

2017

Retiree Benefits Overview



CITY OF
LONG BEACH

Annual Open Enrollment: October 10 – 21, 2016

Look Inside For 2017
Benefit Changes!

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Benefits that Fit

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 is the reason the City offers you comprehensive, flexible benefits that fit your life.

The Open Enrollment period is from October 10, 2016 through October 21, 2016. Before choosing your coverage options that will become effective January 1, 2017, 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 brief summary of what's new for 2017:

- The cost for health coverage has changed.
- Confirmation of your health coverage enrollment will be reflected on your IRS1095-C form that the City is required to provide you in 2017.
- Prescription drug coverage for Anthem Blue Cross HMO members will now be administered by CVS Caremark Pharmacy.
- All Anthem Blue Cross members (new and existing) will receive new ID cards.
- UnitedHealthcare® Group Medicare Advantage (HMO) will no longer be offered and will be replaced with UnitedHealthcare® Group Medicare Advantage (PPO).
- Our vision plan (for retirees under age 65 or non-Medicare dependents) will be moving from MES Vision to Vision Service Plan (VSP).
- CVS will now offer the Condition Alerts program for all City retirees covered on an HMO or PPO plan.
- Anthem Blue Cross will now offer the same wellness programs to both HMO and PPO members.
- Three (3)-tier health plan rates (single, two-party and family) will be implemented for retired employees.

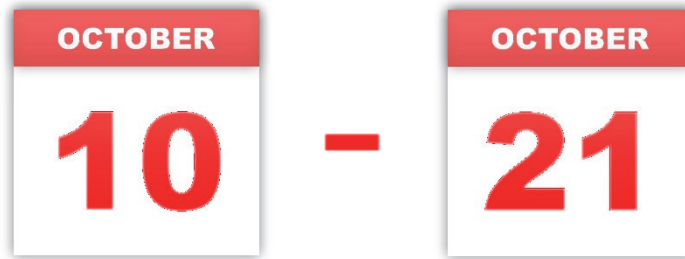
We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Share and discuss this information with your family so that together, you can carefully make the best decision regarding your health care options. Ask about any important issues that are not addressed here. A list of plan contacts is provided at the back of this summary. During the open enrollment period, Human Resources will host one webinar, in addition to the scheduled in-person Q&A session.

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. These can be found on our internet website at <http://www.longbeach.gov/hr/>. Anthem documents can also be found at Anthem.com/ca/colb.

The benefits in this summary are effective:

January 1, 2017 - December 31, 2017

Mark Your Calendar!



Event	Date	Location	Time
Start of Open Enrollment	Monday, October 10, 2016	N/A	N/A
Open Enrollment In Person Q&A	Friday, October 7, 2016	Main Library	10:00 AM to 12:00 PM
Open Enrollment Teleconference/Webinar Presentation	Wednesday, October 12, 2016	Teleconference/Webinar	9:30 AM to 11:00 AM
End of Open Enrollment (Last day to make changes!)	Friday, October 21, 2016	N/A	N/A
New Plan Year Effective Date (Date your changes take effect!)	Sunday, January 1, 2017	N/A	N/A

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 page 26). 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 10, 2016 and end on Friday, October 21, 2016. Any changes you make during this time will become effective on **January 1, 2017**.

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 requires Social Security Numbers for each dependent enrolled on our plans so be prepared to provide this information.

Don't forget - The open enrollment deadline is October 21, 2016!

WHAT'S NEW THIS YEAR?

Good news! We have some exciting changes this year. Below are the changes for the new plan year effective January 1, 2017:

- **HMO Prescription Drugs** – Prescription drug coverage for Anthem HMO members will now be administered by CVS Caremark Pharmacy, who currently administers prescription for our PPO plan. See pages 13-14 for more information.

- **New Anthem ID Cards** - All Anthem Blue Cross members (new and existing) will receive new ID cards with the updated City of Long Beach logo regardless if making a change or not. These are combo medical and prescription ID cards (Anthem Blue Cross and CVS Caremark).
- **UnitedHealthcare® Group Medicare Advantage (PPO)** – UnitedHealthcare® Group Medicare Advantage (HMO) will no longer be offered and will be replaced with UnitedHealthcare® Group Medicare Advantage (PPO) plan. See page 16-19 for additional information.
- **Vision Service Plan (VSP)** – City of Long Beach is happy to provide new vision benefits through Vision Service Plan (VSP) who has been voted consumer's #1 choice in vision care for five years in a row! VSP features a broad provider network, including 77,000 access points, across the country in a variety of settings. See page 24-25 for additional information on our new plan!
- **CVS Caremark Condition Alerts** – The Condition Alerts program, which notifies members of gap in care relating to medical and pharmacy claims, is now available to all CVS Caremark members.
- **Anthem Wellness Programs** – Anthem Blue Cross will now offer the same wellness programs to both HMO and PPO members:
 - LiveHealth Online and Mobile Health Consumer will be available to HMO members.
 - MyHealth Advantage and Mobile Health Consumer will be available to PPO members.

