015

CHOOSEWELL. LIVEWELL. BEWELL.

CHOOSEWELL. LIVIEWELL. BEWELL.

At the City of Long Beach, our employees are our most important asset, and your health and well-being are among our highest priorities. Helping you and your families achieve and maintain good health physically, and emotionally is the reason the City offers you comprehensive, flexible benefits.

The Open Enrollment period is from October 12, 2015 through October 30, 2015. Before choosing your coverage options that will become effective January 1, 2016, we encourage you to take some time to understand your available options, how the plans work, what you will pay for coverage, where to get help, and most importantly, how to enroll.

Here is a summary of what's new for 2016:

- The cost for health coverage has changed, but the City still pays the majority of the cost toward coverage for you and your covered family members. The value of your health coverage will be reflected on your W-2 form and the new 1095-C form that the City is required to provide you in 2016.
- Employees will have 60 days to add a new dependent.
- Health, dental, vision, and flexible spending elections will be made electronically via LifeView.
- All benefits-eligible employees who are currently enrolled in employer-paid life insurance, are now able to enroll in voluntary (additional) life insurance.
- Waiver of Premium is now included with employer-paid life insurance. If you meet the carrier's disability criteria and are on an unpaid leave of absence, your life insurance will continue at no cost.

We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Share and discuss this information with your family so that together, you can carefully make the best decision regarding your health care options. Ask about any important issues that are not addressed here. A list of plan contacts is provided at the back of this summary, and Q&A sessions will be held during the open enrollment period.

While we've made every effort to make sure that this guide is thorough, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your carrier plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid and will always prevail.

The benefits in this summary are effective:

January 1, 2016 - December 31, 2016

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Open Enrollment

WHAT IS OPEN ENROLLMENT?

Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event (see page 15). During open enrollment, you can choose to add coverage for the first time, waive coverage, change plans, and add or drop dependents.

WHEN IS OPEN ENROLLMENT?

Open enrollment is generally held every year in October for a January 1st effective date. This year, open enrollment will begin on Monday, October 12, 2015 and end on Friday, October 30, 2015. Voluntary Life Insurance through The Standard will have a separate open enrollment in November. Any changes you make during this time will become effective on January 1, 2016.

WHAT DO I NEED TO DO FOR OPEN ENROLLMENT?

In order to streamline our benefits management and ensure the enrollment process is simple and easy for you, we will now be moving to an online Benefits Administration system, LifeView. Moving forward, open enrollment benefit elections for most of our plans (medical, dental, vision, and FSA) must be made online via LifeView. Due to new implementation, every employee is required to make an active open enrollment election this year whether you are choosing to enroll or decline. Also, please note that the IRS now requires Social Security Numbers for each dependent enrolled on our plans so be prepared to provide this information. See page 3 of this booklet for step by step instructions on how to log into LifeView and complete your benefit elections.

WHAT'S NEW THIS YEAR?

Good news! We do not have any major changes this year. Below are the changes for the new plan year effective January 1, 2016:

- **New Dependents** – Employees will now have 60 days to add a new dependent due to marriage or birth.
- **LifeView** – This year, we are implementing an online Benefits Administration system, LifeView. Moving forward, all open enrollment elections must be made on LifeView. Please see page 3 for more information on how to enroll.
- **Employee Assistance Program (EAP) through MHN** – Just when you think you have it figured out, along comes a challenge. Whether these challenges are big or small, your EAP is here to help you and your family find a solution and restore your piece of mind. MHN provides problem-solving support, services to help keep a work-life balance, as well as several health and wellness resources. Although this new plan was added effective August 1st, we want to make sure employees are fully taking advantage of this benefit as it is 100% paid for by the City of Long Beach. Please see page 17 for more information on this plan.
- **Voluntary Life Insurance through The Standard** – All benefit eligible employees are now able to enroll in voluntary life insurance. You are able to purchase additional coverage of up to \$500,000 for yourself, up to \$100,000 for your spouse/domestic partner, and up to \$10,000 for dependent children. For this year's open enrollment only, The Standard is allowing you and your dependents to enroll up to guaranteed issue amounts with no medical questions asked! Please see page 14 for more information on this plan.

Let's Rock Enroll - All elections (enrollments and declinations), excluding Voluntary Life, must be made by October 30th!

LifeView

HOW TO ENROLL AND CHANGE DEPENDENTS DURING OPEN ENROLLMENT?

This year, you will use LifeView to confirm your open enrollment choices for 2016 (enroll, change, waive, or no changes) for health, dental, vision and FSA plans. LifeView is available on the City of Long Beach Intranet website at: <http://clbnet/default.asp>.

1. When you are ready to electronically select your 2016 open enrollment options, you will log on to LifeView using your employee ID number (SSN) and password that you created. If you would like to change your password, click “change password” at the top of the LifeView screen and follow the prompts.
2. Choose a password that you can remember – a combination of up to eight characters (numbers and/or letters).
3. If this is your first time logging on to LifeView, you will log in by typing in your SSN in the User Name field, and “LVHR” (all capital letters) in the password field – you will then be prompted to change your password.
4. If you need assistance with logging in, please call the help desk at 8-6100.
5. Once you have logged in, click on the Open Enrollment tab at the top of the page to make your selections. Look on the right-hand side of the screen for the link to “LifeView OE Instructions” document.
6. Once you make your selections, click the “Electronic Signature” box and then click the “Submit” button. You are able to make open enrollment changes on LifeView until October 30, 2015.
7. Click the “Dependents” tab (located next to “Open Enrollment” tab) to review your list of eligible dependents. If you need to add or delete a dependent(s), please click on the link to “Dependent Form,” located on the right-hand side of the screen, to download. Submit the completed form to your Department PPA, along with any required documentation.



