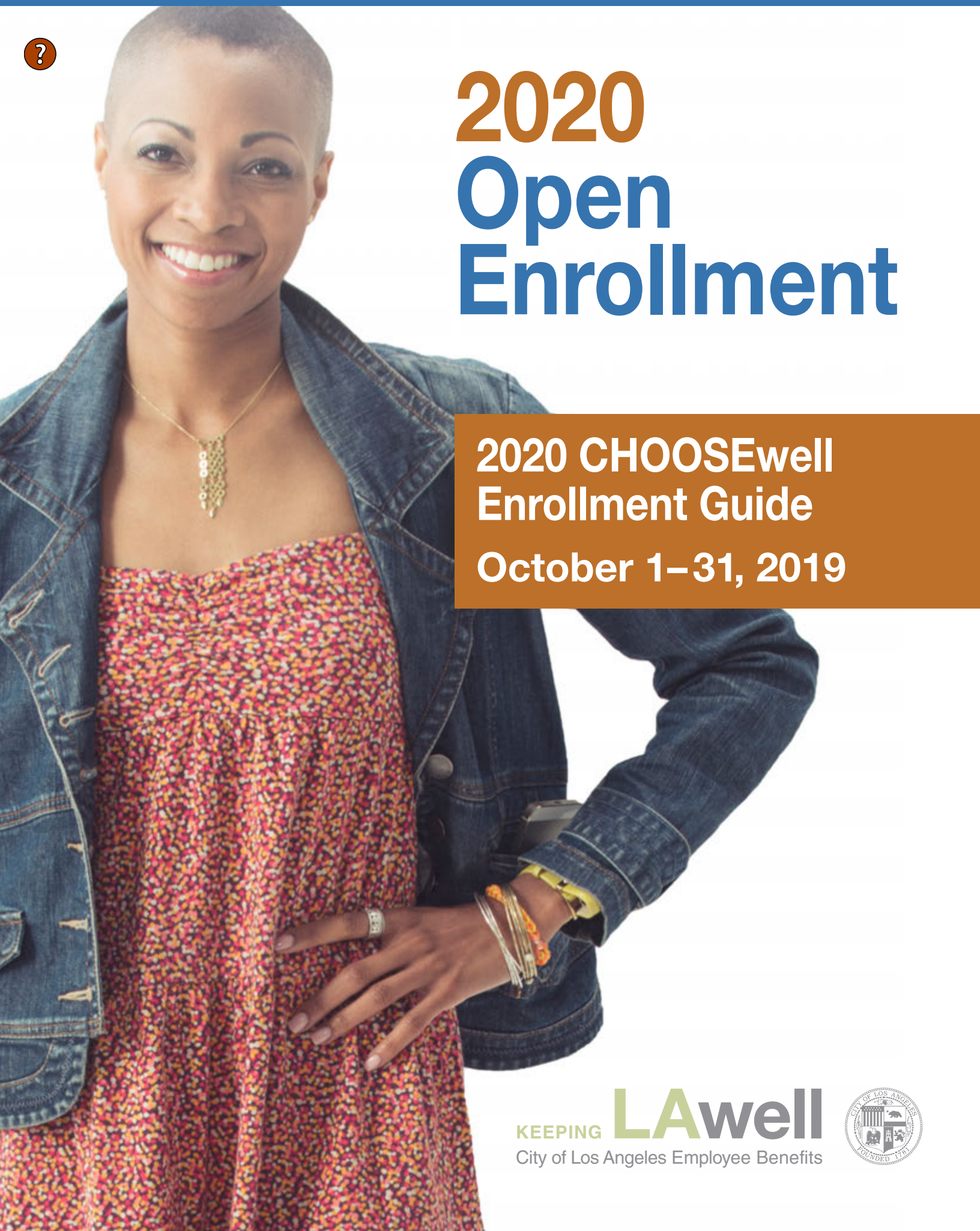


2020 Open Enrollment

2020 CHOOSEwell Enrollment Guide

October 1–31, 2019

KEEPING LAwell

City of Los Angeles Employee Benefits

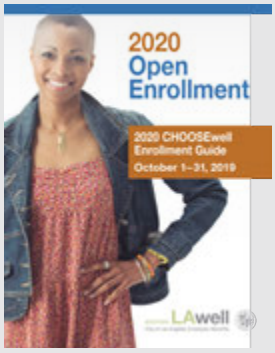
How to use this CHOOSEwell Enrollment Guide

First 1

Review your current enrollment and your 2020 costs and options using your Personalized Benefit Statement or by logging into your account at **keepingLAwell.com**.

Second 2

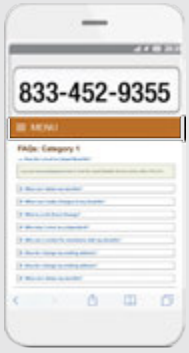
Review the **CHOOSEwell** Enrollment Guide to learn more about **using your benefits,** and any **rules/restrictions** that may apply.



Review your **CHOOSEwell** Highlights for a quick overview of 2020 benefits.

Third 3

Make your 2020 enrollment elections by October 31, 2019! Go to **keepingLAwell.com** or call **833-4LA-WELL (833-452-9355)** to make elections.



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 2020 unless you experience a qualifying life event. Choose wisely, and **CHOOSEwell**! For additional details about these benefits, please visit **keepingLAwell.com**.

Your Detailed Enrollment Checklist

- ☑ Review your Personalized Benefit Statement.
- ☑ Review your options in the CHOOSEwell Enrollment Guide and at **keepingLAwell.com**.
- ☑ Review your dependent information and eligibility rules (on page 47) to verify current dependents, add new dependents, or remove ineligible dependents.
- ☑ Document your dependents by December 10, 2019; 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 **833-4LA-WELL** (this is for federal tax reporting purposes).
- ☑ Review the eligibility section and other pertinent sections of the CHOOSEwell Enrollment Guide to understand plan rules and successfully manage your benefits over time.
- ☑ Make your 2020 enrollment elections!
- ☑ Review your confirmation statement when you receive it in mid-November.

Your Enrollment Resources

- ✓ **To enroll or make changes online or on the phone, visit keepingLAwell.com** or contact the Benefits Service Center at **833-4LA-WELL (833-452-9355)** (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 Wednesday, October 30 and Thursday, October 31: 8 a.m. to 7 p.m.** On Saturday and Sunday, October 26 and 27, the Benefits Service Center will **NOT** be available via phone; however you can still enroll online.

Attend a weekly event and learn more:

Date	Event Type	Duration	Location
Oct 9	Benefits Onsite – LAWA	10:00 am – 3:00 pm	**Los Angeles World Airport (LAWA)** 1 World Way West, Admin West Lobby
Oct 10	Benefits Onsite – LAWA	10:00 am – 3:00 pm	**Los Angeles World Airport (LAWA)** 1 World Way West, Admin West Lobby
Oct 10	Lunchtime Seminar/Webinar 2020 LAwell Benefits Overview/Q&A	12:00 – 12:30 pm (Q&A to follow)	**In-Person Seminar:** Los Angeles World Airport (LAWA) 1 World Way West, Training Room 7307-A **Live Webinar:** keepingLAwell.com/events
Oct 16	Benefits Onsite – GARLAND	10:00 am – 3:00 pm	**Garland Building** 1200 W 7th St, 8th Floor, Lounge Room
Oct 17	Benefits Onsite – GARLAND	10:00 am – 3:00 pm	**Garland Building** 1200 W 7th St, 8th Floor, Lounge Room
Oct 23	Benefits Onsite – PUBLIC WORKS	10:00 am – 3:00 pm	**Public Works Building** 1149 S Broadway, Sub-basement Room 7
Oct 24	Benefits Onsite – PUBLIC WORKS	10:00 am – 3:00 pm	**Public Works Building** 1149 S Broadway, Sub-basement Room 6
Oct 24	Lunchtime Seminar/Webinar 2020 LAwell Benefits Overview/Q&A	11:30 am – 12:00 pm (Q&A to follow)	**In-Person Seminar:** **Public Works Building** 1149 S Broadway, Sub-basement Room 6 **Live Webinar:** keepingLAwell.com/events
Oct 24	Nighttime Seminar/Webinar 2020 LAwell Benefits Overview/Q&A	5:30 – 6:00 pm (Q&A to follow)	**In-Person Seminar:** **City Hall East** 200 N Main Street, Room 351 **Live Webinar:** keepingLAwell.com/events
Oct 31	Lunchtime Seminar/Webinar 2020 LAwell Benefits Overview/Q&A	11:30 am – 12:00 pm (Q&A to follow)	**In-Person Seminar:** **City Hall East** 200 N Main Street, Room 351 **Live Webinar:** keepingLAwell.com/events
Oct 31	Lunchtime Seminar/Webinar 2020 LAwell Benefits Overview/Q&A	12:40 – 1:10 pm (Q&A to follow)	**In-Person Seminar:** City Hall East 200 N Main Street, Room 351 **Live Webinar:** keepingLAwell.com/events

Visit **keepingLAwell.com** for more information about attending a weekly event. Webinars will be recorded and available for viewing at **keepingLAwell.com**.

Meet a Member Advocate

Member advocates from our health 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, 2019

Events: Webinars, lunchtime and nighttime seminars, and Benefits Onsite meetings will be offered throughout Open Enrollment—check for updates at **keepingLAwell.com**.

Last day to make changes:
October 31, 2019

Documentation deadline:
December 10, 2019

Benefit changes take effect:
January 1, 2020; Health plan ID cards will be issued shortly thereafter.

What's Inside

CHOOSEwell Benefit Overview 6

Online Open Enrollment 8

Online Account Registration 8

Easy-to-Use Navigation 9

Make Open Enrollment Elections 10

Medical Coverage & Cash-in-Lieu 12

Your Medical Plan Choices 12

What is Cash-in-Lieu? 13

Your 2020 Medical Plan Coverage Costs Per Pay Period 16

CHOOSEwell—A Medical Plan Coverage Comparison 18

Dental Coverage 24

Dental Coverage Choices 24

Your 2020 Dental Coverage Costs Per Pay Period 26

CHOOSEwell – Dental Plan Coverage Comparison 27

Vision Coverage 28

Your Vision Coverage 28

The EyeMed Network 28

In- and Out-of-Network Vision Benefits 29

How EyeMed Benefits Work with Medical Plan Vision Benefits 30

Support Plus: Employee and Family Assistance Program 31

Benefits for All Employees and Their Family Members 31

Life Insurance 32

Life Insurance Options Overview 32

Requirements to Enroll into Life Insurance Coverage 33

Your Monthly Cost for Supplemental Life and Dependent Insurance 34

Accidental Death & Dismemberment (AD&D) Insurance 36

Accidental Death & Dismemberment Insurance Overview 36

Requirements to Enroll into Coverage 36

AD&D Coverage Costs 37

What's Inside

Disability Coverage 38

Basic and Supplemental Disability Overview 38

Requirements to Enroll into Disability Coverage 38

Definition of Disability 40

Health and Dependent Care Tax-Advantaged Spending Accounts 41

How the Accounts are Different 41

How Much You Can Set Aside 41

Filing Claims 44

Dependent Coverage Rules for Special Situations 45

Eligibility 47

Who is Eligible for Benefits? 47

Dependent Eligibility Criteria 48

Dependent Documentation Information Is Required 49

Removing Ineligible Dependents 49

Life Events 50

Qualifying Life Event Requirements 50

Leaves Of Absence 52

How Benefits Can Be Affected During A Leave Of Absence 54

Important Legal Notices 55

Prescription Drug Coverages and Medicare 63

RETIREwell 67

Deferred Compensation Plan 67

COMMUTEwell 68

Commuter Spending Accounts (TSA and PSA) 68

LIVEwell 69

Section Details 70

Important Websites and Phone Numbers 73

CHOOSEwell Benefit Overview

Here are three top things you should know:

1. Open Enrollment is your only opportunity to make coverage elections for yourself and your dependents for 2020 (unless you experience a qualifying life event change in 2020).
2. Generally, your previously elected 2019 benefit elections will automatically roll over to 2020, 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 2020 or become a new participant in one of these accounts for 2020, you will need to elect to do so during Open Enrollment.

Here are some important questions and the answers:

When do my benefits start?

- Open Enrollment elections are effective January 1, 2020.
- Newly hired employee elections are effective the date you enroll.
- Employees who are rehired or have their benefits reinstated will have varied effective dates of coverage. See page 53 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 of 2020.

