2018 **CHOOSE**well Sworn Enrollment Guide

October 1-31, 2017

KEEPING LAwell
City of Los Angeles Employee Benefits

Welcome to your **LAwell** Sworn Benefits Open Enrollment for 2018

How to use this **CHOOSEwell Sworn Enrollment** Guide

First 1

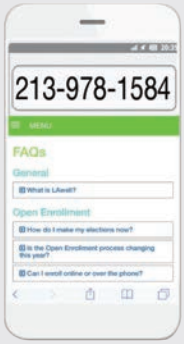
Review your **Personal Sworn Enrollment Letter**.

Second 2

Review the **CHOOSEwell** Sworn Enrollment Guide to learn more **about using your benefits**, and any **rules/restrictions** that may apply.

Third 3

Complete forms to enroll or make changes to your current benefits by **October 31, 2017!** Questions: call **213-978-1584 or visit keepingLAwell.com**.



Why Should You CHOOSEwell?

Your benefit choices are important in supporting the health and wellbeing of you and your dependents. Open Enrollment benefit elections will be in effect for all of 2018 unless you experience a qualifying life event. Choose wisely, and **CHOOSEwell**! For complete details about these benefits, please visit **keepingLAwell.com**.

Your Detailed Enrollment Checklist

- ☐ Review your Personal Sworn Enrollment Letter (PSL).
- ☐ Review your options in the CHOOSEwell Sworn Enrollment Guide and **keepingLAwell.com**. Review your Memorandum of Understanding (MOU) for more information on your health and dental benefits, including your eligible subsidy amounts during calendar year 2018.*
- ☐ Review your dependent information and eligibility rules (on page 35) to verify current dependents, add new dependents, or remove ineligible dependents.
- ☐ Document your dependents by December 11, 2017; adding a dependent does not entitle that individual to coverage unless the City receives the appropriate documentation of eligibility.
- ☐ Provide Social Security numbers or Taxpayer Identification numbers for your dependents, if you have not already done so, by calling **213-978-1584** (this is for federal tax reporting purposes).
- ☐ Review the eligibility section and other pertinent sections of this CHOOSEwell Sworn Enrollment Guide to understand plan rules and successfully manage your benefits over time.
- ☐ Make your 2018 enrollment elections!

* The City subsidies shown in this CHOOSEwell Sworn Enrollment Guide are current as of the printing of this book. However, the subsidy amounts are valid through to the end of June 2018 and may change effective July 1 2018. Check your MOU for any changes to the subsidy amount that are scheduled to take effect in July.

Your Enrollment Resources

- ✓ **To enroll for LAwell Medical or Dental coverage, add dependents, or make other changes,** submit the applicable form by October 31, 2017! See the Forms section, pages 56 to 66.
- ✓ **Enroll in Cash-in-Lieu, the Healthcare Flexible Spending Account, or the Dependent Care Reimbursement Account or make changes to these three benefit options online or on the phone, visit** keepingLAwell.com or contact the Benefits Service Center at **800-778-2133** (for TDD or TTY service, call **800-735-2922**). Representatives are available 8 a.m. to 5 p.m., Pacific Time, Monday – Friday. **Extended phone hours are provided on Monday, October 30 and Tuesday, October 31: 8 a.m. to 7 p.m.** On Saturday and Sunday, October 28 and 29, the Benefits Service Center will **NOT** be available via phone; however you can still enroll online.
- ✓ **Call Maria Lopez at 213-978-1584** or email **per.empbenefits@lacity.org** with any other questions about your **LAwell** benefit options

Attend a Wednesday Webinar and learn more:

September 27	Health Plans 101
October 4	Dental Plans 101
October 18	Vision Benefits
October 25	Dependent Eligibility

Register for webinars at **keepingLAwell.com**. Webinars will be recorded and available for viewing at **keepingLAwell.com**.

Meet a Member Advocate

Member Advocates from our Health and Dental providers will provide personal, one-on-one assistance in our office in City Hall, 200 N. Spring Street, Room 867, during Open Enrollment and throughout the year.

Anthem	Kaiser
8:00 AM – 4:00 PM	
Monday - Friday	Tuesday - Thursday

IMPORTANT DATES

- ✓ **Open Enrollment:** **October 1 – October 31, 2017**
- ✓ **Webinars and Onsite Meetings:** Webinars and onsite meetings will be offered throughout Open Enrollment—check for updates at **keepingLAwell.com.**
- ✓ **Last day to make changes:** **October 31, 2017**
- ✓ **Documentation deadline:** **December 11, 2017**
- ✓ **Benefit changes take effect:** **January 1, 2018**; Health plan ID cards will be issued shortly thereafter.

What's Inside

What's Inside

CHOOSEwell Benefit Overview

Here are three top things you should know:

1. **Open Enrollment is your only opportunity to make LAwell benefit coverage elections for yourself and your dependents for 2018 (unless you experience a qualifying life event change in 2018).**

2. **Generally, your previously elected 2017 LAwell benefit elections will automatically roll over to 2018 unless you make a change during Open Enrollment.**

3. **Enrollment in either the Dependent Care Reimbursement Account (DCRA) and/or the Healthcare Flexible Spending Account (HCFSA) does not automatically roll over— if you wish to continue participating in 2018 or become a new participant in one of these accounts for 2018, you will need to elect to do so during Open Enrollment.**

How do I enroll during Open Enrollment?

For LAwell Medical or Dental coverage: Submit forms by October 31, 2017! See the Forms section, pages 56 to 66.

For Cash-In-Lieu, the Healthcare Flexible Spending Account, or the Dependent Care Reimbursement: Call 800-778-2133 or log on to keepingLAwell.com

Here are some important questions and the answers:

When do my benefits start?

- ✓ Open Enrollment elections are effective January 1, 2018.
- ✓ New Hire elections are effective the date you enroll.
- ✓ Employees who are rehired or who have their benefits reinstated will have varied effective dates. See page 41 for more information.

How do I make a change during the year?

The benefit choices you make during Open Enrollment will stay in effect through December 31, 2018.

You cannot change your choices during the year unless you have a life event as described by federal rules.

Common **qualifying life events** include:

- ✓ You get married or divorced
- ✓ You begin or end a domestic partnership
- ✓ You add or lose an eligible dependent
- ✓ Your spouse/domestic partner's employment status, work schedule, or residence changes, significantly changing eligibility or coverage under the other employer's plan

(See page 38 for more information on Life Events)

What is required to make a qualifying life event change during the year?

You must notify the Plan within **30 days** of the qualifying life event by contacting the Maria Lopez at 213-978-1584. You will be asked to provide documents showing proof of the qualifying life event within **60 days** of the date you report the change. If you do not provide the required documents by the deadline, your requested changes will not be implemented. (See page 38 for more information).

Important questions and answers *continued*:

What are my Benefit options and costs?

	Your Benefit Options	Provider	Your Cost*	See Page
Medical	HMO health plans PPO health plan	Anthem and Kaiser	Cost varies based on coverage level elected and your MOU	8-19
	Cash-in-Lieu	City	None. Pays you up to $100** each month.	9
Dental	PPO dental plan DHMO dental plan	Delta Dental	Cost varies based on coverage level elected	22-25
Vision	In-Network Out-of-Network reimbursements	EyeMed	**Included at no cost for LAwell Medical Plan Members**	26-28
Tax-Advantaged Spending Accounts	Health Care Flexible Spending Account	WageWorks	You elect voluntary contributions up to maximum limit	29
	Dependent Care Reimbursement Account			31
	Parking & Commuter Accounts			55

*Your personal cost options are detailed in your Personal Sworn Enrollment Letter. Check your MOU for any changes to your subsidy amounts
** Amounts represent full-time employment status.

Who can I cover and what is required?

Generally, any person who is your legal dependent is eligible to be added to your coverage. Supporting documentation to prove your relationship will be required to keep your dependent on your benefits. See page 35 for detailed eligibility information.

When does my coverage end?

- ✓ Retired employees: Last day of the month
- ✓ Terminated employees: Effective date of termination
- ✓ Employees on leave: Effective date of leave, unless Direct Bill purchase
- ✓ Dependent children lose coverage on the last day of the month in which they turn age 26.

For more information see page 37.

What happens if I go on leave?

Your benefits may continue while you are on certain leave-from-work statuses, but still employed. However, you will be required to pay for all, or a portion, of the premiums for these benefits.

For more information see page 40.

Who do I call to learn more about my benefits?

You may get the answers to your benefits questions by calling Maria Lopez at **213-978-1584**, or email **per.empbenefits@lacity.org**.

Medical Coverage & Cash-in-Lieu

Your Medical Plan Choices

Anthem

- ✓ Anthem PPO – doctors/providers available nationally
- ✓ Narrow Network (Select) HMO – doctors/providers available throughout Southern California and other areas
- ✓ Vivity (LA & Orange Counties) HMO – doctors/providers available through select locations of Los Angeles and Orange Counties

Kaiser

- ✓ Kaiser Permanente HMO – doctors/providers only available through Kaiser facilities, which are regionally located in nine states

Cash-in-Lieu

- ✓ Cash benefit paid to employee in-lieu of enrollment into one of the City's health plans. Only available for employees who prove coverage with a qualifying alternative option (see page 9 for details).

THE AFFORDABLE CARE ACT (ACA)

Under the ACA, everyone is required to have medical coverage or pay a tax penalty; some exemptions apply. This is called the individual mandate. If you enroll in LAwell medical benefits, you meet the individual mandate. If you plan to enroll in coverage through another plan, it's a good idea to confirm that other coverage meets ACA requirements for the individual mandate. To learn more visit coveredca.com or call them at 888-975-1142.

Understanding HMO and PPO Plans

HMOs – Health Maintenance Organizations (HMOs) provide healthcare through a network of doctors, hospitals and other healthcare providers. With an HMO plan, you must access covered services through a network of physicians and facilities as directed by your Primary Care Physician, except for emergencies. LAwell provides coverage where most City employees live. See the Residence/Worksite Proximity to Service Providers section of this guide (page 11) for more information about health coverage out of the Los Angeles City limits.

PPOs – Preferred Provider Organizations (PPOs) are nationwide networks of doctors, hospitals, and other healthcare providers that have agreed to offer quality medical care and services at discounted rates. You can use in-network providers for a higher level of reimbursed benefit coverage, or go to a licensed out-of-network provider and receive a lower level of reimbursed benefits.

The following table provides highlights of key differences between the medical plans offered by the City:

	Anthem Narrow Network (Select HMO)	Anthem Vivity (LA & Orange Counties)	Kaiser Permanente HMO	Anthem PPO
In-network care	You designate a primary care physician; you must see this physician first when you need specialty care.	You designate a primary care physician; you must see this physician first when you need specialty care.	You may visit any Kaiser Permanente facility; a primary care physician is recommended but not required.	You may visit a network provider of your choice; no primary care physician or specialist referrals required.
Out-of-network care	Not covered unless you need care for a serious medical emergency outside of your HMO's network service area.			You may visit any licensed provider you choose, and no primary care physician or specialist referrals are required. However, you will receive a lower level of benefits for out-of-network care.

What is Cash-in-Lieu?

If you already have eligible medical coverage you may be able to waive LAwell coverage and receive a taxable payment each month.

What coverage is eligible for Cash-in-Lieu?

The eligible medical coverage options include:

- ✓ Dependent coverage through your spouse's or domestic partner's employer
- ✓ Individual/Family coverage through your second employer
- ✓ Retiree coverage through your previous employer
- ✓ Medicare
- ✓ TRICARE

Note: Coverage you and/or your spouse obtain through the Covered California Marketplace, any other program that is not an employer-offered health plan, a parent or guardian, and Medi-Cal or Medicaid **do not** qualify as eligible coverage for the Cash-in-Lieu program.

How much does Cash-in-Lieu pay?

- ✓ Full-time employees receive an additional $50 in taxable income in your paycheck each pay day, up to $100 per month.

Open Enrollment is your only opportunity to make coverage elections for yourself and your dependents for 2018 (unless you experience a qualifying life event change in 2018).

How Do I Enroll in Cash-in-Lieu?

For first-time elections:

1. Select Cash-in-Lieu during Open Enrollment.
2. Complete the **Cash-In-Lieu Affidavit**, providing required supporting documentation of your eligible health coverage, by the **December 11, 2017** deadline.

Download the Affidavit at **keepingLAwell.com**. You will also receive a copy along with your confirmation statement.

Additional first-time enrollment rules:
If you enroll during Open Enrollment for 2018, participation is effective January 1, 2018. If currently have LAwell health coverage, it will terminate December 31, 2017.

Your first "Cash-In-Lieu" payment will be reflected in your gross wages on the paycheck you receive on January 3, 2018, for the pay period ending December 23, 2017. If you do not submit a Cash-In-Lieu Affidavit by December 11, 2017 for 2018 Open Enrollment or within 60 days of a qualifying life event change that you have in 2018, your participation in Cash-In-Lieu will be canceled.

Approval of your Cash-in-Lieu Affidavit is subject to review and verification by the Employee Benefits Division and your participation in the Cash-in-Lieu program may also be canceled based on the information you provide on your Affidavit.

For continuing elections:

To continue your current Cash-in-Lieu election, nothing is required. Cash-in-Lieu will continue until you notify us of a qualifying life event change.

Questions?

ONLINE:
Anthem Blue Cross
anthem.com/ca/cityofla

Kaiser Permanente
my.kp.org/ca/cityofla

CALL:
Anthem Narrow
844-348-6111

Anthem Vivity
844-348-6110

Anthem PPO
833-597-2362

Kaiser Permanente
800-464-4000

IN PERSON:
Member Advocates at City Hall Room 867

Anthem Blue Cross
Mon-Fri, 8am-4pm

Kaiser Permanente
Tue-Thurs, 8am-4pm

If you have further questions, please contact Maria Lopez at **213-978-1584**.

Si tiene preguntas adicionales, por favor llame a la Maria Lopez: **213-978-1584**.

Finding Network Providers

To find a network provider for one of the Anthem plans:

- ✓ Go to **anthem.com/ca/cityofla**
- ✓ Select Find a Doctor, Pharmacy, Hospital or Urgent Care Center
- ✓ Identify your plan type and profile information, as required, then select one of the following plans:
  - Narrow Network (Select HMO)
  - Vivity
  - PPO (Prudent Buyer)

For help finding a PCP, you may call Anthem HMO (Narrow) **844-348-6111** or Anthem Vivity **844-348-6110** Monday through Friday, 8 a.m. to 8 p.m. or visit **anthem.com/ca/cityofla**.

To find a network provider for the Kaiser Permanente HMO plan:

- ✓ Call **800-464-4000** or
- ✓ Go to **my.kp.org/ca/cityofla**.
  - Choose Find a Doctor
  - Choose Southern California

For help finding a PCP, you may call Kaiser Member Services at **800-464-4000**.

About Your Primary Care Physician (HMO Plans only)

Anthem – Members in an Anthem HMO Plan will choose a Primary Care Physician (PCP) or medical group. You and your family members do not have to enroll with the same PCP or medical group, but a PCP designation is required to see a doctor. For help finding a PCP, you may call Anthem HMO (Narrow) at **844-348-6111** or Anthem Vivity at **844-348-6110** Monday through Friday, 8 a.m. to 8 p.m. or visit **anthem.com/ca/cityofla**.

If you enroll in an Anthem plan for the first time, you and your family will be automatically assigned a PCP. You may call the Anthem Blue Cross Customer Service number on the back of your ID card to change your PCP assignment. Anthem members are typically allowed to change their PCP designation no more than once a month.

Kaiser – Kaiser Permanente members are not required to select a PCP before coverage starts and will not be automatically assigned a PCP. Kaiser members can receive urgent care or emergency care services without choosing a PCP. Kaiser members may elect to choose a PCP before or while making a regular doctor's appointment.

Health Plan Member Advocates

Los Angeles City Hall
200 N. Spring Street Room 867
Los Angeles, CA 90012

Anthem	Kaiser
8:00 AM – 4:00 PM	
Monday - Friday	Tuesday - Thursday

FOR HELP FINDING A PCP, YOU MAY CALL:

Anthem at 844-348-6111 (Narrow) or 844-348-6110 (Vivity) Monday through Friday, 8 a.m. to 8 p.m. or visit anthem.com/ca/cityofla.

To find a network provider for the Kaiser Permanente HMO plan, call 800-464-4000 or go to: my.kp.org/ca/cityofla.

Residence/Worksite Proximity to Service Providers

Health coverage with an HMO plan is typically restricted to a specific distance from a home or work address. As City employees, your health coverage options discussed in this guide are available to City of Los Angeles work addresses.

If you select HMO coverage and you reside outside of the Los Angeles City limits, ensure that you and your dependents are able to receive Primary Care Physician services in or near your area of residence or that you are capable and willing to travel into the Los Angeles area every time you seek care. To review PCP availability in other areas, review the "Finding Network Providers" section of this guide on page 10.

Understanding Your Out-of-Pocket Costs

A **deductible** is the amount you are responsible for paying for eligible health care services before your plan begins to pay benefits.

Coinsurance is your share of the cost of a covered service you receive.

A **copay** is the dollar amount that you or your eligible dependents must pay directly to a provider at the time services are performed.