See page 12 for more details on each of the offered programs.

- **Three (3)-tier Health Plan Rates** – The three (3)-tier health plan rates (single, two-party and family) will be implemented for retired employees.

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 can eliminate 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. HMO members are required to select a PCP. PPO members can also decide to work with a specific doctor (i.e., internal medicine physician, family care physician, etc.) to help manage health care. 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 or go to an Urgent Care clinic.



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.

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
- Former stepchildren as a result of divorce

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)
- Additional documentation such as tax returns or utility bills to demonstrate dependent disability

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.

Cost of Coverage

PLAN	MONTHLY COST	VISION INCLUDED
Medical – Anthem Blue Cross PPO		
Single Retiree	\$957.29	Yes
Retiree with 1 Dependent	\$1,193.68	Yes
Retiree with 2 or More Dependents	\$1,254.00	Yes
Medical – Anthem Blue Cross Medicare Supplement (Must have Medicare Parts A & B)		
One Medicare (Single)	\$628.92	No
One Medicare & One Anthem PPO Non-Medicare Dependent	\$1,193.68	Yes
One Medicare & Two/More Anthem PPO Non-Medicare Dependents	\$1,254.00	Yes
Two Medicare (Retiree & Spouse)	\$1,257.54	No
Two Medicare & One Anthem PPO Non-Medicare Dependent	\$1,864.21	Yes
Medical – Anthem Blue Cross Premier HMO – CA ONLY		
Single Retiree	\$768.29	Yes
Retiree with 1 Dependent	\$1,373.53	Yes
Retiree with 2 or More Dependents	\$1,491.43	Yes
Medical – Anthem Blue Cross Classic HMO – CA ONLY		
Single Retiree	\$630.64	Yes
Retiree with 1 Dependent	\$847.26	Yes
Retiree with 2 or More Dependents	\$928.20	Yes
Medical – UnitedHealthcare® Group Medicare Advantage (PPO) – CA Only (Must have Medicare Parts A & B)		
One Medicare (Single)	\$462.60	No
Two Medicare (Retiree & Spouse)	\$925.20	No
One Medicare & One Anthem Premier HMO Non-Medicare Dependent	\$1,230.89	Yes
Two Medicare & One Anthem Premier HMO Non-Medicare Dependent	\$1,693.49	Yes
One Medicare & Two Anthem Premier HMO Non-Medicare Dependents	\$1,836.13	Yes
One Medicare & Three/More Anthem Premier HMO Non-Medicare Dependents	\$1,954.03	Yes
One Medicare & One Anthem Classic HMO Non-Medicare Dependent	\$1,093.24	Yes
Two Medicare & One Anthem Classic HMO Non-Medicare Dependent	\$1,555.84	Yes
One Medicare & Two Anthem Classic HMO Non-Medicare Dependents	\$1,309.86	Yes
One Medicare & Three/More Anthem Classic HMO Non-Medicare Dependents	\$1,390.80	Yes
Medical – SCAN Health Plan Medicare Advantage – CA Only (Must have Medicare Parts A & B)		
One Medicare (Single)	\$363.55	No
Two Medicare (Retiree & Spouse)	\$727.10	No
One Medicare & One Anthem Premier HMO Non-Medicare Dependent	\$1,131.84	Yes
Two Medicare & One Anthem Premier HMO Non-Medicare Dependent	\$1,495.39	Yes
One Medicare & Two Anthem Premier HMO Non-Medicare Dependents	\$1,737.08	Yes
One Medicare & Three/More Anthem Premier HMO Non-Medicare Dependents	\$1,854.98	Yes
One Medicare & One Anthem Classic HMO Non-Medicare Dependent	\$994.19	Yes
Two Medicare & One Anthem Classic HMO Non-Medicare Dependent	\$1,357.74	Yes
One Medicare & Two Anthem Classic HMO Non-Medicare Dependents	\$1,210.81	Yes
One Medicare & Three/More Anthem Classic HMO Non-Medicare Dependents	\$1,291.75	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)	\$38.67	N/A

Note: Other combinations of health plan enrollments may be available for non-Medicare retirees with Medicare-eligible dependents, or Medicare-eligible retirees with non-Medicare dependents. Please contact the Benefits Office for additional information.

Medical – Retirees under age 65 & not eligible for Medicare

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 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:

1. Consider the location of your physician. They should be within a reasonable distance (about 30 miles) of your home or office.
2. 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.
3. 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.
4. The Anthem Blue Cross HMO plan covers urgent and emergency services outside your service area when you travel.