Making the Most of Your Benefits Program

Helping you and your family members stay healthy and making sure you use your benefits program to its best advantage is our goal in offering this program. Here are a few things to keep in mind.

STAY WELL!

Harder than it sounds, of course, but many health problems are avoidable. Take action—from eating well, to getting enough exercise and sleep. Taking care of yourself eliminates a lot of potential problems.

ASK QUESTIONS AND STAY INFORMED

Know and understand your options before you decide on a course of treatment. Informed patients get better care. Ask for a second opinion if you're at all concerned.

GET A PRIMARY CARE PROVIDER

Having a relationship with a PCP gives you a trusted person who knows your unique situation when you're having a health issue. Visit your PCP or clinic for non-emergency healthcare.

USING THE EMERGENCY ROOM

Did you know most ER visits are unnecessary? Use them only in a true emergency—like any situation where life, limb, and vision are threatened. Otherwise, call your doctor, your nurse line or LiveHealth Online (PPO plan), or go to an Urgent Care clinic. You'll save a lot of money and time.

AN APPLE A DAY

Eating portioned meals and healthy foods really does help keep the doctor away. Stay away from fat-heavy, processed foods and instead focus on whole grains, vegetables, and lean meats to be the healthiest you can be.

TAKE YOUR PILLS!

Always follow your doctor's and pharmacist's instructions when taking medications. You can worsen your condition(s) by not taking your medication or by skipping doses. If your medication is making you feel worse, contact your doctor.

GOING TO THE DOCTOR?

To get the most out of your doctor visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of what you want to talk about with your doctor

If you need a medication, you could save money by asking your doctor if there are generics or generic alternatives for your specific medication.



Cost of Coverage

The City of Long Beach pays on average 80% of the monthly medical premium costs for health coverage for you and your family. In 2016, the City will continue to pay the full cost of coverage for Delta Dental DHMO, MES Vision coverage, Basic Life, and the Employee Assistance Program. The City pays the majority of the monthly premium cost if you are enrolled in the Delta Dental PPO plan, and you pay the full cost of enrollment in the FSA and other voluntary plans, such as voluntary life, long-term care, and retirement savings plans.

In general, you pay for benefits coverage before federal, state and social security taxes are withheld, so you pay less in taxes. Please note that (registered) domestic partner contributions, are regulated by the IRS and generally must be made on an after-tax basis. Similarly, the company contribution toward the cost of domestic partner coverage and his/her dependents is taxable income to you. Contact your tax advisor for more details on how this tax treatment applies to your specific situation.

MEDICAL *

	Anthem HMO	Anthem PPO
Single	\$185.00	\$139.00
Two Party	\$223.00	\$175.00
Family	\$248.00	\$201.00

VISION*

	MES Vision
Single	\$0.00
Two Party	\$0.00
Family	\$0.00

DENTAL *

	Delta Dental DHMO	Delta Dental DPPO
Single	\$0.00	\$11.00
Two Party	\$0.00	\$15.00
Family	\$0.00	\$20.00

*Costs shown are monthly.

Cost of Coverage – Contribution Scenarios

PLAN COMBINATIONS	SINGLE MONTHLY PAYROLL DEDUCTION	TWO-PARTY MONTHLY PAYROLL DEDUCTION	FAMILY MONTHLY PAYROLL DEDUCTION
Anthem PPO	\$139.00	\$175.00	\$201.00
Delta Dental DPPO	\$11.00	\$15.00	\$20.00
MES Vision	\$0.00	\$0.00	0.00
TOTAL	\$150.00	\$190.00	\$221.00
Anthem PPO	\$139.00	\$175.00	\$201.00
Delta Dental DHMO	\$0.00	\$0.00	\$0.00
MES Vision	\$0.00	\$0.00	\$0.00
TOTAL	\$139.00	\$175.00	\$201.00
Anthem HMO	\$185.00	\$223.00	\$248.00
Delta Dental DPPO	\$11.00	\$15.00	\$20.00
MES Vision	\$0.00	\$0.00	\$0.00
TOTAL	\$196.00	\$238.00	\$268.00
Anthem HMO	\$185.00	\$223.00	\$248.00
Delta Dental DHMO	\$0.00	\$0.00	\$0.00
MES Vision	\$0.00	\$0.00	\$0.00
TOTAL	\$185.00	\$223.00	\$248.00



Medical

Medical coverage provides you with benefits that help keep you healthy such as preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

City of Long Beach provides you with comprehensive coverage through Anthem Blue Cross.

HMO PLAN

When you enroll in the Anthem Blue Cross HMO plan, you agree to use only Anthem Blue Cross doctors, facilities and medical groups for all of your medical care. You must choose a Participating Medical Group (PMG) or Independent Physician Association (IPA), and Primary Care Physician (PCP) to manage your care. Anthem Blue Cross covers most services at 100%, with no deductible, as long as you use providers who belong to your PMG/IPA. Office visit copayments are \$20, and there are no claim forms. Any care you receive without approval from your PCP is not covered. Emergency room services require a \$100 copayment per visit. This copayment is waived if you are admitted to the hospital.