Your **out-of-pocket limit** is the most you will have to pay for covered medical expenses in a calendar year through deductible, copays and coinsurance before your plan begins to pay 100 percent of eligible medical expenses.

Health plan options generally cover the same types of care but have differences in what they pay for covered care. The comparison charts on the following pages show how each medical plan pays for some covered services when received from a network provider. To find out if a specific service not shown on the charts is covered, call the plan's Member Services number.

For details on outpatient prescription drug coverage, see page 17.

Medical Plan Costs and Coverage Levels

The LAwell Medical Plan has four coverage level options available for enrollment:

- ✓ **Employee Only** (Single Party - Employee)
- ✓ **Employee & Spouse/DP*** (Two Party - Employee and another adult legal spouse or legal DP)
- ✓ **Employee + Child(ren)*** (Two+ Party - The Employee and any legal child and/or disabled child dependents in the household)
- ✓ **Employee + Family*** (Three+ Party - The Employee and all legal dependents)

See page 36 for more information on eligible dependents.

The majority of health insurance premium costs are paid by the City with the subsidy you receive. This demonstrates the City's commitment to employees and their families – adding up to a valuable part of your total compensation.

The amount of premium you are responsible for depends on the MOU that applies to you, the number of dependents you cover (if any), and the specific plan you choose.

Your maximum subsidy is provided for by the employee's MOU. If you have questions regarding your health plan contributions, please refer to your applicable MOU.

The employee portion of the premiums is automatically deducted from your paychecks two times per month. The tables on the next pages list each benefit plan's per pay period premium cost for both the employee and City.

*Domestic partnerships are not recognized under federal tax law and enrollment of domestic partner dependents may result in different taxable income treatment of the employee. See page 34 for more information.

The majority of health insurance premium costs are paid by the City with the subsidy you receive. This demonstrates the City's commitment to employees and their families – adding up to a valuable part of your total compensation. Review your Memorandum of Understanding (MOU) for more information on your health and dental benefits, including your eligible subsidy amounts during calendar year 2018

LAwell Plan

Your 2018 Medical Coverage Costs Per Pay Period (Every Two Weeks)

Premium Rates for Calendar Year 2018. City Subsidy applies to 07/01/17-06/30/18 and is subject to change based on your applicable MOU. Review your MOU for more information about your subsidy amount.

	MOUs 22, 23, 24, & 25		
Coverage Level	City Pays**...	Employee Pays...	Total Cost of Coverage Bi-Weekly (per Pay Period)
Kaiser HMO			
Employee Only	$305.85	$0.00	$305.85
Employee & Spouse/DP*	$672.81	$0.00	$672.81
Employee + Child(ren)*	$611.70	$0.00	$611.70
Employee + Family*	$675.00	$120.18	$795.18
Anthem Narrow Network (Select HMO)			
Employee Only	$318.96	$0.00	$318.96
Employee & Spouse/DP*	$675.00	$26.73	$701.73
Employee + Child(ren)*	$606.04	$0.00	$606.04
Employee + Family*	$675.00	$154.32	$829.32
Anthem Vivity (LA & Orange Counties HMO)			
Employee Only	$304.07	$0.00	$304.07
Employee + Spouse/DP*	$668.98	$0.00	$668.98
Employee + Child(ren)*	$577.75	$0.00	$577.75
Employee + Family*	$675.00	$115.61	$790.61
Anthem PPO			
Employee Only	$455.00	$34.79	$489.79
Employee + Spouse/DP*	$675.00	$402.56	$1,077.56
Employee + Child(ren)*	$675.00	$255.61	$930.61
Employee + Family*	$675.00	$598.48	$1,273.48

*Domestic partnerships are not recognized under federal tax law and enrollment of domestic partner dependents may result in different taxable income treatment of the employee. See page 34 for more information.

**The City subsidy is current as of the printing of this book. The subsidy amount will through to the end of June 2018 and may change effective July 1 2018. Check your MOU for changes to the subsidy amount that are scheduled to take effect in July.

CHOOSEwell—A Medical Plan Coverage Comparison

The Evidence of Coverage (EOC), a document that describes in detail the benefits covered by the health plan, is available on the plans' websites or through the forms section of **keepingLAwell.com**.

	Anthem Narrow Network (Select HMO)	Anthem Vivity (LA & Orange Counties)	Kaiser Permanente HMO
Calendar Year Deductible	$0		$0
Calendar Year Out-of-Pocket Limit	$500/person, $1,500/family		$1,500/person; $3,000/family
Choice of physicians and facilities (hospital, etc.)	Access covered services through the Anthem Blue Cross network of physicians and facilities as directed by your PCP, except for emergencies***		Access covered services through the Kaiser network of physicians and facilities, except for emergencies
Routine Office Visits	Plan pays 100% after $15 copay/visit		Plan pays 100% after $15 copay/visit
Pediatric Office Visits	Plan pays 100% after $15 copay/visit up to age 5		Plan pays 100% up to age 5
Preventive Care*	Plan pays 100%		Plan pays 100%
Inpatient Hospitalization	Plan pays 100%		Plan pays 100%
Outpatient Surgery	Plan pays 100%		Plan pays 100% after $15 copay/procedure
Maternity Care (Office Visits)	Plan pays 100% if preventive. Plan pays 100% after $15 copay/visit if non-preventive.		Plan pays 100%
Diagnostic Lab Work and X-rays	Plan pays 100%		Plan pays 100% at a Kaiser facility
Emergency Room Care for True Emergencies (such as severe chest pains or breathing difficulties, severe bleeding, poisoning)	Plan pays 100% after $100 copay/visit; copay waived if admitted		Plan pays 100% after $100 copay/visit; copay waived if admitted
Mental Health			
Inpatient**	Plan pays 100%		Plan pays 100%
Outpatient**	Plan pays 100% for facility-based care; 100% after $15 copay/visit for physician visits		Plan pays 100% after $15 copay/visit for individual visit, $7 copay/visit for group session
Chemical Dependency Treatment			
Inpatient**	Plan pays 100%		Plan pays 100%
Outpatient**	Plan pay s 100% for facility-based care; 100% after $15 copay/visit for physician visits		Plan pays 100% after $15 copay/visit for individual visit; $5 copay/visit for group session
Hearing Aid Benefit	Plan pays for one hearing aid per ear every 24 months		Plan pays for one device per ear every 36 months; covers all visits for fitting, counseling, adjustment, cleaning and inspection
Prescription Drugs *see additional information on page 17	See "Outpatient Prescription Drug Coverage Details" on page 17 for details		

*Preventive care coverage includes preventive services rated A or B by the U.S. Preventive Services Task Force and federal regulations. Go to the website for your health plan or call your health plan if you have questions about coverage.

**The mental health inpatient and outpatient benefits shown here are general benefit provisions. Consult with your plan for specific information regarding benefits available.

*** To find a provider or verify physicians, **contact Anthem PPO at 833-597-2362, Anthem (Narrow) at 844-348-6111 or Anthem Vivity at 844-348-6110.**

Anthem PPO		
	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible	$750/person; $1,500/family	$1,250/person; $2,500/family
Calendar Year Out-of-Pocket Limit	$2,000/person; $4,000/family, in-network and out-of-network combined	
Choice of Physicians and Facilities (hospitals, etc.)	Access covered services through Prudent Buyer PPO preferred providers	Access covered services through any provider
Routine Office Visits	Plan pays 100% after $30 copay/visit with no deductible; 90% after deductible for any procedures as part of visit	Plan pays 70% of allowed charges*** after deductible
Online Office Visits	Plan pays 100% after $30 copay	N/A
Pediatric Office Visits Well Baby & Well-Child Care	Plan pays 100% after $30 copay/visit with no deductible; 90% after deductible for any procedures as part of visit; Plan pays 100% for Well Baby & Well Child Care	Plan pays 70% of allowed charges*** after deductible
Preventive Care*	Plan pays 100%, no deductible	Plan pays 70% of allowed charges*** after deductible
Inpatient Hospitalization	Plan pays 90% after deductible; prior authorization needed.****	Plan pays 70% of allowed charges*** after deductible, up to $1,500 per day maximum allowed charges.You are responsible for all charges in excess of $1,500 per day. Prior authorization is needed.****
Outpatient Surgery	Plan pays 90% after deductible	Plan pays 70% of allowed charges*** after deductible, up to $350 per day maximum allowed charges. You are responsible for all charges in excess of $350 per day.
Maternity Care (office visits)Pregnancy & Maternity Care Office Visits	Prenatal and postnatal office visits and ACA mandated services: 100% after $30 copay, no deductible. Other services: Plan pays 100% after deductible $30 copay/visit	Plan pays 70% of allowed charges*** after deductible
Diagnostic Lab Work and X-Rays	Plan pays 90% after deductible	Plan pays 70% of allowed charges*** after deductible
Emergency Room Care for True Emergencies (such as severe chest pains or breathing difficulties, severe bleeding, poisoning)	Plan pays 90% after $100 copay/visit; copay waived if admitted and regular hospitalization benefits apply	Plan pays 90% after $100 copay/visit; copay waived if admitted and regular hospitalization benefits apply
Hearing Aid Benefit	Plan pays for one hearing aid per ear every 24 months	Plan pays for one device every 24 months; 20% coinsurance
Prescription Drugs *see additional information on page 17	See “Outpatient Prescription Drug Coverage Details” on page 17 for details	

*Preventive care coverage includes preventive services rated A or B by the U.S. Preventive Services Task Force and federal regulations. Go to the website for your health plan or call your health plan if you have questions about coverage.

**The mental health inpatient and outpatient benefits shown here are general benefit provisions. Consult with your plan for specific information regarding benefits available in your situation.

***When members use non-preferred providers, they must pay the applicable copayment and coinsurance plus any amount that exceeds Anthem Blue Cross’s allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or out-of-pocket limit.

****You or your doctor must contact Anthem for preauthorization and approval at a non-participating provider before a hospital stay or you will be responsible for a penalty of $250.

CHOOSEwell—A Medical Plan Coverage Comparison

Anthem PPO, continued		
	In-Network	Out-of-Network
MENTAL HEALTH		
Inpatient**	Plan pays 90% after deductible. Prior authorization is required.****	Plan pays 70% of allowed charges*** after deductible. Prior authorization is required.****
Outpatient**	Plan pays 90% after deductible for facility-based care; 100% after $30 copay/ visit for physician office visit	Plan pays 70% of allowed charges*** after deductible. For physician office visit, Plan pays 70% of allowed charges.
SUBSTANCE ABUSE TREATMENT		
Inpatient**	Plan pays 90% after deductible. Prior authorization is required.****	Plan pays 70% of allowed charges*** after deductible. Prior authorization is required.****
Outpatient**	Plan pays 90% after deductible for facility-based care; 100% after $30 copay/ visit for physician office visit	Plan pays 70% of allowed charges*** after deductible. Plan pays 70% of allowed charges for physician office visit.

*Preventive care coverage includes preventive services rated A or B by the U.S. Preventive Services Task Force and federal regulations. Go to the website for your health plan or call your health plan if you have questions about coverage.

**The mental health inpatient and outpatient benefits shown here are general benefit provisions. Consult with your plan for specific information regarding benefits available in your situation.

***When members use non-preferred providers, they must pay the applicable copayment and coinsurance plus any amount that exceeds Anthem Blue Cross's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or out-of-pocket limit.

****You or your doctor must contact Anthem for preauthorization and approval at a non-participating provider before a hospital stay or you will be responsible for a penalty of $250.

Successfully Managing Dependent Coverage

- ✓ **Not everyone who lives with you is a dependent. Check the eligibility rules listed on page 35 before you request enrollment of a dependent.**
- ✓ **Document any added dependents (e.g., birth certificates, marriage license, etc.) by December 11, 2017; adding a dependent does not entitle that individual to coverage unless the City receives the appropriate documentation of eligibility.**
- ✓ **To add a new dependent during the year through a qualified life event you must do so within 30 days of the date he or she becomes your eligible dependent. If you do not act in a timely manner, you will not be able to enroll that dependent until the following year. See Life Events on page 38 for more information.**
- ✓ **To remove an ineligible dependent during the year you must do so within 30 days of the date he or she no longer meets the City's eligibility requirements. If you do not act in a timely manner, you may be subject to paying the cost of dependent claims for periods of ineligibility. See Life Events on pages 38-43 for more information.**

Prescription Drug Coverage Details

Prescription drug benefits are part of the medical plan you elect.

Participating Pharmacy

To have a prescription filled, simply show your member ID card and pay a copayment when you go to a participating Anthem or Kaiser pharmacy. Note that:

- ✓ You do not have to submit claim forms.
- ✓ **For all Anthem plans,** you can fill prescriptions at any retail pharmacy that participates in the Anthem pharmacy network. Prescriptions from non-participating pharmacies are also covered, but the member's cost share is significantly higher. To find a participating pharmacy, go to **anthem.com/ca/cityofla** and select Benefits, then Pharmacy.
- ✓ **For the Kaiser Permanente HMO,** you must fill prescriptions at a Kaiser pharmacy. Prescriptions from non-participating pharmacies are not covered unless they are associated with covered emergency services.

WHAT IS A DRUG FORMULARY?

A formulary is a preferred list of commonly prescribed brand-name medications compiled by an independent group of doctors and pharmacists. It includes medications for most medical conditions that are treated on an outpatient basis. You pay lower copayments when you use a drug on the formulary. You can access the Anthem drug formulary by going to anthem.com/ca/cityofla and selecting Benefits, then Pharmacy. You can access the Kaiser drug formulary by going to kp.org/formulary.

	Anthem Plans	Kaiser Permanente HMO
PHARMACY		
Generic Copay	$10 for up to 30-day supply	$10 for up to 30-day supply
Brand-name Copay	Formulary Drug: $20 for up to 30-day supply Non-Formulary Drug: $40 for up to 30-day supply	$20 for up to 30-day supply
MAIL ORDER (HOME DELIVERY) SERVICE		
Generic Copay	$20 for up to 90-day supply	$20 for up to 100-day supply
Brand-name Copay	Formulary Drug: $40 for up to 90-day supply Non-Formulary Drug: $80 for up to 90-day supply	$40 for up to 100-day supply
FOR QUESTIONS		
Pharmacies or Mail Order	Anthem PPO **833-597-2362**, Anthem (Narrow) **844-348-6111** or Anthem Vivity **844-348-6110** or **anthem.com/ca/cityofla** or visit a member advocate (see pg 10)	800-464-4000 or **my.kp.org/ca/cityofla** or visit a member advocate (see page 10)

For Anthem members: If a member requests a brand-name drug and a generic equivalent is available, the member is responsible for paying the generic drug copayment plus the difference in cost between the brand-name drug and its generic drug equivalent. Some examples of expenses the prescription drug program does not cover include:

- ✓ Most over-the-counter drugs (except insulin), even if prescribed by your doctor
- ✓ Vitamins, except those requiring a prescription like prenatal vitamins
- ✓ Any drug available through prescription but not medically necessary for treating an illness or injury
- ✓ Any drug not purchased through a network pharmacy or mail order program

Chiropractic Care and Acupuncture

Anthem – Anthem plans include coverage for chiropractic care and acupuncture, with some limitations on the number of visits covered each year. You can visit any participating chiropractor from the network without a referral from your primary care physician. Simply call a participating provider to schedule an initial exam. Contact Anthem PPO at **833-597-2362,** Anthem (Narrow); at **844-348-6111** or Anthem Vivity at**844-348-6110** or go to **anthem.com/ca/cityofla,** or visit a member advocate (see page 10) if you have questions about coverage for chiropractic care and acupuncture.

Kaiser – Kaiser Permanente HMO does not cover chiropractic care, but member discounts on these services are available. Physician-referred acupuncture is covered at a $15 per visit copay. For more information, go to **kp.org/healthyroads** or call **877-335-2746,** or visit a member advocate (see page 10).