LiveHealth[®]
O N L I N E

LIVEHEALTH ONLINE

With LiveHealth Online, members can see a board-certified doctor or licensed therapist through live video on their smartphone, tablet or computer with a webcam. LiveHealth Online is quick, easy to use and will help you get **the care you need when you need it**. Use the app for things like the flu, a cold, pink eye, rashes and more! **Doctors are available 24/7** and can even send a prescription to your pharmacy of choice. Help is available at a cost of only a \$20 copay per visit. **All you have to do is sign up online at livehealthonline.com or download the free app.**



Medical Summary

Plan Provisions	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	\$0 per individual \$0 per family	\$0 per individual \$0 per family	\$150 per individual \$300 per family	\$350 per individual \$700 per family
Annual Out-of-Pocket Max	\$1,000 per individual \$3,000 per family	\$1,500 per individual \$3,000 per family	\$2,650 per individual \$5,300 per family	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)
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}

Medical Summary

Plan Provisions	Anthem Blue Cross Premier HMO	Anthem Blue Cross Classic HMO	Anthem Blue Cross PPO	
	In-Network	In-Network	In-Network	Out-Of-Network
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 American Specialty Health (ASH) network.

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

Anthem Wellness Programs

Anthem Blue Cross offers several wellness programs to supplement our plans. All of these programs are available to both HMO and PPO members.

CONDITION CARE

If you have, or one of your dependents has, a long-term health problem, ConditionCare is for you. It's a program that helps people with asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart failure, coronary artery disease (CAD) and more. You'll get:



Educational resources, like email newsletters.



24/7 access to a nurse care manager for health questions.



Depending on your health, you may be asked to complete a health questionnaire. Your answers will help Anthem figure out how to best support you.



Then, Anthem will put you in touch with a nurse care manager who'll provide guidance on reaching your health goals. He or she will also follow up periodically to offer encouragement and advice.

You can participate at no extra cost, just call (800) 522-5560.

MYHEALTH ADVANTAGE

Anthem reviews medical histories, pharmacy claims and doctor visits, and then connects the dots to find ways to help you avoid health problems, stay healthy or save money. If they find something you could do to improve your health, you'll get a MyHealth Note in the mail, you don't have to lift a finger! MyHealth Notes have information on tips to save money, prescriptions drug refill reminders, checkups, tests and exam appointment reminders, as well as easy-to-read summaries on recent pharmacy claims.

Coming soon to a mailbox near you!

24/7 NURSELINE

You can call any time to talk to a registered nurse about your health concerns. You can get answers to questions, whether you're sick or not. A nurse can help you decide where to go if your doctor isn't available – just call the number on your ID card.

MOBILE HEALTH CONSUMER

Mobile Health Consumer is a customized digital health and wellness companion that empowers members by centrally connecting the Health Plan, Provider and Patient. With MobileHealth Consumer, you have access to the following:



- ✓ ID card and plan benefit summary
- ✓ Health Risk Assessment <5 minutes
- ✓ Receive coaching, condition care referrals & gap in care notifications
- ✓ Biometric and activity tracking
- ✓ Participation incentives and team challenges
- ✓ Quick access to LiveHealth Online
- ✓ Connectivity to medical care team (for HMO members only)

Support via smartphone (iOS & Android), tablet and web – register today at [Anthem.com/ca](https://www.anthem.com/ca).



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 through CVS Caremark.

PHARMACY (RETAIL)

The City offers a three-tier prescription drug program through CVS Caremark for retirees enrolled in the Anthem Blue Cross HMO and PPO plans. 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.

HMO Plans (Premier & Classic)

Pharmacy	
Generic	\$10 copay
Preferred Brand	\$25 copay
Non-preferred Brand	\$40 copay
Supply Limit	30 days

PPO Plan

Pharmacy	In-Network	Out-of-Network
Generic	\$10 copay	When you use a non CVS/Caremark pharmacy, you must file a claim form with CVS/Caremark; benefit amount paid will be reduced.
Preferred Brand	\$25 copay	
Non-preferred Brand	\$40 copay	
Supply Limit	30 days	

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).

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 two copays, you receive a 90-day supply rather than a 30-day supply (does not apply to generic under the HMO plan).