PPO PLAN

The PPO plan offers you access to a large network of physicians who agree to discount their fees for services. Under this plan, you are not required to select a Primary Care Physician (PCP) and you can access different physicians and specialists at your own discretion. While you may go to any doctor or hospital each time you need care, your copay or coinsurance will be lowest when you go to an in-network PPO provider. As long as you use providers who participate in the network, your care will be covered at the highest benefit level – 90% after deductible for most services.

You also have the option to see a non-PPO provider, but services are then covered at 50% of Usual, Customary, and Reasonable charges (UCR), higher deductible amounts apply, and claim forms are required. Some providers may also require payment in full at the time of service. Out-of-network benefits are paid based on 90th percentile of UCR charges, which means the plan pays charges for non-network providers based on fees charged by 9 out of 10 doctors in their geographic area. This means you could receive a bill for any charges over UCR. If the UCR amount is lower than the actual charge, the provider may take a loss or you, the patient, may be responsible for the difference. **Note: If you use non-network providers, Anthem will mail the reimbursement check to you (not to the non-network provider). It is your responsibility to reimburse non-network providers with the money you receive from Anthem.**

ABOUT THE HEALTH CARE PROVIDER GROUPS

Here are some things to keep in mind as you weigh your medical plan options:

- Consider the location of your physician. They should be within a reasonable distance (about 30 miles) of your home or office.
- You must select a PCP if you enroll in the Anthem Blue Cross HMO plan. You may choose different PCPs for yourself and each of your family members, if you wish.
- The Anthem Blue Cross PPO plan has national networks of physicians and hospitals. Network providers are often available when you travel or if your dependents live in other areas.
- The Anthem Blue Cross HMO plan covers urgent and emergency services outside your service area when you travel.

Medical Summary

	Anthem Blue Cross Premier HMO	Anthem Blue Cross PPO	
	In-Network	In-Network	Out-Of-Network
Annual Deductible (Individual/Family)	\$0 \$0	\$150 \$300	\$350 \$700
Annual Out-of-Pocket Max (Individual/Family)	\$1,000 \$3,000	\$2,650 \$5,300	Unlimited Unlimited
Lifetime Max	Unlimited	Unlimited	Unlimited
Office Visit	\$20 copay per visit	\$20 copay per visit	\$40 copay then 50% after deductible
Outpatient X-ray & Lab	No Charge	10% after deductible	50% after deductible
Maternity Care	\$20 copay for initial prenatal visit; no copay for subsequent visits	10% after deductible	\$300 deductible then 50% after deductible ^{1,2}
Birthing Centers	No Charge	No Charge	No Charge
Ambulatory Surgical Centers	No Charge	10% after deductible	50% after deductible
Home Health Care	No Charge	No charge (limited to combined maximum of 100 visits/calendar year, one visit by home health aide equals four hours or less; not covered while insured person receives hospice care) ²	50% after deductible (in-network limitations apply) ²
Preventive Services	No Charge	No Charge	50% after deductible
Chiropractic Care	\$10 copay per visit (up to 30 visits per year combined with acupuncture) ³	10% after deductible (up to 34 visits per year, combined in and out-of-network)	50% after deductible (up to 34 visits per year, combined in and out-of-network)
Acupuncture	\$10 copay per visit (up to 30 visits per year combined with chiro) ³	10% after deductible (up to 34 visits per year, combined in and out-of-network)	50% after deductible (up to 34 visits per year, combined in and out-of-network)
Lab & X-Ray	No Charge	10% after deductible (at contracted facilities)	50% after deductible
Inpatient Hospitalization	No Charge	10% after deductible ²	\$300 deductible then 50% after deductible ^{1,2}
Outpatient Surgery	No Charge	10% after deductible	50% after deductible

Medical Summary

Emergency Room (copay waived if admitted)	\$100 copay per visit	\$100 copay per visit	\$100 copay per visit
Durable Medical Equipment (Including hearing aids offered one hearing aid per year every three years)	No Charge	10% after deductible	50% after deductible
Physical Therapy	\$10 copay per visit	10% after deductible	50% after deductible
Skilled Nursing Facility (Limited to 100 days per year)	No Charge	10% after deductible ²	50% after deductible ^{1,2}
Hospice Care	No Charge	No Charge	50% ¹
Mental Health & Substance Abuse – Inpatient/Facility Based Care	No Charge for unlimited days; pre-authorization required	10% ²	\$300 deductible then 50% after deductible ^{1,2}
Mental Health & Substance Abuse – Inpatient/Physician Visits	No Charge	10% after deductible	50% after deductible
Mental Health & Substance Abuse – Outpatient/Facility Based	No Charge; pre-authorization required	10% ²	\$300 deductible then 50% after deductible ^{1,2}
Mental Health & Substance Abuse – Outpatient/Physician Visits	\$20 copay per visit	\$20 copay per visit	\$40 copay then 50% after deductible

1. The per confinement deductible and plan coinsurance will apply to facility charges. The calendar year deductible and plan coinsurance will apply to any physician charges.
2. Subject to utilization review.
3. Services must be medically/clinically necessary except for emergency services and initial exam. A referral from your primary care doctor is not necessary but chiropractor/acupuncturist must be in the ASH Plans network.

For additional information and a complete list of benefits, please visit [anthem.com/ca/colb](https://www.anthem.com/ca/colb).

Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. If you enroll in medical coverage, you will automatically receive coverage for prescription drugs.

HMO: Prescription drugs under the Anthem Blue Cross HMO plan are administered through Express Scripts.

PPO: The City offers a three-tier prescription drug program through CVS Caremark for employees enrolled in the Anthem Blue Cross PPO plan. PPO members will receive combo medical and prescription ID cards (Anthem Blue Cross and CVS Caremark). When you present your ID card at a participating pharmacy, you will be charged a copay based on the type of prescription you receive.