Special Health Coverage

Coverage for Special Circumstances

Care While Traveling

<table>
<tr><th>Type of Care</th><th>Anthem Narrow Network (Select) HMO
Anthem Vivity (LA & Orange Counties) HMO</th><th>Anthem PPO</th><th>Kaiser Permanente HMO</th></tr>
<tr><td rowspan="2">Emergency Care in the U.S.</td><td colspan="2">Covered 24 hours a day, 7 days a week.
Call 911 or go immediately to the closest emergency facility for medical attention.
Emergency room copayment will be waived if you are admitted.</td><td></td></tr>
<tr><td colspan="2">Within 48 hours of admission, contact Anthem Blue Cross Customer Service at the number listed on your member ID card.</td><td>Call 800-225-8883 immediately if you are admitted to a non-participating hospital.</td></tr>
<tr><td>Emergency Care outside the U.S.</td><td colspan="2">Before traveling, contact Anthem Blue Cross Customer Service at the number listed on your member ID card for a list of participating hospitals.
Always go to the closest emergency facility; request an itemized bill (in English) before leaving to file a claim for reimbursement.
The BlueCross Blue Shield Global Core Service Center is available 24 hours a day, seven days a week toll free at 800-815-BLUE or by calling collect at 804-673-1177. An assistant coordinator, along with a medical professional, will arrange doctor or hospitalization needs.</td><td>Go to the nearest emergency facility and call 800-225-8883 if you receive treatment. Request an itemized bill (in English) and save your receipt to file a claim for reimbursement.</td></tr>
<tr><td>Urgent Care</td><td>In-Area: If you are in-area (15 miles or 30 minutes or less from your medical group), call your primary care physician or medical group and follow their instructions.
Out-of-Area: If you can't wait to return for an appointment with your primary care physician, get the medical help you need right away. If you are admitted to a hospital, call Anthem Customer Service within 48 hours at the number listed on your member ID card.</td><td>Go to the closest urgent care or emergency facility. Contact Anthem Blue Cross Customer Service at the number listed on your member ID card or look up a provider on the anthem website, anthem.com/ca to locate the nearest in-network facility.</td><td>Within the service area, call for an appointment or contact the advice nurse at the number listed in Your Guidebook.
Outside service area, but in California, call 800-225-8883 for assistance.</td></tr>
<tr><td>Prescription Coverage</td><td colspan="2">In the U.S.: Call Anthem Blue Cross Customer Service at the number listed on your member ID card or visit anthem.com/ca/cityofla to find a participating pharmacy that accepts your coverage.
Outside the U.S.: Request an itemized bill (in English) and save your receipt to file a claim for reimbursement.</td><td>Within the service area, go to any Kaiser pharmacy.
Outside the service area, only emergency/urgent prescriptions are covered; ask for an itemized bill (in English) and save your receipt to file a claim for reimbursement.</td></tr>
</table>

Care for Dependents Who Do Not Live with You

Type of Care	Anthem Narrow Network (Select) HMO Anthem Vivity (LA & Orange Counties) HMO	Anthem PPO	Kaiser Permanente HMO
Routine care for a dependent who does not live with you	✓ **In California**: Select a primary care physician by calling Anthem Blue Cross Customer Service at the number listed on your member ID card or by visiting **anthem.com/ca/cityofla**. ✓ **Outside California:** Contact Anthem Blue Cross Customer Service at the number listed on your member ID card to apply for a Guest Membership in a medical group in the city where you are residing.	Contact Anthem Blue Cross Customer Service at the number listed on your member ID card or visit **anthem.com/ca/cityofla** to locate the nearest network providers for highest level of benefit coverage.	Go to any Kaiser facility for covered care. To find a Kaiser facility, visit **kp.org** or call **800-464-4000**. If no Kaiser facility is available, only emergency care is covered.

SPECIAL COVERAGE SITUATIONS FOR DEPENDENTS

Eligible dependents under your plan may fall under special coverage situations that could affect their ability to remain on your coverage. See DEPENDENT COVERAGE RULES FOR SPECIAL SITUATIONS on page 33.

Additional Wellness Coverage

To support your current and future health and wellbeing, **LAwell** includes many other benefits. Here are some of the additional—and very important—parts of your benefits package.

	Anthem Plans anthem.com/ca/cityofla	Kaiser Permanente HMO mykp.org/ca/cityofla
Annual Checkups	**Annual physical and other in-network preventive care is generally covered at 100% in-network**	
Nurse Help Line 24 hours a day, 7 days a week	Call the 24/7 Nurseline at the number listed on your member ID card	**888-576-6225**
Weight Management and Nutrition Counseling	✓ Diabetes Prevention Program for pre-diabetics (in-person and online) ✓ Diet and nutrition advice ✓ Diabetic Care self-management training (after copay) ✓ Discounts on weight loss products and programs, including Jenny Craig, Living Lean, nutrition bars and drinks ✓ Bariatric surgery if authorized as medically necessary	✓ Nutrition counseling available with doctor referral; copay applies ✓ Lifestyle Weight Management Course plus other health education programs ✓ Free online personalized Weight Management Program ✓ Weight Watcher discounts ✓ Bariatric surgery referral to a specialist for weight loss surgery
Smoking/Tobacco Cessation	Quitting smoking is the most important thing that current smokers can do to live a longer, healthier life. Anthem offers these tools and resources to help you beat the addiction: ✓ Smoking/tobacco cessation support ✓ Over-the-counter nicotine replacement medications with no copayment ✓ Prescription smoking cessation medications	✓ Nicotine patches at regular drug copayment for up to six months when registered for a smoking cessation class ✓ Stop smoking classes offered at no fee to members ✓ Members can meet with a Clinical Health Educator for one-on-one counseling at regular office copay ✓ Free, online personalized Stop Smoking Program ✓ Quit smoking with Breathe™
Health Coaching	Contact Anthem Concierge support for resources and wellness services.	Offers a phone-based and web-based Health Coaching program available to all members focused on health habits, like managing weight, quitting tobacco, reducing stress, becoming more active, and eating healthier.
Exercise	Offers a web-based walking program that allows members to earn points and join an online community supporting their walking goals.	Offers a web-based walking program called “10,000 Steps” which allows members to set goals and track individual progress.
Chronic Care Management	Call **800-552-5560** to sign up for ConditionCare and get 24/7 toll-free access to a nurse care manager; health screenings and follow-up calls; educational guides; and tools on how to take care of your health.	Complete Care disease management program is designed to prevent or manage chronic conditions through a combination of clinical care, health education, and self-management tools. Members with specific medical conditions are automatically identified using disease-specific case identification protocols through our clinical information systems. Call Member Services at **800-464-4000**.
Other Online Tools	Go to **anthem.com/ca/cityofla** and select Health & Wellness to find: ✓ Preventive health guidelines for men, women, children and seniors ✓ Videos on a range of wellness topics ✓ Articles on alternatives to Western medicine ✓ First aid information ✓ Comprehensive health library ✓ LiveHealth Online doctors	✓ Total Health Assessment with Succeed™ ✓ Exercise videos ✓ Physical and mental health quizzes and calculators ✓ Downloadable podcasts ✓ Fitness widgets ✓ Interactive “Kid Wisdom” site geared for Child health

Dental Coverage

Your Dental Coverage Choices

You have a choice of two dental options administered by Delta Dental:

DeltaCare USA DHMO is a dental HMO; you choose a Primary Care Dentist (PCD) and see this dentist first whenever you need care.

Delta Dental PPO provides care through a network of dentists who have agreed to offer covered services at discounted rates.

Dentists who are not part of Delta's PPO network may still be Delta dentists and agree to accept Delta's reasonable and customary (R&C) fee. In California, 89% of dentists belong to a Delta network.

CHOOSEwell – A Dental Plan Comparison

	DeltaCare USA DHMO	Delta Dental PPO
Features a network of providers	Yes	Yes
Offers flexibility to use non-network providers	No	Yes – paid at out-of-network level
Covers preventive care	Yes	Yes
Covers services other than preventive care – such as basic and major services	Yes	Yes
Has a calendar year deductible	No	Yes
Has an annual maximum benefit	No	Yes
Includes set copayments for most services	Yes	No
Requires you to choose a primary care dentist	Yes	No
Covers emergency care outside the provider network*	Yes – up to $100 per incident after any copay**	Yes – paid at out-of-network level

* For emergency care provided by a dentist who is not part of Delta's network, you must pay for services and submit a claim. For claim instructions, contact Delta Dental Customer Service at ***800-765-6003*** for PPO or ***800-422-4234*** for DeltaCare USA DHMO.

** Contact your primary care dentist (PCD) or Delta Dental Customer Service at ***800-422-4234*** before receiving treatment. If you do not, you may be responsible for any charges related to treatment.

Delta Dental Network Providers

If you enroll in the DeltaCare USA DHMO option, you must use that network's providers to receive benefits. Below is general information on using each dental plan option:

DeltaCare USA DHMO	Delta Dental PPO
Benefits paid for network services only	Plan pays highest level of benefit when you use network providers
You must select a Primary Care Dentist (PCD) from the DeltaCare USA network	Network providers offer discounted fees. No charges above reasonable and customary (R&C) limits

Finding a Network Provider

You can request a provider directory (at no cost) for the Delta Dental DeltaCare USA DHMO or PPO option by:

- ✓ Calling Delta Dental Customer Service at **800-765-6003** for the Delta Dental PPO options or **800-422-4234** for the DeltaCare USA DHMO option; or
- ✓ Searching provider directories at **deltadentalins.com/enrollees/index.html** and selecting "Find a Dentist." From the drop-down menu, choose DeltaCare USA for the DHMO option or Delta Dental PPO for the Delta Dental PPO option.

How to Register for a Delta Dental Online Account

You can go online to verify your assigned dentist and other information, such as eligibility, your enrolled family members, claim status and benefit specifics. Here's how to register online:

1. Go to **deltadentalins.com/enrollees/index.html**
2. Select "Register for an Online Account" from the right side of the page
3. Select "Enrollee" from the pull-down menu
4. Enter your personal information

Dental Coverage Costs and Coverage Levels

The majority of employee-only coverage dental insurance premium costs are paid by the City's subsidy. The LAwell Plan offers the same four coverage level options for Dental plans as for Health enrollment (see page 12). For more information on eligible dependents, see page 35.

The amount of premium you are responsible for depends on the coverage level you choose, and the specific plan you choose.

For 2018, the maximum DHMO dental plan subsidy is $16.78 per month for all employees. The maximum PPO dental plan subsidy is $44.60 per month for full-time employees.

CHOOSING A PRIMARY CARE DENTIST (PCD)

If you enroll in DeltaCare USA DHMO, you must select a PCD from the DeltaCare USA network to receive benefits. If you want to change your PCD at any time during the year, call Delta Dental Customer Service at 800-422-4234. Because the DeltaCare USA DHMO option does not cover care that is not coordinated by your PCD, it is important that you do not go to another dentist without first contacting Delta Dental Customer Service.

LAwell Dental Pay Plan

Your 2018 Dental Coverage Costs Per Pay Period (Every Two Weeks)

	MOU 23			MOUs 22, 24, & 25		
Coverage Level	City Pays...	Employees Pays...	Total Cost of Coverage Bi-Weekly	City Pays...	Employee Pays...	Total Cost of Coverage Bi-Weekly
DeltaCare USA DHMO						
Employee Only	$8.39	$0.00	$8.39	$8.39	$0.00	$8.39
Employee + Spouse/DP*	$8.39	$7.25	$15.64	$15.64	$0.00	$15.64
Employee + Child(ren)*	$8.39	$5.64	$14.03	$14.03	$0.00	$14.03
Employee + Family*	$8.39	$9.73	$18.12	$18.12	$0.00	$18.12
Delta Dental PPO						
Employee Only	$26.23	$0.00	26.23	$26.23	$0.00	$26.23
Employee + Spouse/DP*	$26.23	$22.94	49.17	$40.00	$9.17	$49.17
Employee + Child(ren)*	$26.23	$24.75	50.98	$40.00	$10.98	$50.98
Employee + Family*	$26.23	$42.16	68.39	$40.00	$28.39	$68.39

*Domestic partnerships are not recognized under federal tax law and enrollment of domestic partner dependents may result in different taxable income treatment. See page 34 for more information.

WHAT IS REASONABLE AND CUSTOMARY (R&C)?
The amount quoted for a dental service that is based on what is typically charged within a specific geographic area is called the Reasonable and Customary (R&C) charge.

Use Delta Dental's Dental Care Cost Estimator tool to research R&C cost estimates. Log into your Delta Dental of California account at www.deltadentalins.com to access the tool.

CHOOSEwell – A Dental Plan Coverage Comparison

This chart shows how the three options pay for certain services. If you have questions about how a specific service is covered, call Delta Dental at **800-765-6003** for Delta Dental PPO or **800-422-4234** for DeltaCare USA DHMO.

How Benefits Are Paid	DeltaCare USA DHMO	Delta Dental PPO	
		In-Network	Out-of-Network
Calendar year deductible	None	$25/person; $75/family	$50/person; $150/family
Diagnostic and Preventive Care			
✓ Two cleanings and exams/year ✓ Two sets of bitewing X-rays/year for children up to age 18; one set/year for adults ✓ Two fluoride treatments/year for children up to age 19 (not covered by Preventive Only)	Plan pays 100% - Covers one series of four bitewing X-rays in any six-month period for children or adults	Cleanings, X-rays and exams; Plan pays 100% with no deductible (includes an additional oral exam and a routine cleaning during pregnancy). Diagnostic and Preventive Care charges are not applied to the annual maximum.	Cleanings, X-rays and exams; Plan pays 80% of R&C* with no deductible (includes an additional oral exam and a routine cleaning during pregnancy). Diagnostic and Preventive Care charges are not applied to the annual maximum.
Basic Services			
Amalgam fillings, extractions	Plan pays 100% for fillings; you pay up to $90 for extractions	Plan pays 80%	Plan pays 80% of R&C*
Root canal	Your copay is $45–$220 per procedure	Plan pays 80%	Plan pays 80% of R&C*
Periodontal scaling and root planing	Plan pays 100% up to 4 quadrants in 12 months	Plan pays 80% once per quadrant every 24 months	Plan pays 80% of R&C,* once per quadrant every 24 months
Major Services			
Crown	Your copay is $55–$195 per procedure**	Plan pays 80%	Plan pays 50% of R&C*
Dentures	Your copay is $80–$170 per procedure	Plan pays 50%	Plan pays 50% of R&C*
Implants	Not covered	Plan pays 50%	Plan pays 50% of R&C*
Orthodontia			
Children under age 19	Your copay is $1,000 plus start up fees of $300	Plan pays 50%	Plan pays 50% of R&C*
Children age 19 to age 26	Your copay is $1,350 plus start up fees of $300	Plan pays 50%	Plan pays 50% of R&C*
Adults	Your copay is $1,350 plus start up fees of $300	Not covered	Not covered
Plan Maximums			
Annual maximum benefit (does not include diagnostic and preventive services)	None	$1,500/person***	$1,500/person***
Lifetime orthodontia maximum benefit	None	$1,500/child	$1,500/child

* R&C is the reasonable and customary charge – the usual charge for specific services in the geographic area where you are treated.
** When there are more than six crowns in the same treatment plan, an enrollee may be charged an additional $100 per crown beyond the sixth unit.
*** If you use both in-network and out-of-network dentists, your total annual maximum benefit will never be more than $1,500 per person.

Vision Coverage

Your Vision Coverage

Sworn employees who are enrolled in a LAwell Medical Plan receive vision care benefits through a vision plan offered through **EyeMed**. **The City provides this benefit at no cost to you and your eligible dependents,** and you will be enrolled automatically. Your benefits through EyeMed include exams, frames, and either lenses or contacts every 12 months.

The EyeMed Network

EyeMed provides care through a network of vision care specialists who have agreed to offer covered services at discounted rates. The EyeMed Insight network has over 71,000 providers, including 50,000 independent providers plus national retail chains such as LensCrafters®, Sears Optica®, Target Optical®, JCPenney Optical® and most Pearle Vision® locations. To find a provider near you and schedule an appointment, visit **eyemedvisioncare.com/cityofla** or download the EyeMed mobile app and choose the Insight network from the list of network options.

Out-of-Network Providers

You can visit a vision care provider who does not participate in the EyeMed network and still receive benefits for covered services. You will be reimbursed up to a maximum dollar amount if you provide EyeMed with an itemized receipt and a completed claim form. Claim forms are available at **eyemedvisioncare.com/cityofla** or by calling the EyeMed Customer Care Center at **855-695-5418**.

To access benefits, you just need to provide your name and date of birth to an In-Network EyeMed provider.

No ID cards are needed, but can be printed on eyemedvisioncare.com/cityofla.

Annual Benefit to Purchase Eyeglasses & Contact lenses		
	Covered	**Not Covered**
Option 1	$150 Contact Lens Allowance + $150 Frame ONLY Allowance	Eyeglass lens
Option 2	$150 Frame Allowance + Eyeglass lens copay	Contact lenses

Sworn employees on Cash-in-Lieu are only eligible for EyeMed vision benefits in 2018 if they are a covered dependent on another City or Sworn employee who is enrolled as the primary in a LAwell medical plan

In- and Out-of-Network Vision Benefits

Benefits are available to you and your covered dependents **once every twelve months**.

Benefits	EyeMed In-Network Provider What you pay	Out-of-Network Provider What the Plan reimburses
Routine Eye Exam[1]	$10 copay	$45 reimbursement maximum*
Exam Options:		
Standard Contact lens fit & follow-up	$55 copay	N/A
Premium Contact lens fit & follow-up	90% of Retail Price	
Retinal Screening	$10 copay	$21 reimbursement maximum*
Frames[2]	$150 Allowance, 80% of balance over $150	$104 reimbursement maximum*
EyeGlass Lenses[2]		
Lenses[2]		
Single Vision	$10 Copay	$35 reimbursement maximum*
Bifocal	$10 Copay	$50 reimbursement maximum*
Trifocal	$10 Copay	$65 reimbursement maximum*
Standard Progressive†	$75 Copay	$70 reimbursement maximum*
Premium Progressive Tier 1†	$95 Copay	$70 reimbursement maximum*
Premium Progressive Tier 2†	$105 Copay	$70 reimbursement maximum*
Premium Progressive Tier 3†	$120 Copay	$70 reimbursement maximum*
Premium Progressive Tier 4†	$75 Copay, 80% of charge less $120 Allowance	$70 reimbursement maximum*
Contact Lenses		
Lens Options[2]		
UV Treatment	$15	N/A
Tint (Solid & Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate – Adults	$40	N/A
Standard Polycarbonate – Kids under 19	$0 Copay	$28 reimbursement maximum*
Standard Anti-Reflective Coating†	$45	N/A
Premium Anti-Reflective Tier 1†	$57	N/A
Premium Anti-Reflective Tier 2†	$68	N/A
Premium Anti-Reflective Tier 3†	80% of charge	N/A
Polarized	80% of Retail Price	N/A
Photocromatic / Transitions Plastic	$75	N/A
Other Add-ons	80% of Retail Price	N/A
Contact Lenses[2]		
Conventional	$150 Allowance	$120 reimbursement maximum*
Disposable	$150 Allowance	$120 reimbursement maximum*
Medically Necessary	$0 Copay, Paid-in-Full	$210 reimbursement maximum

* Subject to review and approval of a completed claim form with an itemized receipt submitted to EyeMed

† Tier levels reflect Name Brand categories.

