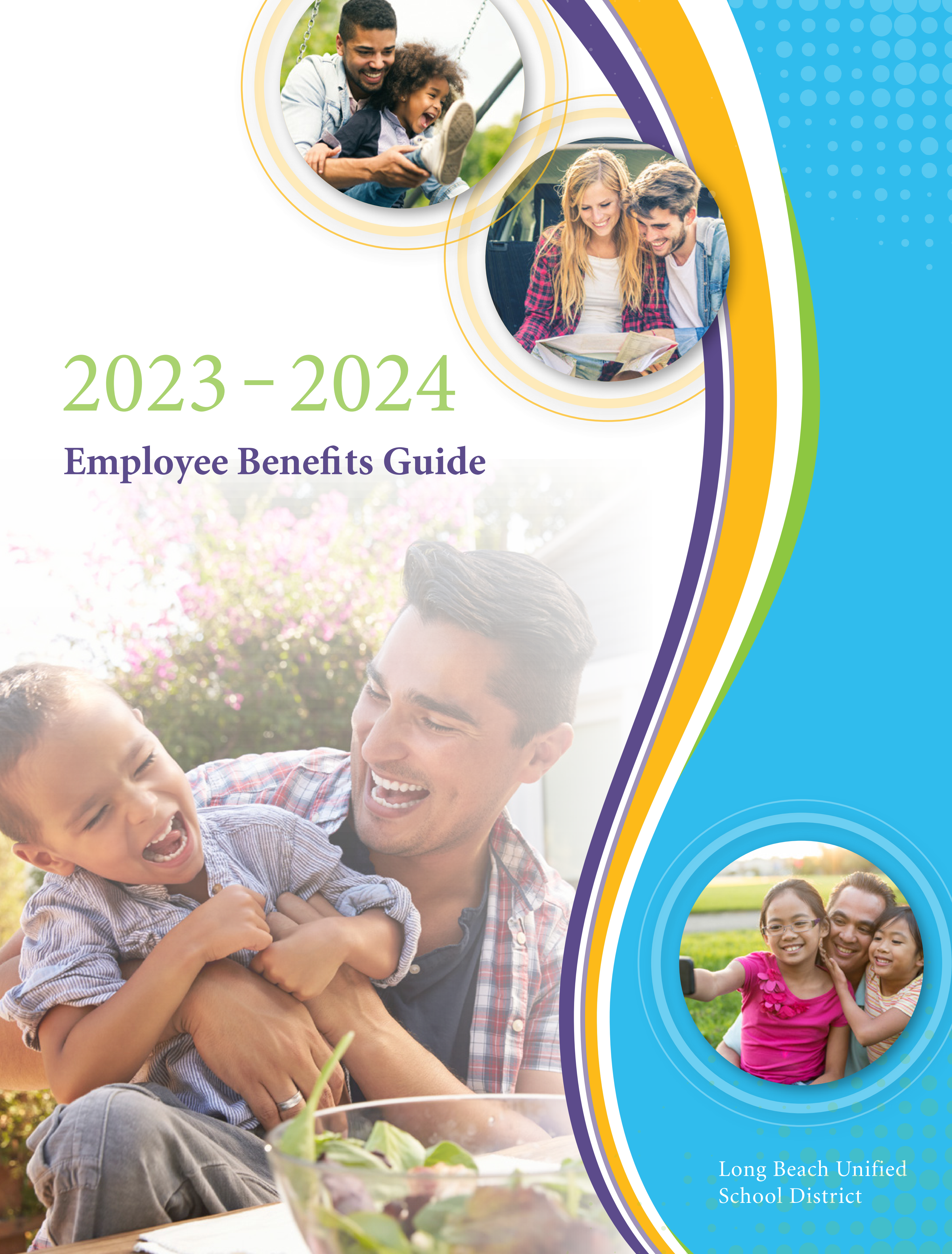

2023 – 2024

Employee Benefits Guide

Long Beach Unified School District

OFFICE OF THE SUPERINTENDENT
1515 Hughes Way, Long Beach, CA 90810-1839
www.lbschools.net

May, 2023

Dear Long Beach Unified Team,

As the past three years have shown us, the health and welfare benefits described in this guide are crucial to the wellbeing of our team, and they're an important way we invest in our employees. All the benefits available are evaluated each year by LBUSD in partnership with CSEA and TALB to ensure that we continue to provide comprehensive, affordable benefits that offer choices for our diverse employee needs.

This year, we were once again able to keep our current benefit plans, without asking our full-time staff to contribute toward medical premiums. We need your help to continue that trend in the coming years. We encourage you to be a smart consumer when using the benefits available to you. After all, feeling good - whether it is physically or mentally - is an integral part of your success at work, and in your everyday life.

To assist you, all of our medical plans offer telemedicine services and behavioral health services, which have become more important during the higher stress of the pandemic environment. This means you can access a doctor 24/7/365 using the video chat function on your smartphone, tablet, or computer, or speak with a provider over the phone. We also encourage you to: use in-network providers because they charge lower, discounted rates; choose generic prescription drugs; use urgent care centers instead of the emergency room when possible; and take advantage of our vision and dental benefits, because your overall health means more than just using medical services.

WW (formerly Weight Watchers), and the school district, have partnered to help you start, and/or maintain, healthy habits. If you enroll through the LBUSD WW program, you can get more than 50% off the cost of the regular WW membership price. Benefit-eligible spouses and medical plan-enrolled retirees and retiree spouses, also have access to the discounted membership.

Your wellness is important, and we will continue providing resources to help you feel your best. Our benefits and wellness website, **www.lbusdbenefits.com**, is your one-stop shop for benefits information, wellness resources, and answers to frequently asked questions. The website is updated regularly with tips and other important information.

Part of being a smart consumer means that you will take the time to evaluate your health care needs and ensure you have the right level of coverage during our annual enrollment. Choosing the right benefits coverage is one of the most important decisions you will make each year, and I encourage you to make the most of your opportunity by exploring the website and using this guide to fully understand your benefits.

Warmly,

Jill

Jill A. Baker, Ed. D.

Superintendent of Schools

Our Mission:

To support the personal and intellectual success of every student, every day.

Our Vision:

Every student a responsible, productive citizen in a diverse and competitive world.

What’s Inside

This booklet includes important details about your District benefits, including which benefits you can enroll your eligible dependents in, details about your plans, and the steps you need to take to enroll. You’ll also find information about how and when to enroll.