CVS Caremark Pharmacy offers a unique service, Maintenance Choice, which provides members with choices and savings. Members can receive a 90-day supply of long-term medication(s) through CVS Caremark Mail Service or at a local CVS Pharmacy for the same copay. Note: For prescriptions taken on a long-term basis, members will be allowed to obtain three fills of maintenance drugs at a retail pharmacy. For all subsequent fills of the same prescription, you must use CVS Caremark Mail Service Pharmacy or a

local retail CVS Pharmacy. If you continue to fill your long-term prescription at a retail pharmacy, you will pay 2x the retail copayment and receive a 30-day supply.

Important: If you request a brand-name drug when there is a generic equivalent, you must either purchase the generic drug, or pay 100% of the difference between the brand-name price and the generic price, plus the generic copayment. The only exception to this rule is if your doctor writes “Dispense As Written,” or “DAW,” on your prescription, in which case the brand-name drug will be dispensed at the brand name formulary or brand name non-formulary copay (depending on the drug).

Save With Mail Order: If you take maintenance medications for conditions such as high blood pressure, diabetes, or asthma, you can save money by purchasing your prescriptions through CVS Caremark for PPO members and Express Scripts for HMO members. For two copays, you receive a 90-day supply rather than a 30-day supply.

CVS Caremark Vaccine Services allows members to visit any CVS/pharmacy for approved vaccinations. Vaccinations are available whenever there is an immunizing pharmacist or MinuteClinic® Practitioner on duty. No appointment is necessary and there is no cost to you or your family.

	Anthem Blue Cross Premier HMO	Anthem Blue Cross Medical PPO	
	In-Network	In-Network	Out-Of-Network
Annual Out-of-Pocket Limit (Individual/Family)	\$1,000 (combined with medical) \$3,000 (combined with medical)	\$3,950 \$7,900	Unlimited Unlimited
Pharmacy Generic Preferred Brand Non-preferred Brand Supply Limit	\$10 copay then 100% \$25 copay then 100% \$40 copay then 100% 30 days	\$10 copay then 100% \$25 copay then 100% \$40 copay then 100% 30 days	When you use a non CVS/Caremark pharmacy, you must file a claim form with CVS/Caremark; benefit amount paid will be reduced.
Mail Order Generic Preferred Brand Non-preferred Brand Supply Limit	\$10 copay then 100% \$50 copay then 100% \$80 copay then 100% 90 days	\$10 copay then 100% \$50 copay then 100% \$80 copay then 100% 90 days	When you use a non CVS/Caremark pharmacy, you must file a claim form with CVS/Caremark; benefit amount paid will be reduced.

Dental

Regular visits to your dentists can help more than protect your smile, they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes and heart disease. City of Long Beach gives you a choice between two dental plans through Delta Dental.

Please note: If an employee elects to waive dental benefits, upon re-enrollment, there will be a 12-month waiting period for all major services including orthodontia (applies only to the DPPO plan).



DHMO PLAN

DeltaCare USA DHMO Plan - When you enroll, you choose a dentist who belongs to the DeltaCare USA DHMO network of providers. DeltaCare USA DHMO dentists are located in most areas of California. When you use the dentist you select at the time you enroll, treatments are covered at the stated copay. However, if you use any other dentist, you receive no benefits. Each dependent may choose a different dentist and claim forms are not required.

DPPO PLAN

The Delta Dental DPPO plan allows you to use any dentist of your choice. Your out-of-pocket costs are determined by the dentist you use - a Delta PPO dentist, Delta Premier Dentist, or an out-of-network dentist. It is to your advantage to select a dentist who participates in the Delta PPO or Premier network. For care from PPO providers, you pay no deductible and the plan pays a plan year maximum of \$2,000. When you use a Delta "Premier" dentist or an out-of-network dentist, you first pay a deductible, then the plan pays a percentage of your costs up to \$1,000 each plan year in covered benefits. However, by using one of the many Delta dentists throughout California, you will receive the advantage of a lower fee than you would receive from an out-of-network dentist.

Note: The \$2,000 (DPPO dentist) and \$1,000 (Premier and out-of-network dentist) plan maximums are not cumulative. The maximum benefit you receive under your dental plan cannot exceed \$2,000 per year.

With the Delta Dental DPPO Plan, you have the option to go to a specialist of your choice without pre-approval, and you may change your dentist at any time without pre-approval. Claim forms are required only if you receive care from out-of-network dentists. Please note that dental cleanings are based on a calendar year.

If you choose to waive dental coverage for 2016, there will be a late entrant penalty of a 12-month waiting period on major services and orthodontia upon re-enrollment.