1 Eye Exam coverage through EyeMed applies to a routine eye exam for a vision prescription. Medical eye exams are typically covered through your health care provider. See the chart on page 28 and visit **keepinglawell.com** for more information.

2 The Frame allowance can be used with either the Contact Lenses allowance OR the Eyeglass Lenses copay options during a calendar year. Contact Lenses and Eyewear Lenses benefits cannot be used together in the same calendar year. Visit **keepinglawell.com** for more information.

Retinal Screening Exams

Retinal screening uses a laser to scan the eyes and then produces digital images of the retinas. The images can be useful in finding abnormalities and comparing the condition of retinas from year to year. You may receive one retinal screening every 12 months for an additional $10 copay.

How EyeMed Benefits Work with Medical Plan Vision Benefits

Anthem and Kaiser members who prefer to receive an annual vision exam through their medical plan providers may do so but are not entitled to an eyewear allowance through their medical plan. Eyewear (frames, lenses, and contacts) received from a medical plan provider may be submitted to EyeMed for reimbursement as an out-of-network provider. Members may also visit an EyeMed in-network provider using their medical plan provider prescription and purchase eyewear using their EyeMed materials benefit. The following chart outlines how your EyeMed benefit can be used with your medical plan:

DESCRIPTION	EYEMED	KAISER	ANTHEM
Routine Eye Exam	**Covered with copay.**	**Covered with copay**	**Not covered.**
Eyewear – Frames & Lenses or Contacts	**Up to $150** allowance every year (does not roll over if not used).	Not covered (Partial reimbursement available from EyeMed if member files an out-of-network claim).	
Medical Eye Exams (e.g. Screening for medical vision conditions like glaucoma, cataracts, etc.)	May be covered. Check with EyeMed vision provider **before** seeking ophthalmology related services.	Covered with copay.	Covered with copay. Primary Care Physician (PCP) referral and/or medical group authorization may be required under HMO plans. Please contact your PCP for information regarding their referral process **before** seeking care from a specialist.
Treatment of Vision Conditions (e.g. glaucoma, cataracts, etc.)	Not covered.	Covered with copay.	Covered with copay. Primary Care Physician (PCP) referral and/or medical group authorization may be required under HMO plans. Please contact your PCP for information regarding their referral process **before** seeking care from a specialist.

*Allowances may vary per specific benefit, based on the type of benefit item purchased, and do not apply to all benefits.

Vision Plan Costs and Coverage Levels

All vision insurance premium costs are paid by the City.

Enrollment in the vision plan will match your elected enrollment into medical coverage. For more information on eligible dependents, see page 35.

Sworn employees electing Cash-in-Lieu are not eligible for EyeMed vision benefits unless they are covered as a dependent of another City or Sworn employee enrolled in a LAwell Medical Plan.

Health and Dependent Care Tax-Advantaged Spending Accounts

Types of Accounts

The City offers accounts for tax savings on eligible expenses:

- ✓ A **Healthcare Flexible Spending Account (HCFSA)** for eligible healthcare expenses
- ✓ A **Dependent Care Reimbursement Account (DCRA)** for dependent day care expenses

When You Can Enroll

You can enroll in the Healthcare Flexible Spending Account and the Dependent Care Reimbursement Account during Open Enrollment. You can only make a change to your account or enroll during the year if you have a qualifying life event. If you want to continue to participate, you must re-enroll each year at Open Enrollment.

How the Accounts are Different

Healthcare Flexible Spending Account (HCFSA)	Dependent Care Reimbursement Account (DCRA)
• Use it to reimburse yourself for eligible healthcare expenses for you and your eligible dependents • Eligible healthcare expenses include medically necessary expenses that are not covered by any medical, dental or vision plan	• Use it to reimburse yourself for day care expenses for your eligible dependents • Eligible dependents generally include your dependent children under age 13 and a disabled spouse or dependent who is incapable of self-care

When you enroll in any of these accounts, you set aside pre-tax dollars from your pay to cover eligible expenses.

About the Healthcare Flexible Spending Account

Use the HFSA to pay for eligible healthcare expenses that are not covered by any medical, dental, or vision coverage. Generally, eligible healthcare expenses are claimable only for expenses incurred during the period when you are enrolled in a City-sponsored medical plan.

How Much You Can Set Aside

You can set aside from **$300 up to $2,600** (maximum amounts subject to Federal law revision) annually in a Healthcare Flexible Spending Account. Your contributions are deducted from your paycheck (pre-tax) each pay period.

ADMINISTRATIVE FEE

If you choose to contribute to one of these accounts, a per pay period administrative fee of $1.50 will automatically be deducted from your paycheck each pay period. Only one administrative fee applies if you contribute to more than one account.

DEBIT CARD

A Convenient Way to Access Money in Your Healthcare Flexible Spending Account

You will automatically receive a debit card to use for eligible healthcare expenses at any provider or retailer that accepts debit cards. The debit card is an additional convenience option and is not intended to replace the traditional claim process. Some eligible healthcare expenses may not be available through the debit card and will only be eligible through filing a traditional claim.

There is no debit card option for the Dependent Care Reimbursement Account.

Examples of Eligible and Ineligible Expenses

The Healthcare Flexible Spending Account Can Be Used To Pay For:	The Healthcare Flexible Spending Account CANNOT Be Used To Pay For:
✓ Acupuncture ✓ Chiropractic services ✓ Crutches and wheel chairs ✓ Eye exams, eyeglasses ✓ Laser eye surgery ✓ Hearing aids ✓ Lamaze classes ✓ Mental health and substance abuse treatment ✓ Orthodontia ✓ Copayments, coinsurance and deductibles you pay out of your pocket for medical, prescription drug, dental and vision care ✓ Over-the-counter medications with a doctor's prescription and insulin	✓ Cosmetic surgery or procedures, including teeth whitening or bleaching ✓ Your bi-weekly premium contributions for health and dental insurance ✓ Procedures or expenses not medically necessary ✓ Weight loss programs not prescribed by a doctor ✓ Exercise equipment and health club dues not prescribed by a doctor ✓ Nutritional supplements not prescribed by a doctor, such as vitamins taken for general health ✓ Most over-the-counter medications and products without a prescription such as cosmetics, soaps and toiletries

Go to **wageworks.com/employees/support-center/healthcare-fsa-eligible-expenses-table/** to view a searchable list of HCFSA-eligible expenses.

LEARN MORE

Go to wageworks.com and savesmartspendhealthy.com to learn more about the benefits of using an HCFSA. Get tips and guidance to help you decide whether to participate in an HCFSA. You can learn how to stretch your budget if you choose to participate.

HEALTHCARE FLEXIBLE SPENDING ACCOUNTS (FSA) AND HEALTHCARE SAVINGS ACCOUNTS (HSA)

The LAwell program does not offer a high-deductible health plan and the Flexible Spending Account offered through the LAwell program is not established as a HSA-compatible option. If you are enrolled in a high-deductible health plan with your spouse/domestic partner, former employer, or other organization and are enrolled (or plan to enroll) into a Health Savings Account (HSA) for 2018, you should consult with your tax advisor before enrolling into LAwell's HCFSA. Enrolling in a FSA account is considered an irrevocable election; see "Important Deadlines and Restrictions" for more information.

About Eligible Dependents

IRS rules determine who is an eligible dependent. You may use a an HCFSA for healthcare expenses of:

✓ Your spouse and any child you claim as a dependent on your tax return.

✓ Anyone who is your "health plan tax dependent" as defined by the IRS.

See page 31 for a definition of "health plan tax dependent."

Estimate Expenses Carefully

It is important to estimate HCFSA expenses carefully and set aside only the amount you think you will need while you are contributing to the account during 2018. You must file claims for 2018 expenses by **April 30, 2019**. If you do not file claims by this deadline, you forfeit any money left in your account. This is an Internal Revenue Code rule and the **LAwell** program cannot make exceptions.

You may be able to make a limited change if you have a qualifying life event (see pages 38-43 for more on life events). For the dependent care account, certain changes to your day care provider or the cost of care may also qualify as an eligible change event, subject to approval of the **LAwell** benefits program.

The elections you make for the HCFSA or DCRA are valid for the 12-month plan year. Changes are **NOT** permitted outside of a qualifying life event as approved by the **LAwell** program. **This is an Internal Revenue Code rule and the LAwell program cannot make exceptions**.

About the Dependent Care Reimbursement Account

You can use a Dependent Care Reimbursement Account for day care expenses you have for your eligible dependents while you and your spouse work or go to school full-time. Your eligible dependents are:

- ✓ Children under age 13 you claim as dependents on your tax return.
- ✓ Anyone age 13 or older who meets the IRS definition of "health plan tax dependent," lives with you more than half the year, and is physically or mentally unable to care for themselves. This may include an elderly parent or disabled dependent.

See the box below for a definition of "health plan tax dependent."

Generally, dependent day care expenses are claimable only on days you work. There are exceptions. For a short absence, such as a minor illness or vacation, day care expenses are claimable if those expenses are paid on a weekly or longer basis. In addition, if you work part-time, expenses are claimable if you are required to pay a fixed rate – such as a full weekly rate – rather than paying for only the time you are working.

WHO IS A "HEALTH PLAN TAX DEPENDENT"?

Under federal tax law, "health plan tax dependent" includes your children (biological, adopted, step and foster) through the end of the year in which they turn age 26. It also includes other covered individuals for whom you can claim an exemption on your federal taxes. In addition, it includes family members – or an unrelated person who lives with you for the entire year – if they receive more than half of their support from you; are a U.S. citizen, resident or national, or a citizen of Mexico or Canada; and are not claimed as a "qualifying child" dependent on anyone else's tax return. These rules are complex and may require the assistance of your tax advisor.

To be reimbursed, day care must be provided by a person for who you can provide a Social Security Number or day care facility with a Taxpayer Identification Number. Day care provided by any sitter who you or your spouse claims as a dependent on your tax return cannot be reimbursed through your account. This includes day care services provided by your children or stepchildren under age 19. In addition, day care provided by your spouse or former spouse is not eligible for reimbursement.

How Much You Can Set Aside

Generally, you can set aside from **$600 up to $4,992*** (maximum amounts subject to Federal law revision) annually. Your contributions come out of your check each pay period.

The total amount you can set aside may change depending on your tax filing status and whether your spouse's employer offers a similar Dependent Care Reimbursement Account. If you and your spouse both work, your maximum contribution cannot be more than the income of the lower-paid individual – you or your spouse – and cannot exceed $4,992*.

Based on your tax status…	You can set aside…
If single or married filing jointly	Up to $4,992*
If married filing jointly and your spouse's employer offers a DCRA	Up to $5,000 in total to the two accounts
If married filing separate returns	Up to $2,500

*City payroll deferral elections must be a whole dollar amount, and your election cannot exceed the annual maximum. $208 per paycheck over 24 pay periods provides a cumulative annual deferral of $4,992.

About the Dependent Care Reimbursement Account and Taxes

As you consider a Dependent Care Reimbursement Account, think about what works best for you – the reimbursement account or the dependent care tax credit provided by federal law. It is important to keep in mind that you cannot take the tax credit for any amounts that are reimbursed through a reimbursement account. In some cases, the tax credit may provide more savings than a reimbursement account.

Generally, you will save more on federal taxes using the Dependent Care Reimbursement Account in these situations:

- ✓ You are eligible for the Earned Income Tax Credit. You are eligible for the credit if you have less than $3,400 in investment income and your income (or the income of you and your spouse, if you are married filing jointly) is less than the amount set forth for 2018 in the following table depending on your number of children:

Number of Children	Income less than…
1	$39,131 ($44,651 if married filing jointly)
2	$44,454 ($49,974 if married filing jointly)
3 or more	$47,747 ($53,267 if married filing jointly)

- ✓ You are single, you file your taxes as head of household and your household taxable income is approximately $40,000 or more (assuming one dependent).
- ✓ You are married, you file a joint return and your household taxable income is approximately $41,000 or more (assuming one dependent).

Dollar amounts are based on federal tax law effective for 2018 federal income taxes. These are just guidelines and do not take into account state taxes.

If you have questions about tax savings, please consult a tax advisor.

Important Deadline and Restrictions

HCFSAs and/or the DCRAs are not a savings accounts. You can use the money you set aside in 2018 only for eligible expenses you have during the 2018 plan year while you are contributing to the account. **If you have unused contributions at the end of the plan year , those contributions will not carry forward and will be forfeited.**

Also, if you leave your employment with the City mid-year, you can file HCFSA claims and receive reimbursement only for expenses you had up to the date your LAwell benefits end, and you will forfeit any additional amount left in your account. For more information on when benefits end, see pages 35-36. You may be able to continue a HCFSA and/or the DCRA under COBRA if your employment ends, with some limitations. Employees who terminate employ-ment, retire, or transfer to DWP and then subsequently return to the City within the same calendar year may have their account re-established based on their prior elections, subject to review and approval by the LAwell program and subject to applicable Internal Revenue Code rules.

ESTIMATING EXPENSES AND TAX SAVINGS

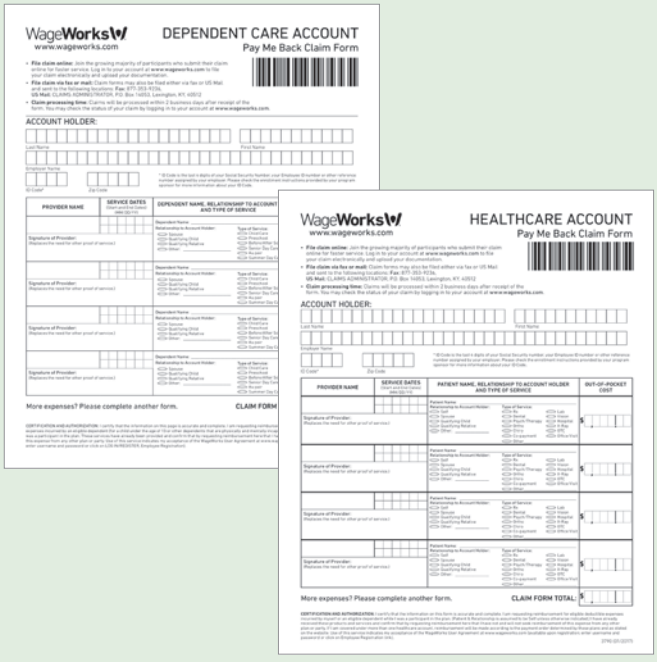
To estimate your annual expenses and the tax savings of setting up a Healthcare Flexible Spending Account and/or Dependent Care Reimbursement Account, go to keepingLAwell.com. As part of the enrollment process, you'll find links to a calculator for each account.

Filing Claims

Generally, you pay eligible healthcare and dependent care expenses out of your pocket first, then file a claim with documentation of your expenses in order to be reimbursed from your account.

Account	Reimbursement
HCFSA	You may be reimbursed the full amount of your claim (including tax) when you file a claim for an eligible expense, up to the amount you have chosen to put into your account. This applies even if your account does not yet have enough in it to cover the expense. However, you will be reimbursed only for expenses you or an eligible family member have while you are contributing to the account.
DCRA	You may be reimbursed for your claim up to the amount in your account at the time of the claim. Any unpaid claims will remain in "pending" status and will be reimbursed as you make additional contributions to your account through payroll deduction.

As long as you file claims regularly, you can receive reimbursement promptly. Generally, you receive a reimbursement check within two weeks for a paper claim or one to two days for an online claim. For claim forms, go to **per.lacity.org/bens/docforms.htm**. You can submit claims and upload receipts online, pay your provider directly for some services, and use EZ Receipts mobile application from WageWorks.



Dependent Coverage Rules for Special Situations

Dependent Coverage Rules for Special Situations

Important Information about Eligibility Criteria for Disabled Child Over Age 26

You can continue coverage for a disabled child age 26 or older who is dependent on you for support if that child was disabled before age 26. To be eligible, your child must remain unmarried, dependent on you for financial support and disabled as determined by your medical plan.

You must request a disability certification package or the required application from your medical plan, ask your dependent's primary care physician to complete it, then return it to your medical plan for review. The ***Employee Benefits Division must be notified of the medical plan's determination regarding the disabled certification application.***

When Two LAwell-Eligible City Employees Are Married, Are Domestic Partners or Have Dependent Children Together

✓ For medical, dental and vision coverage, you cannot enroll as both an employee and as a dependent of your spouse/domestic partner. Only one spouse/domestic partner can cover dependent children.