We encourage you to keep this booklet for your reference throughout the year. If you still have questions after reviewing the booklet, feel free to contact the Employee Service Center. You can find important notices about state and federal laws that affect your benefits on our LBUSD Benefit website at **www.lbusdbenefits.com**.

The Employee Service Center

The District’s Employee Service Center is ready to help if you have any benefits-related questions. Need detailed information about your medical benefits? Want to know if your dependent is eligible for coverage? Have a question about enrollment? Just give the Employee Service Center a call at **(866) 844-9744**, option 4. Representatives are available Monday through Friday from 5 a.m. to 5 p.m., Pacific time, excluding holidays.

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This booklet is intended to provide highlights of your benefits only; it is not an Evidence of Coverage (EOC) plan document. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including a complete list of exclusions and limitations, please refer to each carrier's EOC. The EOCs are available on our LBUSD Benefit website, **www.lbusdbenefits.com**.

Benefits Eligibility

Employee Eligibility

In general, you're eligible for medical, dental, vision, and life and AD&D insurance benefits if you're:

- A probationary or permanent employee; and
- You work 50% or more of a full-time assignment (at least 80 hours every four weeks).

In addition, job share participants may enroll in District plans under certain conditions.

If you're a represented employee, we encourage you to review your collective bargaining contract each year to verify your specific eligibility requirements. You may also call the Employee Service Center at (866) 844-9744, option 4, for more information.

Residency Requirements

Some plans have residency requirements. If you're going to be covering a dependent out of state, please contact your plan's member services or refer to the Evidence of Coverage for more information.

Dependent Eligibility

If you enroll yourself in District benefits, you can also enroll your eligible dependents in certain plans (vision coverage, life insurance and AD&D insurance are available to employees only). You must provide appropriate proof of the dependent relationship when you enroll your dependent.

Eligible dependents include:

- **Your legal spouse.** (Required documentation: a marriage certificate in English)
- **Your California-registered domestic partner.** A California-registered domestic partner is the same gender as you, or may be opposite-gender. (Required documentation: a certified copy of the Declaration of Domestic Partnership filed with the Secretary of State). *Please note: Domestic partners do not receive the same tax benefits as legal spouses. You and your domestic partner must become legal spouses to receive tax benefits.*
- **Your natural children, stepchildren, or adopted children up to age 26.**
  - Adopted children must have been placed by a recognized county or private agency and must be in the physical control of you or your spouse or domestic partner, and you must have the right to control the health care of the child. (Required documentation: a birth certificate).

Important!

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

- **Your natural children, stepchildren, or adopted children after age 25 who are developmentally or physically disabled.** Your dependent must also:
  - Be chiefly dependent on you or your spouse or domestic partner for support and maintenance;
  - Have been disabled continuously prior to reaching age 26;
  - Have been enrolled as a dependent under your coverage before reaching age 26; and
  - The proof of disability must be submitted to the Employee Service Center within 30 days after the onset of the disability, the attainment of age 26, or the time of initial enrollment. (Required documentation: a birth certificate and a physician's written certification of the disability).
- **Any children for whom you are the legal, non-temporary guardian (excluding foster children) or whom you are required to support as part of a Qualified Medical Child Support Order (QMCSO).** (Required documentation: court or administrative orders from the District Attorneys' office, State Department of Health Services, or the courts). Children who meet these requirements are eligible for coverage as long as they don't have access to medical coverage through their employer.

Your Cost for Benefits

Each year, the District will pay a maximum contribution toward medical coverage premiums for you and your dependents. If the District's maximum medical contribution does not cover the full cost of the premium (based on the plan and coverage level you elected), you will pay the remaining amount through payroll deductions. Keep in mind that the lowest cost HMO plan will be free to eligible employees each year. The lowest cost plan may change on an annual basis.

Each year, the District will increase the prior year's District annual maximum contribution toward insurance premiums by 3.5%. The rates for July 1, 2023 – June 30 , 2024 will apply to all coverage levels: employee only, employee plus one and family, as shown below.

Your premiums for benefits can be found on the **www.lbusdbenefits.com** website. If you're making changes to your benefits outside the new hire or Annual Enrollment period because of a qualifying change in status, you may access the **www.lbusdbenefits.com** website, or contact the Employee Service Center at **(866) 844-9744**, option 4, for your cost information.

Tier	July 2023 – June 2024 District Annual Maximum (DAM)	July 2023 – June 2024 Employer Costs	July 2023 – June 2024 Employee Cost
Employee	$14,495	$14,067	$0.00
Employee + 1	$26,509	$25,816	$0.00
Family	$33,291	$31,942	$0.00

Although the District pays the full cost of coverage for most employees, job share and other employees who work less than full time are required to pay a portion of the premium for this benefit. **If you do not want to pay these premiums, you must elect to waive this benefit during your enrollment.**

If you're a collective bargaining employee, please refer to your collective bargaining agreement to determine District-paid premiums. You can find the full details of the plans in the Certificate of Insurance, which is available on our LBUSD Benefit website at **www.lbusdbenefits.com**.

When to Enroll

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

- When you're initially eligible;
- During the Annual Enrollment period; or
- If you experience a qualifying status change.

Enrolling When You're First Eligible

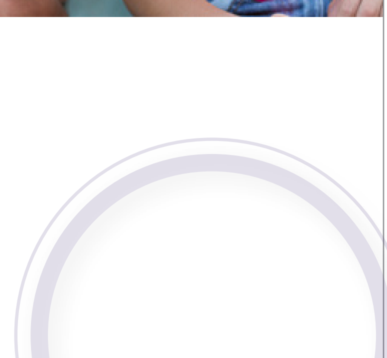
You must enroll yourself and your dependents within 30 days of becoming eligible for District benefits. You can enroll eligible dependents at the same time you enroll yourself. If you don't enroll, you'll receive the default coverage shown below.

Default Coverage

If you're eligible for 100% District-paid benefits and you don't elect or waive coverage within the 30-day window, you'll automatically be enrolled as follows:

- **TALB and Non-represented employees:**
  - Aetna Choice POS II (Open Access) medical plan;
  - Delta PPO Plus Premier dental plan;
  - Vision;
  - Life and accidental death & dismemberment insurance; and
  - Employee Assistance Program (EASE).
- **CSEA:**
  - Kaiser HMO medical plan;
  - DeltaCare DHMO dental plan;
  - Vision;
  - Life and accidental death & dismemberment insurance; and
  - Employee Assistance Program (EASE).

Your dependents will not be covered under default coverage.