HMO Plans (Premier & Classic)

Mail Order	
Generic	\$10 copay
Preferred Brand	\$50 copay
Non-preferred Brand	\$80 copay
Supply Limit	90 days

PPO Plan

Mail Order	In-Network	Out-of-Network
Generic	\$20 copay	When you use a non CVS/Caremark pharmacy, you must file a claim form with CVS/Caremark; benefit amount paid will be reduced.
Preferred Brand	\$50 copay	
Non-preferred Brand	\$80 copay	
Supply Limit	90 days	

DID YOU KNOW

CVS Caremark Pharmacy offers a unique service, Maintenance Choice, which provides members with choices and savings. For two retail copays (excluding generic under the HMO plan) 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

Prescription Drugs

ANNUAL OUT-OF-POCKET

You must meet an annual out-of-pocket limit in order for your plan to cover benefits at 100%. The following out-of-pocket limits apply to each plan:

HMO Plans

	Premier HMO	Classic HMO
Annual Out-of-Pocket Limit	Combined with medical	
Individual	\$1,000	\$1,500
Family	\$3,000	\$4,500

PPO Plan

	In-Network	Out-of-Network
Annual Out-of-Pocket Limit		
Individual	\$3,950	Unlimited
Family	\$7,900	Unlimited

CVS DISCOUNTS

ExtraCare Health Card holders receive a 20 percent discount on regular, non-sale priced, CVS/pharmacy Brand health-related items.

CVS/PHARMACY NOW AT TARGET

Members can get their 30-day or 90-Day Maintenance Choice fills at any CVS or Target location.

CVS VACCINE PROGRAM

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



MINUTE CLINICS

MinuteClinic® walk-in medical clinics are staffed by nurse practitioners and physician assistants who specialize in family health care. They care for children and adults, every day with no appointment needed.

While life happens, they can help you feel better. MinuteClinic® practitioners:

- Diagnose, treat and write prescriptions for common family illnesses such as strep throat, bladder infections, pink eye, and infections of the ears, nose and throat
- Provide common vaccinations for flu, pneumonia, and hepatitis, among others
- Treat minor wounds, abrasions, joint sprains, and skin conditions such as poison ivy, ringworm, lice and acne
- Provide a wide range of wellness services including TB testing, sports and camp physicals, and lifestyle programs such as smoking cessation and a weight loss program
- Offer routine lab tests and education for those with diabetes, high cholesterol or high blood pressure
- Provide care to adults and children 18 months and older for most services
- Share records with primary care provider with patient permission

Go to [CVS.com/minuteclinic/](https://www.cvs.com/minuteclinic/) to find a location near you!

CONDITION ALERTS

City of Long Beach employees are automatically enrolled in the CVS Condition Alerts Program which is a comprehensive approach to addressing RX and medical gaps. The program's goals include:

- Continuously review pharmacy claims, medical claims and lab data for a broader view of member's physician care plan
- Establish a comprehensive member profile including both Rx and medical gaps
- Identify potential gaps in care for over 100+ conditions
- Support members in all points of therapy, in accordance with their physician care plan

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. For 2016, you pay up to \$411 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 (\$104.90 each month in 2016). 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 (based on 2014 tax returns and income levels) 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	\$121.80
Above \$85,000 up to \$107,000	Above \$170,000 up to \$214,000	\$170.50
Above \$107,000 up to \$160,000	Above \$214,000 up to \$320,000	\$243.60
Above \$160,000 up to \$214,000	Above \$320,000 up to \$428,000	\$316.70
Above \$214,000	Above \$428,000	\$389.80

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 copayments, coinsurance, or deductibles for these services. The City of Long Beach offers two Medicare Advantage Plans, UnitedHealthcare® Group Medicare Advantage (PPO) 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 copay or coinsurance 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 only a small coinsurance or copayment 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 at (562) 570-6302 to let them know you now have a Medicare Part D plan. They will also explain any additional information you should know. 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 UnitedHealthcare® Group Medicare Advantage (PPO), you DO NOT need to enroll in Medicare Part D through Centers for Medicare & Medicaid Services (CMS), as SCAN or UnitedHealthcare® will automatically enroll you in Medicare Part D upon completion of the SCAN or UnitedHealthcare® Retiree application.**

Note: Details regarding our plans for Medicare eligible retirees can be found on the following pages. For the most current Medicare rates and information, please visit Medicare.gov.

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 a total of three choices; two Medicare Advantage Plans and one Medicare Supplement Plan. The two Advantage plans offered are the UnitedHealthcare® Group Medicare Advantage (PPO) plan and the SCAN Medicare Advantage plan. We also offer the Anthem Blue Cross Medicare Supplement plan. Medicare eligible retirees must have Medicare Parts A & B.

SCAN HEALTH PLAN

SCAN Health Plan Medicare Advantage 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 have obtain routine care from an 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 benefit except under non-routine circumstances.

SILVERSNEAKERS®

No cost gym membership with access to all basic amenities including pool, spa, specialized fitness classes, walking groups and social events. SCAN members are also enjoy access to healthy recipes and fitness advice. For participating fitness locations, just call (800) 522-5560 or visit Silversneakers.com.