- Medical and vision coverage: If your spouse/domestic partner chooses family coverage, you must choose Cash-in-Lieu and you can be covered as a dependent of your spouse/ domestic partner.
- Dental coverage: Each employee must enroll in his/her own dental plan. Your spouse/domestic partner cannot cover you as a dependent.

If you have dependent children with another City employee who is not currently your spouse/ domestic partner, only one parent can purchase medical coverage, dental coverage, life or AD&D insurance for the dependent children. Employees who enroll dependents in violation of the rules in this section, or as otherwise listed in this guide, are considered to be making an improper use of their benefits. The LAwell plan will have authority to take corrective action to any employees coverage, or the employees applicable dependents coverage, who are found to make an improper use of benefits.

Children Who Are City Employees

Children who are benefits-eligible employees of the City cannot be covered as dependents under their City employee parents however, they may be beneficiaries of life insurance.

Domestic Partner Coverage and Pre-Tax Benefits

The City of Los Angeles offers domestic partners of City employees, and domestic partners' children, equal access to its employee benefit programs, including medical, dental and vision plans. To obtain these benefits, you must enroll your dependents during the specified times and provide the required dependent eligibility documentation. Please refer to pages 36-37 for more information on enrolling dependents.

Federal Taxes vs State Taxes

Under **Federal tax law**, pre-tax dollars cannot be used to purchase benefits for a domestic partner or their children. Unless your partner and the partner's children meet an exception, you pay your share of the coverage cost with after-tax dollars. The amount the LAwell program pays toward the cost of your domestic partner's coverage will be taxable as regular income on 24 paychecks a year.

Based on **California state law**, if you provide LAwell coverage for a domestic partner, and/or their dependents, you can purchase medical or dental coverage with pre-tax dollars as long as your domestic partnership meets eligibility requirements and is registered with the State of California. The amount the City of Los Angeles pays toward coverage cost will be excluded from your reported State income. You must provide a copy of the approved State certificate to receive this tax benefit. For more information on the California income tax benefit, including how to register a domestic partner, contact the City's Domestic Partnership for Sworn Employees Coordinator at **213-978-1600**.

Eligibility

Who is Eligible for Benefits?

Sworn employees are eligible for **LAwell** if they are members of Memorandums of Understanding (MOU) 22, 23, 24, or 25 and work at least 30 hours per week of qualifying hours (such as HW, SK, VC, HO, etc.), or the number of qualifying hours specified by their MOU to be considered full time and eligible for benefits.

Family Members of Employees

If you are eligible for **LAwell** benefits, you can also enroll your eligible family members if your dependents meet the criteria listed on page 36 and you submit the required documentation by the deadlines. You MUST review your dependent elections and verify that each dependent enrolled —and dependents you add —continue to meet the **LAwell** eligibility criteria at all times. You must provide the required documentation to confirm your dependents, as determined by the Benefits Division. Restrictions apply to family members who are also City employees, see page 33 for details.

Ineligible Dependents

The following are examples of individuals who are **not** considered eligible dependents: your spouse following a divorce; someone else's child (such as your grandchildren, nieces, or nephews), unless you have been awarded legal custody or guardianship; or parents, parents-in-law, or grandparents, regardless of their IRS dependent status.

You must drop coverage for your enrolled dependent within 30 days of the date he or she loses eligibility (e.g., within 30 days of a divorce). If you fail to remove ineligible dependents, you will be required to pay all costs for any benefits that were paid on their behalf and you may be subject to disciplinary action.

ELIGIBLE CHILDREN

Your children may include your natural children, legally adopted children or children placed with you for adoption, children for whom you have legal custody or guardianship, foster children placed in your home pending a permanent placement with you, and stepchildren. These children are eligible if they meet the age requirements listed on page 36.

Dependent Eligibility Criteria

The following chart describes eligible dependents for medical, vision, and dental coverage. See "About Eligible Dependents" on page 30 for information on eligible dependents for the Healthcare Flexible Spending Account and Dependent Care Reimbursement Account.

Dependent Type	Age	Eligibility Definition	Documents Required for Verifying Eligibility
Spouse	N/A	Person of the opposite or same sex to whom you are legally married	Marriage certificate
Domestic Partner	N/A	Meet City's domestic partner eligibility requirements. See Domestic Partnership Information Sheet and Affidavit form at **per.lacity.org/bens/docforms.htm**	City of Los Angeles Affidavit of Domestic Partnership, or Declaration of Partnership filed with the California Secretary of State
Biological Child (Natural child)	Up to age 26*	Employee's married or unmarried child(ren) under age 26	Child's birth certificate, hospital verification of birth or court document that verifies your relation to the child (an abstract document is not sufficient in most cases)
Stepchild	Up to age 26*	Employee's spouse's married or unmarried child(ren) under age 26	Child's birth certificate and certificate showing spouse/domestic partner as parent
Adopted child or child placed for adoption	Up to age 26*	Minor or adult child legally adopted by employee under age 26 (married or unmarried)	Child's birth certificate and court documentation
Child of Domestic Partner	Up to age 26*	Minor or adult child of employee's domestic partner under age 26 (married or unmarried)	Child's birth certificate and City of Los Angeles Domestic Partner Affidavit or Declaration of Partnership filed with the California Secretary of State
Disabled Child	Age 26 and older	Disabled child over the age of 26 who is dependent on you for support and was disabled before age 26. To be eligible, your child must remain unmarried, dependent on you for financial support and disabled as determined by your health plan.	Birth certificate and disability application from your health plan completed by your child's doctor and returned to your health plan for approval each year as requested by the insurance company
Child under a legal guardianship	Up to age 26*	Child (unmarried) up to age 26 if you show proof of legal custody	Child's birth certificate and court documentation
Grandchildren	Up to age 26*	Your grandchildren can be added to the plan if their parent is your child who • is under age 19, unmarried, and financially dependent on you or • is age 19-26 and meets the full-time student status, is unmarried, and financially dependent on you If coverage for your child ends, coverage for your grandchildren will end.	Child's and grandchild's birth certificates; valid proof of dependent status and/or full-time student certification for your child

**Eligibility continues up to the end of the month in which your dependent turns age 26.*

For information on income tax treatment of your eligible Domestic Partner(s) dependent(s), see page 34. For other eligibility, such as Medicare, Medicaid, etc., see the Legal Notice section starting on page 44.

Dependent Documentation Is Required

Documentation is required to enroll dependents. If you do not provide required proof of dependent status information, your dependent will be ineligible for coverage. Contact the Maria Lopez at **213-978-1584** with any questions.

If You Added Your Dependent During…	Deadline	Important Considerations
Open Enrollment (October 1- October 31)	**If you enroll your dependent who is not currently covered during Open Enrollment (October 1- October 31, 2017), documents must be received by December 11, 2017.**	If you fail to provide the required documentation to the Personnel Department Benefits Division by the deadline, your dependent coverage will not take effect for your added dependent on January 1, 2018. You will not be able to re-enroll your dropped dependent until the next Open Enrollment period or within 30 days of a qualifying life event.
Outside Open Enrollment	**If you enroll your dependent during the year, documents must be received within 60 days of the date you report enrolling the dependent.**	If you fail to provide the required documentation to the Personnel Department Benefits Division by the deadline, your dependent coverage will not take effect. You will not be able to re-enroll your dependent until the next Open Enrollment period or within 30 days of a qualifying life event.

Removing Ineligible Dependents

You must drop coverage for your enrolled dependent within 30 days of the date he or she loses eligibility. If you fail to remove ineligible dependents, you will be required to pay all costs for any benefits that were paid on their behalf and you may be subject to disciplinary action. Leaving an ineligible dependent on City coverage is fraud.

The following table illustrates some common examples of individuals who are **not** considered eligible dependents, however this is not an exhaustive list. Please contact **800-778-2133** with questions about terminating coverage.

WHERE TO SEND REQUIRED DOCUMENTS

Write your name and employee ID number for the dependent you are adding on each certificate or document and fax documents to 213-978-1623, e-mail to per.empbenefits@lacity.org or mail or deliver in person to:

Personnel Department Employee Benefits Division
200 N. Spring Street Room 867
Mail Stop 621
Los Angeles, CA 90012.

Dependent Type	What is an Eligible Termination Life Event?	When Coverage can Terminate	Documents* Required for Verifying Termination must be submitted (within 60 days of reporting)
Spouse	A final divorce	The date you report, as long as the report date is on or after the event date	Signed Divorce Judgment
Note: Hiring an attorney to initiate the divorce process does not qualify as a termination life event.			
Domestic Partner	Terminating your relationship Marrying your DP	The date you report, as long as the report date is on or after the event date	✓ City of Los Angeles Termination of Domestic Partnership ✓ Marriage certificate.
Child	Turning age 26	Coverage will terminate the end of the month that your child turns 26	None
	Legal change in custody; Disabled child age 26 and older is no longer disabled	The date you report, as long as the report date is on or after the event date	Court Order or other official documentation
Grandchildren	Your child (Parent of grandchild) turns 26	Coverage will terminate the end of the month that your child turns 26	None

*Documents listed serve as examples. Other documents may apply. Call 213-978-1584 or email per.empbenefits@lacity.org to ask what documents apply to your specific life event.

Life Events

When Your Choices Will Apply

The benefit choices you make during Open Enrollment each October stay in effect from January 1 through December 31 of the following year. If you enroll as a new hire during the year, your benefit choices stay in effect through December of that year.

Exceptions: You can enroll in or change your participa-tion in the **Deferred Compensation Plan** or **Commuter Spending Accounts** at any time. See the pages 54-55 for more information about these benefits.

When You Can Make **LAwell** Benefit Changes

Changes to your benefit elections can be made under two situations, 1) Open Enrollment, and 2) a qualifying life event. For qualifying life events: Changes can be made within 30 days of the life event and will go into effect when you report the change **IF** your event meets the **requirements** outlined in this section and you complete all the requirements for the change.

Exception: Changes in the Deferred Compensation Plan or Commuter Spending Accounts can be done at any time ***without*** a qualifying event.

Qualifying Life Event Requirements

You cannot change your benefit elections during the year unless you have a qualifying life event in compliance with federal rules and LAwell program requirements. **The LAwell Program** will determine if your change request is permit-ted. All changes must be reported within **30 days** of the event date in order to be considered for eligibility. In most cases, supporting documentation will be required within **60 days** of the date you report **or your requested change will not take effect**.

Some common Life Events and their reporting requirements are shown in the table below. This is not an exhaustive list and is subject to change. View more information on **keepinglawell.com**.

LIFE EVENT	Report the Life Event within 30 days of the…	Where to Report	Supporting Documents* required 60 days from reporting?
Marriage	…date of the marriage	Phone: 213-978-1584	Yes: Marriage Certificate
Domestic Partnership, start or end	…effective date		Yes: LAwell Domestic Partnership Affidavit
Divorce	…date divorce is final		Yes: Signed Divorce Judgment
Additions due to Birth, Adoption, Legal Custody, etc	…date of birth …date of legal custody		Yes: Birth Certificate
Dependent loses non-City or COBRA coverage	…last day of coverage		Yes: Confirmation letter of loss of coverage
Death of a Dependent	…date of the death		Yes: Death Certificate
Entitled to or lose eligibility for Medicare or Medicaid	…first day of coverage		Yes: Proof of Medicare/Medicaid
Move outside Medical or Dental plan's service area	…day you move		May be required: Change of Address
Half-time to Full-time (Employee)	- Not Applicable -		Depends on benefit change requested
Go on leave (see Direct Bill, page 40), or Return to work after leave	- Not Applicable -		Depends on benefit change requested

*Documents listed serve as examples. Other documents may apply. Call 213-978-1584 or email per.empbenefits@lacity.org to ask what documents apply to your specific life event.

Failure to give LAwell timely notice (as noted above) may: ✓ cause coverage of a dependent to not start or to end, and ✓ result in your liability to repay the Plan if any benefits are paid to an ineligible person.

What Benefits Can Change For A Life Event?

In general, LAwell benefit changes you can make during a qualifying life event must be consistent with that type of life event change.

For example: If you are reporting a divorce life event, you are typically able to only remove your ineligible spouse from the LAwell benefits for which he/she is currently covered. Making changes to your own LAwell benefits coverage, or the coverage of another dependent, may not be allowed.

For more information on your benefit change options, call Maria Lopez at **213-978-1584**.

Documents Are Required

You have **60 days from the date you report** to provide any required documentation. If you do not submit the required documents by the deadline, any change you made will not take effect. For example, if you add a dependent to your health coverage and fail to provide the required documentation within **60 days** of the date you report, that dependent's coverage will not take effect. **Any medical, vision or dental expenses your dependent incurred before the dependent became properly enrolled will be your financial responsibility.**

Contact the Maria Lopez at **213-978-1584** if you have questions about life events**.**

ABOUT CONTINUATION COVERAGE

If you leave the City, except for retirement, and in other special situations, you may be able to continue certain LAwell benefits.

Medical, dental, and vision coverage **may be continued through COBRA. You have 60 days from the date of COBRA notification to enroll and 45 days from your enrollment to pay your first premium to the appropriate insurance company.**

Contact the LAwell COBRA Coordinator at 213-978-1655 as soon as you know that you will be leaving City service.

Leaves of Absence

How Benefits Can Be Affected Due to Work Schedule Changes, Leaves of Absences, or Return to City Employment

What benefits does the City subsidize?

The City provides a subsidy for your medical, dental, vision, basic disability, and basic life insurance benefits only.

The amount of the subsidy will vary based on your MOU and employment status. You must have minimum compensated hours* per pay period for the City to continue to pay the subsidy for your benefits.

**Compensated hours include hours worked, banked sick or vacation time, and other hours for which you received approved pay from the City, as specified by your MOU.*

Can I continue my **LAwell** benefits if my work schedule changes or I go on a leave of absence?

If you do not have sufficient compensated hours per pay period or are on a leave of absence, which may affect the number of hours you are compensated per pay period, you may still be able to continue your benefits based on the methods outlined in the chart below.

Method of Continuing LAwell Benefits	
Direct Bill	✓ City employees receiving benefits while on any of the type of leaves of absence listed on pages 42-43 may not be able to pay their share of benefits cost(s) through City payroll and must pay their cost(s) (or the full premium if City Subsidy no longer applies) to the Personnel Department. ✓ If on direct bill you will receive a bill for outstanding benefits cost(s) due from the Personnel Department, Direct Billing Section. Your payment must be received within **15 days** of the date of the billing letter or benefits will end. ✓ Call **213-978-1655** or visit **keepingLAwell.com** for more information on Direct Bill.
COBRA	City employees receiving a COBRA offer pay the full premium cost of the benefit plus any administration fee.

State Rate is not considered an "active" payroll status unless the State Rate is supplemented with at least 40 hours of sick, vacation or overtime (CTO) in a two-week pay period (20 hours of compensation in a two-week pay period for half-time employees). If State Rate is supplemented with compensated time, the City will continue to pay the subsidy for benefits. Please contact the Employee Benefits Division at 213-978-1655 to understand your coverage options and costs.

Which **LAwell** benefits can continue?

Continue Benefits?	Direct Bill	COBRA
Continue with payment	✓ Medical insurance ✓ Dental insurance ✓ Vision insurance	✓ Medical insurance ✓ Dental insurance ✓ Vision insurance
Continue through other action	N/A	N/A
Not eligible to continue	Healthcare Flexible Spending and Dependent Care Reimbursement Accounts are tax-advantaged savings accounts that provide for deductions to be taken through City payroll. Your ability to use these accounts will end when you terminate employment.	

Returning to City Employment

Employees who terminate City employment and subsequently return to City employment in a different plan year, are considered "Rehire" employees and will receive a new benefits package in the mail when they become benefit eligible.* Contact the Maria Lopez at **213-978-1584** if you do not receive a benefits package within four to six weeks after returning to work.

Employees who terminate City employment and subsequently return to City employment in the same plan year, are considered "Reinstate" employees and will have their former benefits elections reinstated once they become benefits eligible.* Reinstate employees will have a period of time to make corrections/changes to their reinstated benefits.

**Minimum compensated hours as required by your MOU. Returning to City employment may not be considered as new hire employment status for benefit purposes.*

BENEFITS WHILE ON LEAVE OR IN NON-PAY STATUS

HCFSA and DCRA contributions cannot be continued while you are on leave or in non-pay status. Some other benefits, such as medical, dental, and vision insurance can continue through COBRA after 6 months.