Making Changes During Annual Enrollment

Once you've enrolled in benefits, you generally aren't allowed to make changes until the next Annual Enrollment. Annual Enrollment is your one chance each year to review your coverage and make changes to your benefits. It's also your chance to enroll if you declined coverage when you first became eligible.

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

Please note, Flexible Spending Accounts (FSAs) are now part of the regular plan year and are effective July 1 – June 30 each year. If you don't use your whole balance by June 30, 2024, you'll have a grace period to use the funds and submit claims. **If you don't use your balance by September 15, 2024 and submit claims by September 28, 2024 you'll forfeit any remaining funds.**

Making Changes During the Year

Other than during Annual Enrollment, you can make changes to your benefits during the year only if you experience a qualifying status change. *Any changes must be made within 30 days of the qualifying status change.* A qualifying status change can include:

- **A change in family status,** such as your marriage or registration of a domestic partnership, the birth or adoption of a child, divorce or dissolution of a domestic partnership, or the death of a dependent. You must provide the Employee Service Center with proof of the event (such as a marriage certificate, birth certificate, state domestic partnership certificate, divorce order, or court order).
- **The loss of existing coverage** for you and/or your eligible dependents (for example, the termination of coverage that was provided through your spouse's employer).
- **A qualified court or administrative order** that requires you to provide coverage for an eligible dependent.

Any benefit changes must be consistent with the qualifying status change. Provided you make changes within 30 days of the event, the change will take effect on the date of the event for a birth, adoption, or placement for adoption; changes you make as a result of other qualifying status changes will take effect the first day of the month after the event. You must submit the appropriate documentation to the Employee Service Center.

Notice of Special Enrollment Rights for Medical Plan Coverage

If you've declined enrollment in a District medical plan for yourself ,or your dependents (including your spouse or domestic partner) because of other medical plan coverages, you and/or your dependents may be able to enroll in a District medical plan without waiting for the next Annual Enrollment period, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

The District will also recognize and allow a special enrollment opportunity in a medical plan if you or your eligible dependents:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you're no longer eligible; or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these new enrollment opportunities only, you'll have 60 days — instead of 30 — from the date of the Medicaid/CHIP eligibility change to request enrollment in a District medical plan.

For more information or to request a special enrollment after a qualifying status change, contact the Employee Service Center at **(866) 844-9744**, option 4.

Make Sure You're Up-to-Date!

If you use the online enrollment system, make sure you're using a recent version of your web browser; you may have problems if you're using an older version of a browser.

Steps to Upload Your Benefit Documents Online

1. Save the documentation to a file on your computer
2. Login to **www.lbusdbenefits.com**
3. Enter your login information

   Your login is your unique user name and the password you created
4. Click "Upload" next to the "Required" document
5. Click "Browse" and select the file to upload
6. Click "Upload" again to submit your file
7. A confirmation screen will appear when your file has been uploaded successfully
8. Your file must be less than 10MB in size, and one of the following types: PDF, JPEG, TIFF, GIF, BMP, or PNG

How to Enroll

Once you've decided which benefits you'd like, the easiest way to enroll is through the District's online enrollment site, **www.lbusdbenefits.com**.

When you enroll online, you'll be able to review your benefit elections and make sure your dependent information is correct. The online enrollment site also has all the details about each plan, right at your fingertips.

Here are the steps to take to click your way through online enrollment:

1. Go to **www.lbusdbenefits.com**.
2. Log-in. Your user name is your employee number in E00123456 format. Your initial password is your date of birth in MMDDYYYY format, plus your 5-digit home zip code. (If you were born 5/12/75, and live at 90715, password will be 0512197590715).
3. After you log-in to the site for the first time, you'll be prompted to change your password.
4. Click the appropriate event link on the Home Page.
5. Review each page and update as necessary. Click "Next" as each page is completed, to move to the next benefit.
6. On the last page, click "Complete Enrollment" to save all your elected benefits. Print this page.
7. You'll also receive a confirmation statement in the mail. If there is an error, contact the Employee Service Center immediately.
8. If you wish to review your entries, click "Modify" under your event link on the Home Page. Walk through the process again. You may do this until the end of the enrollment period specific to your event. You must Complete Enrollment again to re-save your entries.

Before You Enroll!

Before you begin enrollment, make sure you have:

- Your dependent's Social Security numbers; and
- Your primary care provider's (PCP's) name and PCP ID, if you're enrolling in the Aetna HMO plan and/or the DeltaCare DHMO dental plan. (If you don't provide a PCP ID, you'll automatically be assigned a PCP).

Once you enroll, you'll also be required to send the Employee Service Center the required documentation for your newly added dependents.

Employee Service Center

In addition to using the online enrollment system, you may enroll through the Employee Service Center. Speak with an Employee Service Center representative by calling (866) 844-9744, option 4. Employee Service Center representatives are available Monday through Friday from 5 a.m. to 5 p.m., Pacific time, excluding holidays.

Waiving Coverage

When you enroll online, you may choose to waive enrollment in one or more benefit plans by selecting the "Waive" button. Keep in mind that if you choose to waive coverage, it means that you are declining coverage from July 1, 2023 through June 30, 2024. It DOES NOT mean that you will continue with the same coverage you currently have. If you waive coverage during this enrollment, you will not be able to re-enroll for coverage during this period unless you experience a qualifying status change. If you elect to waive health coverage, you will be required to complete and sign a waiver form. If this form is not completed within 30 days, you only (and not your dependents) will be placed in the default coverage.

NOTE: Do not submit any enrollment forms to the Employee Service Center or Risk Management, other than requested supporting documentation, such as marriage or birth certificates.

An Overview of Your Benefits

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

Health Care Benefits	
Medical	The District offers two HMO Plans: • Kaiser Permanente HMO • Aetna HMO The District also offers the following plans: • Aetna Choice POS II (Open Access) • Aetna Choice POS II (Open Access) HDHP (for Non-represented employees only) All medical plans include prescription drug coverage. A summary of these benefits is provided on pages 11 – 16.
Dental	The District offers two dental plans: • Delta PPO Plus Premier • Delta Care DHMO You can find a summary of your dental benefits on page 17.
Vision	The EyeMed vision plan is available to employees only. More information about this plan is available on page 18.
Employee Assistance Program (EASE)	The District provides EASE to assist employees with personal and work/life issues. You can find additional information about EASE on page 16.
Financial Savings & Security	
Flexible Spending Accounts (FSAs)	FSAs give you the option to set aside pre-tax funds to pay for certain eligible health care and dependent care expenses. You can find more details about FSAs on page 19.
Group Life and Group Accidental Death & Dismemberment (AD&D) Insurance	The District provides eligible employees with life and AD&D insurance coverage to help provide financial protection. More details about these coverages are available on page 20.
Deferred Compensation (IRC 457 and/or 403(b)) Retirement Plans	So you can set aside pre-tax money for retirement, the District offers you the opportunity to participate in a Deferred Compensation Plan. Details about this plan can be found on page 21.
IRC Section 125 Flexible Fringe Benefits Plan	This plan allows you to pay premiums for certain District benefits and potentially reduce your taxes at the same time. Details about this plan can be found on page 21.