UNITEDHEALTHCARE® GROUP MEDICARE ADVANTAGE (PPO) PLAN

UnitedHealthcare® Group Medicare Advantage (PPO) plan is a Medicare Advantage plan that delivers all the benefits of Original Medicare (Part A & B), includes prescription drugs (Part D) and offers additional benefits and features.

With Medicare Advantage PPO plan, you are not required to select a Primary Care Provider (PCP) and there is no referral needed to see a specialist. The plan also offers you access to a large network of participating providers who accept Medicare assignments and will submit claims directly to UnitedHealthcare® for payment, not Medicare.

UnitedHealthcare® Group Medicare Advantage (PPO) plan strives to make it easier by giving you the tools and resources you may need to help make good health decisions for you. You have access to a secure and website that provides information on valuable programs and resources, as well as provider and pharmacy information. Log onto UHCRetiree.com for more details.

SILVERSNEAKERS®

Stay active with SilverSneakers® Fitness Program. Members receive basic fitness memberships to more than 13,000 participating locations. For members you don't have access to SilverSneakers® location, you have the option to enroll in SilverSneakers® Steps for personalized fitness programs that best fit your needs – general fitness, strength, walking or yoga.

Disclaimer: Consult a health care professional before beginning any exercise program. Availability of the SilverSneakers® program varies by plan/market. Refer to your Evidence of Coverage for more details. Healthways and SilverSneakers® are registered trademarks of Healthways, Inc. and/or its subsidiaries. © 2016 Healthways, Inc. All rights reserved.

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.

Medical Summary – Medicare Advantage Plans

Plan Provisions	SCAN Health Plan Medicare Advantage Plan	UnitedHealthcare® Group Medicare Advantage (PPO) Plan	
	In-Network	In-Network	Out-Of-Network
Annual Out-of-Pocket Max (Individual/Family)	\$3,400	Unlimited	Unlimited
Office Visit	\$5 copay per visit	No Charge	No Charge
Outpatient X-ray & Lab	No Charge	No Charge	No Charge
Home Health Care	No Charge; may require prior authorization and referral from your doctor	No Charge	No Charge
Preventive Services	No Charge	No Charge	No Charge
Chiropractic Care	You can self-refer to a Plan Chiropractor in network for a \$5 copay/visit (up to 20 visits per year)	No Charge (Medicare-covered Chiropractic Visits only)	No Charge (Medicare-covered Chiropractic Visits only)
Acupuncture	Not Covered	Not Covered	Not Covered
Inpatient Hospitalization	No Charge	No Charge	No Charge
Outpatient Surgery	No Charge	No Charge	No Charge
Emergency Room (copay waived if admitted)	\$50 copay/visit \$25 copay for non-network out-of-area urgent care	No Charge	No Charge
Durable Medical Equipment	No Charge	No Charge	No Charge
Physical Therapy	\$5 copay per visit	No Charge	No Charge
Skilled Nursing Facility	No Charge for 100 days per benefit period	No Charge (up to 100 days)	No Charge (up to 100 days)
Hospice Care	No Charge from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan.	No Charge	No Charge
Inpatient Mental Health & Substance Abuse	No Charge; limited to a lifetime of 190 days in a Medicare-participating psychiatric hospital	No Charge; limited to a lifetime of 190 days in a Medicare-participating psychiatric hospital	No Charge; limited to a lifetime of 190 days in a Medicare-participating psychiatric hospital
Outpatient Mental Health & Substance Abuse	\$5 copay per visit	No Charge	No Charge

Medical Summary – Medicare Advantage Plans

Plan Provisions	SCAN Health Plan Medicare Advantage Plan	UnitedHealthcare® Group Medicare Advantage (PPO) Plan	
	In-Network	In-Network	Out-Of-Network
Routine Dental Benefits	<p>Provided by Delta Dental through the DeltaCare network. \$0 copay for exam 2 cleanings and x-rays every six months.</p> <p>To find a dentist, just call (800) 422-4234 or visit www.deltadentalins.com</p>	<p>Not Included. Dental benefits are limited to what is covered by Medicare</p>	<p>Not Included. Dental benefits are limited to what is covered by Medicare</p>
Routine Vision Benefits	<p>Provided by EyeMed. \$3 copay for exam \$20 copay for lenses \$100 allowance for glasses and/or \$130 allowance for contacts every two years.</p> <p>To find an EyeMed Vision Care provider near you, just call (844) 226-2850</p>	<p>No Charge (coverage for Medicare-covered eye exam and routine eye exam refraction only)</p>	<p>No Charge (coverage for Medicare-covered eye exam and routine eye exam refraction only)</p>

INDEPENDENT LIVING POWER (SCAN MEMBERS ONLY)

Independent Living Power® enables retirees that qualify to continue living at home. This service helps you during recovery from a hospital stay or provide support during an acute or long-term illness. The benefits provide extra help necessary to remain out of a nursing home. Services are available in Los Angeles, Orange, Riverside and San Bernardino counties. Qualifying members are eligible for up to \$500 per month for these services:

- ✓ Homemaker service
- ✓ Home delivered meals
- ✓ Personal care
- ✓ Emergency response team
- ✓ Unlimited routine transportation
- ✓ Personal care coordinator
- ✓ Inpatient custodial care
- ✓ In-home caregiver relief

Prescription Drugs - Medicare Advantage Plans

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.