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 50 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 Benefits Service Center. A confirmation statement will be sent to you that documents your request and outlines any additional requirements. You will be requested to provide documents showing proof of the qualifying life event within **60 days** of the date on the confirmation statement reflecting such change. If you do not provide the required documents by the deadline, your requested changes will not be implemented. See page 50 for more information.

How do I enroll during Open Enrollment?

Call **833-4LA-WELL** or log on to **keepingLAwell.com**. The deadline to enroll or make changes is October 31!

See your Detailed Enrollment Checklist on page 3.

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	8-21
	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
	Preventive Only plan		None. Pays you up to $5** each month.	22-25
Vision	In-Network Out-of-Network reimbursements	EyeMed	**Included at no cost**	26-28
Support Plus	Employee and Family Assistance counseling services	Optum	**Included at no cost**	29
Insurance	Disability – **Basic Coverage** (up to 50% of earnings for a maximum of 2 years)	Standard Insurance Company	**Included at no cost**	30-38
	Life – **Basic Coverage** ($10,000 for full-time, $5,000 for half-time).		**Included at no cost**	
	Disability – **Supplemental Coverage** (up to 66 2/3% of earnings until retirement age) Life – **Supplemental Coverage** (up to 5x your annual salary) Life – Spouse/Domestic Partner Coverage (up to $100,000) Life – Child Coverage ($5,000 per child) Accidental Death & Dismemberment (AD&D) (up to $500,000)		Cost varies based on coverage level elected and is calculated by age and income. See your Personalized Benefit Statement or log into your account at **keepingLAwell.com** for your specific cost details.	
Tax-Advantaged Spending Accounts	Healthcare Flexible Spending Account	WageWorks	You elect voluntary contributions up to maximum limit	39-42
	Dependent Care Reimbursement Account			39-42
	Parking & Commuter Accounts			65

*Your personal cost options are detailed in your Personalized Benefit Statement. They are also available by logging into your account at **keepingLAwell.com**.
** Amounts represent full-time employment status. For half-time employees, the benefit is reduced 50%.

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 47 for detailed eligibility information.

When does my coverage end?

- Retired employees and employees who transfer to DWP: Last day of the month
- Terminated employees: effective date of termination
- Employees on leave: effective date of leave, unless on direct bill
- Dependent children lose coverage on the last day of the month in which they turn age 26.

For more information see pages 47 and 53.

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 pages 52-54.

Why should I update my beneficiary(ies)?

Beneficiaries for your insurance coverage elections are unique to your **LAwell** benefits. Your beneficiary elections for your LACERS retirement, Deferred Compensation Plan, or other City benefits are separate from the beneficiaries you designate for your **LAwell** Life and AD&D Insurance options.

Keeping your beneficiary designation up to date, and informing your designated beneficiary where and how to file a claim, help to ensure your heirs get access to all of the benefits as you intended.

For more information see page 34.

Who do I call to learn more about my benefits?

Call the Benefits Service Center at **833-4LA-WELL**, or visit **keepingLAwell.com**.

Online Open Enrollment

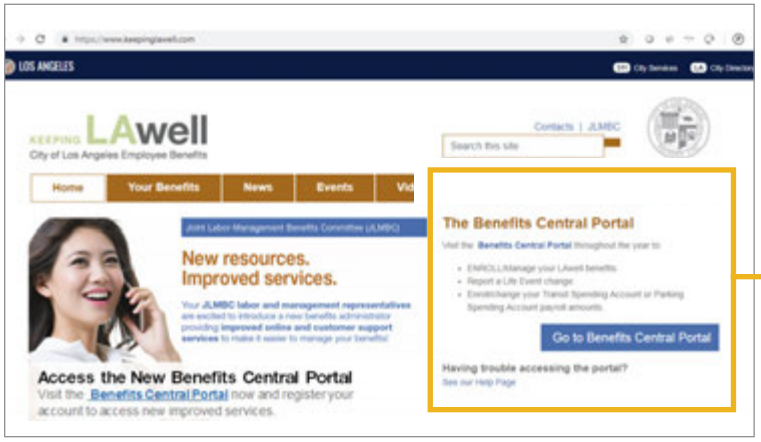
The LAwell Benefits Program has introduced improved online and customer support services to make it easier to manage your benefits. The new **Benefits Central Portal** allows LAwell members easier access to their personal benefits information and to perform transactions. This section provides instructions on accessing and using the new Benefits Central Portal.

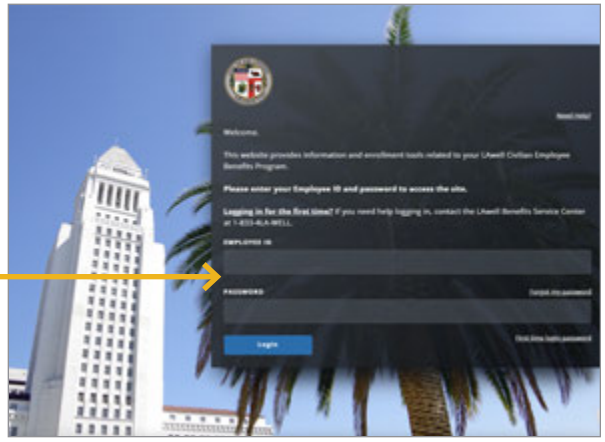
Online Account Registration

Register your online account by visiting **keepingLAwell.com** and clicking on the link or button to access the Benefits Central Portal.

Your user name is your Employee ID. When you first use the system, your temporary password will be your birthdate and the last four digits of your Social Security Number. If you need help logging in, review the help link information on the login page, or call **1-833-4LA-WELL** for assistance.

You'll be asked to establish a new password and set security questions to complete your registration. That's it! You'll then have access to all of your current benefits information.





All LAwell members must register their online account for Benefits Central Portal access.

As of April 2019, the new Benefits Central Portal requires all LAwell members to re-register. Your previous user ID and password will no longer grant you access to the new system.

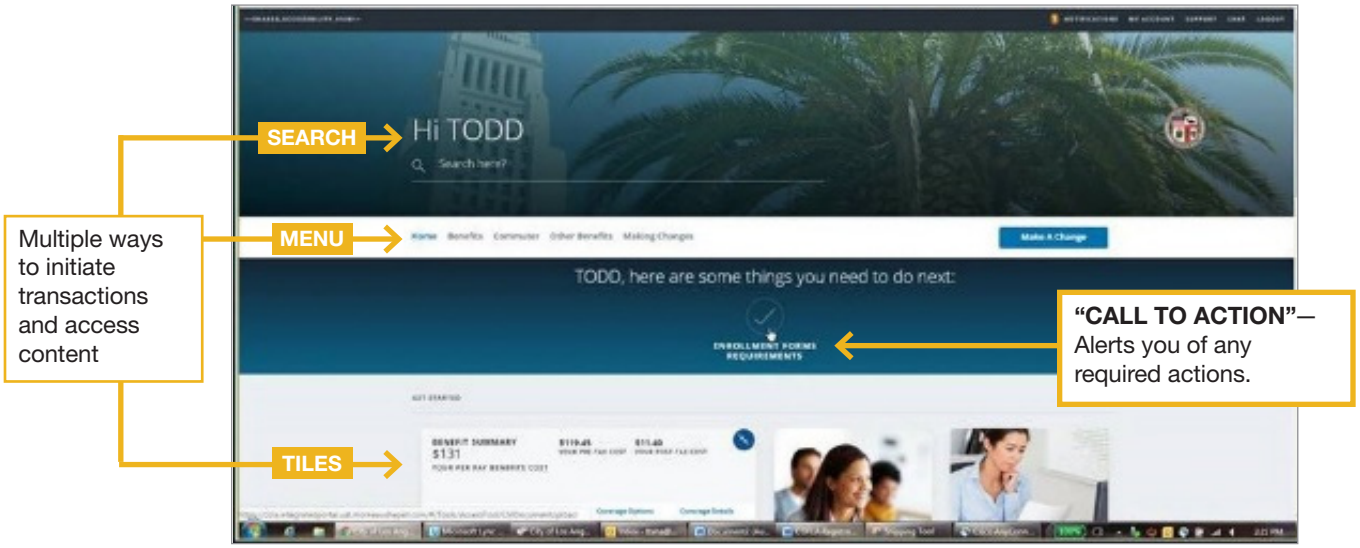
Your user name is your Employee ID. When you first use the system, your temporary password will be your birthdate and the last four digits of your Social Security Number. If you need help logging in, review the help link information on the login page, or call **1-833-4LA-WELL** for assistance.

Who can I talk to if I have questions?

Call the LAwell Benefits Service Center at **1-833-4LA-WELL (833-452-9355)**, between the hours of 8:00am – 5:00pm Pacific Time, Monday to Friday.

Easy-to-Use Navigation

Access the Benefits Central Portal from both your computer and mobile device. The tile-based website is optimized to change its display based on your device. An intuitive design also allows users to access content and start transactions in multiple ways. And a "Call to Action" notification system keeps you informed of any outstanding or required actions.



Making Your 2020 Choices Online

The Benefits Central Portal makes it easy to complete your 2020 enrollment online. Use this guide, along with your Personalized Benefit Statement, to learn about rules and restrictions and to compare your 2020 options to your current 2019 coverage.

To review your current 2019 coverage, access your Personalized Benefit Statement through the **My Forms and Documents** tile or by selecting the "View Benefits Selection" link from your Benefit Summary. Both of these options are located on the home page of your Benefits Central Portal.

To enroll for 2020, follow the instructions on the next two pages to make your Open Enrollment elections online.

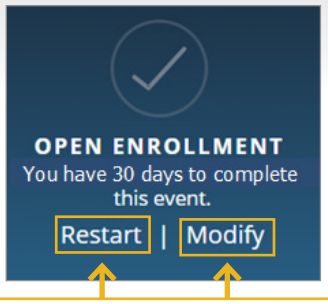
Make Open Enrollment Elections Online

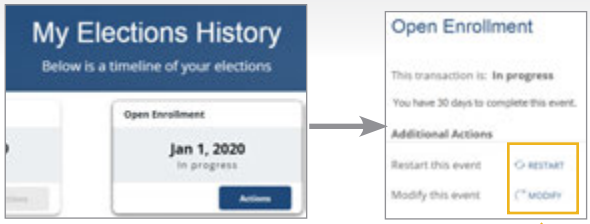
The Benefits Central Portal enrollment tool is a multiple step, online process that allows you to restart or modify your 2020 choices at any time during the Open Enrollment period (October 1 - 31). Follow these instructions to complete your 2020 enrollment online.

• Start your Open Enrollment event.

LAwell members are automatically (passively) enrolled into benefits for the next year. If you want to keep the same elections, you do not need to enroll; your current elections will automatically continue at the new 2020 per pay period costs.

Select the Call To Action banner **OR** **Access through the My Forms and Documents tile**





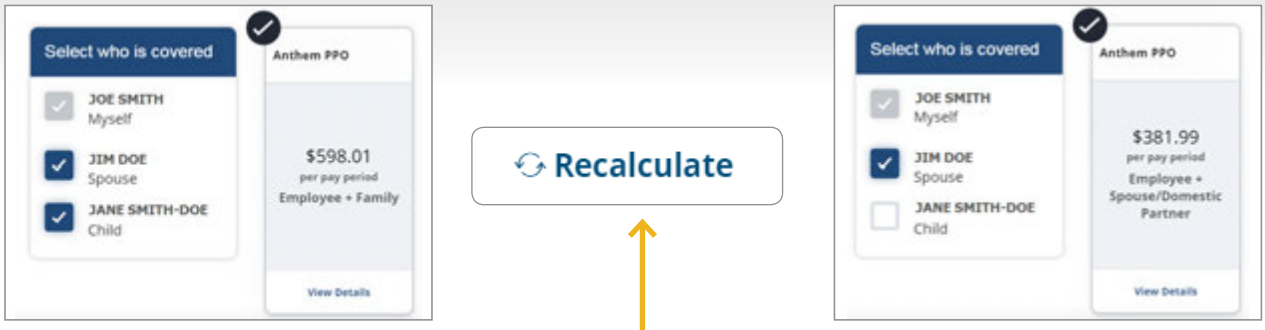
To change your elections for 2020, **Restart** or **Modify** your Annual Enrollment event.