Telemedicine — A Great Resource for Your Medical Needs

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

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

Medical Coverage Options

Your medical benefits are designed to help maintain the wellness and health of you and your family. The District offers three types of medical plan options.

- **HMO Plans:** With the HMO options, you must receive care from providers in the plan's network; the plan won't pay any benefits for care received outside the network except in an emergency.
- **Choice POS II (Open Access) Plan:** With this plan, you have the flexibility to receive care from any provider; however, the plan will pay a higher level of benefits when you receive care from a provider who participates in the plan's network.
- **Choice POS II (Open Access) HDHP Plan (non-represented employees only):** With this plan, you have the coverage of a POS plan, and can establish an account that allows you to save for health care expenses tax-free (known as a Health Savings Account, or HSA). More information about the HSA is available at **www.lbusdbenefits.com**.

Keep in mind that certain benefits in each plan may vary, depending on your bargaining unit. For employees represented by CSEA, a summary of your benefits is provided on page 11. Employees represented by TALB can find a summary of their benefits on page 13, while a summary of the benefits for Non-represented employees can be found on page 12.

CSEA — 2023 – 2024 Medical Coverage Options

This chart is intended to provide highlights of your benefits only; it is not an Evidence of Coverage (EOC) plan document. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including a complete list of exclusions and limitations, please refer to each carrier's EOC.

	Kaiser HMO[1]	Aetna HMO[1]	Aetna Choice POS II	
			In-Network	Out-of-Network
Plan Year Deductible Individual/Family	None	None	$300/$600	$500/$1,000
Plan Year Out-of-Pocket Maximum (including deductible) Individual/Family	$1,500/$3,000	$250/$500	$1,300/$2,600	$5,500/$11,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	
Member Cost for Covered Services				
Inpatient Hospital	No charge	No charge	20%	40%
Outpatient Surgery	$10 copay	No charge	20%	40%
Ambulatory Surgery Center and Outpatient Services	$10 copay	No charge	20%	40%
Emergency Room Facility	$100 copay (waived if admitted)[2]	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)
Emergency Room Physician	No charge	No charge	20% after deductible	20% after deductible
Physician Office Visit	$10 copay	$10 copay	20%	40%
Routine Physical	No charge	No charge	No charge[3]	40%
Well-Baby & Well-Child Care	No charge	No charge	No charge[3]	40%
Well-Woman Exams	No charge	No charge	No charge[3]	40%
Maternity Care	No charge	No charge	No charge[3]	40%
Lab and X-ray	No charge	No charge	20%	40%
Physical or Occupational Therapy	$10 copay	$10 copay	20%	40%
Chiropractic Care	$5 copay (Up to 30 visits/ year)	$5 copay (Up to 30 visits/ year)	20%[7]	40%[7]
Durable Medical Equipment	No charge	No charge	20%	40%
Mental Health				
Inpatient	No charge	No charge	20%	40%
Outpatient	$10 copay	$10 copay	20%	40%
Prescription Drugs[4]	**Kaiser**	**Aetna**	**Express Scripts**	
Out-of-Pocket Maximum Individual/Family	None	Combined with medical	$5,550/$11,100	
Retail	100 day supply Generic: $5 copay Brand: $10 copay Non-formulary: $10 copay[5]	30 day supply Generic: $5 copay Brand: $10 copay Non-formulary: $35 copay	30 day supply[6] Generic: $5 copay Brand: $20 copay Non-formulary: $50 copay	Not covered
Mail Order	100 day supply Generic: $5 copay Brand: $10 copay Non-formulary: $10 copay[5]	90 day supply Generic: $5 copay Brand: $10 copay Non-formulary: $35 copay	90 day supply Generic: $0 copay Brand: $20 copay Non-formulary: $50 copay	

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

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

[3] Preventive care is 100% covered in-network with no deductible required. Routine tests and screenings are also free to you when you use in-network providers.

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

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

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

[7] Medical Necessity guidelines apply. Refer to the SPD for more information.

If you don't enroll for coverage when you're first eligible, you'll be automatically enrolled in the CSEA default coverage for yourself only: Kaiser HMO medical plan, DeltaCare DHMO dental plan, vision coverage, life and accidental death & dismemberment insurance, and the employee assistance program.

NON-REPRESENTED — 2023 – 2024 Medical Coverage Options

This chart is intended to provide highlights of your benefits only; it is not an Evidence of Coverage (EOC) plan document. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including a complete list of exclusions and limitations, please refer to each carrier's EOC.