Dental Summary

	DeltaCare USA DHMO	Delta Dental of California DPPO	
	In-Network	In-Network	Out-Of-Network
Calendar Year Deductible (Individual/Family)	\$0 \$0	\$0 \$0	\$50 \$150
Annual Plan Maximum	Not Applicable	\$2,000 ¹ per person	\$1,000 ¹ per person
Waiting Period	Not Applicable	12 Months for Major Services, Prosthodontics, and Orthodontics (only applicable to late entrant)	12 Months for Major Services, Prosthodontics, and Orthodontics (only applicable to late entrant)
Diagnostic and Preventive (Oral exams, teeth cleanings, x-rays)	\$0-\$45 copay (varies by service; refer to fee schedule)	Plan pays 100% ² (cleanings based on calendar year)	Plan pays 100% ³ (cleanings based on calendar year)
Basic Services			
Restorative	\$0-\$195 copay (varies by service; refer to fee schedule) then 100%	Plan pays 80% ²	Plan pays 80% after deductible ³
Endodontics	\$0-\$220 copay (varies by service; refer to fee schedule) then 100%	Plan pays 80% ²	Plan pays 80% after deductible ³
Periodontics	\$0-\$195 copay (varies by service; refer to fee schedule) then 100%	Plan pays 80% ²	Plan pays 80% after deductible ³
Major Services (includes prosthodontics)	\$0-\$195 copay (varies by service; see contract for fee schedule) then 100%	Plan pays 80% ²	Plan pays 80% after deductible ³
Orthodontic Services			
Orthodontia	\$200-\$1,900 copay (refer to fee schedule)	Plan pays 50% ²	Plan pays 50% ³
Lifetime Maximum	Covers up to 24 months of active treatment	Adult: \$1,000 Child: \$2,000	Adult: \$1,000 Child: \$2,000 (combined with in-network)
Dental Accident	N/A	Plan pays 100% ^{2,4}	Plan pays 100% ^{3,4}

1. Plan year maximums are not cumulative.
2. Based on DPPO allowed fees.
3. Based on Delta's allowed fees.
4. No separate maximum per person per calendar year.

Vision

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions.

Vision care is provided by a network of eye care professionals called Medical Eye Services (MES). Comprehensive eye exams are covered in full, every 12 months. Please note that the contact lens exam is not part of the comprehensive eye exam but can be taken out of the contact lens benefit. You must wait a complete 12 months between exams. One pair of eyeglass lenses, frames, and/or contact lenses is also covered every 12 months. To receive 100% coverage, you must use an MES provider. To locate an MES provider, contact (800) 877-6372. MES Vision Optics is an online optical provider for items such as readers, sunglasses, and contact lens accessories available for purchase. MES Vision plan members simply go to www.mesvision.com/Optics and login. If you do not have access to the website, you can also contact MES Vision Optics at (866) 651-2228.

	Medical Eye Services (MES) Vision	
	In-Network	Out-Of-Network
Examination Benefit	Plan pays 100% (once per 12 months)	\$57.50 for an optometrist \$67.50 for an ophthalmologist
Frequency	12 months	12 months
Eyeglass Lenses		
Single Vision Lens	Plan pays 100%	Up to \$45
Bifocal Lens	Plan pays 100%	Up to \$63
Trifocal Lens	Plan pays 100%	Up to \$80
Frequency	12 months	12 months
Frames		
Benefit	Up to \$90	Up to \$50 (combined with in-network)
Frequency	12 months	12 months
Contacts		
Benefit (Elective)¹	Up to \$100 (in lieu of lenses and frames)	Up to \$100 (in lieu of lenses and frames)
Benefit (Medically Necessary)^{1,2}	100%	Up to \$250
Frequency	12 months (in lieu of lenses and frames)	12 months (in lieu of lenses and frames)

1. Includes hard and soft contact lenses.
2. One paid, in lieu of other eyewear, except when specially provided. A report from the provider and approval from MESVision is required.

Life Insurance

If you have loved ones who depend on your income for support, having life insurance can help protect your family's financial security.

EMPLOYER-PAID BASIC LIFE

Basic Life Insurance pays your beneficiary a lump sum if you die. The cost of coverage is paid in full by the City. Coverage is provided by The Standard.

Employee Basic Life Amount	\$20,000
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Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefits. You may change your beneficiary at any time.

Our life plans are portable and can be taken with you if your employment discontinues or upon retirement. Please contact The Standard at (800) 378-4668, ext. 6785 for portability rates and forms.

Waiver of Premium is now included with employer-paid life insurance. If you meet the carrier's disability criteria and are on an unpaid leave of absence, your life insurance will continue at no cost until you are able to return to work.

VOLUNTARY LIFE

Voluntary Life Insurance, also provided by The Standard, allows you to purchase additional life insurance to protect your family's financial security.

Employee Voluntary Life Amount	Minimum of \$25,000 up to a maximum of \$500,000 in increments of \$25,000 (not to exceed 5x earnings)
Spouse Voluntary Life Amount	Minimum of \$5,000 up to a maximum of \$100,000 in increments of \$5,000 (not to exceed 50% employee amount)
Child(ren) Voluntary Life Amount	Flat \$10,000 (unmarried children only)

Evidence of Insurability: Depending on the amount of coverage you select, you may need to submit an Evidence of Insurability form, which involves providing the insurance company with additional information about your health.

Guarantee Issue: The following amounts are guaranteed, without Evidence of Insurability (EOI), only during your initial eligibility period and during our special 2015 open enrollment period. Full plan amount available with approved Evidence of Insurability. There will be no guarantee issue outside of our 2015 special open enrollment period and your initial eligibility period.

- Employee: Lesser of 3x annual salary or \$300,000
- Spouse: \$35,000
- Child: \$10,000

Special enrollment information for life coverage will be communicated separately.

Employee/Spouse	Monthly Cost
Under age 30	0.059 per \$1,000
Age 30-34	0.080 per \$1,000
Age 35-39	0.090 per \$1,000
Age 40-44	0.108 per \$1,000
Age 45-49	0.162 per \$1,000
Age 50-54	0.257 per \$1,000
Age 55-59	0.430 per \$1,000
Age 60-64	0.660 per \$1,000
Age 65-69	1.270 per \$1,000
Age 70-74	2.396 per \$1,000
Age 75+	3.148 per \$1,000
Children	Monthly Cost
\$10,000	.120 per \$1,000

Who Can You Cover?