How Benefits Can Be Affected During A Leave Of Absence

Leaves Of Absence			
Type of Leave	**What is it?**	**Can my LAwell benefits continue?**	**Can my City subsidy continue?**
Family Medical Leave	FMLA is approved protected leave for qualified employees that falls under the provisions of the Family Medical Leave Act (FMLA). Your department must approve a FMLA absence.	Yes – Most of your LAwell benefits can continue. Continuation Method: Direct Bill*	Yes. City Subsidy can continue for a maximum of 9 pay periods* within a 12-month period, regardless of the number of incidents. A 12-month period shall begin on the first day of leave. **Exception: Maternity Leave – up to 9 pay periods for childbirth disability and up to an additional 9 pay periods for purposes of bonding. The aggregate period for parents who both work for the City is limited to the time allowed for one employee.*
Workers' Compensation Leave	An approved leave for a work related injury or illness, and you are receiving injury or disability "IOD" pay through the City's payroll or State Rate from Workers' Compensation.	Yes – Most of your LAwell benefits can continue. Continuation Method: Direct Bill or COBRA	***Only*** if your approved leave is supplemented with the **minimum** number of compensated hours to be considered Full-Time and benefit eligible per your MOU.
Military Leave	An approved leave to actively serve in a branch of the military.	Yes – Most of your LAwell benefits can continue. Continuation Method: Direct Bill	***Only*** if your approved leave qualifies for the City Subsidy. Military leave types vary. Ask your human resources or personnel division for more information.

**Most benefits can continue through your City paycheck for these types of leaves if you continue to have the minimum required number of compensated hours. If you exhaust compensated hours, you can continue these benefits through direct bill.*

Leaves Of Absence			
Type of Leave	**What is it?**	**Can my LAwell benefits continue?**	**Can my City subsidy continue?**
Reduction of hours, and non-paid leaves	During any two-week pay period, you **do not** meet the minimum number of compensated hours to be considered Full-Time and benefit eligible per your MOU. *Note: Compensated hours include hours worked, banked sick or vacation time, and other hours for which you receive approved pay from the City.*	Yes – Most of your LAwell benefits can continue. Continuation Method: Direct Bill or COBRA (depends on situation)	**No,** you must pay the full unsubsidized premium for your LAwell benefits to continue.
Termination	You end employment with the City, either voluntarily or through City action.	Your LAwell benefits will end the day your employment ends. You can only continue benefits through COBRA.	**No,** COBRA enrollment requires you to pay the full cost of your LAwell benefit, plus any COBRA administrative fees.
Retirement	You end employment due to your start of retirement benefits through Fire and Police Pensions (PENSIONS) *Note: A non-PENSIONS retirement is considered a "termination"*	Your LAwell benefits will end the last day of the month in which you retire or transfer to DWP. You can only continue LAwell benefits through COBRA.	

Important Legal Notices

Binding Arbitration

Narrow HMO: Select, Full HMO: CACare, Regional HMO: Vivity, PPO Prudent Buyer, and Kaiser Permanente HMO health plans use binding arbitration to settle disputes, including benefit claims, medical malpractice claims and disputes relating to the delivery of service under the plan. It is understood that any dispute as to medical malpractice that is to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings.

By enrolling in any LAwell health plan, you agree to give up your constitutional right to have any dispute decided in a court of law before a jury, and instead, are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute for medical malpractice, relating to the delivery of service under the plan, and to any claims in tort, contract or otherwise, between the individuals seeking services under the plan, whether referred to as a member, subscriber, dependent, enrollee, or otherwise (whether a minor or adult), or the heirs–at–law or personal representatives of any such individual(s), as the case may be; and the health plan (including any of their agents, successors – or predecessors–in–interest, employees, or providers).

Women's Health and Cancer Rights Act

As required by federal law, for individuals receiving mastectomy-related benefits, all LAwell medical plan options will provide coverage in a manner determined in consultation with the attending physician and the patient for all stages of reconstructive surgery of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, as well as prostheses and treatment of any physical complications of the surgery, including lymphedema. These services are covered in the same way as other surgery and services under each option. For questions about mastectomy-related benefits, contact your medical plan (see your ID card).

About Hospital Stays for Mothers and Newborns

Medical plans 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 (C-section). However, federal law generally does not prohibit the plan from paying for a shorter stay when the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In any case, plans may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact your medical plan to precertify the extended stay (see your ID card).

Privacy and Your Health Coverage

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require that the healthcare services you receive under the LAwell plan comply with privacy rules and periodically remind you about the availability of the privacy notice and how to obtain that notice.

These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

The LAwell privacy notice explains your rights and the plans' legal duties with respect to personal health information and how the LAwell plan may use or disclose your personal health information. These rules have been revised to reflect changes in the law which 1) expand and clarify the circumstances under which the plan needs your written authorization to use protected health information and 2) require a description of your rights if we discover a breach of your unsecured protected health information.

To obtain a copy of the LAwell privacy notice or for any questions about the plans' privacy policies, please contact the Plan's Privacy Officer in the Employee Benefits Division at **213-978-1655.** You can also go online to **per.lacity.org/bens/docforms.htm**.

Personal Physician Designations and OB/GYN Visits in the Anthem Blue Cross HMOs

The Anthem Blue Cross HMOs generally require the designation of a Personal Physician. You have the right to designate any Personal Physician who participates in the particular HMO network and who is available to accept you or your family members. Until you make this designation, Anthem Blue Cross designates one for you.

You do not need prior authorization from the Anthem Blue Cross HMO or from any other person (including a Personal Physician) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the 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 information on how to select a Personal Physician, and for a list of the participating Personal Physician and health care professionals who specialize in obstetrics or gynecology, contact the Anthem Blue Cross Member Services Concierge at **844-497-5954**.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **877-KIDS NOW** or visit **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your state for more information on eligibility.

If you live in California, you may be eligible for assistance to pay your employer health plan premiums. You should contact the California Department of Health Care Services for further information on eligibility.

CALIFORNIA

The California Department of Health Care Services (DHCS) may pay medical insurance premiums for full scope Medi-Cal beneficiaries who have a high cost medical condition. If you live in California, you can learn more about the voluntary Health Insurance Premium Payment (HIPP) program at **http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx.**

You can contact HIPP's Sacramento office by email at **HIPP@dhcs.ca.gov** or by fax at **916-440-5677**

Other California Premium Assistance Resources:

Medicaid Website
www.dhcs.ca.gov

Medicaid Phone: **1-800-541-5555**

CHIP Website
https://www.insurekidsnow.gov/state/ca/index.html

CHIP Phone: **(800) 880-5305**

ALABAMA – Medicaid
Website: www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

Arkansas – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/
State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website:
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website:
http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website:
http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

Contact the Department of Labor at **www.dol.gov/ebsa/pdf/chipmodelnotice.pdf** to view the complete state eligibility information.

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
(866) 444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
(877) 267-2323, Ext. 61565

Health Insurance Marketplace

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Benefits Service Center at **800-778-2133** or **www.keepinglawell.com**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** or **CoveredCa.com** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name City of Los Angeles		4. Employer Identification Number (EIN) 95-6000735
5. Employer address 200 N Spring Street, Room 867		6. Employer phone number 800-778-2133
7. City Los Angeles	8. State CA	9. ZIP code 90012
10. Who can we contact about employee health coverage at this job? Employee Benefits Division		
11. Phone number (if different from above) 213-978-1655	12. Email address Per.empbenefits@lacity.org	

Here is some basic information about health coverage offered by this employer:

✓ **As your employer, we offer a health plan to:**

- ☐ All employees. Eligible employees are:
- ☒ Some employees. Eligible employees are: Full-time, Permanent, Half-Time, and Temporary Employees who work qualifying hours

✓ **With respect to dependents:**

- ☒ We do offer coverage. Eligible dependents are: Spouse, Domestic Partners, and Children
- ☐ We do not offer coverage.

☒ **If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.**

** *Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.*

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** or **CoveredCa.com** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** or **CoveredCa.com** to find out if you can get a tax credit to lower your monthly premiums.

Important Information About Your COBRA Continuation Coverage Rights

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care (medical and dental) coverage at their own cost when there is a "qualifying event" that would result in a loss of coverage. Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each "qualified beneficiary" who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

Who are the qualified beneficiaries?

A qualified beneficiary is an individual who was covered by a group health plan on the day before a qualifying event occurred that caused him or her to lose coverage. Depending on the type of qualifying event, qualified beneficiaries can include an employee or former employee, the covered employee's spouse or former spouse, and the covered employee's dependent child(ren).

Are there other coverage options besides COBRA Continuation Coverage?

Yes. There may be other coverage options for you and your family through the Health Insurance Marketplace, a Federal program providing resources enabling eligible citizens to find, compare, and buy private health insurance. A "qualifying event" that results in a loss of coverage provides a "special enrollment" period that allows you 60 days to enroll in an insurance plan on the Marketplace; otherwise you must wait until regular Open Enrollment. You may be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions (including your out-of-pocket costs for deductibles, coinsurance, and copayments), and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. You can access the Marketplace at **www.HealthCare.gov**. You may also be eligible for Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period," or through private health insurance exchanges. Legal residents of the State of California who do not have health insurance from their employer or another government program may be eligible to purchase health insurance through the State of California's Health Insurance Marketplace called "Covered California."For more information, please visit **www.CoveredCA.com** or call **800-300-1506**. Some of these options may cost less than COBRA continuation coverage.

If you elect COBRA continuation coverage, when will your coverage begin and how long will the coverage last?

If elected, COBRA continuation coverage will begin retroactively to the date of loss of coverage. In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for 18 months. In the case of loss of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuat ion coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- ✓ Any required premium is not paid in full on time,
- ✓ A qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan,
- ✓ A qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- ✓ The employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your medical and/or dental plan of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event (see additional information on page 50) may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available to the entire family of qualified beneficiaries enrolled in COBRA if any one of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension, for a maximum of 29 months, if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

Second Qualifying Event

An 18-month extension of coverage, for a maximum of 36 months, will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the spouse or dependent child to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage. For more information about extending the length of COBRA continuation coverage visit **http://www.dol.gov/ebsa/publications/cobraemployee.html**.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary may independently elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of any or all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends. You also have special enrollment rights to enroll in the Health Insurance Marketplace within 60 days after your group health coverage ends. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualifiedbeneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in your personalized notice.

When and how must payment for COBRA continuation coverage be made?

You will be billed by your medical/dental plans for your first payment and all periodic payments for continuation coverage. If you elect continuation coverage, you do not need to send any payment with the Election Form.

First payment for continuation coverage

You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is post-marked, if mailed), or you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You should contact your medical/dental plans to confirm the correct amount of your first payment since you will be paying retroactively to the date you lost coverage.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments can be made on a monthly basis. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available through your insurance carrier(s). If you have any questions concerning the information in this notice or your rights to coverage, you should contact your insurance carrier(s).

For more information about health insurance options available through the Health Insurance Marketplace, and to locate assistance in your area who you can talk to about the different options, visit **www.HealthCare.gov** or **www.CoveredCA.com**.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep your department, the Personnel Department/Employee Benefits Division and your insurance carrier(s) informed of any changes to your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to your insurance carrier(s).

To update your address with the City, please contact your department's HR section and complete a Form 41 change. Contact your insurance company to update your address with them as well.

Availability of Summary Health Information

LAwell offers a series of medical plan options. To help you make an informed choice, and as required by law, the plan and insurance companies make available a Summary of Benefits and Coverage (SBC), which summarizes important information about each medical plan option in a standard format, to help you compare across options. The SBC summarizes and compares important information including what is covered, what you need to pay for various benefits, what is not covered, and where to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC.

The most current SBC documents for the LAwell medical plan options are available online at **per.lacity.org/bens/docforms.htm** or contact **213-978-1584** to get a free copy.

To request special enrollment or obtain more information, contact **213-978-1584** , Monday – Friday, 8 a.m. to 5 p.m. Pacific.

Important Reminder To Provide The Plan With The Taxpayer Identification Number (TIN) Or Social Security Number (SSN) Of Each Enrollee In A Health Plan

Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: **http://www.socialsecurity.gov/online/ss-5.pdf**. Applying for a social security number is FREE.

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact **213-978-1584** , Monday – Friday, 8 a.m. to 5 p.m. Pacific Time.

Important Notice from the City of Los Angeles for **LAwell**-Eligible Employees and Dependents about Prescription Drug Coverage for People who Are Already Medicare-Eligible or May Become Medicare-Eligible during 2018

Medicare and the City

If you are an active Sworn employee with **LAwell** Benefits, please note the following:

- ✓ If you have enough service credits you will receive Medicare Part A at age 65 at no cost. You will be contacted by Social Security and will receive a Medicare ID card. At this time you may be asked if you would like to enroll in Medicare Part B, C and/or D. If you are not retired or planning to retire at or around age 65, you may not want to purchase Medicare since you have City benefits.
- ✓ To prevent errors in coverage and payments, we recommend that you do not enroll in Medicare Part B or Part D as long as you have City of Los Angeles **LAwell** Benefits (active employee coverage). When you are planning to retire, please contact PENSIONS at (**213) 279-3000** so that they may help you sign up for Medicare and to ensure you do not experience a lapse in coverage. As long as you had the City's creditable active employee coverage beginning from the time you became eligible for Medicare (for most people, age 65) through the date your Medicare enrollment becomes effective (typically after age 65), you will not be charged a late-enrollment penalty for signing up after becoming eligible.
- ✓ If you do decide to enroll into Medicare as an active employee and you also retain your enrollment with **LAwell** coverage, it is important that you remember to use your Medicare coverage as a secondary insurance provider. Medicare will not pay primary insurer costs for individuals with dual coverage.
- ✓ If you have already signed up for Medicare and also have **LAwell** coverage, please inform your doctor(s) so that there are no issues with payments. Some doctors do not accept Medicare patients. When you are filling out your claim information, please provide the Employee Benefits Division address as your work location. Do not provide the address of your actual work location or that of your department's administrative office.
- ✓ The federal government does not recognize Domestic Partners as eligible dependents. Domestic Partners being covered under **LAwell** Benefits will receive a penalty for late-enrollment in Medicare if they do not sign-up when they become eligible. Domestic Partners should consider enrolling in Medicare when they become eligible.

Important Notice from City of Los Angeles 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 Los Angeles 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. The City of Los Angeles has determined that the prescription drug coverage offered by the Anthem Vivity (LA & Orange Counties HMO), Anthem Narrow Network (Select HMO), Anthem Full (CA Care), Anthem PPO, and Kaiser Permanente HMO, is **creditable** meaning that, on average for all plan participants, it is expected to pay out as much as standard Medicare prescription drug coverage pays are therefore considered Creditable Coverage. Because your existing medical plan coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current City of Los Angeles medical plan coverage will not be affected.

Having dual prescription drug coverage under the City's Plan and Medicare means that the City's Plan will coordinate its drug payments with Medicare, as follows:

✓ For Medicare-eligible Active Employees and their Medicare-eligible Dependents, the group health plan pays primary and Medicare Part D coverage pays secondary.

Note that you may not drop just the prescription drug coverage under one of the City's Plans. That is because prescription drug coverage is part of the entire medical plan.

Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as:

✓ PDPs may have different premium amounts;

✓ PDPs cover different brand name drugs at different costs to you;

✓ PDPs may have different prescription drug deductibles and different drug copayments;

✓ PDPs may have different networks for retail pharmacies and mail order services.

If you do decide to join a Medicare drug plan and drop your current City of Los Angeles medical plan coverage, be aware that you and your dependents will be able to get this coverage back at the next open enrollment time if you remain an active employee or have a mid-year qualifying life event allowing you to make a change.

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 the City 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 Employee Benefits Division at **213-978-1655**. **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 Los Angeles, Personnel Department 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 **www.medicare.gov**.

✓ Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**.

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

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

RETIREwell

Deferred Compensation Plan

The City of Los Angeles Deferred Compensation Plan plays a vital role in creating your future retirement income security. This voluntary retirement savings plan supplements benefits available to you through your primary City retirement plan.

Why Should I Consider Joining?

The purpose of saving for retirement is creating income security after your working years are over. The ideal goal is to have sufficient income at retirement to maintain the standard of living you had while working. At the City of Los Angeles, you have two resources for creating retirement income security:

- ✓ **Fire and Police Pensions (PENSIONS) —** Benefits are based on a formula that takes into account final average salary and years of service. They are also based on the plan you're a member of (Tier 2 through Tier 6) and the benefit formulas that apply to each Tier.

- ✓ **Deferred Compensation Plan —** Benefits are based on the total balance (contributions + earnings) you accumulate in your account. You can begin drawing on your balance when you retire. You have several withdrawal options, although ideally you would convert your balance into a steady income stream over many years to supplement your PENSIONS income.

Your optimal goal should be to produce income from both programs to equal or exceed 100% of the amount of salary you're actually living off at the time you retire.

How do I enroll or find out more information?

You can obtain enrollment materials by visiting the Plan website at LA457.com; calling 844-523-2457; or visiting the Plan Service Center located in the Employee Benefits Division, Room 867 City Hall, Monday through Friday from 8 a.m. to 4 p.m.

COMMUTEwell

The City of Los Angeles offers the following transportation benefits to eligible employees:

- ✓ **Commuter Spending Accounts** (read more below)
- ✓ **Transit Reimbursement Program** – Submit monthly forms for up to $50 per month reimbursement of public transportation.
- ✓ **Vanpool/Carpool Program** – Assists City employees in joining/forming vanpools, and may provide carpool parking permits for City lots.
- ✓ **Parking Benefits** – City lot permit availability is subject to space availability and upon meeting all program terms and conditions. Costs vary by permit type.
- ✓ **Bike/Walk to Work** – Submit monthly forms for up to $50 per month reimbursement to walk/bike to work.
- ✓ **Commute Options & Parking Administration** – Contact a representative at **213-978-1634** or send an email to **per.commuteoption@lacity.org**.