PHARMACY

SCAN Health Plan Medicare Advantage Plan

Pharmacy	
Tier 1: Preferred Generic	\$7 copay
Tier 2: Generic	\$7 copay
Tier 3: Preferred Brand	\$14 copay
Tier 4: Non-Preferred Brand	\$14 copay
Tier 5: Specialty	\$40 copay
Tier 6: Select Care Drugs	\$14 copay
Supply Limit	30 days

UnitedHealthcare® Group Medicare Advantage (PPO) Plan

Pharmacy	
Tier 1: Generic	\$10 copay
Tier 2: Preferred Brand	\$25 copay
Tier 3: Non-Preferred Drugs	\$40 copay
Tier 4: Specialty	\$40 copay
Supply Limit	30 days

Save on the cost of generic prescription drugs through Pharmacy Saver™. No additional enrollment is necessary. To see listing of drugs available through Pharmacy Saver or to find a participating pharmacy, visit UnitedPharmacySaver.com.

Disclaimer: Other pharmacies are available in our network. Members may use any pharmacy in the network, but may not receive Pharmacy Saver pricing. Pharmacies participating in the Pharmacy Saver program may not be available in all areas.

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 mail order. For two copays, you receive a 90-day supply rather than a 30-day supply.

SCAN Health Plan Medicare Advantage Plan

Pharmacy	
Tier 1: Preferred Generic	\$14 copay
Tier 2: Generic	\$14 copay
Tier 3: Preferred Brand	\$28 copay
Tier 4: Non-Preferred Brand	\$28 copay
Tier 5: Specialty	Not Offered
Tier 6: Select Care Drugs	\$28 copay
Supply Limit	90 days

UnitedHealthcare® Group Medicare Advantage (PPO) Plan

Mail Order	
Tier 1: Generic	\$20 copay
Tier 2: Preferred Brand	\$50 copay
Tier 3: Non-Preferred Drugs	\$80 copay
Tier 4: Specialty	\$80 copay
Supply Limit	90 days

Please note that additionally, members that reach the Catastrophic phase pay the following for their prescription drugs:

- \$3.30 copay for generics
- \$8.25 copay for all other drugs

Once you've spent \$4,850 out-of-pocket in 2016, you're out of the coverage gap. Once you get out of the coverage gap (Medicare prescription drug coverage), you automatically get "catastrophic coverage." It assures you only pay a small coinsurance amount or copayment for covered drugs for the rest of the year. Go to Medicare.gov for more information.

Medical Summary – Medicare Supplement Plan

Plan Provisions	Anthem Blue Cross Medicare Supplement	
	In-Network	Out-Of-Network
Annual Out-of-Pocket Max (Individual/Family)	Unlimited	Unlimited
Office 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
Outpatient X-ray & Lab	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare	No Charge; Plan pays Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit
Home Health Care	20% after a \$50 calendar year deductible up to a lifetime maximum of \$5,000 (100 visits per calendar year)	
Preventive Services	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	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
Inpatient Hospitalization	No Charge; 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+: Not Covered	No Charge; 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+: Not Covered
Outpatient Surgery	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
Emergency Room (copay waived if admitted)	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
Durable Medical Equipment	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

Medical Summary – Medicare Supplement Plan

Plan Provisions	Anthem Blue Cross Medicare Supplement	
	In-Network	Out-Of-Network
Physical Therapy	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
Skilled Nursing Facility	No Charge; Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare up to the plan limit of 100 days	No Charge; Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit. No plan benefit is payable after the 100 th day.
Hospice Care	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
Inpatient Mental Health & Substance Abuse	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
Outpatient Mental Health & Substance Abuse	No Charge; Plan pays 100% of the eligible charges for the service subject to a \$250 calendar year maximum	Plan pays the Medicare deductible and any applicable coinsurance for a confinement at a Medicare-participating hospital

Prescription Drugs

Prescription drugs are covered under CVS Caremark. 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.