WHO IS ELIGIBLE?

Permanent, full-time City employees working 80 or more hours per pay period are eligible for the benefits outlined in this overview.

You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your registered same or opposite sex (age 62+) domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit. Please review the affidavit carefully because it includes important information about the guidelines for adding, ending or changing your domestic partner. Any premiums for your domestic partner paid for by City of Long Beach are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- Your children (including natural children, step-children, domestic partner's children, adopted children, children fostered under legal custody, and children covered under legal guardianship):
 - Under the age of 26 are eligible to enroll in coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
 - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
 - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, siblings, aunts/uncles, nieces/nephews, and grandchildren.
- Divorced spouses.
- Temporary employees, contract employees, or employees residing outside the United States.

DEPENDENT VERIFICATION

Adding dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You may be required to provide proof of one or more of the following:

- Marriage Certificate or License
- Domestic Partner Affidavit
- Birth Certificate (hospital certificates are not official birth records and will not be accepted as proof of birth)
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children, and children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)

WHEN CAN I ENROLL?

Coverage for new hires begins on the 1st of month following 30 days from date of hire. New employees must complete a health and dental enrollment form and return it within 30 days of their hire date. If you do not return your completed forms by this deadline, you will be automatically enrolled in the following plans and payroll deductions will apply:

- Anthem Blue Cross PPO Plan - Employee Only
- Delta Dental Plan DPPO - Employee Only
- MES Vision – Employee Only
- Life Insurance (Employer Paid)

Your benefits will remain unchanged until the next open enrollment period, unless a qualifying event occurs. Make sure to notify Human Resources right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election. These changes include (but are not limited to):

- Birth or adoption of a baby or child (60 days)
- Marriage (60 days)
- Loss of other healthcare coverage (31 days)
- Eligibility for new healthcare coverage (31 days)
- Divorce (31 days)

As you can see, depending on the type of event, you have 31 to 60 days to make your change.

Flexible Spending Account (FSA)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. The catch is that you have to use the money in your account by the end of the plan year or the 2 ½ month grace period (3/15/2017). Otherwise, that money is lost, so plan carefully. You must re-enroll in this program each year.

IMPORTANT CONSIDERATIONS

- Expenses must be incurred between 01/01/16 and 03/15/17 and submitted for reimbursement no later than 04/15/17.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- Unused amounts will be lost at the end of the grace period, so it is very important that you plan carefully before making your election.
- FSA funds can be used for you, your spouse, and your tax dependents only.
- You can obtain reimbursement for eligible expenses incurred by your spouse or tax dependent children, even if they are not covered on the City of Long Beach health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).
- Keep your receipts. In most cases, you'll need to provide proof that your expenses were considered eligible for IRS purposes.

HEALTHCARE FSA ACCOUNT

This plan allows you to pay for eligible out-of-pocket healthcare expenses with pre-tax dollars. Eligible expenses include medical, dental, or vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. You may access your entire annual election from the first day of the plan year and you can set aside up to \$2,550 this year.

DEPENDENT CARE FSA ACCOUNT

This plan allows you to pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. Eligible expenses may include daycare centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are considered your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can set aside up to \$5,000 per household for eligible dependent care expenses for the year.

Other Programs

Here are some other valuable programs for employees:

EMPLOYEE ASSISTANCE PROGRAM

There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through MHN can help you with life's many challenges. Best of all, it's 100% paid for by the City.

Our EAP with MHN offers six face-to-face sessions and two phone or web-video consultations per incident, per plan period with licensed professionals in their network. Professionals can help with:

- Marriage, family, and relationship issues
- Problems in the workplace
- Stress, anxiety, and sadness
- Grief, loss, or response to traumatic events
- Concerns about your use of alcohol or drugs
- Childcare and eldercare assistance
- Financial services (budgeting, credit and financial questions, retirement planning)
- Legal services (civil, consumer, and criminal law)
- Identity theft recovery
- Daily living services
- Health & wellness coaching

Help is available 24 hours a day, 7 days a week by calling (888) 426-0025 (TTY users dial 711) or by visiting mhn.advantageengagement.com (company code: LBBWell).

LONG TERM CARE

The City of Long Beach is pleased to offer Long Term Care Insurance. This plan provides financial help if you require care in a nursing facility, in assisted living or at home, as a result of a loss of functional capacity or cognitive impairment due to injury, sickness, or advanced age. Qualifying for benefits is based upon a need for assistance with any two of seven activities

of daily living including eating, bathing, dressing, toileting, continence, ambulating, or transferring, and/or cognitive impairment such as dementia or Alzheimer's disease.

The basic plan (Plan 1) provides \$1,000 of monthly benefits for up to three years in a facility. Plan "Buy up Options" allow you to increase monthly benefits in units of \$1,000 up to \$8,000 monthly, and to add professional home care and inflation protection.

The plan is portable and can be taken with you if your employment discontinues or upon retirement. The plan is also available to spouses, parents, grandparents, and in-laws. The younger you are, the lower the premium. Premiums are based on age at time of enrollment and the level of benefits selected. For more information, please see your departmental Payroll/Personnel Assistant.