Note: Healthcare and Dependent Care accounts do not automatically continue and require an annual election.

• Add your LAwell eligible dependents.

In Step 1 you will add your **LAwell** eligible dependents. Select through all other steps to change your **LAwell** coverage elections and to add and remove dependents from coverage.

Add and remove eligible dependents

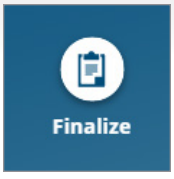


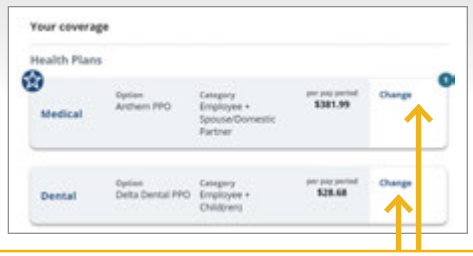
Click **Recalculate** to see how changes to covered dependents impact your per pay period costs.

• Finalize and complete your elections.

Review your full list of benefit elections on the Finalize screen (Step 6) and ensure your elections are accurate. You can make changes to any benefit by clicking the Change link on each associated benefit.

Review your elections and make changes if needed

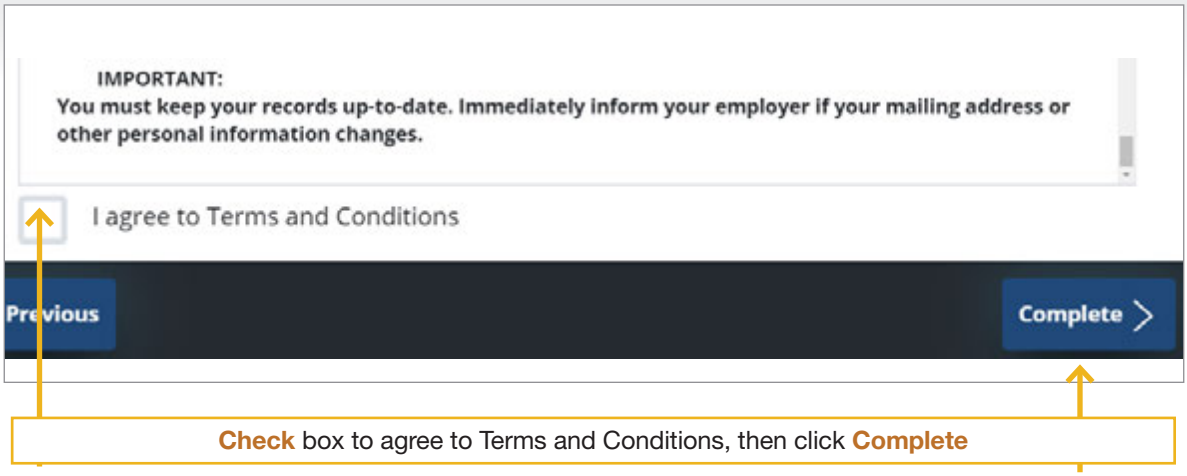




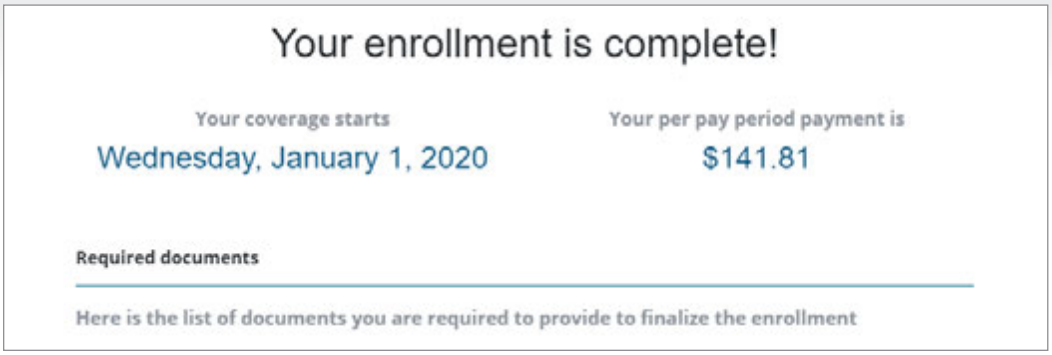
Click **Change** if you want to make changes

When you are satisfied with your elections, review and accept the Terms and Conditions, then click **Complete** to finish your enrollment and receive confirmation.

Agree to Terms and Conditions; Complete



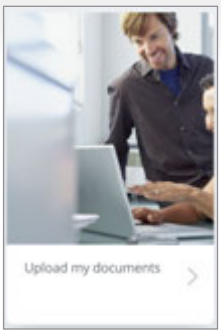
Receive your enrollment confirmation



• Submit documentation.

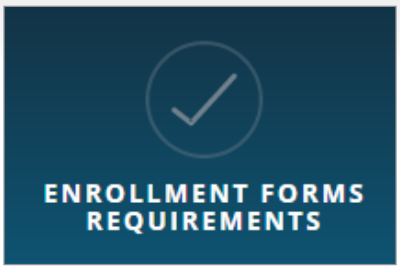
Some election actions, such as adding dependents to coverage, require your submission of supporting documentation. Upload your supporting documents directly to your account using the **Upload My Documents** tile, or select the **Enrollment Forms Requirements** Call To Action that should appear after you successfully complete an applicable enrollment event. You can also monitor the status of your uploaded documents.

Select the Upload my documents tile



OR

Select the Enrollment Forms Requirements Call To Action



Medical Coverage & Cash-in-Lieu

Your Medical Plan Choices

Anthem

- Anthem PPO – doctors/providers available nationally
- Full Network (CACare) HMO – doctors/providers available throughout California
- Narrow Network (Select) HMO – doctors/providers available throughout Southern California and other areas
- Vivity (LA & Orange Counties) HMO – doctors/providers available throughout select locations in 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 13 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 15) for more information about health coverage outside 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 benefit coverage.

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

	Anthem Narrow Network (Select HMO) **Anthem Full Network** (CACare HMO)	**Anthem Vivity** (LA & Orange Counties HMO)	**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.

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 10, 2019** 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 2020, participation is effective January 1, 2020 and your current **LAwell** health coverage will terminate December 31, 2019. Your first "Cash-In-Lieu" payment will be reflected in your gross wages on the paycheck you receive on January 15, 2020, for the pay period ending January 4, 2020. If you do not submit a Cash-In-Lieu Affidavit by December 10, 2019 for 2020 Open Enrollment or within 60 days of a qualifying life event change that you have in 2020, your participation in Cash-In-Lieu will be canceled and you will be enrolled in employee-only health coverage. If you have no prior coverage elections in our records, you will be enrolled into the default health coverage plan for that year. 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?

For questions about Cash-in-Lieu, contact the LAwell Benefits Service Center at **833-4LA-WELL** or call the Employee Benefits Division at **213-978-1655**.

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 their paycheck each pay day, up to $100 per month.
- Half-time employees receive $25 per paycheck, up to $50 per month.

Open Enrollment is your only opportunity to make coverage elections for yourself and your dependents for 2020 (unless you experience a qualifying life event change in 2020).

Finding Network Providers

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

- Go to **anthem.com/ca/cityofla**
- Select Find Care
- Identify your plan:
  - Vivity HMO (Los Angeles and Orange Counties)
  - Select HMO (Narrow Network)
  - CACare HMO (Full Network)
  - Prudent Buyer PPO

For help finding a PCP, you may call Anthem (Narrow, Full) **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**.

For help finding a PCP, you may call:

Anthem (Narrow, Full) 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.

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

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 (Narrow or Full) **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** or visit an onsite member advocate at City Hall.

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

Medical Services via Phone or Web

Anthem and Kaiser members can access phone or web appointments for certain types of services. Visit each health plan's website, or ask a member advocate for eligibility information.

LGBTQIA Health Care Providers

Your provider can offer care that is personalized and most relevant to your sexual orientation, gender identity, or gender expression. You and your provider can decide what information to add to your medical record that will best meet your care needs.

For assistance in finding an LGBTQIA provider, please contact your network directly, or visit the health plan member advocate at City Hall.

For further information:

Anthem

Contact your provider's office staff to ask about updating your medical record. If you have questions or concerns, please contact Anthem Blue Cross at **833-597-2362**.

Kaiser

For questions about transgender or nonbinary health care, please call the Transgender Care line at **323-857-3818** to speak to a nurse case coordinator. This line is available from 7:30 a.m. to 5:00 p.m.

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, be sure 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 15.

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% 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.

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/Domestic Partner (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 47 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 your employment status (full-time or half-time), the Memorandum of Understanding (MOU) that applies to you, the number of dependents you cover (if any), and the specific plan you choose. There are two contribution structures: **LAwell Plan** and **LAwell Pay Plan**.

LAwell Plan: Pays up to the City's maximum subsidy without additional premium cost-sharing. Covered MOUs include 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 29, 31, 32, 34, 36, 37, 61, 63, and 64.

LAwell Pay Plan: Pays up to the City's maximum subsidy with additional premium cost-sharing of 10%. Covered MOUs include 26, 27, 28, 30, 38, 39, and 40.

The City's maximum subsidy is an amount equal to the Kaiser Permanente HMO family premium ($1,612.32 per month) for full-time employees and the Kaiser Permanente HMO employee-only rate ($620.12 per month) for half-time employees, subject to any premium sharing requirements as provided for by the employee's MOU.

If you have questions regarding your health plan contributions, please refer to your applicable MOU or Los Angeles Administrative Code Section 4.307 for non-represented employees.

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 46 for more information.

For details on prescription drug coverage, see page 21.

LAwell Plan

Your 2020 Medical Plan Coverage Costs Per Pay Period (Every Two Weeks)

	Full-Time Employees (MOUs 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 29, 31, 32, 34, 36, 37, 61, 63, and 64.)		Half-Time Employees (MOUs 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 29, 31, 32, 34, 36, 37, 61, 63, and 64.)		
Coverage Level	City Pays…	Employee Pays…	City Pays…	Employee Pays…	Total Cost of Coverage Bi-Weekly (per Pay Period)
Kaiser HMO					
Employee Only	$310.06	$0.00	$310.06	$0.00	$310.06
Employee & Spouse/DP*	$682.13	$0.00	$310.06	$372.07	$682.13
Employee + Child(ren)*	$620.12	$0.00	$310.06	$310.06	$620.12
Employee + Family*	$806.16	$0.00	$310.06	$496.10	$806.16
Anthem Narrow Network (Select) HMO					
Employee Only	$335.83	$0.00	$310.06	$25.77	$335.83
Employee & Spouse/DP*	$738.86	$0.00	$310.06	$428.80	$736.86
Employee + Child(ren)*	$638.11	$0.00	$310.06	$328.05	$638.11
Employee + Family*	$806.16	$67.05	$310.06	$563.15	$873.21
Anthem Full Network (CACare) HMO					
Employee Only	$335.83	$138.40	$310.06	$164.17	$474.23
Employee + Spouse/DP*	$738.86	$304.43	$310.06	$733.23	$1,043.29
Employee + Child(ren)*	$638.11	$262.91	$310.06	$590.96	$901.02
Employee + Family*	$806.16	$426.84	$310.06	$922.94	$1,233.00
Anthem Vivity (LA & Orange Counties) HMO					
Employee Only	$281.92	$0.00	$281.92	$0.00	$281.92
Employee + Spouse/DP*	$620.24	$0.00	$310.06	$310.18	$620.24
Employee + Child(ren)*	$535.65	$0.00	$310.06	$225.59	$535.65
Employee + Family*	$733.00	$0.00	$310.06	$422.94	$733.00
Anthem PPO					
Employee Only	$540.06	$0.00	$310.06	$230.00	$540.06
Employee + Spouse/DP*	$806.16	$381.99	$310.06	$878.09	$1,188.15
Employee + Child(ren)*	$806.16	$219.95	$310.06	$716.05	$1,026.11
Employee + Family*	$806.16	$598.01	$310.06	$1,094.11	$1,404.17

* Domestic partnerships are not recognized under federal tax law, and enrollment of domestic partner dependents may result in different taxable income treatment. See page 46 for more information.