	Kaiser HMO[1]	Aetna HMO[1]	Aetna Choice POS II		Aetna Choice POS II HDHP	
			In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible Individual/Family	None	None	$300/$600	$500/$1,000	$1,500/$3,000 (For family coverage, full family deductible must be met before plan pays benefits)	
Plan Year Out-of-Pocket (includes deductible) Maximum Individual/Family	$1,500/$3,000	$250/$500	$1,300/$2,600	$5,500/$11,000	$3,275/$6,550 (For family coverage, full family out-of-pocket maximum must be met before plan pays benefits)	
Lifetime Maximum	Unlimited	Unlimited	Unlimited		Unlimited	
Health Savings Account (HSA)	None	None	None		Available (includes District contribution)	
Member Cost for Covered Services						
Inpatient Hospital	No charge	No charge	20%	40%	10%	40%
Outpatient Surgery	$10 copay	No charge	20%	40%	10%	40%
Ambulatory Surgery Center and Outpatient Services	$10 copay	No charge	20%	40%	10%	40%
Emergency Room Facility	$100 copay (waived if admitted)[2]	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted), then 10%	$100 copay (waived if admitted), then 10%
Emergency Room Physician	No charge	No charge	20% after deductible	20% after deductible	10% after deductible	10% after deductible
Physician Office Visit	$10 copay	$10 copay	20%	40%	10%	40%
Routine Physical	No charge	No charge	No charge[3]	40%	No charge[3]	Not covered
Well-Baby & Well-Child Care	No charge	No charge	No charge[3]	40%	No charge[3]	Not covered
Well-Woman Exams	No charge	No charge	No charge[3]	40%	No charge[3]	Not covered
Maternity Care	No charge	No charge	No charge[3]	40%	No charge[3]	40%
Lab and X-ray	No charge	No charge	20%	40%	$25 then you pay 10%	40%
Physical or Occupational Therapy	$10 copay	$10 copay	20%	40%	No charge	40%
Chiropractic Care	$5 copay (Up to 30 visits/year)	$5 copay (Up to 30 visits/year)	20%[8]	40%[8]	10% (Up to 20 visits/year)	40% (Up to 20 visits/year)
Durable Medical Equipment	No charge	No charge	20%	40%	10%	40%
Mental Health						
Inpatient	No charge	No charge	20%	40%	10%	40%
Outpatient	$10 copay	$10 copay	20%	40%	10%	40%
Prescription Drugs[4]	**Kaiser**	**Aetna**	**Express Scripts**		**Aetna[5]**	
Out-of-Pocket Maximum Individual/Family	None	Combined with medical	$5,550/$11,100		Combined with medical	
Retail	100 day supply Generic: $5 copay Brand: $10 copay Non-formulary: $10 copay[7]	30 day supply Generic: $5 copay Brand: $10 copay Non-formulary: $35 copay	30 day supply[7] Generic: $5 copay Brand: $20 copay Non-formulary: $50 copay	Not covered	30 day supply Generic: $5 copay Brand: $10 copay Non-formulary: $35 copay	Not covered
Mail Order	100 day supply Generic: $5 copay Brand: $10 copay Non-formulary: $10 copay[6]	90 day supply Generic: $5 copay Brand: $10 copay Non-formulary: $35 copay	90 day supply Generic: $0 copay Brand: $20 copay Non-formulary: $50 copay		90 day supply Generic: $5 copay Brand: $10 copay Non-formulary: $35 copay	

[1] If you enroll in an HMO plan, you can obtain services only within the plan's geographic service area, except for urgent and emergency services.
[2] The Emergency Room Copay does apply if you are admitted for observation but are not admitted as an inpatient.
[3] Preventive care is 100% covered in-network with no deductible required. Routine tests and screenings are free to you when you use in-network providers, too.
[4] Some contraceptive prescriptions for women are 100% covered in-network with no copay or deductible required. Age limits may apply. Contact the plan for details.
[5] For the Choice POS II HDHP, prescription drugs count towards annual deductible.
[6] For Kaiser plans, non-formulary brand-name drugs are not listed on the drug formulary and aren't covered unless approved through an exception process initiated by the members plan physician. If approved, non-preferred (non formulary) brand-name drugs are covered at the brand copay.
[7] Diabetic medications are available in 90 day supplies at select retail pharmacies.
[8] Medical Necessity guidelines apply. Refer to the SPD for more information.

If you don't enroll for coverage when you're first eligible, you'll be automatically enrolled in the non-represented default coverage for yourself only: Aetna Choice POS II medical plan, Delta PPO Plus Premier plan, vision coverage, life and accidental death & dismemberment insurance, and the employee assistance program.

TALB — 2023 – 2024 Medical Coverage Options

This chart is intended to provide highlights of your benefits only; it is not an Evidence of Coverage (EOC) plan document. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including a complete list of exclusions and limitations, please refer to each carrier's EOC.

	Kaiser HMO[1]	Aetna HMO[1]	Aetna Choice POS II	
			In-Network	Out-of-Network
Plan Year Deductible Individual/Family	None	None	$300/$600	$500/$1,000
Plan Year Out-of-Pocket Maximum (includes deductible) Individual/Family	$1,500/$3,000	$250/$500	$1,300/$2,600	$5,500/$11,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	
Member Cost for Covered Services				
Inpatient Hospital	No charge	No charge	20%	40%
Outpatient Surgery	$10 copay	No charge	20%	40%
Ambulatory Surgery Center and Outpatient Services	$10 copay	No charge	20%	40%
Emergency Room Facility	$100 copay (waived if admitted)[2]	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)
Emergency Room Physician			20% after deductible	20% after deductible
Physician Office Visit	$10 copay	$10 copay	20%	40%
Routine Physical	No charge	No charge	No charge[3]	40%
Well-Baby & Well-Child Care	No charge	No charge	No charge[3]	40%
Well-Woman Exams	No charge	No charge	No charge[3]	40%
Maternity Care	No charge	No charge	No charge[3]	40%
Lab and X-ray	No charge	No charge	20%	40%
Physical or Occupational Therapy	$10 copay	$10 copay	20%	40%
Chiropractic Care	$5 copay (Up to 30 visits/year)	$5 copay (Up to 30 visits/year)	20%[7]	40%[7]
Durable Medical Equipment	No charge	No charge	20%	40%
Mental Health				
Inpatient	No charge	No charge	20%	40%
Outpatient	$10 copay	$10 copay	20%	40%
Prescription Drugs[4]	**Kaiser**	**Aetna**	**Express Scripts**	
Out-of-Pocket Maximum Individual/Family	None	Combined with medical	$5,550/$11,100	
Retail	100 day supply Generic: $5 copay Brand: $10 copay Non-formulary: $10 copay[5]	30 day supply Generic: $5 copay Brand: $10 copay Non-formulary: $35 copay	30 day supply[6] Generic: $5 copay Brand: $20 copay Non-formulary: $50 copay	Not covered
Mail Order	100 day supply Generic: $5 copay Brand: $10 copay Non-formulary: $10 copay[5]	90 day supply Generic: $5 copay Brand: $10 copay Non-formulary: $35 copay	90 day supply Generic: $0 copay Brand: $20 copay Non-formulary: $50 copay	

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

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

[3] Preventive care is 100% covered in-network with no deductible required. Routine tests and screenings are free to you when you use in-network providers, too.

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

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

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

[7] Medical Necessity guidelines apply. Refer to the SPD for more information.

If you don't enroll for coverage when you're first eligible, you'll be automatically enrolled in the TALB default coverage for yourself only: Aetna Choice POS II medical plan, Delta PPO Plus Premier plan, vision coverage, life and accidental death & dismemberment insurance, and the employee assistance program.

