

2016

Retiree Benefits Overview



CITY OF
LONG BEACH

Annual Open Enrollment: October 12-30, 2015

CHOOSEWELL. LIVEWELL. BEWELL.

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At the City of Long Beach, our employees are our most important asset, and your health and well-being are among our highest priorities. As a former employee, helping you and your families achieve and maintain good health physically, and emotionally remains 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. The value of your health coverage will be reflected on the new 1095-C form that the City is required to provide you in 2016.
- Retirees will have 60 days to add a new dependent.

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 and retirees can make changes to their benefit elections without a qualifying life event (see previous page). During open enrollment, you can choose to waive coverage, change plans, and drop dependents. If you or your spouse turns 65 at any time during this coming plan year, make sure to factor this into your decisions for 2016.

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. Any changes you make during this time will become effective on January 1, 2016.

WHAT DO I NEED TO DO FOR OPEN ENROLLMENT?

Please return the enclosed open enrollment form to HR confirming your enrolled dependents, address, and let us know if you are making any changes to your health plans. Please note that the IRS now requires Social Security Numbers for each dependent enrolled on our plans so be prepared to provide this information.

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** – Retirees will now have 60 days to add a new dependent due to marriage or birth.
- UHC offers silver sneakers gym membership and fitness program at no additional cost.
- UHC will offer Medicare Advantage rewards to enrollees who complete annual wellness visits.
- Under SCAN, the copay for Tier 5 specialty drugs will increase to \$40.

**Let's Rock Enroll - All forms must be received by
October 30th!**

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.



Medical – Retirees under age 65 & not eligible for Medicare

Medical coverage provides you with benefits that help keep you healthy like 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 Classic HMO	Anthem Blue Cross PPO	
	In-Network	In-Network	In-Network	Out-Of-Network
Annual Deductible (Individual/Family)	\$0 \$0	\$0 \$0	\$150 \$300	\$350 \$700
Annual Out-of-Pocket Max (Individual/Family)	\$1,000 \$3,000	\$1,500 \$3,000	\$2,650 \$5,300	Unlimited Unlimited
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited
Office Visit	\$20 copay per visit	\$20 copay per visit	\$20 copay per visit	\$40 copay then 50% after deductible
Outpatient X-ray & Lab	No Charge	No Charge	10% after deductible	50% after deductible
Maternity Care	\$20 copay for initial prenatal visit; no copay for subsequent visits	\$20 copay for initial prenatal visit; \$250 copay/admission plus 20%	10% after deductible	\$300 deductible then 50% after deductible ^{1,2}
Birthing Centers	No Charge	No Charge	No Charge	No Charge
Ambulatory Surgical Centers	No Charge	No Charge	10% after deductible	50% after deductible
Home Health Care	No Charge	No Charge (limited to 100 visits/calendar year)	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	No Charge	50% after deductible
Chiropractic Care	\$10 copay per visit (up to 30 visits per year combined with acupuncture) ³	\$15 copay per visit (up to 20 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	\$15 copay per visit (up to 20 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)

Medical Summary

Lab & X-Ray	No Charge	No Charge	10% after deductible (at contracted facilities)	50% after deductible
Inpatient Hospitalization	No Charge	\$250 copay per admission plus 20% for unlimited days	10% after deductible ²	\$300 deductible then 50% after deductible ^{1,2}
Outpatient Surgery	No Charge	No Charge	10% after deductible	50% after deductible
Emergency Room (copay waived if admitted)	\$100 copay per visit	\$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	No Charge	10% after deductible	50% after deductible
Physical Therapy	\$10 copay per visit	\$15 copay per visit	10% after deductible	50% after deductible
Skilled Nursing Facility (Limited to 100 days per year)	No Charge	20%	10% after deductible ²	50% after deductible ^{1,2}
Hospice Care	No Charge	No Charge	No Charge	50% ¹
Mental Health & Substance Abuse – Inpatient/Facility Based Care	No Charge for unlimited days; pre-authorization required	\$250 copay/admission plus 20% 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	No Charge	10% after deductible	50% after deductible
Mental Health & Substance Abuse – Outpatient/Facility Based	No Charge; pre-authorization required	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	\$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.