LAwell Pay Plan

Your 2020 Medical Plan Coverage Costs Per Pay Period (Every Two Weeks)

	Full-Time Employees (MOUs 26, 27, 28, 30, 38, 39, and 40)		Half-Time Employees (MOUs 26, 27, 28, 30, 38, 39, and 40)		
Coverage Level	City Pays…	Employee Pays…	City Pays…	Employee Pays...	Total Cost of Coverage Bi-Weekly (per Pay Period)
Kaiser HMO					
Employee Only	$279.06	$31.00	$279.06	$31.00	$310.06
Employee & Spouse/DP*	$613.92	$68.21	$279.06	$403.07	$682.13
Employee + Child(ren)*	$558.11	$62.01	$279.06	$341.06	$620.12
Employee + Family*	$725.55	$80.61	$279.06	$527.10	$806.16
Anthem Narrow Network (Select) HMO					
Employee Only	$302.25	$33.58	$279.06	$56.77	$335.83
Employee + Spouse/DP*	$664.98	$73.88	$279.06	$459.80	$738.86
Employee + Child(ren)*	$574.30	$63.81	$279.06	$359.05	$638.11
Employee + Family*	$725.55	$147.66	$279.06	$594.15	$873.21
Anthem Full Network (CACare) HMO					
Employee Only	$302.25	$171.98	$279.06	$195.17	$474.23
Employee + Spouse/DP*	$664.98	$378.31	$279.06	$764.23	$1,043.29
Employee + Child(ren)*	$574.30	$326.72	$279.06	$621.96	$901.02
Employee + Family*	$725.55	$507.45	$279.06	$953.94	$1,233.00
Anthem Vivity (LA & Orange Counties) HMO					
Employee Only	$253.73	$28.19	$253.73	$28.19	$281.92
Employee + Spouse/DP*	$558.22	$62.02	$279.06	$341.18	$620.24
Employee + Child(ren)*	$482.09	$53.56	$279.06	$256.59	$535.65
Employee + Family*	$659.70	$73.30	$279.06	$453.94	$733.00
Anthem PPO					
Employee Only	$486.06	$54.00	$279.06	$261.00	$540.06
Employee + Spouse/DP*	$725.55	$462.60	$279.06	$909.09	$1,188.15
Employee + Child(ren)*	$725.55	$300.56	$279.06	$747.05	$1,026.11
Employee + Family*	$725.55	$678.62	$279.06	$1,125.11	$1,404.17

* Domestic partnerships are not recognized under federal tax law, and enrollment of domestic partner dependents may result in different taxable income treatment. See page 46 for more information.

CHOOSEwell—A Medical Plan Coverage Comparison

The Medical Plan Coverage Comparison displays only a few highlights of your benefit options. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **anthem.com/ca/cityofla** or **kp.org/plandocuments**. Additional information is available through **keepingLAwell.com**.

	Anthem Narrow Network (Select HMO) **Anthem Full Network** (CACare HMO)	**Anthem Vivity** (LA & Orange Counties HMO)	**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 (including pediatric visits)	Plan pays 100% after $15 copay/visit ****		Plan pays 100% after $15 copay/visit ****
Preventive Care,* Maternity Care (Office Visits) & Inpatient Hospitalization	Plan pays 100%		Plan pays 100%
Outpatient Surgery	Plan pays 100%		Plan pays 100% after $15 copay/procedure
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
Hearing Aid Benefit	Plan pays for one hearing aid per ear every 24 months after $15 copay/visit; covers all visits for fitting, counseling, adjustment, cleaning, and inspection		Plan pays up to $2,000 for one device per ear every 36 months; covers all visits for fitting, counseling, adjustment, cleaning, and inspection
Prescription Drugs	See "Prescription Drug Coverage Details" on page 21 for details		
Mental Health & Substance Abuse Treatment			
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, $5-7 copay/visit for group session****

* 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 HMO (Narrow, Full) at 844-348-6111, or Anthem Vivity at 844-348-6110**.

**** Copay varies by office visit type. See the Evidence Of Coverage for more details.

CHOOSEwell—A Medical Plan Coverage Comparison

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	Prenatal and postnatal office visits for ACA mandated services: 100%; no copay, no deductible. Other prenatal and postnatal office visits: Plan pays 100% after $30 copay/visit with no deductible. Other services: Plan pays 90% after deductible	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 80% after deductible for one hearing aid per ear every 24 months; covers all visits for fitting, counseling, adjustment, cleaning, and inspection	Plan pays 80% of allowed charges*** after deductible for one hearing aid per ear every 24 months; covers all visits for fitting, counseling, adjustment, cleaning, and inspection
Prescription Drugs	See “Prescription Drug Coverage Details” on page 21 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 pages 47-49 before you request enrollment of a dependent.

Document any added dependents (e.g., birth certificates, marriage license, etc.) by December 10, 2019; 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 50 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 page 50 for more information.

Prescription Drug Coverage Details

Prescription 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 your cost share may be significantly higher. To find a participating pharmacy, go to **anthem.com/ca/cityofla** and select Drug Lists (Formularies) at the bottom of the page, then select "Anthem National Drug List."
- **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. To find a Kaiser pharmacy, visit **kp.org**.

What is a Drug Formulary?

A formulary is a preferred list of commonly prescribed, FDA-approved medications compiled by an independent group of doctors and pharmacists. It includes medications for most medical conditions that are treated on an outpatient basis. Your out-of-pocket costs are lower when you use a drug on the formulary. You can access the Anthem drug formulary by going to **anthem.com/ca/cityofla** and selecting Drug Lists (Formularies) at the bottom of the page, and then selecting "Anthem National Drug List." You can access the Kaiser drug formulary by going to **kp.org/formulary**.

Your copayment for covered drugs will not exceed the lesser of any applicable copayment listed below for the listed supply amount or the actual cost of the drug. The cost for variations from the below list may vary. Contact your health plan or visit your health plan member advocate at City Hall if you have questions about prescription drug copayments.

	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 at **833-597-2362**, Anthem HMO (Narrow, Full) at **844-348-6111**, Anthem Vivity at **844-348-6110** or **anthem.com/ca/cityofla** or visit a member advocate (see pg. 14)	**800-464-4000** or **my.kp.org/ca/cityofla** or visit a member advocate (see pg. 14)

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
- Non FDA-approved drugs, or drugs determined to used for experimental or investigative indications.

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 HMO (Narrow, Full) at **844-348-6111** or Anthem Vivity at **844-348-6110**, go to **anthem.com/ca/cityofla**, or visit a member advocate (see page 14) 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**, call **877-335-2746**, or visit a member advocate (see page 14).

Special Health Coverage

Coverage for Special Circumstances

Care While Traveling

Type of Care	Anthem Narrow Network (Select HMO) Anthem Full Network (CACare HMO) Anthem Vivity (LA & Orange Counties HMO)	Anthem PPO	Kaiser Permanente HMO
Emergency Care in the U.S.	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.		
	Within 48 hours of admission, contact Anthem Blue Cross Customer Service at the number listed on your member ID card.		Call **800-225-8883** immediately if you are admitted to a non-participating hospital.
Emergency Care outside the U.S.	Always go to the closest emergency facility; request an itemized bill (in English) before leaving to file a claim for reimbursement. The BlueCross BlueShield Global Core Service Center is available 24 hours a day, seven days a week, toll-free, at **800-810-BLUE** or by calling collect at **804-673-1177**. An assistant coordinator, along with a medical professional, will arrange doctor or hospitalization needs.		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.
Urgent Care	**In-Area:** If you are within 15 miles or 30 minutes 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, call Anthem Customer Service within 48 hours at the number listed on your member ID card.	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.	**In-Area:** Go to the nearest Kaiser Permanente urgent care facility. You can also call for an appointment or contact the Nurse Help Line at the number listed in your guidebook. **Out-of-Area:** Go to the nearest urgent care facility or MinuteClinic. Kaiser Permanente members can use their Kaiser Permanente ID card at MinuteClinic locations and only pay their normal copay.
Prescription Coverage	**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.		**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.

Care for Dependents Who Do Not Live with You

Type of Care	Anthem Narrow Network (Select HMO) Anthem Full Network (CACare 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 the 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 45.

Wellness Program

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 my.kp.org/ca/cityofla
Annual Checkups	Annual physical and other in-network preventive care is generally covered at 100% in-network	
Nurse Help Line **4 hours a day, 7 days a week**	**800-977-0027**	**888-576-6225**
Weight Management and Nutrition Counseling	• Solera Diabetes Prevention Program for pre-diabetics (in-person and online). Visit **solera4me.com/cityofla** to take a 1-minute quiz to find out if you qualify for the program. • Online tools and resources to support your diet, fitness and weight management goals. Log into your member account at **anthem.com/ca/cityofla** and select Health and Wellness Center to get started. • Active&Fit Direct™ – provides discounted gym memberships. Log into your member account at **anthem.com/ca/cityofla** and select Discounts to learn more. • Discounts on weight loss products and programs, including Jenny Craig, Living Lean, Lindora Clinic, nutrition bars and drinks. Log into your member account at **anthem.com/ca/cityofla** and select Discounts to learn more.	Nutrition counseling available with doctor referral; copay applies. Access **https://healthy.kaiserpermanente.org/health-wellness** for the following benefits: • Lifestyle Weight Management Course plus other health education programs • Free online personalized Weight Management Program • Weight Watcher discounts
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: • Online smoking/tobacco cessation support. Log into your member account at **anthem.com/ca/cityofla** and select Health and Wellness Center to learn more. • Coverage for FDA-approved, over-the-counter nicotine replacement medications with no copayment, when obtained with a doctor's prescription. • Coverage for FDA-approved prescription smoking cessation medications with no copayment. Contact your Anthem provider for more information.	Access Quit Smoking Services: • Contact your doctor • Call Health Coaching by phone at **866-862-4295** • Attend an in-person workshop, "Freedom From Tobacco" – visit **kp.org/centerforhealthyliving** for more information
Health Coaching	Anthem offers an array of support programs to help you manage your condition(s). Contact Anthem at **833-597-2362** for assistance with finding the program that's right for you.	Offers a phone-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. Call **866-862-4295**.
Exercise	Active&Fit Direct™ – provides discounted gym memberships. Log into your member account at **anthem.com/ca/cityofla** and select Discounts to learn more.	Member discounts to gyms through Active&Fit Direct. Visit **kp.org/choosehealthy** for more information
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	Log into your member account at **anthem.com/ca/cityofla** and select Health & Wellness Center to find: • Preventive health guidelines for men, women, children, and seniors • Online information for 200 health topics • Health Assessment • Digital Health Assistant • Personal Health Record • Pregnancy Assistant	Total Health Assessment with Succeed™ • Physical and mental health quizzes and calculators • Downloadable podcasts • Interactive "Kid Wisdom" site geared for child health The Total Health Assessment (THA) can be completed on a mobile device or computer. To find it, go to **kp.org/tha**. If you haven't already, you'll need to create an account at **kp.org** to participate. To do so, just go to **kp.org/registernow**.

Dental Coverage

Dental Coverage Choices

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

Delta Dental Preventive Only provides preventive dental care only. It does not cover other services such as fillings, crowns and orthodontia. Those who choose this option receive additional pre-tax **LAwell** dollars of $5.00 per month or $2.50 per month for regular half-time employees.

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, 89.9% of dentists belong to a Delta network.

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.

CHOOSEwell – A Dental Plan Comparison

	Delta Dental Preventive Only	DeltaCare USA DHMO	Delta Dental PPO
Features a network of providers	Yes	Yes	Yes
Offers flexibility to use non-network providers	Yes	No	Yes – paid at out-of-network level
Covers preventive care	Yes	Yes	Yes
Covers services other than preventive care – such as basic and major services	No	Yes	Yes
Has a calendar year deductible	No	No	Yes
Has an annual maximum benefit	No	No	Yes
Includes set copayments for most services	No	Yes	No
Requires you to choose a primary care dentist	No	Yes	No
Covers emergency care outside the provider network*	No	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. With the Preventive Only option and the Delta Dental PPO, you can choose a network or non-network provider each time you need care. Below is general information on using each dental plan option:

Delta Dental Preventive Only	DeltaCare USA DHMO	Delta Dental PPO
Plan pays highest level of benefit when you use network providers	Benefits paid for network services only	Plan pays highest level of benefit when you use network providers
Network providers offer discounted fees	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 Preventive Only, DeltaCare USA DHMO, or PPO option by:

- Calling Delta Dental Customer Service at **800-765-6003** for the Delta Dental Preventive Only and 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 Preventive Only or 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 /Adult Dependent" 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 medical enrollment (see page 26). For more information on eligible dependents, see page 47.