	Plan 1	Plan 2	Plan 3	Plan 4
Age	Option	Option	Option	Option
18-30	\$1.80	\$3.00	\$6.60	\$9.40
35	\$2.10	\$3.40	\$7.60	\$10.70
40	\$2.60	\$4.10	\$8.90	\$12.30
45	\$3.40	\$5.20	\$10.60	\$14.60
50	\$4.50	\$6.60	\$12.70	\$16.70
55	\$6.40	\$8.70	\$15.90	\$19.80
60	\$9.60	\$11.90	\$20.50	\$24.10
65	\$16.30	\$18.70	\$30.70	\$34.10
70	\$27.90	\$30.80	\$46.10	\$50.00

Patient Protection and Affordable Care Act

The **Patient Protection and Affordable Care Act (PPACA)**, commonly called the Affordable Care Act (ACA), is a United States federal statute signed into law by President Barack Obama on March 23, 2010.

The ACA was introduced to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of health care for individuals and the government. It introduced mechanisms such as mandates, subsidies, employer and employee reporting requirements, and insurance exchanges. The regulations under the ACA continue to evolve, and we want to make sure you're in the loop and aware of how you and the City are affected by these regulations.

Effective January 1, 2015, both health insurance providers and employers with 50 or more full-time employees have new reporting requirements to ensure they are meeting health care coverage obligations. The information-reporting obligations are meant to provide the IRS with policy details for each person covered under our health plans.

This year, the City will be required to report information such as:

- Your length of full-time status
- Proof of the minimal essential coverage offered
- Your coverage dates and how much you pay for coverage
- Taxpayer identification numbers for you and your dependents
- The addresses we have on file for you and your enrolled dependents

In addition to reporting this information to the IRS, we must also share this information with you in order to help you meet your tax filing requirements. You will receive a form 1095-C along with your W-2 form for the 2015 tax year no later than January 31, 2016. Please retain this document for your records, and provide it to your tax consultant when you complete your tax filing for the 2015 tax year.

Long Beach Memorial Ambassadors

PPO MEMBERS ONLY:

Are you seeking care from Long Beach Memorial Medical Center or an affiliated medical practice? Do you have questions regarding medical-related issues and do not know who to ask? If so, **Sandee Gruner** is your Ambassador and is available to help you with a variety of needs:

- Anthem Blue Cross PPO claims/billing
- Long Beach Memorial Center claims/billing
- Questions/concerns regarding your physician
- Setting appointments

This service is free to City employees and dependents and is available Monday through Friday. Sandee can be reached at (562) 933-1233 or via email at sgruner@memorialcare.org.

Jean M. Miller, R.N. is your Care Manager Registered Nurse who is responsible for planning, managing, coordinating and evaluating your ongoing care when you are admitted to Long Beach Memorial Medical Center as an admitted or emergency room patient. Jean collaborates with members of the healthcare team and your family to ensure that you receive the best possible care at Memorial Medical Center.

Jean will provide you with information that will assist you in understanding your medical needs and will provide follow-up care after you have been released from the hospital, as necessary. Jean can also provide you with referrals to the appropriate physician specialist. It is her pleasure to serve you as your Manager of Clinical Services. This service is free to City employees and dependents. Please call Jean before or when you arrive at Memorial Medical Center to ensure you get the best care possible. Jean can be reached at (562) 933-1232.

HMO MEMBERS ONLY:

For Anthem Blue Cross HMO Members: For employees who need assistance with their Anthem Blue Cross HMO medical benefits, please call (877) 800-7339.

Key Terms

MEDICAL/GENERAL TERMS	
Allowable Charge	The negotiated amount that in-network providers have agreed to accept as full payment.
Balance Billing	A practice where out-of-network providers bill a member for charges that exceed the plan's allowable charge.
Coinsurance	The percentage cost share between the insurance carrier and a member.
Copay	The dollar amount a member must pay directly to a provider at the time of service.
Explanation of Benefits (EOB)	The statement you receive from the insurance carrier that details how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay your provider until you have received this except for copays. Applies to PPO only.
Family Deductible	The maximum dollar amount any one family will pay out in individual deductibles in a year.
Individual Deductible	The dollar amount a member must pay each year before the plan will pay benefits for certain services.
In-Network	Services received from providers (doctors, hospitals, etc.) who have agreed to limit their fees for health plan members to a negotiated allowable charge.
Out-of-Network	Services received from providers (doctors, hospitals, etc.) who have not agreed to limit their fees to a negotiated allowable charge. Out-of-network benefits are usually lower and additional balance billing charges will apply whenever the provider charges more than the plan's allowable charge.
Out-of-Pocket Maximum	That maximum amount that you will pay each year for covered services.
Preventive Care	A routine exam - usually yearly that may include a physical exam, immunizations and tests for cancer.

PRESCRIPTION DRUG TERMS	
Brand Prescription Drug	A drug which is produced and distributed under patent protection with a trademarked name from a single drug manufacturer. A generic drug may be available if the patent has expired.
Dispense as Written (DAW)	A prescription that does not allow for substitution of an equivalent generic or similar brand drug.
Maintenance Medications	Medications taken on a regular basis for an ongoing condition. Examples of maintenance medications include oral contraceptives, blood pressure medication and asthma medications.
Non-Preferred Brand Drug	A brand drug for which alternatives are available from either the insurance carrier's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.