Reimbursement for Hearing Aids

Active employees who are insured in one of the District's medical plans may request reimbursement from the District for the costs of hearing aids. The maximum amount of reimbursement is $1,000 within any three-year period. The cost of hardware, fitting tests, and other tests related to the hearing aids is included for reimbursement purposes. Dependents covered by District medical plans are not eligible for this benefit.

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

Prescription Drug Costs

Keep in mind, prescription drug copays accrue towards the out-of-pocket maximum for all medical plans. Note there is a separate prescription drug out-of-pocket maximum for the Choice POS II plan ($5,550 individual/$11,100 family, in-network only).

Prescription Drug Benefits

Each of our medical plans has a three-tiered prescription drug benefit. With this type of plan, the amount you pay for prescriptions depends on:

- The type of drug you choose;
- Whether the drug is a generic or brand, part of your plan's drug formulary (a list of drugs the insurance company considers "preferred choices" based on their effectiveness and cost), or not (non-formulary); and
- Whether you fill your prescription at a retail pharmacy or through the mail-order program.

Generally:

- **Generic drugs** are in the plan's first tier and are your lowest copay option;
- **Brand-name drugs that are on your plan's drug formulary** are in the second tier for most plans, and are your mid-range copay option; and
- **Brand-name drugs that are not on your plan's drug formulary (non-formulary)** are in the third tier for some plans, or may not be covered under certain plans; if they're covered under your plan, these are generally your highest copay option.

Generic drugs are the cheaper equivalent of many brand-name drugs. In fact, they have to prove that they're just as effective as the brand-name drug before they're approved. In addition, many brand-name drugs that aren't on the formulary have similar equivalents that are. So if your doctor prescribes a drug that's not on the formulary, ask whether a generic or formulary brand drug would work just as well.

Using the Mail-Order Pharmacy

If you're taking a medication on an ongoing basis for a chronic condition such as diabetes or heart disease, you may want to consider using your plan's prescription drug mail-order service. The mail-order service usually saves you money, because you can order a larger supply of your medication for the same copay. When you use the mail-order pharmacy, you generally receive about a three-month supply of the medication.

Prior Authorization and Specialty Drugs

Depending on your pharmacy plan, you may be required to receive prior authorization before you can fill prescriptions for certain drugs. In addition, you may need to use a Specialty Pharmacy designated by your plan to fill prescriptions for certain drugs. For more information, contact your plan's member services or visit the plan's website.

SafeGuard Rx Diabetes Care Value Program

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

Advanced Utilization Step Therapy Program

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

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

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

HOW IT WORKS

When your doctor writes you a prescription:

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

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

A Special Note about Express Scripts

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

If you participate in any of the other medical plans, your prescription drug coverage is provided through your medical plan.

If your prescription drug coverage is provided through Express Scripts, you'll receive a separate ID card for prescription drug coverage. You should be prepared to present your Express Scripts ID card whenever you have a prescription filled at a retail pharmacy. If you don't, you may be denied benefits and have to pay for your prescription up front.

To receive benefits, you must fill your prescription by using either the mail-order pharmacy or a participating retail pharmacy. To find a participating pharmacy, you can call Express Scripts Member Services at **(866) 662-0297** or visit **www.express-scripts.com**.

The Specialty Pharmacy

Certain drugs covered by the Express Scripts plan require you to purchase them through Accredo, Express Scripts' Specialty Pharmacy program. These drugs include growth hormone medications as well as drugs to treat cystic fibrosis, multiple sclerosis, and viral hepatitis. These drugs may be dispensed through mail-order only. For more information about the Specialty Pharmacy program, call Express Scripts Member Services at **(866) 662-0297**.

Your Prescription Drug Benefits

Your prescription drug benefits depend on your medical plan. You can find more details on the following pages:

- CSEA: page 11
- Non-Represented: page 12
- TALB: page 13

Keep in mind that to receive those benefits, you'll need to use a pharmacy that's part of your plan's network.

Clinical Prior Authorization

With the Express Scripts plan, certain prescriptions require approval from the plan, or "clinical prior authorization," before they'll be covered. These include, but aren't limited to, biological response modifiers and anti-obesity, insomnia, and migraine medications. To request approval, you, your pharmacy, or your physician should call **(866) 662-0297**. When you call, you'll need to have the name of the medication, your physician's name and phone number, and your member ID and group number (which are printed on your Express Scripts ID card).

Is Your Drug on the Formulary?

If you're enrolled in the Aetna Choice POS II plan, you can contact Express Scripts Member Services, **(866) 662-0297**, or visit the Express Scripts website, **www.express-scripts.com**, for information about which drugs are on the national preferred formulary. Keep in mind that your benefits will be highest if you receive a generic drug.

Employee Assistance Program (EASE)

EASE is an additional benefit and specialized program provided by Employee Assistance Service for Education (EASE), which is part of the Los Angeles County Office of Education. EASE is available to you and your immediate family members.

EASE provides professional and confidential counseling to help you with:

- Family troubles with spouse or children;
- Emotional distress;
- Drug or alcohol abuse;
- On-the-job anxieties and stress;
- Grief, loss, and transitions;
- Legal or financial referrals; and
- Worksite and phone consultations.

Access to all of the EASE services is just a phone call away — **(800) 882-1341**.

Dental Plan Options

Because regular dental care is vital to your overall health well-being, your dental benefits are an important part of your health care package.

With the DeltaCare USA DHMO plan, you must receive care from a provider in the plan's network or no benefits will be paid. For the Delta PPO Plus Premier plan, you have the flexibility to receive care from any provider; however, you may pay less if you receive care from a Delta Dental contracted provider, because Delta Dental negotiates lower fees for Delta plan members.