The amount of premium you are responsible for depends on your employment status (full-time or half-time), the coverage level you choose, and the specific plan you choose.

For 2020, 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 and $26.24 per month for half-time employees.

LAwell Dental Pay Plan

Your 2020 Dental Coverage Costs Per Pay Period (Every Two Weeks)

	Full-Time Employees (All MOUs)		Half-Time Employees (All MOUs)		
Coverage Level	City Pays…	Employee Pays…	City Pays…	Employee Pays…	Total Cost of Coverage Bi-Weekly (per Pay Period)
Delta Dental Preventive Only					
Employee Only	$6.35	($2.50)*	$5.10	($1.25)*	$3.85
Employee & Spouse/DP**	$3.85	$3.21	$3.85	$3.21	$7.06
Employee + Child(ren)**	$3.85	$4.07	$3.85	$4.07	$7.92
Employee + Family**	$3.85	$7.59	$3.85	$7.59	$11.44
DeltaCare USA DHMO					
Employee Only	$8.39	$0.00	$8.39	$0.00	$8.39
Employee + Spouse/DP**	$8.39	$7.25	$8.39	$7.25	$15.64
Employee + Child(ren)**	$8.39	$5.64	$8.39	$5.64	$14.03
Employee + Family**	$8.39	$9.73	$8.39	$9.73	$18.12
Delta Dental PPO					
Employee Only	$22.30	$3.93	$13.12	$13.11	$26.23
Employee + Spouse/DP**	$22.30	$26.87	$13.12	$36.05	$49.17
Employee + Child(ren)**	$22.30	$28.68	$13.12	$37.86	$50.98
Employee + Family**	$22.30	$46.09	$13.12	$55.27	$68.39

* Additional **LAwell** dollars credited to employee

** Domestic partnerships are not recognized under federal tax law, and enrollment of domestic partner dependents may result in different taxable income treatment. See page 46 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 – 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 Preventive Only and PPO or 800-422-4234 for DeltaCare USA DHMO.

How Benefits Are Paid	Delta Dental Preventive Only	DeltaCare USA DHMO	Delta Dental PPO	
			In-Network	Out-of-Network
Calendar Year Deductible	None	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% In-Network or 100% of R&C* Out-of-Network (includes an additional oral exam and routine cleaning during pregnancy)	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	Not covered	Plan pays 100% for fillings; you pay up to $90 for extractions	Plan pays 80%	Plan pays 80% of R&C*
Root canal	Not covered	Your copay is $45–$220 per procedure	Plan pays 80%	Plan pays 80% of R&C*
Periodontal scaling and root planing	Not covered	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				
Crowns	Not covered	Your copay is $55–$195 per procedure**	Plan pays 80%	Plan pays 50% of R&C*
Dentures	Not covered	Your copay is $80–$170 per procedure	Plan pays 50%	Plan pays 50% of R&C*
Implants	Not covered	Not covered	Plan pays 50%	Plan pays 50% of R&C*
Orthodontia				
Children under age 19	Not covered	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	Not covered	Your copay is $1,350 plus start up fees of $300	Plan pays 50%	Plan pays 50% of R&C*
Adults	Not covered	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)	Not applicable	None	$1,500/person***	
Lifetime orthodontia maximum benefit	Not covered	None	$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

City employees 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.

Using Your EyeMed Benefit

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**.

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 98,000 providers, including 50,000 independent providers plus national retail chains such as LensCrafters®,Sears Optical®, 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 (available in the Apple App Store and Google Play) 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**.

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

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
Photochromic/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 30 and visit **keepingLAwell.com** for more information.

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

Retinal Imaging

Retinal imaging 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.

Diabetic eye care benefit

Starting January 1, 2020, your vision plan will include a benefit that provides follow-up care and supplementary diagnostic testing for members with type 1 or type 2 diabetes. With this benefit, eligible members can obtain an additional vision evaluation every six months to detect or monitor signs of diabetic complications. Diagnostic testing once every six months, including fundus photography (retinal imaging), extended ophthalmoscopy, gonioscopy, and laser scanning, is available with no in-network copay, subject to provider determination. An out-of-network reimbursement is also available.

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.)	Check with EyeMed provider **before** seeking medical/ 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 47.

Employees electing Cash-in-Lieu will be automatically enrolled in the Employee-Only level of vision coverage. However, employees who are covered as a dependent of another City employee will only receive one coverage benefit as a dependent.

Support Plus: Employee and Family Assistance Program

Support Plus: Employee and Family Assistance Program (EFAP) is a service that provides you and your family with professional and confidential counseling support, and is designed to help you manage life challenges and improve your quality of life. Your EFAP program is completely confidential and voluntary.

How It Works

The EFAP offers services over the phone, as well as web-based and face-to-face counseling. When you call, a specialist will listen to your needs and connect you to the appropriate resources. Clinicians, counselors, mediators, lawyers, and financial advisors are ready to help you with:

- Stress, anxiety, and depression
- Marriage and parenting issues
- Workplace conflicts
- Sleeping problems
- Financial or legal questions
- Substance abuse or other addictions

You can call the EFAP counselors anytime – 24 hours a day, 7 days a week – toll-free at **800-213-5813**. English- and Spanish-speaking counselors are available. Any of your household family members can also use the EFAP. This includes dependents who are away from home at college.

SUPPORT PLUS
Employee and Family Assistance Program

EFAP Provider	Optum
Website	**Liveandworkwell.com**
Access Code	CityofLA
Phone	**800-213-5813**

Harbor Department Employees

If you are a Harbor Department employee, you are not eligible for the **LAwell** EFAP. Instead, your EFAP coverage is provided through Empathia Pacific Inc. at **800-367-7474**.

Benefits for All Employees and Their Family Members

- **Consultation and Counseling:** Receive unlimited 24/7 access to EFAP Specialists over the phone. In addition, you are eligible for five face-to-face and web-video consultations per person, per incident, per benefit period at no cost to you. EFAP sessions will be coordinated by Optum.
- **Liveandworkwell.com:** Reliable, trusted website with resources to address all life's challenges.
- **Work-Life Support:** Concierge-like services including eldercare, referral service, and convenience services. More than 100 service areas covered.
- **Legal Assistance and Financial Counseling:** Consultations on specific legal and financial issues at no initial cost and other discounted fees for attorneys retained through EFAP.

Please note that after you have used all your available EFAP benefits, charges for additional EFAP services will be your responsibility. The health plan you choose provides mental health and substance abuse coverage. To receive benefits, however, you may be required to have a referral and use a participating network provider. If you receive counseling through the EFAP, make sure you understand how many visits are covered. Contact your health plan for information on how that plan covers mental health and substance abuse services.

Life Insurance

Life Insurance

Life insurance offers important financial protection for you and your family. **LAwell** provides basic life insurance at no cost to you and gives you options to purchase supplemental employee insurance and dependent life insurance using pre-tax dollars.

Life Insurance Options Overview

Insurance for Yourself	Coverage Amount	Your Cost
Basic Life Insurance	$10,000 for full-time employees; $5,000 for regular half-time employees	$0.00 This is a City paid benefit.
Supplemental Life Insurance	Up to 5 times your annual base salary rounded up to the nearest $1,000	Varies – See page 34.

Insurance for Your Dependents	Coverage Amounts	Your Cost
Spouse or Domestic Partner Life Insurance	• $10,000 • $25,000 • $50,000 • $75,000 • $100,000	Group rate
Child Life Insurance	$5,000 per child	Group rate

Under federal law, you may be taxed on the value of coverage, called imputed income, over a certain dollar amount. See page 35 for more information on imputed income.

Learn More.

Visit **https://www.standard.com/employee-benefits/city-los-angeles**

Or call **844-505-6025**

Supplemental Life Insurance

Your supplemental life insurance amounts will be the multiple of annual base pay you choose – one times pay up to five times pay – rounded up to the nearest one thousand. Below is an example of an employee who chooses coverage at four times pay.

Supplemental Life Insurance Example:	
Employee Annual Base Pay	$43,552
Coverage Level Selected	4 times
Subtotal	$174,208
New Subtotal (round up to nearest $1,000)	$175,000
Actual Coverage Purchased	**$175,000**

You buy supplemental life insurance you choose with pre-tax dollars from your pay. See "Your Monthly Cost for Supplemental Life and Dependent Insurance" on page 34 for life insurance rates. Below is the per pay period cost for the previous employee choosing supplemental life coverage of four times pay, assuming the employee is 46 years old.

Supplemental Life Insurance Cost Example:	
Coverage Amount	$175,000
Subtotal (divided by $1,000)	175
Times Rate*	$0.12
Monthly Rate	$21.00
Per-Pay Period Cost	**$10.50**

*See chart on page 34. Example assumes employee is 46 years old.

Travel Assistance

LAwell members have a travel assistance program included with their City-paid basic life insurance coverage, which provides travel information and travel arrangement assistance before and during travel. To inquire about service 24 hours a day, 7 days a week, call **866-455-9188** (or **+1 240-330-1380** outside the US) or visit **standard.com/travel**.

Online Calculator

Use the online calculator to help you determine how much insurance you need. From **keepingLAwell.com**, access the calculator directly through Standard Insurance Company's City of LA microsite available on the 'Contacts' page.

Requirements to Enroll into Life Insurance Coverage

Active Work Requirement

You must meet the active at work definitions of the Group Policy for your elected life insurance to take effect. If you cannot work because of sickness, injury, or pregnancy on the day before your life insurance takes effect, including any increases in coverage, that coverage will not become effective until the day after you complete one full day of active work as an eligible employee.

Medical History Statement Requirement

Some life insurance coverage levels available to you will require you and/or your dependent to complete a Medical History Statement. A Medical History Statement ("MHS"), available at **keepingLAwell.com**, asks a series of questions (about five) regarding your current and past medical condition. Once received, Standard Insurance Company will review your statement and determine if any additional information or action is required of you or your dependent before an approval of coverage determination can be made.

You must complete and return the MHS before your submission deadline **and** it must be approved by Standard Insurance Company before your coverage can take effect. If your or your dependents' MHS has not been provided by the deadline, any pending coverage will be removed from your benefits account and the City will send a confirmation statement of this change to you. If the MHS is submitted before your deadline, but Standard Insurance Company requires additional information/action before an approval determination can be made, your coverage will become effective on the date of approval. The City will not take payroll deductions until the insurance company provides a date of approval.

When is MHS Required?

For your coverage:

There are many situations when a MHS is required. View offer options on your Personalized Benefit Statement or in your online account at **keepingLAwell.com** to see if your election will require you to complete a MHS. However, in general, current **LAwell** members choosing to increase their current coverage by more than one level or choosing coverage over the amount of $750,000 or three times your annual earnings will be required to complete the MHS.

For your dependent spouse/domestic partner coverage:

For currently enrolled **LAwell** members, a MHS will be required to enroll in spouse/domestic partner life insurance for the first time **or** to increase coverage. This can be waived only if you are adding a spouse/domestic partner within 30 calendar days of a marriage or beginning a domestic partner relationship.

For your dependent child coverage:

Not applicable

What is the MHS submission deadline?

After your enrollment in a plan that requires a MHS, you will receive a confirmation statement that provides you a deadline for submitting the MHS. During Open Enrollment, the deadline is March 1. During a Life Event, the deadline is, typically, 60 days from the date of your confirmation statement.

However, you can complete the form online at any time. The MHS form is available at **keepingLAwell.com**.

Reductions Based on Age

Life insurance coverage for you (basic and supplemental) and your spouse/domestic partner is reduced based on your age. **From age 65 to 69, coverage amounts will be reduced to 65%. At age 70, coverage amounts will be reduced to 35%.** The reduction is effective on the date of your 65th or 70th birthday for your basic and supplemental life insurance coverage and for spouse/domestic partner dependent life insurance coverage. Employees in certain MOUs may have additional basic life benefit reductions at age 70. Consult your MOU for details.

Supplemental Life Insurance Age Reduction Example:	
Employee Annual Base Pay	$43,552
Coverage Level selected	4 times
Subtotal	$174,208
New Subtotal (Round up to nearest $1,000)	$175,000
Age 67 reduction	65%
Actual coverage purchased	$113,750

Dependent Life Coverage Level and Eligibility Requirements

Spouse/Domestic Partner

Under California law, the spouse/domestic partner life insurance coverage you choose cannot be more than your total life insurance coverage (basic + supplemental). See example on next page.