Below are brief overviews of each benefit.
To learn more or to obtain forms, please visit **http://per.lacity.org/commuter.htm**.

Commuter Spending Accounts

The City offers two programs to help you save on the cost of public transportation or parking as part of commuting to work. These programs allow you to set aside pre-tax dollars and use them for qualified expenses, reducing your net cost. The programs also allow for certain conveniences when making transit/parking purchases.

- ✓ **Transit Spending Account (TSA) (includes City contribution match of up to $50 per month)** – set aside up to $255 per month on a pre-tax basis to pay for public transit expenses, including bus, rail, train and subway fares.
- ✓ **Parking Spending Account (PSA)** – set aside up to $255 per month on a pre-tax basis to pay for parking expenses related to commuting from home to work. Note: cannot be used for parking provided by the City of Los Angeles to its employees at City owned or leased lots (e.g., lots at City Hall East, Figueroa Plaza, Police Administration Building, etc.).

Unlike other benefit programs, elections to participate in TSA and PSA may be modified throughout the year, not just during Open Enrollment. To enroll or make changes, go to **keepingLAwell.com**.

Important Information About the TSA and PSA

- ✓ You may enroll, suspend, or modify your participation in these programs at any time of year, including during Open Enrollment.
- ✓ The minimum contribution to either account is $10 per payday.
- ✓ There are no “use it or lose it” provisions that happen at year-end; funds roll over to subsequent years indefinitely (until you terminate employment with the City), at which point you have ninety (90) days to use your funds before they are forfeited.
- ✓ You are not required to make your transit purchases in the month you make your contribution; funds can be accumulated and used whenever you wish as long as you do not accumulate more than $1,500 in your WageWorks PSA/TSA account and $1,500 in your Parking and/or Commuter Card.

Forms

Please feel free to detach Forms on the following pages

Open Enrollment Form

2018 Health and Dental Plan
Sworn LAPD & LAFD

City of Los Angeles • Personnel Department • Employee Benefits Division • 213-978-1584

KEEPING LAwell
City of Los Angeles Employee Benefits

SECTION A

EMPLOYEE/SUBSCRIBER INFORMATION

Name (Last, First, Middle Initial)	Employee ID or Social Security Number	Sex ◯ Female ◯ Male

Address	City	State	Zip Code

Phone Number	Email Address

SECTION B

I would like to ENROLL into the following medical/dental plans	I would like to CANCEL my enrollment in the following medical/dental plans
◯ Kaiser Permanente HMO (17)	◯ Kaiser Permanente HMO (17)
◯ Anthem Narrow Network (Select HMO) (16)	◯ Anthem Narrow Network (Select HMO) (16)
◯ Anthem Vivity (LA & Orange Counties) (14)	◯ Anthem Vivity (LA & Orange Counties) (14)
◯ Anthem PPO (13)	◯ Anthem PPO (13)
○ DeltaCare USA DHMO (19)	○ DeltaCare USA DHMO (19)
○ Delta Dental PPO (18)	○ Delta Dental PPO (18)
◯ Cash-In-Lieu (CL) can also be elected using the online site	◯ Cash-In-Lieu (CL)
	○ I do not wish to cancel my current coverage

Employees and their dependents covered under a health plan election for 2018 will be automatically enrolled into EyeMed vision coverage.

SECTION C

DEPENDENT INFORMATION (Add or Delete Coverage)

Name	Sex		SSN	Relationship	Birth Date	Coverage		Primary Care IDs	
	Female	Male				Add	Delete	Physician[1]	Dentist[2]
	○	○				○ Medical ○ Dental	○ Medical ○ Dental		
	○	○				○ Medical ○ Dental	○ Medical ○ Dental		
	○	○				○ Medical ○ Dental	○ Medical ○ Dental		
	○	○				○ Medical ○ Dental	○ Medical ○ Dental		
	○	○				○ Medical ○ Dental	○ Medical ○ Dental		
	○	○				○ Medical ○ Dental	○ Medical ○ Dental		

[1] Fill out the Primary Care Physician ID only if you selected the Anthem Narrow Network or Anthem Vivity plan. To find the ID of your doctor/medical group, please visit anthem.com/ca/cityofla or call Anthem Narrow 844-348-6111 or Anthem Vivity 844-348-6110 Monday through Friday, 8:00 a.m. to 8:00 p.m. and use the "Find a Provider" option.

[2] Fill out the Primary Care Dentist ID only if you selected the DeltaCare USA DHMO plan. To find the ID of your dentist, please visit deltadentalins.com and use the "Find a Dentist" option.

SECTION D: If deleting coverage for a family member, please fill out the information below.

For the purpose of notifying the removed dependent of their COBRA rights, please provide the dependent's name and mailing address.	
Dependent's Name	Mailing Address

You have until October 31, 2017 to submit this change form to the Employee Benefits Division.

You have until December 11, 2017 to submit supporting documentation to the Employee Benefits Division. This includes, but is not limited to, documents such as birth certificates, marriage certificates, divorce decrees, court orders, full-time student certificates, Cash-In-Lieu Affidavits, Domestic Partnership Affidavits, etc.

All required documentation, including this form, must be submitted to:

City of Los Angeles, Personnel Department, Employee **Benefits Division**
200 North Spring Street, City Hall #867, Los Angeles, CA 90012

You may also fax the documents to 213-978-1623 **or email them to per.empbenefits@la**city.org
(E-mail is preferred so that you can receive an acknowledgement of receipt.)

Contact Maria Lopez at 213-978-1584 if you have questions.

SECTION E

I understand this election will remain in effect so long as I remain eligible or until I make another election during a valid enrollment period or qualifying life event. I hereby authorize 1) the City of Los Angeles' Office of the Controller to deduct my share of monthly premiums from my salary as a result of this election; and 2) my medical and/or dental insurance provider to pay claims under the plan selected. By signing this form, I indicate my interest in enrolling myself and any listed dependents into the City's **LAwell** Plan and I understand that it is my responsibility to report any change in the eligibility of my dependents. I also understand that I must abide by the provisions of the health plan in which I enroll, and that any dispute between any member and their health plan (including its agents, staff physicians, employees, and providers) is subject to binding arbitration.

BINDING ARBITRATION
Anthem Narrow HMO: Select, Anthem Regional HMO: Vivity, Anthem PPO Prudent Buyer, and Kaiser Permanente HMO health plans use binding arbitration to settle disputes, including benefit claims, medical malpractice claims and disputes relating to the delivery of service under the plan. It is understood that any dispute as to medical malpractice that is to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings.

By enrolling in any LAwell **health plan, you agree to give up your constitutional right to have any dispute decided in a court of law before a jury, and instead, are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute for medical malpractice, other disputes relating to the delivery of service under the plan, and to any claims in tort, contract or otherwise, between the individuals seeking services under the plan, whether referred to as a member, subscriber, dependent, enrollee, or otherwise (whether a minor or adult), or the heirs−at−law or personal representatives of any such individual(s), as the case may be; and the health plan (including any of their agents, successors− or predecessors−in−interest, employees, or providers).**

Employee Signature

Date

Qualifying Life Event Change Form

2018 Health and Dental Plan

Sworn LAPD & LAFD

City of Los Angeles • Personnel Department • Employee Benefits Division • 213-978-1584

KEEPING LAwell
City of Los Angeles Employee Benefits

When you experience a qualifying life event, you have **30 days** from the date of the event to notify and make changes to your benefits by contacting Maria Lopez at **213-978-1584**. You will have **60 days** from the date of contact to submit documentation to the Employee Benefits Division. This includes, but is not limited to documents such as birth certificates, marriage certificates, divorce decrees, court orders, full-time student certificates, Cash-In-Lieu Affidavits, Domestic Partnership Affidavits, etc. Failure to submit documentation within **60 days** will cancel your changes on day 61. New dependents will not be offered COBRA. You will be responsible for any rejected claims that are incurred as a result of the cancellation, regardless of when you are notified of the cancellation.

SECTION A

EMPLOYEE/SUBSCRIBER INFORMATION

Name (Last, First, Middle Initial)	Employee ID or Social Security Number	Sex O Female O Male	
Address	City	State	Zip Code
Phone Number	Email Address		

SECTION B

WHAT QUALIFYING LIFE EVENT DID YOU/YOUR DEPENDENT EXPERIENCE?

- O Marriage
- O Divorce
- O Death
- O Birth/Adoption
- O Moved Outside of Service Area
- O Begin Domestic Partnership
- O End Domestic Partnership
- O Significant change in spouse/ domestic partner's employer coverage
- O Gain of Coverage
- O Loss of Coverage
- O Court Order
- O Child no longer eligible

SECTION C

DEPENDENT INFORMATION (Add or Delete Coverage)

Name	Sex		SSN	Relationship	Birth Date	Coverage		Primary Care IDs	
	Female	Male				Add	Delete	Physician[1]	Dentist[2]
	O	O				O Medical O Dental	O Medical O Dental		
	O	O				O Medical O Dental	O Medical O Dental		
	O	O				O Medical O Dental	O Medical O Dental		
	O	O				O Medical O Dental	O Medical O Dental		
	O	O				O Medical O Dental	O Medical O Dental		
	O	O				O Medical O Dental	O Medical O Dental		

[1] Fill out the Primary Care Physician ID only if you selected the Anthem Narrow Network or Anthem Vivity plan. To find the ID of your doctor/medical group, please visit anthem.com/ca/cityofla or call the Anthem Blue Cross Member Services Concierge at 844-497-5954 Monday through Friday, 8:00 a.m. to 8:00 p.m. and use the "Find a Provider" option.

[2] Fill out the Primary Care Dentist ID only if you selected the DeltaCare USA DHMO plan. To find the ID of your dentist, please visit deltadentalins.com and use the "Find a Dentist" option.

SECTION D: As a result of my qualifying life event, I would like to…

SWITCH coverage and join the following plan(s)	CANCEL my enrollment in the following plan(s)	MAKE NO CHANGE
○ Kaiser Permanente HMO (17) ○ Anthem Narrow Network (Select HMO) (16) ○ Anthem Vivity (LA & Orange Counties) (14) ○ Anthem PPO (13)	○ Kaiser Permanente HMO (17) ○ Anthem Narrow Network (Select HMO) (16) ○ Anthem PPO (13) ○ Anthem Vivity (LA & Orange Counties) (14)	
○ DeltaCare USA DHMO (19) ○ Delta Dental PPO (18)	○ DeltaCare USA DHMO (19) ○ Delta Dental PPO (18)	
○ Cash-In-Lieu (CL) can also be elected using the online site	○ Cash-In-Lieu (CL)	○ No Change

SECTION E: If ending coverage for a family member, please fill out Section E.

For the purpose of notifying any removed dependents of their COBRA rights, provide their mailing address
Mailing Address

All required documentation, including this form, must be submitted to:

City of Los Angeles, Personnel Department, Employee **Benefits Division**
200 North Spring Street, City Hall #867, Los Angeles, CA 90012

You may also fax the documents to 213-978-1623 **or email them to per.empbenefits@lacity.org**
(E-mail is preferred so that you can receive an acknowledgement of receipt.)

Contact Maria Lopez at 213-978-1584 if you have questions.

SECTION F

I understand this election will remain in effect so long as I remain eligible or until I make another election during a valid enrollment period or qualifying life event. I hereby authorize 1) the City of Los Angeles' Office of the Controller to deduct my share of monthly premiums from my salary as a result of this election; and 2) my medical and/or dental insurance provider to pay claims under the plan selected. By signing this form, I indicate my interest in enrolling myself and any listed dependents into the City's **LAwell** Plan and I understand that it is my responsibility to report any change in the eligibility of my dependents. I also understand that I must abide by the provisions of the health plan in which I enroll, and that any dispute between any member and their health plan (including its agents, staff physicians, employees, and providers) is subject to binding arbitration.

BINDING ARBITRATION

Anthem Narrow HMO: Select, Anthem Regional HMO: Vivity, Anthem PPO Prudent Buyer, and Kaiser Permanente HMO health plans use binding arbitration to settle disputes, including benefit claims, medical malpractice claims and disputes relating to the delivery of service under the plan. It is understood that any dispute as to medical malpractice that is to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings.

By enrolling in any LAwell health plan, you agree to give up your constitutional right to have any dispute decided in a court of law before a jury, and instead, are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute for medical malpractice, other disputes relating to the delivery of service under the plan, and to any claims in tort, contract or otherwise, between the individuals seeking services under the plan, whether referred to as a member, subscriber, dependent, enrollee, or otherwise (whether a minor or adult), or the heirs−at−law or personal representatives of any such individual(s), as the case may be; and the health plan (including any of their agents, successors− or predecessors−in−interest, employees, or providers).

Employee Signature

Date

KEEPING LAwell
City of Los Angeles Employee Benefits
CHOOSEwell
Health, Dental, Vision, Life, Disability, EAP, Tax-Savings Accounts

Cash-In-Lieu Affidavit
For Sworn Employee

City of Los Angeles
Personnel Department
Employee Benefits Division
213-978-1584

Please print all information–Signature required below

EMPLOYEE INFORMATION

Name (Last, First, Middle Initial)		Employee ID Number	
Street Address	City	State	Zip Code

For Cash-In-Lieu coverage with:

- Spouse/Domestic Partner – Complete Section **A & B**
- Another employer/union or retiree benefit – Complete Section **B** only
- Medicare or TRICARE – Complete Section **C** only

A NAME OF SPOUSE/DOMESTIC PARTNER WHOM COVERAGE IS PROVIDED THROUGH

Name (Last, First, Middle Initial)	Employee ID of Spouse/DP *(Only for City employees)*
Relationship:	

B HEALTHCARE COVERAGE VERIFICATION

Must be completed by the Spouse's or Domestic Partner's Employer, your other employer, or union/benefit administrator. If both you and your spouse/domestic partner are City employees, must be completed by the Employee Benefits Division.

Name of Insurance Company/Provider/Administrator		Policy/Membership Number
Health Plan/Insurance Telephone Number	Name of Employer Offering Coverage	
Name of Authorized Signer	Signature of Employer or Provider	Date Signed
Title	Telephone Number	

C GOVERNMENT INSURANCE

Indicate program and provide the required enrollment proof	☐ MEDICARE – Attach a copy of your Medicare Card
	☐ TRICARE – Attach Proof of Insurance Letter www.tricare.mil/Plans/Eligibility/DEERS/milConnect/Proof

IMPORTANT!

If you enroll into Cash-in-Lieu, you may later request coverage under a City-sponsored health plan **only** if you experience a qualifying life event change or during a civilian Open Enrollment period

Send completed form and supporting documents to:

Mail: Employee Benefits Division, City Hall, 200 N. Spring Street, Room 867, Los Angeles, CA 90012
(For inter-departmental mail: use "Mail Stop #621")
Email: per.empbenefits@lacity.org **Fax: 213-978-1623**

EMPLOYEE SIGNATURE REQUIRED BELOW

I certify that my dependents and I have health coverage under the health benefit plan listed above. I further certify that all information and documentation provided are true and accurate. I understand that any false, deceptive or otherwise improper act may result in the cancelation of my participation in the Cash-In-Lieu Program, and I may be considered ineligible for enrollment in any City health, dental, or other benefit plan.

Day Time Phone Number	Employee's Signature	Date Signed

*In addition to completing this form, you must go online at **www.keepingLAwell.com** (click "Enroll in Benefits or Make Changes") and select Cash-In-Lieu during enrollment to receive Cash-In-Lieu. Call the Benefits Service Center at **800-778-2133** or **800-735-2922** if hearing or speech impaired if you need assistance. Si necesita ayuda en Español, por favor llame al **800-778-2133**.*

What is the Cash-In-Lieu option?

If you have health coverage through your spouse's or domestic partner's employer, through a second employer, as a retiree from your previous employer, or through Medicare or TRICARE, you may receive a taxable $100 a month "Cash-In-Lieu."

Who is eligible?

To be eligible for this option you must be an active sworn employee of the City who:

- is **not enrolled** as a primary member in any health plan with the City, Union, or other Association (but you may be enrolled in one of these plans as a dependent of another City employee); and
- is compensated for at least thirty (30) hours or more per week as a full-time or the number of qualifying work time specified by your Memorandum of Understanding (MOU) to be considered full-time and benefit eligible; and
- is eligible for membership in one of the employee representation units for which a City-sponsored health plan has been negotiated in Memorandum Of Understanding (MOU)

When can I enroll?

Each fall, during Open Enrollment, you have an opportunity to enroll for the following calendar year. During the year you may enroll only if you have a qualifying life event.

How do I apply?

An employee who wants to participate in the Cash-In-Lieu option can go online at **www.keepingLAwell.com** to select Cash-In-Lieu during open enrollment and complete this affidavit (see other side) verifying coverage under another employer group health plan, through a spouse or domestic partner, or Medicare/TRICARE and return it to:

Employee Benefits Division, 200 N. Spring Street, Room 867, Los Angeles, CA 90012
(Located in City Hall; include "Mail Stop #621" if using inter-departmental mail)
Email: per.empbenefits@lacity.org Fax:213-978-1623

Approval of your Cash-in-Lieu Affidavit is subject to review and verification by the Employee Benefits Division and your participation in the Cash-in-Lieu program may also be canceled based on the information you provide on your Affidavit

When will the "Cash-In-Lieu" begin?