Preferred Brand Drug	A brand drug that an insurance carrier has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of their clinical effectiveness and their cost.
Specialty Pharmacy	Provide special drugs that are used to treat complex conditions such as multiple sclerosis, cancer and HIV/AIDS.
Step Therapy	The practice of beginning drug therapy for a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

DENTAL TERMS	
Basic Services	Basic services generally include coverage for fillings and oral surgery.
Diagnostic and Preventive Services	Diagnostic and preventive services generally include services such as routine cleanings, oral exams, x-rays, sealants and fluoride treatments. Most plans limit the frequency of preventive exams and cleanings to two times a year.
Endodontics	Commonly known as root canal therapy.
Implants	Dental implants are surgically implanted replacements for the natural tooth root of missing teeth. Many dental plans do not cover implants.
Major Services	Generally include coverage for restorative dental work such as crowns, bridges, dentures, inlays and onlays.
Orthodontia	A benefit that is offered under some dental plans. It generally includes services for the treatment of alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.
Periodontics	The diagnosis and treatment of gum disease.
Pre-Treatment Estimate	An estimate that the insurance company provides detailing how much they will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

For Assistance

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website	Policy/Group #
Medical	Anthem Blue Cross HMO	(877) 800-7339	Anthem.com/ca/colb	276800
Medical	Anthem Blue Cross PPO	(877) 800-7339	Anthem.com/ca/colb	276800
Medical	Anthem Blue Cross Nurse Line	(800) 977-0027	Anthem.com/ca/colb	276800
Pharmacy	Express Scripts	(800) 700-2541 (retail) (800) 824-0898 (mail order)	Anthem.com/ca/colb	276800
Pharmacy	CVS Caremark	(855) 559-7917	Caremark.com	N/A
Mental Health	Anthem Blue Cross Behavioral Health Network	(800) 274-7767	Anthem.com/ca/colb	276800
Long Beach Memorial Ambassadors	Sandee Gruner Provider Assistance	(562) 933-1233	Email: sgruner@memorialcare.org	N/A
Long Beach Memorial Ambassadors	Jean M. Miller, R.N. Manager of Clinical Services	(562) 933-1232	Email: jmmiller@memorialcare.org	N/A
Dental	Delta Dental DHMO	(800) 422-4234	deltadentalins.com/colb/	11104
Dental	Delta Dental DPPO	(800) 765-6003	deltadentalins.com/colb/	3712
Vision	MES Vision	(800) 877-6372	mesvision.com	2007-008
EAP	MHN	(888) 426-0025 (TTY Users dial 711)	Mhn.advantageengagement.com , company code: LBBWell	N/A
Long Term Care	Unum	(800) 421-0344	Unum.com	N/A
FSA	Anthem Blue Cross	(888) 209-7976	Anthem.com/ca/colb	276800
Life	Standard Insurance Company	800-628-8600	Standard.com	448651

IMPORTANT! Visit our intranet website at <http://clbnet/hr/default.asp> (Click on “HR Employee Portal” then “Benefits”) for links to plan documents including Summary of Benefits and Coverage (SBCs), Federal Required Notices including the Medicare Part D and COBRA notices, and much more!

Planning Your Retirement

If you plan to retire from the City in 2016, please refer to the option and rates below. Please note: you must be Medicare eligible to enroll in a Medicare Supplement or Medicare Advantage health plan.

PLAN	MONTHLY COST	VISION INCLUDED
MEDICAL – ANTHEM BLUE CROSS PPO		
Single Retiree	\$1,004.17	Yes
Retiree with Dependent(s)	\$1,253.31	Yes
MEDICAL – ANTHEM BLUE CROSS MEDICARE SUPPLEMENT (MUST HAVE MEDICARE PART A & B)		
Single Retiree	\$638.41	No
Retiree with Dependent(s) on Anthem PPO	\$1,253.31	Yes
Retiree and Spouse	\$1,276.52	No
One Medicare with Dependent(s) on Anthem PPO	\$1,891.72	Yes
Two Medicare with Dependent(s) on Anthem PPO	\$1,903.63	Yes
MEDICAL – ANTHEM BLUE CROSS PREMIER HMO – CA ONLY		
Single Retiree	\$793.36	Yes
Retiree with Dependent(s)	\$1,490.74	Yes
MEDICAL – ANTHEM BLUE CROSS CLASSIC HMO – CA ONLY		
Single Retiree	\$633.65	Yes
Retiree with Dependent(s)	\$927.51	Yes
MEDICAL – UHC GROUP MEDICARE ADVANTAGE – CA ONLY (MUST HAVE MEDICARE PART A & B)		
One Medicare Risk (Single)	\$435.59	No
Two Medicare Risk (Retiree & Spouse)	\$871.18	No
One Medicare & One Anthem Premier HMO Non-Medicare Dependent	\$1,228.95	Yes
Two Medicare & One Anthem Premier HMO Non-Medicare Dependent	\$1,664.54	Yes
One Medicare & Two/More Anthem Premier HMO Non-Medicare Dependent(s)	\$1,926.33	Yes
MEDICAL – SCAN MEDICARE ADVANTAGE – CA ONLY (MUST HAVE MEDICARE PART A & B)		
One Medicare Risk (Single)	\$363.55	No
Two Medicare Risk (Retiree & Spouse)	\$727.10	No
One Medicare & One Anthem Premier HMO Non-Medicare Dependent	\$1,156.91	Yes
Two Medicare & One Anthem Premier HMO Non-Medicare Dependent	\$1,520.46	Yes
One Medicare & Two/More Anthem Premier HMO Non-Medicare Dependent(s)	\$1,854.29	Yes
DENTAL – DELTA DENTAL DPPO		
Retiree with or without Dependent(s)	\$110.56	N/A
DENTAL – DELTA DENTAL DHMO		
Retiree with or without Dependent(s)	\$37.91	N/A



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