The spouse/domestic partner you purchase coverage for must be a named dependent for your **LAwell** coverage.

Child

The child you purchase coverage for must be a named dependent for your **LAwell** coverage.

Eligibility Requirements for Dependent Life Coverage

You must assign one or more qualified dependents at the time you elect dependent life coverage. If you assign an individual who is not your confirmed dependent, you must provide supporting documentation to prove this individual meets dependent eligibility for the **LAwell** program to retain your elected coverage. For eligibility rules, see pages 33-34.

Spouse/DP Life Insurance Election Example:	
Employee Annual Base Pay	$43,552
Coverage Level selected	1 times
Subtotal	$43,552
New Subtotal (Round up to nearest $1,000)	$44,000
Employee Basic Life Insurance Benefit	$10,000
Total Employee Life Insurance Coverage Level Elected	$54,000
Eligible Spouse/DP Life Insurance coverage options available	
$10,000, $25,000, or $50,000 ONLY	

$75,000 and/or $100,000 options not available.

Claiming Life Insurance Benefits—Things to Consider

Designating a Beneficiary

For your life coverage (Basic and Supplemental):

You can name anyone as the beneficiary of your basic and supplemental life insurance. If you have had a recent change in your family status – such as marriage or divorce – you may need to update your beneficiary. **The beneficiary you name for your life insurance benefit may be separate and different from any other beneficiary you name with the City for your other employee benefits, such as your LACERS pension, Deferred Compensation Plan account, etc.**

It is important to name a beneficiary so death benefits can be paid to the person of your choice if you were to die. To name or update your beneficiary information, go to **keepingLAwell.com**. You can also call the Benefits Service Center at **833-4LA-WELL**.

For your dependent (Spouse/DP and Child) life coverage:

You will be the beneficiary for dependent life insurance.

Accelerated Benefit

The Accelerated Benefit option can provide financial assistance if you become terminally ill and have a life expectancy of 12 months or less. In this case, you may have the right to receive during your lifetime a portion of your insurance as an Accelerated Benefit.

You must have at least $10,000 of insurance in effect to be eligible. You may elect up to 75% of your basic and supplemental insurance, to a maximum of $500,000. The minimum Accelerated Benefit is $5,000 or 10% of your insurance, whichever is greater. However, if coverage is scheduled to reduce in the next 24 months, the Accelerated Benefit is based on the reduced amount. The Accelerated Benefit will be paid in a lump sum. The remaining amount of life insurance will be reduced by an interest charge.

Claims Process

To receive a life insurance benefit, the beneficiary must complete and submit a beneficiary statement with required documentation. If you have designated multiple beneficiaries, each beneficiary must complete and submit their own. The City and its life insurance provider, Standard Insurance Company, will not notify beneficiaries of any eligibility. **It is the responsibility of the beneficiary to initiate the life insurance claim process**. Ensure your beneficiary is informed of their designation as your beneficiary and the process to initiate a claim. View more information at **keepingLAwell.com**, including the Checklist For Surviving Family Members, or call employee benefits at **213-978-1591**.

Funeral Planning Services

The Funeral Planning service option allows for your beneficiary to designate a funeral home assignment, which allows the insurance company to pay the funeral home directly from your life insurance policy. Additional funeral planning services may be available. Review more information on funeral planning services at **keepingLAwell.com**.

Coverage Costs & Imputed Income

Your Monthly Cost for Supplemental Life and Dependent Insurance

Insurance for yourself

Here are the 2020 monthly rates for supplemental life insurance for each $1,000 in coverage. The Personalized Benefit Statement you receive shows your coverage cost.

Age on 9/1/19	Rate per $1,000 of coverage
Under 25	$0.044
25 – 29	$0.051
30 – 34	$0.068
35 – 39	$0.078
40 – 44	$0.086
45 – 49	$0.120
50 – 54	$0.188
55 – 59	$0.352
60 – 64	$0.513
65 – 69	$1.046
70 or above	$1.697

Insurance for your dependents

Dependent coverage costs are based on a group rate by coverage level. Here are the 2020 monthly group rates for dependent coverage:

Dependent Coverage Level & Monthly Group Rate	
Spouse/Domestic Partner – $10,000	$2.26
Spouse/Domestic Partner – $25,000	$5.68
Spouse/Domestic Partner – $50,000	$11.40
Spouse/Domestic Partner – $75,000	$17.10
Spouse/Domestic Partner – $100,000	$22.80
Child – $5,000	$0.42

About Life Insurance and Imputed Income

Insurance for yourself

Under federal tax law, you are taxed on the value of employer-provided life insurance over $50,000. If this situation occurs, imputed income will be reflected on your paystub and included in your W-2 statement as taxable income. Members should consult their tax advisors for more information.

Insurance for your dependents

Under federal law, you may be taxed on the value of coverage above $2,000. Imputed income depends on the ages of your dependents and will generally apply only if you cover a spouse over age 55 or more than one child.

The example below will give you an idea of how much imputed income could be. This example assumes the employee works full-time, has basic life insurance of $10,000 and chooses supplemental life insurance of three times annual pay.

Example of Imputed Income

An example for an employee age 30 with annual pay of $45,000.

Supplemental life insurance ($45,000 × 3)		$135,000
Plus Core life insurance	+	$10,000
Equals Total life insurance	=	$145,000
Minus Amount that's not taxed	–	$50,000
Equals Taxable amount above $50,000	=	$95,000
Divided by 1,000	÷	1,000
Equals Units of coverage	=	95
Times Imputed income from IRS table for age 30 (see table below)	x	.08
Equals Actual imputed income shown on W-2	=	$7.60 a month or $91.20 a year

IRS Table for Calculating Imputed Income

Age	Amount of monthly imputed income for each $1,000 in coverage
Under 25	$0.05
25 - 29	$0.06
30 - 34	$0.08
35 - 39	$0.09
40 - 44	$0.10
45 - 49	$0.15
50 - 54	$0.23
55 - 59	$0.43
60 - 64	$0.66
65 - 69	$1.27
70 and over	$2.06

Continuing Coverage After Your City Employment Ends

Portability and Conversion

If your City employment ends, there are two ways you can take your life insurance with you – portability and conversion. Portability allows you to continue group coverage at group rates, whereas conversion allows you to continue your coverage as an individual policy. Different rules apply. Here is an overview:

Portability

For your life coverage (Basic and Supplemental)

You must be under age 80, able to be gainfully employed, and on the date your employment terminates, you must have been continuously insured under the Group Policy for 12 consecutive months. Portable coverage lets you choose group term life insurance up to the amount of your basic and supplemental life coverage combined—to a maximum of $1,000,000—without a Medical History Statement Form. The minimum amount you may port is $10,000.

For your dependent life coverage (Spouse/DP and Child)

If you choose portable coverage for yourself, you may also take any dependent coverage with you if your dependent(s) meet the following age requirements:

- Spouse/DP must meet the same age requirements listed above for your coverage.
- Children must be under age 26.

Conversion

If your coverage ends or reduces for any reason except failure to pay premium or payment of an Accelerated Benefit, you can convert your life insurance, or your dependents' life insurance, to an individual policy without a Medical History Statement Form. Because group rates will no longer apply, this individual conversion policy will cost substantially more than coverage you have as a City employee through **LAwell**. Conversion is the only option available if you do not qualify for portability.

What You Need to Do

To select portable coverage or to convert coverage, you must complete a form – **within 60 days from the date your employment or dependent coverage ends. Forms are available at keepingLAwell.com.** Call **213-978-1655** for more information.

Salary Changes and Supplemental Life

When you change a job classification (e.g., due to a promotion), your supplemental employee life insurance coverage level amount (and your per pay period cost) will be adjusted based on your new salary. Generally, cost of living and step increases gained during the year without a change in job classification will not adjust your supplemental life insurance benefit/cost until the following plan year.

Accidental Death & Dismemberment (AD&D) Insurance

Accidental Death & Dismemberment Insurance Overview

Accidental Death and Dismemberment (AD&D) insurance offers additional financial protection for an employee if they die in an accident or are dismembered. **LAwell** provides AD&D insurance to you as an option to purchase either supplemental employee-only coverage or supplemental family coverage using pre-tax dollars.

AD&D Insurance Option Overview

Insurance	Coverage Amount	Your Cost
Employee Only	$50,000 to $500,000 ($50,000 increments)	Varies – See page 37
Family Coverage	$50,000 to $500,000 ($50,000 increments)	Varies – See page 37

Requirements to Enroll into Coverage

The **Active Work Requirement** and **Reductions Based on Age for Life Insurance** all apply to AD&D. See box to the right and the next page for more information.

Active Work Requirement

You must meet the active at work definitions of the group policy for your elected life insurance to take effect. If you cannot work because of sickness, injury, or pregnancy on the day before your life insurance takes effect, including any increases in coverage, that coverage will not become effective until the day after you complete one full day of active work as an eligible employee.

Claiming AD&D Benefits – Things to Consider

The **Designating a Beneficiary** and **Claims Process** aspects of Life Insurance all apply to AD&D. See page 34 for more information.

Additional Benefit Payout Rules

AD&D pays a percentage of your total coverage amount for injuries, depending on the type of injury, that results in a loss, such as the loss of a limb or permanent loss of ability (sight, hearing, speech, etc).

For your accidental death (aka loss of life), AD&D pays 100% of your coverage amount, plus an additional $3,000 – up to a maximum of $503,000. Additional benefits may be payable in specific situations, such as air bag and seat belt failures, or in a disaster where more than one family member dies. The AD&D insurance certificate of coverage provides a detailed list of covered losses, benefit amounts, and additional features, and is available online at **keepingLAwell.com** or from the Employee Benefits Division. A brief summary is provided in the table below.

Type of Loss	Percentage Payable
Life[1]	100%
One hand or foot[2]	75%
Sight in one eye	50%
Audible speech	50%
Hearing in both ears	50%
Quadriplegia[3]	100%
Paraplegia[3]	75%

[1] This benefit includes loss of life due to exposure or disappearance.
[2] This benefit is payable whether or not the hand or foot is surgically reattached.
[3] No AD&D benefit will be paid for loss of function of a hand or foot if an AD&D benefit is payable for Quadriplegia or Paraplegia.

AD&D Family Coverage

For Family coverage, your elected AD&D coverage will be split between your family members. Eligible benefit amounts for your family members will depend on the amount of coverage you choose for yourself and the make-up of your family. If you choose family coverage, you will be covering all **LAwell**-eligible persons in your family, not just those who are covered as dependents under your **LAwell** benefits.

If your family includes…	AD&D benefits equal…
Spouse/domestic partner only	60% of the amount you selected by yourself
Eligible children only	20% of the amount you selected for yourself for each child
Spouse/domestic partner and eligible children	50% of the amount you selected for yourself for your spouse/ domestic partner and 10% of the amount you selected for yourself for each child

AD&D Coverage Costs

Here are the 2020 monthly rates for supplemental life insurance for each $1,000 in coverage. The Personalized Benefit Statement you receive shows your coverage cost.

AD&D Coverage Option	Rate per $1,000 of coverage
Employee Only	$0.01
Family Coverage	$0.026

AD&D Cost Example:	
Coverage Amount	$250,000
Subtotal (divided by $1,000)	250
Times Rate*	$0.011
Monthly Rate	$2.75
Per-Pay period	$1.375

**See chart above for rate. Example is Employee Only.*

Reductions Based on Age

Life insurance coverage for you (basic and supplemental) and your spouse/domestic partner are reduced based on your age. From age 65 to 69, coverage amounts will be reduced to 65%. At age 70, coverage amounts will be reduced to 35%. The reduction is effective on the date of your 65th or 70th birthday for your basic and supplemental life insurance coverage and for spouse/domestic partner dependent life insurance coverage. Employees in certain MOUs may have additional basic life benefit reductions at age 70. Consult your MOU for details.

Learn More.

Visit **https://www.standard.com/employee-benefits/city-los-angeles**

Or call **844-505-6025**

Continuing AD&D Coverage After Your City Employment Ends

Portability and Conversion: What You Need to Do

If your City employment ends and is not due to retirement, AD&D may be continued for up to two years if you are able to be gainfully employed and, on the date your employment terminates, you must have been continuously insured under the Group Policy for 12 consecutive months. Portable coverage lets you choose group term AD&D insurance up to the amount of your basic and supplemental life coverage combined – to a maximum of $300,000 – without proof of good health. The minimum amount you may port is $25,000.