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 retirees 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 co-payment. 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 Classic HMO	Anthem Blue Cross Medical PPO	
	In-Network	In-Network	In-Network	Out-Of-Network
Annual Out-of-Pocket Limit (Individual/Family)	\$1,000 (combined with medical) \$3,000 (combined with medical)	\$1,500 (combined with medical) \$4,500 (combined with medical)	\$3,950 \$7,900	Unlimited Unlimited
Pharmacy Generic Preferred Brand Non-preferred Brand Supply Limit	\$10 copay \$25 copay \$40 copay 30 days	\$10 copay \$25 copay \$40 copay 30 days	\$10 copay \$25 copay \$40 copay 30 days	When you use a non CVS/Caremark pharmacy, you must file a claim form with CVS/Caremark; benefits amount paid will be reduced.
Mail Order Generic Preferred Brand Non-preferred Brand Supply Limit	\$10 copay \$50 copay \$80 copay 90 days	\$10 copay \$50 copay \$80 copay 90 days	\$20 copay \$50 copay \$80 copay 90 days	When you use a non CVS/Caremark pharmacy, you must file a claim form with CVS/Caremark; benefits amount paid will be reduced.

Medical – Retirees 65+ and those eligible for Medicare (Must have Parts A & B)

Medical coverage provides you with benefits that help keep you healthy like 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 offers you three choices: Anthem Blue Cross Medicare Supplement plan, the United Healthcare Group Medicare Advantage HMO plan, and the SCAN Medicare Advantage HMO plan. Retirees 65 and over must have Medicare Parts A & B.

ANTHEM MEDICARE SUPPLEMENT

The Anthem Blue Cross Medicare Supplement PPO Plan is designed to supplement Medicare coverage. You have access to Anthem's network of PPO doctors and hospitals.

SCAN HEALTH PLAN

SCAN Health Plan Medicare Advantage HMO Plan offers a network of Primary Care Physicians, Specialists and Hospitals. You must use plan providers, except in emergency or urgent care situations or for out-of-area renal dialysis. If you obtain routine care from out-of-network providers neither Medicare nor SCAN Health Plan will be responsible for the costs. Eligible members must use network pharmacies to access their prescription drug benefit except under non-routine circumstances.

UHC MEDICARE ADVANTAGE HMO

The United Healthcare Group Medicare Advantage (HMO) offers a network of Primary Care Physicians, Specialists, and Hospitals. If you choose to go to a doctor outside of the network, you must pay for these services yourself except in limited situations (for example, emergency care). Neither Medicare nor the plan will pay for these services. You must use a network pharmacy to receive prescription benefits except under non-routine circumstances.



Medical Summary

	SCAN Health Plan Medicare Advantage Plan	UHC Group Medicare Advantage Plan	Anthem Blue Cross Medicare Supplement	
	In-Network	In-Network	In-Network	Out-Of-Network
Annual Out-of-Pocket Max	\$3,400	\$6,700	Unlimited	Unlimited
Office Visit	\$5 copay per visit	\$5 copay per visit	No Charge; plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
Preventive Services	No Charge	No Charge	Medicare will cover one-time preventive physical exam within the first 6 months that you have Medicare Part B. Routine physicals are not covered.	
Chiropractic Care	You can self-refer to a Plan Chiropractor in network for a \$5 co-pay/visit up to 20 visits per year	You can self-refer to a Plan Chiropractor in network for a \$5 co-pay/visit up to 12 visits per year	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
Acupuncture	Not Covered	Not Covered	Not Covered	
Lab & X-Ray	No Charge	No Charge	No co-pay; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No co-pay; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
Inpatient Hospitalization	No co-pay Semi-private room for unlimited days	No co-pay Semi-private room for unlimited days	No co-pay; Days 1-60: Medicare deductible paid at 100% Days 61-90: All Covered Expenses not payable by Medicare will be paid at 100% Days 91-100: All Covered Expenses not payable by Medicare will be paid at 100% Days 101+: No Coverage	No co-pay; Days 1-60: Medicare deductible paid at 100% Days 61-90: Medicare deductible paid at 100% Days 91-100: Plan pays the usual charges for semi-private room services for the hospital concerned Days 101+: No Coverage
Outpatient Surgery	No Charge	No Charge	No co-pay; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No co-pay; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
Physical Therapy	\$5 copay per visit	\$5 copay per visit	Plan pays Medicare deductible and 100% of allowable expenses not payable by Medicare	Plan pays Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
Emergency Room (copay waived if admitted)¹	\$50 co-pay/visit \$25 co-pay for non-network out-of-area urgent care	\$50 co-pay/visit \$5 co-pay for non-network out-of-area urgent care	No co-pay; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No co-pay; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit

1. Emergency Room co-pay waived for UHC Group Medicare plan only if you are admitted to the hospital within 24 hours for the same condition.

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.

	SCAN Health Plan Medicare Advantage Plan	UHC Group Medicare Advantage Plan	Anthem Blue Cross Medicare Supplement	
	In-Network	In-Network	In-Network	Out-Of-Network
Annual Out-of-Pocket Limit	\$3,400	\$6,700	Unlimited	Unlimited
Prescription Copays	\$7 Tier 1 preferred generic \$7 Tier 2 generic \$14 Tier 3 preferred brand \$14 Tier 4 non-preferred & \$40 Tier 5 specialty \$14 Tier 6 select care drugs; 30-day supply Mail order services available at 2 times the regular co-pay for generic, brand, and select care drugs; a 90-day supply.	\$7 Tier 1 preferred generic \$14 Tier 2 preferred brand \$14 Tier 3 non-preferred \$14 Tier 4 Specialty; 30-day supply Mail order services available at 2 times the regular co-pay for a 90-day supply; formulary applies.	Prescription drugs are covered under CVS Caremark. \$10 for generic; \$25 for brand preferred; \$40 or 30% for brand non-preferred. Mail order available. Subject to \$2,000 paid maximum benefit per calendar year. If you are enrolled in Medicare Part D, your benefits will be coordinated under medical plan.	



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.



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.

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 DPO allowed fees.
3. Based on Delta's allowed fees.
4. No separate maximum per person per calendar year.

Vision – For retirees under age 65 & not eligible for Medicare or Non-Medicare dependents

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.

Who Can You Cover?

WHO IS ELIGIBLE?

Early retirees less than age 65, those not eligible for Medicare, and retired from full time employment as well as retirees 65+ and those eligible for Medicare (must have Medicare Parts A & B) 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.
- 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 medical 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.

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 or Baptismal 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 retirees begins on the 1st of month following their retirement date. New retirees must advise HR of their enrollment selections prior to retirement. If you do not advise HR of your selections, you will not receive coverage.

Your benefits will remain unchanged until the next open enrollment period, unless a qualifying event occurs. Make sure to notify HR 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)
- Divorce (31 days)

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

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:

- 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

ANTHEM BLUE CROSS PPO & MEDICARE SUPPLEMENT 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 retirees 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 (including former 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 retirees 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.
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.

Medicare

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)
- Medicare Part C (Combines Part A and Part B Coverage)
- Medicare Part D (Prescription Drug Coverage)

Medicare Part A helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care. You must meet certain conditions to get these benefits. Cost: You usually don't pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes while working. You pay up to \$407 each month if you don't get premium-free Part A. If you pay a late enrollment penalty, this amount is higher. In most cases, if you choose to buy Part A, you must also purchase Part B and pay monthly premiums for both.

Medicare Part B helps cover doctors' services, hospital outpatient care, and home health care. Medicare Part B is optional. You have to enroll in Part B and pay a monthly premium. Your monthly premium depends on your income. Part B also covers some preventive services. **Cost:** Most people pay the standard premium amount. However, if your modified adjusted gross income as reported on your IRS tax return from two years ago (the most recent tax return information provided to Social Security by the IRS) is above a certain amount, you could pay more. Premium amounts can change each year depending on your income. Current Medicare Part B premium amounts are listed below. If you have questions about your Medicare premiums, you can contact Social Security at 1-800-772-1213, Monday through Friday from 7 a.m. to 7 p.m., or TTY call 1- 800-325-0778.