PHARMACY

Pharmacy	In-Network	Out-of-Network
Generic		\$10 copay
Preferred Brand		\$25 copay
Non-preferred Brand		\$40 copay or 30%
Supply Limit		30 days



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 Plan of California. The choice is yours. When it comes to dental health, you want benefits that provide you with the best balance of value and coverage. Delta Dental PPOSM and DeltaCare[®] USA both offer comprehensive dental coverage, quality care and excellent customer service. Each plan has its own advantages.

Please note: If a retiree 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.

FINDING A DENTIST

- Visit the Delta website at Deltadentalins.com
- Click on "Find a Dentist" on the home page
 - For the DPPO, select "Delta Dental PPO" as your plan network
 - For the DHMO "DeltaCare USA" as your plan network

NO ID CARD NECESSARY

Just provide your dental office with your name, birth date and enrollee ID or social security number. Register for Online Services to print an ID card or pull it up on your smartphone at the dentist's office.



Dental Summary

Plan Provisions	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 – Retirees under age 65 (not Medicare eligible) & non-Medicare dependents

City of Long Beach is pleased to announce that vision coverage will be provided through Vision Service Plan (VSP). VSP is committed to improving wellness through eye care, and has been voted consumers' #1 choice in vision care for five years in a row. VSP Choice network features a broad provider network with substantial access across the United States in a variety of settings.

THE NETWORK

You can choose from over 77,000 access points, including the largest national network of independent doctors and nearly 4,900 participating retail chain locations, including Costco. For added convenience, 91% of VSP Doctors offer early morning, evening and weekend appointments, and 24-hour access to emergency care. If you prefer to use a non-network provider, this option is still available under our plan; however, the benefit allowances are lower.

USING YOUR VSP BENEFIT IS EASY

- Find a VSP doctor who's right for you at VSP.com.
- Review your plan coverage before your appointment.
- At your appointment, tell them you have VSP. **There's no ID card necessary but you can print one on VSP.com.**

THE PERKS

In addition to getting true freedom of choice in providers, VSP also offers:

- ✓ WellVision Exam® – the most thorough eye exam, exclusive to VSP
- ✓ Exclusive Member Extras, like rebates, special offers, and promotions
- ✓ Extra \$20 to spend on featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West and more.
- ✓ Eyecare from the best doctors – VSP doctors have met the highest credential requirements
- ✓ The perfect pair of glasses from a wide selection of frames to meet your style and budget
- ✓ Shop for eyewear online at VSP's Eyeconic.com

WHAT YOUR EYES SAY ABOUT YOU

Your eyes may reflect serious health conditions

Viewing blood vessels in the eyes allows vision care providers to see what's going on throughout your body. This often helps them detect signs of health problems, such as hypertension and diabetes.

Annual exams are a great defense

Early detection of problems and treatment can help prevent diabetes-related vision loss. People with diabetes are more susceptible to glaucoma and other serious conditions, like heart disease and stroke. With the VSP WellVision Exam® – the most thorough exam designed to detect eye and health conditions – you'll get the highest level of care.

WHEN TO HAVE AN EYE EXAM

Eye exams are an important part of overall healthcare for your entire family, from children to grandparents, and everyone in between.



Babies

About 80% of what we learn is through our eyes.

Eye Exams

- Six months
- Around two or three years old
- Before kindergarten



Children

Studies show that 60% of students identified with learning disabilities have undetected vision troubles.

Eye Exams

- Once a year



Adults

Even if you've had laser vision surgery or have naturally good eyesight, you still need an annual eye exam. Your VSP doctor can detect signs of health conditions during your exam.

Eye Exams

- Once a year



Seniors

As we age, we're more susceptible to cataracts, glaucoma, and macular degeneration. Detecting these conditions early can help keep your eyes healthy.

Eye Exams

- Once a year

Vision Summary

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. A separate copay applies for those that elect the contact lens exam. 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 a VSP provider. **To locate a VSP provider, go to Vsp.com or contact (800) 877-7195. VSP Member Services representatives are available Monday through Friday from 5:00 am to 8:00 pm, Saturday from 7:00 am to 8:00 pm and Sunday from 7:00 am to 7:00 pm PST.**

Plan Provisions	Vision Service Plan (VSP)	
	In-Network	Out-Of-Network
WellVision Exam		
Benefit	Plan pays 100% (once per 12 months)	Up to \$68
Frequency	12 months	12 months
Prescription Glasses		
Frames	Up to \$90 (or \$110 for featured brands)	Up to \$50
Single Vision Lens	Plan pays 100%	Up to \$45
Lined Bifocal Lens	Plan pays 100%	Up to \$63
Trifocal Lens	Plan pays 100%	Up to \$80
Frequency	12 months	12 months
Contacts (in lieu of glasses)		
Benefit	- Contact lens materials covered up to \$100, copay does not apply - Contact lens exam (fitting and evaluation) covered after copay not to exceed \$60	Up to \$100
Frequency	12 months	12 months

EXTRA SAVINGS

Glasses and Sunglasses

- ✓ Extra \$20 to spend on featured frame brands - visit Vsp.com/specialoffers for details
- ✓ 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam

Retinal Screening

- ✓ Max \$39 copay on routine retinal screening

Laser Vision Correction

- ✓ Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities



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.