To select portable coverage or to convert coverage, you must complete and submit a form along with premium payment within 60 days from the date your employment or dependent coverage ends. Forms are available at **keepingLAwell.com**, or call **213-978-1655** for more information.

Disability Coverage

Disability coverage provides replacement income to you in the event of a qualified disability that prevents you from working. **LAwell** provides basic short-term disability insurance (STD) and long-term disability (LTD) insurance to you at no cost, and gives you the option to purchase a larger supplemental disability insurance benefit using after-tax dollars.

Learn More.

Visit **https://www.standard.com/employee-benefits/city-los-angeles**

Or call **844-505-6025**

Basic and Supplemental Disability Overview

	Benefit*	When Benefits Begin	How Long Can Benefits Last?	Your Cost
Basic Disability Coverage	**50%* of your salary up to a maximum of $3,367 a month**	After all the following are met: • All sick leave is used and; • An application for disability is filed; and • Benefits are approved	Up to 2 Years (STD: 180 days + LTD: 1 year+6 months)	$0.00 – This is a City paid benefit
Supplemental Disability Coverage	**66 2/3%* of your salary up to a maximum of $12,000 a month**		Generally, until you are no longer disabled, or age 65, whichever is earlier. (STD: 180 days + LTD**: up to max benefit age)	Varies (refer to your personal enrollment worksheet)

This summary is not intended to provide a detailed description of coverage. Please refer to your Certificate of Insurance for more information, including definitions, exclusions, limitations, and terminating events.

* Benefits are calculated on your pre-disability earnings and may be reduced by income you receive from other sources.

** LTD benefits last up to 18 months during your entire lifetime for disabilities related to a mental disorder, alcohol use, alcoholism, or drug use or drug addiction. LTD Maximum benefit age may reduce benefit term when a Disability benefit begins after age 61.

Supplemental coverage pays a higher monthly benefit than basic disability coverage, and pays beyond the 24-month limit (short-term and long-term disability combined) if you remain disabled. Supplemental disability coverage costs are calculated based on your age and your annual salary at the time of enrollment. See Disability Definitions on page 40 for more details.

Sick Leave and Disability – What's the Difference?

Sick Leave – You accrue hours in your sick bank that you can use under the City's sick leave policies.

Disability – Disability insurance may replace part of your income if you are disabled because of sickness, injury, or pregnancy. Disability benefits begin when you exhaust your 100% and 75% sick leave banks.

Requirements to Enroll into Disability Coverage

Active Work Requirement

You must meet the active at work definitions of the group policy for your disability insurance to take effect. If you cannot work because of sickness, injury, or pregnancy on the day before your disability coverage (or any coverage increase) becomes effective, your coverage, including any increases, will not become effective until the day after you complete one full day of active work as an eligible employee.

Medical History Statement (MHS) Requirement

In most situations, enrolling in supplemental disability coverage during Open Enrollment will require you to complete a Medical History Statement. A Medical History Statement ("MHS"), available at **keepingLAwell.com**, asks a series of questions about your current and past medical condition. Once received, Standard Insurance Company will review your statement and determine if any additional information or action is required of you or your dependent before an approval of coverage determination can be made.

You must complete and return the MHS before your submission deadline and it must be approved by Standard Insurance Company before your coverage can take effect. If your MHS has not been submitted by the deadline, any pending coverage will be removed from your benefits account and the City will send a confirmation statement of this change to you. If the MHS is submitted before your deadline, but Standard Insurance Company requires additional information/action before an approval determination can be made, your coverage will become effective on the date of approval. The City will not make payroll deductions until the insurance company provides a date of approval.

What is the MHS Submission Deadline?

After your enrollment in a plan that requires a MHS, you will receive a confirmation statement that provides a deadline for submitting the MHS. During Open Enrollment, the deadline is March 1. During a Life Event, the deadline is, typically, 60 days from the date of your confirmation statement. However, you can complete the form online at any time. The MHS form is available at **per.lacity.org/bens/docforms.htm**.

Filing a Disability Claim

If you have a disabling condition that may use up your 100% and 75% sick leave, contact Standard Insurance Company at **844-505-6025** as early as possible to find out what you will need to do to file a claim for disability benefits.

Generally, you will be provided with a claim package with forms to be completed by you, your doctor, and the City – plus an authorization form allowing Standard Insurance Company to contact your doctor for more information. Once Standard Insurance Company receives your completed forms, the review process will begin. Approval may take longer if more information is needed. By starting the process early, you can allow yourself time to complete the paperwork and avoid a lengthy gap in income between the time your sick leave ends and the time disability benefits begin.

Disability Benefits Require Approval

Before you can receive disability benefits, Standard Insurance Company reviews your claim to determine if you meet the eligibility requirements and the definition of disability, as well as other requirements to receive benefits under the terms of the group policy. Standard Insurance Company must approve your claim and you must be under the ongoing care of a physician. Please keep in mind that some conditions may not qualify for benefits. Approved STD and LTD benefits may be eligible for waiver of premium.

Disability Benefits and Other Income Sources

If your disability is work-related and you have filed a Workers' Compensation claim, you should also file a claim with Standard Insurance Company. Standard Insurance Company will consider your STD claim while a decision is being made on your Workers' Compensation claim. However, if your Workers' Compensation claim is accepted, compromised, or settled, it is your responsibility to immediately repay Standard Insurance Company for all of the STD benefits received. You may receive LTD benefits following the Benefit Waiting Period. Workers' Compensation benefits would reduce your LTD benefit.

For disability coverage, benefits may be reduced by any benefits you receive from other sources, like Workers' Compensation, Social Security, LACERS disability or another group plan – including the LA City Club plan. If you are receiving other group disability benefits and you have supplemental disability coverage, those other benefits plus your **LAwell** supplemental disability benefits cannot be more than the highest benefit percentage provided by either plan (offset in excess of 80%).

Benefit Protection Plan

You are eligible for the Benefit Protection Plan for an approved disability subject to approval by Standard Insurance Company. This plan allows you to continue any **LAwell** medical, dental, vision and basic life insurance coverage you had as an active employee for up to **two years** of your disability. You can also continue coverage for any dependents who are enrolled when you become disabled; however, the City subsidy will only continue at the employee-only level, unless there has been no break in your coverage. You will be required to pay the coverage cost you paid as an active employee, if any, plus any costs for your dependent coverage.

Keep in mind that the Benefit Protection Plan is not for work-related injuries or for individuals who have terminated or retired from City service for any reason.

Taxes and Your Disability Benefits

If you receive Short-Term Disability (STD) benefits, state and/or federal income taxes may not be withheld from your basic disability payment. You will be responsible for paying any taxes owed on these basic benefits.

If you become eligible for Long-Term Disability (LTD) benefits, tax-withholding forms will be sent to you.

Basic disability coverage is fully paid by the City, so any basic disability benefits you receive are taxable at the time they are paid to you under IRS rules.

Supplemental disability coverage benefits are less than 100% taxable. The explanation of benefits you receive with your disability check will reflect the amount of benefits that are considered taxable.

Definition of Disability

For short-term disability (STD) benefits – *your first 180 days of disability after exhausting 100% and 75% sick leave* – and **your long-term disability (LTD) benefits –** *the benefits you receive after you have exhausted all sick leave and been disabled for 180 days beyond the exhaustion of your 100% and 75% sick leave:*

- You are required to be totally disabled or partially disabled from your own occupation.
- You are totally disabled from your own occupation if, as a result of physical disease, injury, pregnancy, or mental disorder, you are unable to perform with reasonable continuity the substantial and material acts necessary to pursue your own occupation and you are not working in your own occupation.
- You are partially disabled from your own occupation if you are not totally disabled and you are actually working in your own occupation but, as a result of physical disease, injury, pregnancy or mental disorder, you are unable to earn 80% or more of your indexed pre-disability earnings.
- After 24 months for which LTD benefits are paid, you are required to be totally disabled or partially disabled from all occupations.

For more details, see your Certificate of Insurance, available from the Employee Benefits Division or online at **keepingLAwell.com**.

Definition of Pre-Disability Earnings for Disability Coverage

For disability benefits, your pre-disability earnings are your City base pay, including but not limited to any bonuses or shift differential counted toward your retirement benefit under the Los Angeles City Employees' Retirement System. Any benefits are based on eligible pre-disability earnings on your last full day of active work and will not be adjusted for any later salary increases, including those based on MOU negotiations.

Disability Coverage and Pre-Existing Conditions

LTD benefits are not payable for a disability caused or contributed to by a pre-existing condition until you have been enrolled for coverage for at least 12 months and are actively at work at the end of those 12 months or you have been without treatment for the pre-existing condition for six months.

LTD benefits are the benefits you receive after you have exhausted all of your 100% and 75% sick leave – and been disabled for an additional 180 days – and have applied for benefits and been approved. A pre-existing condition is a mental or physical condition causing or contributing to your disability for which you have consulted a doctor, been treated, or taken prescription drugs during the 90 days before coverage takes effect.

Benefit Exclusions

- STD benefits will not be paid for any period you are eligible to receive benefits under Workers' Compensation or a similar law. Any STD benefit paid while waiting for Workers' Compensation claim determination is subject to repayment to Standard Insurance Company.
- You cannot receive STD benefits when working for wage or profit for anyone other than the City.
- You are not covered for a short-term or long-term disability caused by or contributed to:
  - By an intentionally self-inflicted injury, while sane or insane; or
  - By war or any act of war whether declared or undeclared, civil or international, and any substantial armed conflict between organized forces of a military nature.
- You are not covered for a long-term disability caused by or contributed to by your committing or attempting to commit an assault or felony or actively participating in a violent disorder or riot (except while performing official duties).

Other Benefits to Consider

Disability Retirement

The opportunity to file for disability retirement is limited to individuals who were paid by their employing department within the last 12 months prior to filing. Please contact the Los Angeles City Employees' Retirement Section at **800-779-8328** for information regarding disability retirement eligibility. In addition, disability retirement income may cause a reduction in disability benefits from Standard Insurance Company.

Family and Medical Leave (FMLA) – While you are on FMLA, the City may continue to pay your health, vision, and dental subsidies. Contact the Personnel Section of your department or refer to your MOU for more information on FMLA.

Catastrophic Illness Leave Donation Program – If you are a regular full-time or half-time employee and have passed probation, this program allows you to apply for up to 480 hours of leave to be paid at a 40-hour maximum per pay period. You may use the program once during your City career if you have used all of your 100% and 75% sick time and vacation time, as well as all basic and supplemental disability benefits, and you continue to need time off for your own illness or to care for an eligible family member. Contact the Employee Benefits Division at **213-978-1655** for more information. Go to **keepingLAwell.com** to view the application.

Salary Changes and Supplemental Disability

When you change a job classification (e.g., due to a promotion) your supplemental employee disability insurance coverage level amount (and your per pay period cost) will be adjusted based on your new salary. Generally, cost of living and step increases gained during the year without a change in job classification will not adjust your supplemental disability insurance benefit/cost until the following plan year.

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.

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.

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.

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 (HCFSA)

Use the HCFSA 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 $2,700** (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.

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 2020, you should consult with your tax advisor before enrolling into **LAwell's** HCFSA. Enrolling in an FSA 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 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 43 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 2020. **You must file claims for 2020 expenses by April 30, 2021.** 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 50-54 for more on life events). For the DCRA, 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 (DCRA)

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 shaded 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 dependent care account	Up to $5,000 in total to the two accounts
If married filing separate returns	Up to $2,500

*City payroll deferral 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 $3,600 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 2020 in the table on the next page, depending on your number of children.

Number of Children	Income less than…
1	$41,094 ($46,884 if married filing jointly)
2	$46,703 ($52,493 if married filing jointly)
3 or more	$50,162 ($55,952 if married filing jointly)

- You are single, you file your taxes as head of household, and your household taxable income is approximately $41,000 or more (assuming one dependent).
- You are married, you file a joint return, and your household taxable income is approximately $46,000 or more (assuming one dependent).