If you enroll during Open Enrollment, participation is effective the following January 1. Your first "Cash-In-Lieu" payment will be reflected in your gross wages on the first paycheck you receive in January. However, if you do not submit a Cash-In-Lieu Affidavit by the December 11, 2017 deadline, your participation in Cash-In-Lieu will be canceled.

If you enroll as a new hire or a qualifying life event, your first "Cash-In-Lieu" payment will be reflected in your gross wages within 2-3 pay periods after you enroll. However, if you do not submit a Cash-In-Lieu Affidavit within the 60 day deadline, your participation in Cash-In-Lieu will be canceled.

What if I change my mind?

Re-enrollment in a **LAwell** health plan will be allowed only under the regular policies; if you experience a qualifying life event change (i.e., spouse/domestic partner loses health coverage) or during the **LAwell** Open Enrollment Period. A request for enrollment must be made within 30 calendar days following a qualifying life event change.

Questions?

If you have further questions, please contact Maria Lopez in the Employee Benefits Division at **213-978-1584**
Si tiene preguntas adicionales, por favor llame a la División de Beneficios para Empleados: **213-978-1584**.

Domestic Partnership Information Sheet for City Employees

City of Los Angeles • Personnel Department • Employee Benefits Division • 213-978-1584

KEEPING LAwell
City of Los Angeles Employee Benefits

INTRODUCTION

The City of Los Angeles offers domestic partners of City employees, and their domestic partners' children, equal access to its employee benefits programs, including health and dental plans, the Employee Assistance Program (EAP), and bereavement leave/family illness benefits. To obtain these benefits, you must submit proof that you and your partner are in a domestic partnership as attested by both parties through either:

1. A signed City Affidavit of Domestic Partnership form and appropriate identification; OR
2. A registered State of California Declaration of Domestic Partnership Form, (or proof of a similar legal union validly formed in another state) that has been submitted to and accepted by the City of Los Angeles, Personnel Department Benefits Division. Please refer to the Section on "How to File for Domestic Partnership Benefits" for more detailed information.

You are not required to enroll in a health and/or dental plan in order to file your Affidavit of Domestic Partnership. Your Affidavit may be filed at any time. However, if you wish to enroll in a health or dental plan, you may only do so at specified times (see "When to Enroll Your Domestic Partner…"). Also, you should be aware that if you enroll your domestic partner or the domestic partner's child(ren) in a health plan, you will have to pay income taxes on the amount of health plan subsidy that will be paid by the City to provide coverage (per the Internal Revenue Service). Any questions regarding the tax consequences of adding a domestic partner or the child of a domestic partner to your health/dental plan should be directed to a tax professional.

HOW TO FILE FOR DOMESTIC PARTNER BENEFITS

To obtain domestic partner benefits, you must submit proof that you and your partner are in a domestic partnership as attested by both parties through either: The City Affidavit of Domestic Partnership OR a registered State of California Declaration of Domestic Partnership Form, (or proof of a similar legal union validly formed in another state).

1. City Domestic Partnership Affidavit

To obtain domestic partner benefits under the City Domestic Partnership Affidavit, you and your domestic partner must meet the following conditions and attest to this by completing and signing an Affidavit of Domestic Partnership:

a. You and your partner must be in a committed and mutually exclusive relationship in which you are jointly responsible for each other's welfare and financial obligations.

b. You and your partner must have resided together in the same principal residence for at least 12 months and intend to do so indefinitely.

c. You and your partner must be 18 years of age or older, unmarried, and not blood relatives.

You must submit an Affidavit of Domestic Partnership, signed and dated by both you and your domestic partner and submit copies of your California driver's license or identification card for both you and your domestic partner. The addresses on your respective licenses or identification cards must match one another.

SPECIAL NOTE: If you have a domestic partner and are in the process of divorcing a spouse, be advised that your Affidavit can be processed no earlier than one year from the effective date of your divorce, regardless of how long you may have been living with the domestic partner.

2. State of California Declaration of Domestic Partnership Form

You also may obtain domestic partner benefits under a copy of the Declaration of Domestic Partnership form submitted to the State of California, Secretary of State (or under proof of a similar legal union validly formed in another state). The State of California Declaration of Domestic Partnership form is available on the Secretary of State's website at **sos.ca.gov/dpregistry**.

The documentation must be submitted to the
Personnel Department, Benefits Division 200 N. Spring Street, Room 867, Los Angeles, California 90012.

TAX IMPLICATIONS

The California Domestic Partner Rights and Responsibilities Act of 2003 expanded the rights and responsibilities of domestic partners and modified the procedures for establishing and terminating a domestic partnership beginning January 1, 2005. The California Secretary of State has a different definition of a domestic partnership based upon California Family Code Section 297 and it contains seven requirements for eligibility which are clearly outlined in its "Declaration of Domestic Partnership." Information about registering with the State of California can be obtained by contacting its Los Angeles Office at 300 South Spring Street, Room 12531, Los Angeles, CA 90013 or calling that office at **213-897-3062**. In addition, the Secretary of State's website contains detailed information about its Domestic Partner Registry, the legislation, forms and frequently asked questions. Please visit **sos.ca.gov/dpregistry/index.htm**.

Please note that a major difference between the City and State definition is that the State requires domestic partners to be members of the same sex or one/or both of you is/are over the age of 62 and meet the eligibility criteria under Title II of the Social Security Act.

If you meet the State's definition and register with that agency, please send a copy of the resulting "Certificate of Registration of Domestic Partnership" to our office in order to remove the state income tax liability associated with covering your domestic partner and/or your domestic partner's eligible dependents under your benefits. Registration with the Secretary of State will not have any impact upon the federal income tax liability associated with covering these dependents.

WHEN TO ENROLL YOUR DOMESTIC PARTNER IN A HEALTH AND/OR DENTAL PLAN

Association or Union Plans
For enrollment into health or dental coverage in a sworn Association- or Union-offered plan, contact the organization for details on when you can enroll.

LAwell Plans
You may enroll yourself and your domestic partner and his/her dependent children in a **LAwell** Civilian Benefit Program health and/or dental plans at one of the following times:

- Within 60 days of your original employment date as a new City employee;
- During an annual Open Enrollment Period or within 30 days of a qualifying life event;
- Within 30 days of your meeting the domestic partner definition;

If you do not add your domestic partner and/or his/her dependent children to your health and/or dental plan within the above timeframes, you must wait until the next Open Enrollment Period to do so.

WHEN TO TERMINATE YOUR DOMESTIC PARTNER BENEFITS

If you and your domestic partner no longer meet all of the above definitions, you must notify the City within **thirty (30) days** by filing a Statement of Termination of Domestic Partnership with the Personnel Department's Employee Benefits Office. If you fail to remove an ineligible domestic partner from your health/dental plan, you may be responsible for repayment of the City's portion of the premiums retroactive to the date of ineligibility, as well as the cost of medical services provided to ineligible dependents, to the extent possible under law; and your domestic partner will not be offered an opportunity to continue their coverage in the health/dental plan at their own expense as provided for in the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).

If you fraudulently obtain **LAwell** program benefits for yourself or your dependents, you will be required to pay any costs of any benefits that were paid on your behalf; you will have your coverage retroactively terminated; and at the sole discretion of the City of Los Angeles, you may also be subject to disciplinary action including but not limited to discharge.

You may not file another Affidavit of Domestic Partnership until at least twelve (12) months after you have filed your Statement of Termination of the previous domestic partnership.

WHERE TO OBTAIN FORMS/WHO TO CALL FOR INFORMATION

For a copy of the Affidavit of Domestic Partnership, Statement of Termination of Domestic Partnership, **LAwell** Open Enrollment Form, or **LAwell** Qualifying Life Event Change Form, or to obtain additional information regarding domestic partner benefits, please call the Personnel Department's Sworn Domestic Partner Benefits Coordinator at **213-978-1600**, Monday through Friday between the hours of 8:00 a.m. and 4:00 p.m.

You may also obtain forms by visiting the Employee Benefits Division, 200 North Spring Street, City Hall - Room 867, Los Angeles, CA 90012 or via the internet at **per.lacity.org/Bens/DocForms.htm**.

Affidavit of Domestic Partnership

Sworn Employee

City of Los Angeles • Personnel Department • Employee Benefits Division • 213-978-1584

KEEPING LAwell
City of Los Angeles Employee Benefits

CONFIDENTIAL

1. I, (employee) _____

   and (domestic partner) _____

   reside together and intend to do so indefinitely at: _____

   _____

   We share the necessities of life.

2. By signing this Affidavit of Domestic Partnership, we agree that we both are economically responsible to third parties for the common necessities of life, defined as food, shelter, and medical care, and this shall remain the case for expenses incurred during the period that we are receiving any domestic partnership benefits from the City.

3. We affirm that we began to reside together as domestic partners on: _____

4. We are not married to anyone.

5. We are at least eighteen (18) years of age, or older.

6. We are not related by blood closer than would bar marriage in the state of California and are mentally competent to consent to contract.

7. We are each other's sole domestic partner and intend to remain so indefinitely.

8. I, (employee) _____
   agree to notify the City within thirty (30) days of any change of circumstances attested to in this Affidavit by filing with the Personnel Department's Employee Benefits Office, a Statement of Termination of Domestic partnership. Such Statement of Termination shall be on a form provided by the City and shall affirm under penalty of perjury that the partnership is terminated and that a copy of the Statement of Termination has been provided to my former domestic partner.

9. I, (employee) _____
   understand that I cannot file another Affidavit of Domestic Partnership until twelve (12) months after the Statement of Termination of the previous partnership has been filed.

10. We understand that if the City suffers any loss because of a false statement contained in this Affidavit, the City may bring a civil action against either or both of us to recover its losses, including reasonable attorney's fees and court costs.

11. We understand that the employee is responsible for the payment of applicable income taxes as a result of the City providing health and/or dental benefits to a domestic partner and/or their child(ren).

12. We understand and agree that we are providing the information in this Affidavit solely to allow the City to determine our eligibility for domestic partnership benefits as defined by City ordinance. We understand that this information will be held confidential and will be subject to disclosure only upon our written authorization or pursuant to a legally appropriate process.

13. We understand that in addition to the eligibility requirements of the City for domestic partnership coverage, there are terms and conditions of coverage set forth in the service agreements of each health and dental care plan offered by the City. By executing this Affidavit, each of us agrees to be bound by the terms and conditions of coverage of the health and/or dental care plan selected, as set forth in the applicable service agreement.

14. We understand and agree that the City is not legally required to extend any benefits, other than those benefits specifically granted to an employee and his/her domestic partner by City ordinance. We also understand and agree that upon the termination of this domestic partnership, the City is no longer obligated to provide any domestic partnership benefits to the employee's former domestic partner.

15. We understand that the information we are providing in this Affidavit may be used by either of us as evidence of the existence of our domestic partnership in subsequent legal or administrative proceedings. We understand that before signing this Affidavit, we should seek competent legal and/or tax advice concerning the financial obligations we may be undertaking by signing the Affidavit.

16. I, (employee) _____ understand that in order to provide a retirement survivor benefit to my domestic partner, I must file a separate domestic partnership affidavit with Los Angeles Fire & Police Pensions (LAFPP) or the Los Angeles City Employees' Retirement System (LACERS), and if I do not do so my domestic partner will not be entitled to a retirement survivor benefit.

17. We each declare, under penalty of perjury, that the assertions in this Affidavit are true and correct to the best of our knowledge.

Submit this completed form and documentation to the
Personnel Department, Benefits Division 200 N. Spring Street, Room 867, Los Angeles, CA 90012.

SIGNATURES

Signature of Employee _____ Date _____

Signature of Domestic Partner _____ Date _____

Employee ID or Social Security Number *(Employee ID# is located at the top portion of your payroll check, under your name)* _____

Domestic Partner Social Security Number _____

Employee Date of Birth _____

Domestic Partner Date of Birth _____

Daytime Phone Number _____

SPECIAL NOTE

Please submit a copy of your own and your domestic partner's California Driver's License or identification card. Be advised that the addresses on your respective licenses or identification cards must match one another and be the same as your address of record with the City. Your Affidavit and application cannot be processed until all addresses are consistent.

Statement of Termination of Domestic Partnership

for Sworn Employee

City of Los Angeles • Personnel Department • Employee Benefits Division • 213-978-1584

KEEPING LAwell
City of Los Angeles Employee Benefits

CONFIDENTIAL

I, (employee): _____

affirm the termination of my partnership with (Domestic Partner): _____

Effective date: _____

I have provided a copy of this Statement of Termination of Domestic Partnership to my former domestic partner.

I understand that I will not be able to file a new Affidavit of Domestic Partnership until twelve (12) months after I have filed this Statement of Termination of Domestic Partnership with the Personnel Department's Employee Benefits Division. I further understand and acknowledge that the City is not obligated to provide any Domestic Partnership employee benefits to me under any ordinance or memorandum of understanding until twelve (12) months after I have filed this Statement of Termination of Domestic Partnership and a new validly executed Affidavit of Domestic Partnership has been filed with the Employee Benefits Division.

I declare, under penalty of perjury, that the foregoing is true and correct.

_____ _____

Signature of Employee Date

_____

Employee ID or Social Security Number
(Employee ID# is located at the top portion of your payroll check, under your name)

_____

Employee Date of Birth

Submit this completed form and documentation to the
Personnel Department, Benefits Division 200 N. Spring Street, Room 867, Los Angeles, CA 90012.

Important Websites and Phone Numbers

Health Plan Member Advocates		Los Angeles City Hall 200 N. Spring Street Room 867 Los Angeles, CA 90012	Anthem: Monday – Friday 8:00 am – 4:00 pm Kaiser: Tuesday – Thursday 8:00 am – 4:00 pm	
Plan/Program	**Pages**	**Website**	**Phone Number**	
Anthem PPO Anthem Narrow Anthem Vivity ((LA & OC) HMO	8-19	anthem.com/ca/cityofla	833-597-2362 844-348-6111 844-348-6110	**LAwell Program Benefit Contacts**
Kaiser Permanente HMO	8-19	my.kp.org/ca/cityofla	800-464-4000	
Delta Dental PPO	22-25	deltadentalins.com/enrollees/index.html	800-765-6003	
DeltaCare USA DHMO	22-25	deltadentalins.com/enrollees/index.html	800-422-4234	
EyeMed Vision Care	26-28	eyemedvisioncare.com/cityofla	855-695-5418	
Healthcare Flexible Spending Account or Dependent Care Reimbursement Account	29-32	wageworks.com	877-924-3967	
Commuter Spending Accounts	55	wageworks.com	877-924-3967	
LAwell Medical, Dental, & Vision Plans		e-mail per.EmpBenefits@lacity.org	213-978-1584	**LAwell Direct**
Cash-in-Lieu, and the Healthcare & Dependent Care Accounts		keepingLAwell.com	800-778-2133 Monday – Friday, 8:00 a.m. to 5:00 p.m. Pacific time	
Employee Benefits Division		e-mail per.EmpBenefits@lacity.org	213-978-1655 Monday – Friday, 8:00 a.m. to 4:00 p.m. Pacific time	
Fire and Police Pensions		LAFPP.com	844-885-2377	**Other City Benefit Contacts**
Deferred Compensation Plan		LA457.com	844-523-2457 (Voya) or 213-978-1636 (Employee Benefits Division)	
Parking/Transit Reimbursement/ Rideshare Programs		per.lacity.org/bens/commuteoptions.htm	213-978-1655	
City Employees Club of Los Angeles		cityemployeesclub.com	213-620-0388	
All City Employees Benefits Services Association		acebsa.org	213-485-2485	
City MOUs		cao.lacity.org/MOUS	213-978-7676	
Los Angeles Firemen's Relief Association		lafra.org	323-259-5200	
Los Angeles Police Relief Association		lapra.org	213-674-3701	
United Firefighters of Los Angeles City		uflac.org	213-895-4006	

Sworn Enrollment Guide Section Details

NOTES

NOTES

*This guide is published by the City of Los Angeles Personnel Department. It provides only highlights of the **LAwell** program. It does not change the terms of your benefits or the official documents that control them. If there are any inconsistencies between this guide and the official benefit documents, the benefit documents will govern.*

*By enrolling in, and/or accepting services under the **LAwell** Plan, you agree to abide by all terms, conditions and provisions stated in the 2018* **LAwell CHOOSEwell Sworn Guide**.

You must notify the Benefits Service Center within 30 calendar days if your covered dependent no longer meets eligibility requirements. If an ineligible dependent has been enrolled, or you fail to report a loss of eligibility event such as divorce, within 30 days, you may be responsible for repayment of the City's portion of the premiums retroactive to the date of ineligibility, as well as the cost of medical services provided to ineligible dependents, to the extent possible under law.

*If you fraudulently obtain **LAwell** program benefits for yourself or your dependents, you will be required to pay any costs of any benefits that were paid on your behalf; you will have your coverage retroactively terminated; and at the sole discretion of the City of Los Angeles, you may also be subject to disciplinary action including but not limited to discharge.*

KEEPING LAwell

City of Los Angeles Employee Benefits