Currently, both health insurance providers and employers with 50 or more full-time employees have 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.

The City is 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 2016 tax year no later than January 31, 2017. Please retain this document for your records, and provide it to your tax consultant when you complete your tax filing for the 2016 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/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/retirees 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. 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 Plans				
Medical	Anthem Blue Cross HMO	(844) 653-7399	Anthem.com/ca/colb	276800
Medical	Anthem Blue Cross PPO	(844) 653-7399	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	UnitedHealthcare® Group Medicare Advantage (PPO) Plan	(877) 714-0178	Uhretiree.com	15647
Medical	SCAN Health Plan	(877) 305-7226	Scanhealthplan.com/COLB	119
Pharmacy Benefit Manager				
Pharmacy	CVS Caremark	(855) 559-7917	Caremark.com	N/A
Dental Plans				
Dental	Delta Dental HMO	(800) 422-4234	Deltadentalins.com/colb	11104
Dental	Delta Dental PPO	(800) 765-6003	Deltadentalins.com/colb	3712
Vision Plan				
Vision	VSP	(800) 877-7195	VSP.com	30069959
Behavioral Health and Emotional Well Being				
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	Sgruner@memorialcare.org	N/A
Long Beach Memorial Ambassadors	Jean M. Miller, R.N. Manager of Clinical Services	(562) 933-1232	Jmiller@memorialcare.org	N/A
<p>IMPORTANT! Visit our internet website at http://www.longbeach.gov/hr/ for links to plan documents including Summary Plan Descriptions (SPDs), Summary of Benefits and Coverage (SBCs), Benefit Summaries, and much more!</p>				

Required Federal Notices

NOTICE OF AVAILABILITY OF HIPAA PRIVACY NOTICE

The Federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires that we periodically remind you of your right to receive a copy of the HIPAA Privacy Notice. You can request a copy of the Privacy Notice by contacting Human Resources.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR MEDICAL/HEALTH PLAN COVERAGE

If you decline enrollment in a City of Long Beach health plan for your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in a City of Long Beach health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children’s Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31-60 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in City of Long Beach’s medical plan if your dependent becomes eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

THE WOMEN’S HEALTH AND CANCER RIGHTS ACT

The Women’s Health and Cancer Rights Act (WHCRA) requires employer groups to notify participants and beneficiaries of the group health plan, of their rights to mastectomy benefits under the plan. Participants and beneficiaries have rights to coverage to be provided in a manner determined in consultation with the attending Physician for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the same deductible and co-payments applicable to other medical and surgical benefits provided under this plan. You can contact your health plan’s Member Services for more information.

NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

Required Federal Notices

AVAILABILITY OF SUMMARY INFORMATION

As an employee, the health benefits provided by City of Long Beach represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

City of Long Beach offers a variety of benefit plans to eligible employees. The federal health care reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by City of Long Beach are available by visiting our internet website at <http://www.longbeach.gov/hr/> or Anthem's website at Anthem.com/ca/colb. You may also request a copy from Human Resources.

NOTICE OF CHOICE OF PROVIDERS

The Anthem Blue Cross HMO plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. Until you make this designation, Anthem Blue Cross will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carriers directly.

You do not need prior authorization from Anthem Blue Cross or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Anthem Blue Cross at (844) 653-7399.

MEDICARE PART D

Important Creditable Coverage Notice from 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 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:

1. 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.
2. City of Long Beach has determined that the prescription drug coverage offered by City of Long Beach's health plan 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 through 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.

Required Federal Notices

MEDICARE PART D, CONTINUED

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

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

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 office listed below for further information. NOTE: You'll 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 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'll 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 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 (800) MEDICARE or (800) 633-4227. TTY users should call (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 (800) 772-1213. TTY users should call (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, 2017
Name of Entity: City of Long Beach
Contact: Human Resources
Address: 333 W. Ocean Blvd., Long Beach, CA 90802
Phone: (562) 570-6303



Rev. 9/20/2016

Annual Open Enrollment: October 10 – 21, 2016

Deadline	Date	Location	Time
Open Enrollment In Person Q&A	Friday, October 7, 2016	Main Library	10:00 AM to 12:00 PM
Open Enrollment Teleconference/Webinar Presentation	Wednesday, October 12, 2016	Teleconference/Webinar	9:30 AM to 11:00 AM