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

MAJOR COVERAGE	Delta PPO Plus Premier Plan		DeltaCare USA DHMO Plan
Eligibility	Employee only; dependent coverage at employee's expense		Employee and dependents
Choice of Dentist	For highest level of benefits, you must use In-Network dentists. Enrollees also have the flexibility to see any licensed dentist		You must use a dentist on the panel of primary care dentists
	Delta Dental PPO Dentist	**Any Licensed non-PPO Out-of-Network Dentist**	
Covered Fees	Contracted fees	U&C[1]	All services provided by contract
Annual Maximum	$2,200	$2,000	No maximum
Deductible	None		None
Coinsurance/Copay *Each family member has their own participation level	What the plan pays*,2: • Pays 70% – 1st year of participation • Pays 80% – 2nd year of participation • Pays 90% – 3rd year of participation • Pays 100% thereafter Levels increase each year if member visits dentist at least once a year		Per copay schedule shown in the EOC available on our Benefit website at **www.lbusdbenefits.com**
Preventive Services			
Teeth Cleaning	Covered – 2 per year (see Footnote 2 below)		Covered in full – 2 per year
Full Mouth X-rays	Covered - every 5 years (see Footnote 2 below)		Covered in full – every 2 years
Bite-Wing X-rays	Covered - 2 per year to age 18; 1 per year ages 18 and up (see Footnote 2 below)		Covered in full – 2 per year
Fluoride Treatments	Covered – 2 per year (see Footnote 2 below)		Covered in full – to age 18
Therapeutic Services			
Extractions	Covered (see Footnote 2 below)		Covered in full (uncomplicated)
Fillings	Covered (see Footnote 2 below)		Covered in full (amalgam, acrylic)
Root Canals/Periodontics	Covered (see Footnote 2 below)		Covered subject to copay
Crowns, Dentures, Bridges			
Crown	Covered (see Footnote 2 below)		Covered subject to copay
Denture/Bridge	Paid at 50% (see Footnote 2 below)		Covered subject to copay
Orthodontia			
Children/Adults	Not covered		Covered subject to $350 start-up fee, $1,200 copay

1 If a covered individual uses a Delta PPO Plus Premier dentist, reimbursement under the plan is based on the plan's allowed fees. All other dentists are subject to reimbursements based on the usual & customary (U&C) amount for the service.

2 All services covered at applicable coinsurance participation level.

Vision Coverage

With the EyeMed vision plan, you have coverage for a wide range of vision services. Vision coverage is available to employees only.

After any applicable copay, the plan begins to pay benefits. The amount the plan pays depends on whether or not you visit a participating provider. When you go to a participating provider, the plan provides full coverage for many covered services and materials. When you go to a non-participating provider, charges will be paid on the basis of prevailing fees, but not to exceed the schedule of allowances in the right column of the following chart. Benefit availability is based on date of last service.

For a complete list of covered services and limitations/exclusions, refer to the Benefits Summary, available on our LBUSD Benefit website at **www.lbusdbenefits.com**.

MAJOR COVERAGE	Participating Provider	Non-participating Provider
Annual deductible		
Annual deductible	$0	
The plan pays for the following benefits		
Exams		
Ophthalmic Examination (with or without refraction, once every 12 months)	$10 copay	Plan pays $40
Optometric Examination (with or without refraction, once every 12 months)		Plan pays $40
Frames		
Twice every 24 months	Plan pays 100% for standard frames[1]	Plan pays $42
Lenses (in lieu of contact lenses, twice every 24 months)		
Single Vision (plastic)	Plan pays 100% for standard lenses[2]	Plan pays $30
Bifocal (plastic)		Plan pays $50
Trifocal (plastic)		Plan pays $70
Lenticular (plastic)		Plan pays $70
Progressive - Standard (plastic)		Plan pays $50
Tints (solid and gradient)		
Single vision		Plan pays $8
Bifocals		Plan pays $8
Trifocals		Plan pays $8
Polycarbonate - Standard (< age 19)	Plan pays 100%	Plan pays $20
Contact Lenses (in lieu of lenses, twice every 24 months)		
Medically Necessary	Plan pays 100%[3]	Plan pays $300
Cosmetic	Plan pays up to a $100, plus 85% for conventional	Plan pays $70

[1] A standard frame is any frame that has a retail value of $60 or less; you are responsible for 80% of any charges above $60.
[2] Standard lenses are plastic and fit any frame with an eye size less than 56 mm.
[3] Contact lenses are medically necessary if they are prescribed following cataract surgery, or when they are the only means to correct visual acuity to 20/40 in the better eye, or when necessitated by anisometropia or certain conditions of keratoconus. **Prior authorization from EyeMed is required before contact lenses will be considered medically necessary.**

Flexible Spending Accounts (FSAs)

The District gives all eligible employees access to two flexible spending accounts (FSAs) — a Health Care FSA and a Dependent Care FSA. Non-represented employees who enroll in the Choice POS II (Open Access) HDHP will have access to the Limited Purpose FSA. These accounts let you pay for certain expenses using pre-tax contributions — that means less of your paycheck goes to taxes and you take home more money! The FSAs are administered by WageWorks/Health Equity.

FSAs are now on the plan year and are effective from July 2023 through June 2024. Enrollment for FSA participation will take place during the annual enrollment, in May.

When you take advantage of the FSAs, you can:

- Put more money in your pocket;
- Reduce your income tax liability;
- Budget for non-covered health care expenses; and
- Set aside dollars for day care and other dependent care costs — so you have the money when you need it.

With FSAs, you can also save for expected out-of-pocket costs, such as:

- **Health care expenses** — vision exams and eyeglasses, hearing aids, orthodontia, medical and dental deductibles, even laser vision surgery and other services not covered by your medical benefits plan; and
- **Work-related dependent care expenses** — nursery schools and day care centers for your children, or for an adult dependent.

More information about eligible expenses is available on our LBUSD Benefit website at **www.lbusdbenefits.com**.

When you enroll in an FSA, you elect how much money you want to contribute for the calendar year. The District then takes that amount out of your paychecks in equal installments — before taxes are taken out. You can then submit a claim for reimbursement from these accounts whenever you have eligible expenses.

However, it's important to budget carefully, because any money that's left over at the end of the year will be forfeited. And keep in mind that once you've elected a contribution amount, you're not allowed to change it during the year unless you have a qualifying status change (although not all status changes allow you to change your contribution amount).

FSAs, HSAs, and Your Domestic Partner

You can use the funds in your Health Care FSA and Choice POS II HDHP HSA to pay for expenses for your eligible dependents. However, because of IRS regulations, your California-registered domestic partner is not considered an eligible dependent for purposes of the FSA or HSA unless he or she is an IRS tax dependent. Also, you cannot spend funds from your Dependent Care FSA on the children of your domestic partner, unless the children qualify as your IRS tax dependents.