File Individual Tax Return	File Joint Tax Return	You Pay
\$85,000 or less	\$170,000 or less	\$104.90
Above \$85,000 up to \$107,000	Above \$170,000 up to \$214,000	\$146.90
Above \$107,000 up to \$160,000	Above \$214,000 up to \$320,000	\$209.80
Above \$160,000 up to \$214,000	Above \$320,000 up to \$428,000	\$272.70
Above \$214,000	Above \$428,000	\$335.70

Medicare Advantage Plans (Part C) are another way to get your Medicare benefits. They combine Part A, Part B, and, sometimes, Part D (prescription drug) coverage. Medicare Advantage Plans are managed by private insurance companies approved by Medicare. These plans must cover medically necessary services. However, plans can charge different co-payments, co-insurance, or deductibles for these services. The City of Long Beach offers two Medicare Advantage Plans, United Healthcare Group Retiree Plan and Scan Health Plan.

Medicare Part D is a prescription drug option run by Medicare-approved private insurance companies to help cover the cost of prescription drugs. How it Works: Each year, the member is required to meet a Deductible (not more than \$360 in 2016) before their Prescription Drug Plan begins to pay its share of covered drugs. (Not all members are required to meet this deductible.) Once the deductible has been met, the member pays a co-pay or co-insurance amount (amounts vary among different Medicare Drug Plans), and the Medicare Drug plan pays its share of each covered drug until they together reach the combined Initial Coverage Limit (\$3,310 in 2016, plus the Deductible).

After the Initial Coverage Limit is reached, the member is now in the **Coverage Gap**. In 2016, members are required to pay 45% of their Medicare Plan's covered cost of brand name drugs and 58% of the covered cost for generic drugs. Once the member has paid the out-of-pocket threshold (\$4,850 in 2016), the Coverage Gap ends and **Catastrophic Coverage** begins. Under the Catastrophic Coverage, the member pays on a small co-insurance or co-payment for each covered drug until the end of the plan year.

You will receive enrollment information from Medicare in the weeks ahead. If you are covered by the Anthem Blue Cross Medicare Supplement Plan, **you do not have to enroll in Medicare Part D**; however, if your prescription needs exceed the \$2,000 maximum you have the option to enroll in Medicare Part D under the two (2) month Special Enrollment Period. You should notify the City's employee benefits division to let them know you now have a Medicare Part D plan. They will also explain any additional information you should know. (562) 570-6302. Once you have enrolled in a Medicare Part D and wish to change plans, the enrollment period is October 15th through December 7th of each year. **Note: When you enroll in either the SCAN Health Plan or UHC Group Medicare Advantage Plan, you DO NOT need to enroll in Medicare Part D through Centers for Medicare & Medicaid Services (CMS), as SCAN or United Healthcare will automatically enroll you in Medicare Part D upon completion of the SCAN or United Healthcare Group Retiree application.**

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
Medical	Anthem Blue Cross Medicare Supplement	(877) 800-7339	Anthem.com/ca/colb	276800
Medical	United Healthcare Group Medicare Advantage Plan	(800) 457-8506	Uhcretiree.com	515154
Medical	SCAN Health Plan	Prospective members call: (877) 305-7226 Members call: (800) 559-3500	Scanhealthplan.com/COLB	119
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 DPO	(800) 765-6003	deltadentalins.com/colb/	3712
Vision	MES Vision	(800) 877-6372	mesvision.com	2007-008

Cost of Coverage

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 Dependents 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 DPO		
Retiree with or without Dependent(s)	\$110.56	N/A
DENTAL – DELTA DENTAL DHMO		
Retiree with or without Dependent(s)	\$37.91	N/A

Medicare Part D

Important Notice from the City of Long Beach about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Long Beach and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- The City of Long Beach has determined that the prescription drug coverage offered by the plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your City of Long Beach coverage may be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under City of Long Beach is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your City of Long Beach prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Long Beach and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Long Beach changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2016
Name of Entity: City of Long Beach
Contact: Human Resources
Address: 333 W. Ocean Blvd
Long Beach, CA 90802
Phone Number: (562) 570-6303



Rev. 10/5/2015