2023-2024 FSA Contribution Limits

For 2023-2024, you can contribute the following amounts to your FSA:

- Health Care FSA: $3,050
- Limited Purpose FSA: $3,050
- Dependent Care FSA: $5,000 (if you are single or married and filing taxes jointly) or $2,500 (if you are married and filing taxes separately)

Note: Enrollment for FSAs is now concurrent with the regular plan year, July 2023-June 2024. Contribution amounts may change each year, based on IRS regulations, and will be communicated during the enrollment period in the spring. If you don't use your whole balance by the end of June 2023, you'll have a grace period to use the funds and submit claims. **If you don't use your balance by September 15, 2024 and submit claims by September 28, 2024 you'll forfeit any remaining funds.**

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

If you enroll in the CPOSII HDHP, you cannot enroll in the regular Health Care Flexible Spending Account (FSA). However, you can enroll in a Limited Purpose FSA. You can only use a Limited Purpose FSA to pay certain non-medical expenses, such as eligible dental or vision care.

Important! *If you currently participate in an FSA and want to enroll in the CPOSII HDHP for 2023 – 2024, IRS regulations require that you use up your FSA balance before contributing. If you have no balance ($0.00) in your FSA on June 30 2023, you can contribute to the HSA beginning July 1, 2023. If you don't use your full FSA balance by June 30, 2023, you won't be eligible to open an HSA until July 1, 2024.*

Group Life Insurance and Group Accidental Death & Dismemberment Insurance

If you're eligible, the District automatically provides you with group life and basic AD&D insurance:

- **Group life insurance** pays a benefit to your beneficiary in the event of your death.
- **Group basic AD&D insurance** provides an additional benefit if you die as the result of an accident. It also provides a benefit if you have certain injuries as the result of an accident - the benefit you receive is a percentage of the total benefit, depending on the extent of your injury.

Your coverage level is shown in the chart below.

Employee Group	Level of Coverage
Bargaining and Non-bargaining Unit Employees	• Life insurance benefit equal to one times annual salary, but not less that $15,000 or more than $50,000. • AD&D coverage is provided in the same amount.
Management, Supervisory, and Confidential Employees	• Life insurance benefit of $50,000. • AD&D coverage is provided in the same amount.

Life Insurance Conversion

Your life insurance coverage will terminate at the end of the month in which you are no longer eligible for District benefits. However, you may be eligible to convert to an individual life insurance policy at that time. For more information, please call the life insurance carrier, Reliance Standard, at **(800) 644-1103**.

Retirement Plans

In addition to your pension benefits, the District is pleased to offer you two additional plans to help you save for retirement.

The District offers 403(b) and 457 plans in accordance with the Internal Revenue Code to allow participants to save for retirement with pre-tax dollars. These plans offer the following benefits:

- Contributions are made on a salary-reduction basis;
- Variety of investment choices; and
- Easy payroll deduction.

Under current law, before age 59½, a 10% federal tax penalty may apply to amounts distributed from your plan (and certain deemed distributions) which are attributable to an IRA or another qualified plan. Withdrawals are subject to ordinary income tax.

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

Plan	Plan Contact	Phone Number
403(b)	SchoolsFirst FCU	(800) 462-8328 x4116
457	Nationwide	(877) 677-3678

Internal Revenue Code (IRC) Section 125 Flexible Fringe Benefits Plan

The Long Beach Unified School District is pleased to provide our IRC Section 125 Flexible Fringe Benefits plan. T his plan will be available for all employees, including the Long Beach Unified School District's Board of Education and Personnel Commission, Teachers Association of Long Beach, California Schools Employee Association Chapter #2, Management, Supervisors, and Confidential and Non-represented Employees.

If you pay premiums for certain District benefits, the Section 125 plan allows you to reduce your taxes by paying certain qualified expenses through payroll deductions on a pre-tax basis (for example, if you pay premiums for Delta Dental coverage for your dependents, or you're a job-share employee who pays medical premiums). By participating in a Section 125 plan, you will lower your taxable income, which can result in lower federal and state taxes.

If you pay premiums for your eligible benefits, you'll have the option to enroll in the Section 125 plan.

Important Information About Your Benefits

This section includes some important notices about your rights and responsibilities as a participant in the District's plans. It also includes details about how to appeal a claim or file a grievance. If you have any additional questions about this information, feel free to contact the Employee Service Center at **(866) 844-9744**, option 4.

Appealing a Claim

If a claim has been denied for you or your eligible family members, you may appeal the claim. Each carrier has its specific appeal process to follow. Please call your insurance carrier member services for the specific grievance and appeals process. See page 23 of this booklet for insurance carrier phone numbers.

Filing a Complaint or Grievance

Each insurance carrier has a specific process for effectively handling complaints and grievances. Please call your insurance carrier member services for details. Insurance carrier phone numbers are listed on page 23 of this booklet.

Phone Numbers and Websites

		Phone Number	Website
	LBUSD Employee Resources		
	LBUSD Risk Management – Health Benefits	(562) 997-8234	www.lbschools.net (Click "R" for Risk Management)
	LBUSD Employee Service Center (Member Services)	(866) 844-9744	www.lbusdbenefits.com
CSEA LBUSD TALB	LBUSD Benefit Website	(562) 997-8234	www.lbusdbenefits.com
TELUS Health	**TELUS Health, formerly LIfeWorks and prior Morneau Shepell**		
	COBRA Benefit Billing Center	(855) 274-8493	www.lbusdbenefits.com
aetna	**Aetna**		
	Concierge Member Services (HMO, Choice POS II Plan and Choice POS II HDHP)	(888) 290-6620	www.aetna.com
	HMO and HDHP Rx	(888) 792-3862	www.aetna.com
	Teladoc services	(855) 835-2362	www.Teladoc.com/Aetna
KAISER PERMANENTE	**Kaiser**		
	Member Services (HMO)	(800) 464-4000	https://my.kp.org/lbusd/
EXPRESS SCRIPTS	**Express Scripts**		
	Member Services	(866) 662-0297	www.express-scripts.com
ease	**EASE**		
	Member Services	(800) 882-1341	www.lacoe.edu/ease
DELTA DENTAL	**Delta Dental**		
	Member Services (PPO & Premier) Member Services (DHMO)	(866) 499-3001 (800) 422-4234	www.deltadentalins.com
eye med	**EyeMed**		
	Member Services	(844) 409-3401	www.eyemed.com
WageWorks	**WageWorks/HealthEquity**		
	Member Services	(855) 774-7441	www.wageworks.com
CalPERS	**California Public Employees' Retirement System**		
	Member Services	(888) 225-7377	www.calpers.ca.gov
CALSTRS	**State Teachers' Retirement System**		
	Member Services	(800) 228-5453	www.calstrs.ca.gov
RELIANCE STANDARD	**Reliance Standard**		
	Member Services	(800) 644-1103	