Dollar amounts are based on federal tax law applicable for when you are filing taxes in 2020 for the 2019 tax year. 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 DCRAs are not savings accounts. You can use the money you set aside in 2020 only for eligible expenses you have during the 2020 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 – including transfers to the Department of Water and Power (DWP) – you can file HCFSA claims and receive reimbursement only for expenses you have 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 52-54. You may be able to continue a HFSA and/or the DCRA under COBRA if your employment ends, with some limitations. Employees who terminate employment, 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, 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 **keepingLAwell.com**.

You can also submit claims and upload receipts online, and pay your provider directly for some services, using the "**WageWorks EZ Receipts**" mobile application. Download the free mobile app in the iTunes Store or Google Play.

Dependent Coverage Rules for Special Situations

Important Information About Eligibility Criteria for a 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.
- For life insurance, each of you can purchase supplemental life insurance as an employee. For Dependent Life, only one of you can purchase supplemental dependent life insurance for your spouse/domestic partner and/or child(ren).
- For AD&D insurance, each of you can purchase employee only coverage, or only one of you can purchase family coverage.

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 employee's coverage, or the employee's applicable dependent coverage, if the employee is found to have made an improper use of benefits.

Children Who Are City Employees

Children who are also benefits-eligible employees of the City cannot be covered as both employees and 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 47-49 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 health 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 coordinator at **213-978-1591**.

The chart below shows the dollar value of domestic partner coverage paid by **LAwell** that will be reported as additional bi-weekly taxable income.

Your additional bi-weekly taxable income in 2020 when you enroll yourself and these dependents:

		Kaiser Permanente HMO		Anthem Narrow Network (Select HMO) Anthem Full Network (CACare HMO)		Anthem Vivity (LA & Orange Counties HMO)		Anthem PPO		Delta Dental
FULL-TIME EMPLOYEES										
Coverage Level	Dependent Type	LAwell Plan	LAwell Pay Plan	LAwell Plan	LAwell Pay Plan	LAwell Plan	LAwell Pay Plan	LAwell Plan	LAwell Pay Plan	Preventive, DHMO, PPO
Employee + Domestic Partner (DP) OR Employee + Family	Domestic Partner (DP) Only OR DP + Your Children OR DP + Your Children and DP's Children	$372.07	$334.86	$403.03	$362.73	$338.32	$304.49	$266.10	$239.49	$0.00
	DP + DP's Children	$496.10	$446.49	$470.33	$423.30	$451.08	$405.97	$266.10	$239.49	$0.00
Employee + Child(ren)	DP's Children Only	$310.06	$279.05	$302.28	$272.05	$253.73	$228.36	$266.10	$239.49	$0.00
	Your Children + DP's Children	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
HALF-TIME EMPLOYEES										
Coverage Level	Dependent Type	LAwell Plan	LAwell Pay Plan	LAwell Plan	LAwell Pay Plan	LAwell Plan	LAwell Pay Plan	LAwell Plan	LAwell Pay Plan	Preventive, DHMO, PPO
Emp + DP OR Emp + Family	All DP dependent types	$0.00	$0.00	$0.00	$0.00	$28.14	$25.33	$0.00	$0.00	$0.00
Employee + Child(ren)	DP's Children Only	$0.00	$0.00	$0.00	$0.00	$28.14	$25.33	$0.00	$0.00	$0.00
	Your Children + DP's Children	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Eligibility

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 48 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 Employee Benefits Division. Restrictions apply to family members who are also City employees, see page 45 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 nieces, or nephews), unless you have been awarded legal custody or guardianship; your 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. See requirement and more information on page 49.

Eligible Dependents

Your dependents are eligible if they meet the requirements listed on page 48.

Changes in Employment Status

If you change from regular full-time or regular half-time to part-time/intermittent status, you may not be eligible for LAwell benefits, even if you continue to be a member of the Los Angeles City Employees' Retirement System. For more information on eligibility, contact your department's Human Resources/ Personnel Division.

Who is Eligible for Benefits?

Employees

Regular **full-time*** civilian City employees are eligible for **LAwell** if they are contributing members of the Los Angeles City Employees' Retirement System (LACERS) and paid at least 40 hours per pay period of qualifying hours (such as HW, SK, VC, HO, etc.), or the number of hours of qualifying work time specified by their Memorandum of Understanding (MOU). In addition, they must meet one of these three requirements:

- Eligible for membership in one of the employee representation units for which the civilian benefits program (**LAwell** program) has been negotiated in an MOU
- Not represented by an employee representation unit
- Port Police Officers (MOU 27 or 38) or Airport Police Officers (MOUs 30, 39, or 40) who are a member of of the Fire & Police Pension System

Elected Officials of the City or full-time Members of the Board of Public Works are eligible for **LAwell** benefits.

Regular **half-time*** civilian employees are eligible for **LAwell** benefits if they meet all full-time eligibility requirements listed above and are paid at least 20 hours per pay period of qualifying hours (such as HW, SK, VC, HO, etc.).

However, employees in part-time/intermittent or similar positions are not eligible for **LAwell** benefits.

*Full-time, half-time, part-time, and intermittent statuses are determined by the employing department and are recorded on your payroll record.

The following chart describes eligible dependents for medical, vision, and dental coverage. See "About Eligible Dependents" on page 42 for information on eligible dependents for the Healthcare Flexible Spending Account and Dependent Care Reimbursement Account.

Dependent Eligibility Criteria

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 **keepingLAwell.com**	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, foster child, or child placed for adoption with 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) and their dependent(s), see page 46. For other eligibility, such as Medicare, Medicaid, etc., see the Important Legal Notices section starting on page 55.

Dependent Documentation Information 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 Benefits Service Center at **833-4LA-WELL** with any questions.

If You Added Your Dependent During…	Deadline	Important Considerations
Open Enrollment (October 1-31)	**If you enroll your dependent who is not currently covered during Open Enrollment (October 1-31, 2019), documents must be received by December 10, 2019.**	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 enrolled during Open Enrollment on January 1, 2020. 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 on the confirmation statement you receive after 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 **833-4LA-WELL** with questions about terminating coverage.

Where to Send Required Documents

Log in and upload your documents to your account at **keepingLAwell.com**.

Or write your name and employee ID number on each certificate or document you send to the LAwell Benefits Service Center, and submit in one of the following ways:

Mail:
PO Box 530477
St. Petersburg, FL 33747-4077

Fax: 213-978-1623

Email: **per.empbenefits@lacity.org**

Deliver in person or mail:
Los Angeles City Hall, 200 N Spring Street Room 867, Los Angeles, CA 90012, between the hours of 8:00 am to 4:00 pm Monday to Friday.

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
Notes • Hiring an attorney to initiate the divorce process does not qualify as a termination life event. • A divorce event will also terminate coverage of any covered stepchild.			
Domestic Partner (DP)	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. See page 48 or call **833-4LA-WELL** 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 participation in the Deferred Compensation Plan or Commuter Spending Accounts at any time. See pages 66-67 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 permitted. 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 on your confirmation statement 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**.

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.

Life Event	Report the Life Event within 30 days of the…	Where to Report	Supporting Documents required 60 days from date on Confirmation Statement?
Marriage	…date of the marriage	Online: **keepingLAwell.com** OR Phone: **833-4LA-WELL**	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: Medicare proof
Entitled to or lose eligibility for Medicare	…first day of coverage		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	Phone Only: **833-4LA-WELL**	Yes: Death Certificate
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 52), or Return to work after leave	- Not Applicable -		Depends on benefit change requested

* Documents listed serve as examples. Other documents may apply. See page 48 or call **833-4LA-WELL** or email **per.empbenefits@lacity.org** to ask what documents apply to your specific life event.

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 the Benefits Service Center at **833-4LA-WELL**.

Documents Are Required

You have **60 days from the date on your confirmation statement** to provide any required documentation listed on your confirmation statement. If you do not submit the required documents by the deadline, any change you made online or by calling the Benefits Service Center 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 on your confirmation statement, 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 Employee Benefits Division at **213-978-1655** if you have questions about life events.

About Continuation Coverage

If you leave the City, and in other special situations, you may be able to continue certain **LAwell** benefits through COBRA.

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.

Life insurance may be continued through portability and/or conversion, and AD&D coverage may be continued through portability continuation. You have 60 days from the date coverage ends to submit the required form to Standard Insurance Company. See page 32 for more information on life insurance, page 34 for more information on AD&D insurance.

Contact the **LAwell** COBRA Coordinator at **213-978-1655** when you know that you will be leaving City service for more information.

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* (40 hours for full-time employees and 20 hours for half-time employees) per pay period for the City to continue to pay the subsidy for your benefits.

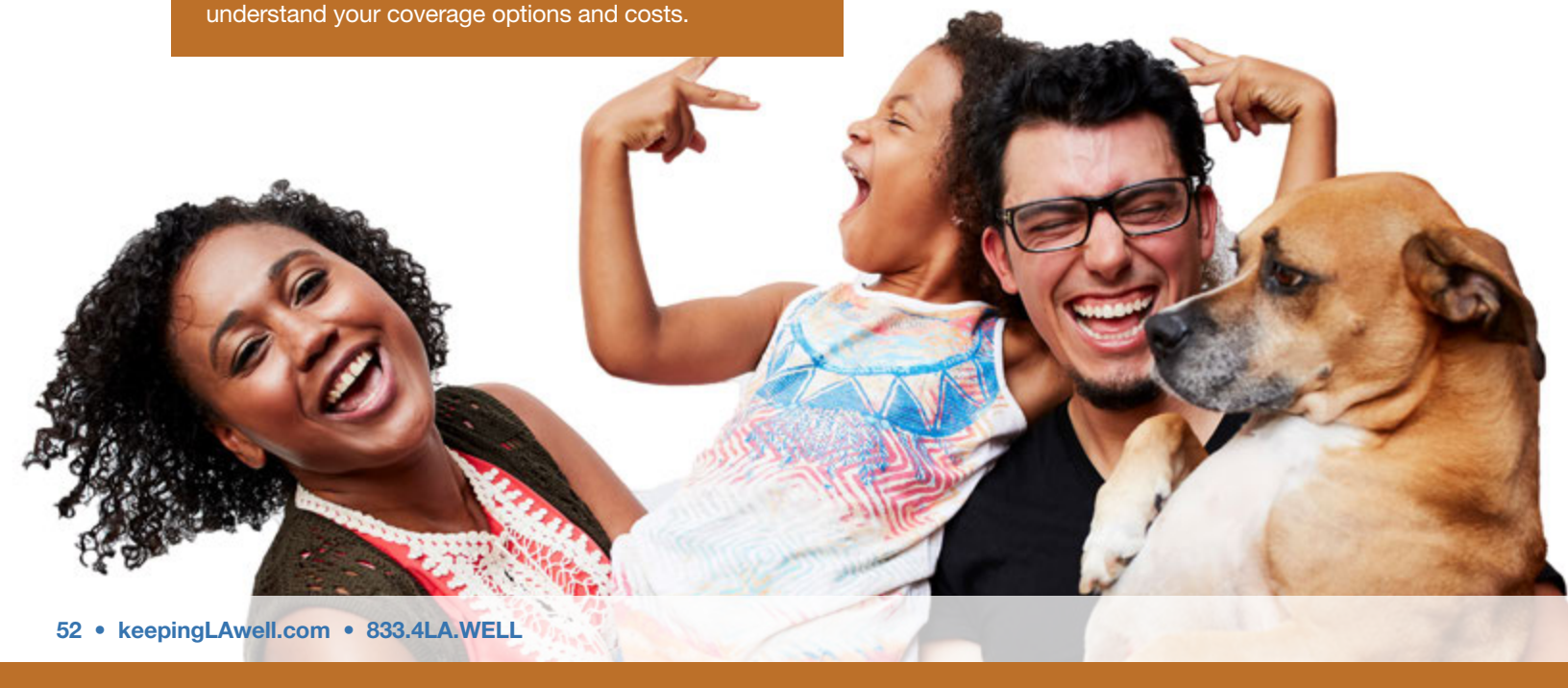
* Compensated hours include hours worked, banked sick or vacation time, and other qualifying hours for which you received approved pay from the City. See page 47 for more information.

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 52-54 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** 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 • Basic & Supplemental Life insurances (including AD&D) • Basic & Supplemental Disability insurance	• Medical insurance • Dental insurance • Vision insurance
Continue through other action	N/A	Basic and Supplemental LIfe insurances can only continue through Portability or Conversion. AD&D insurance can only continue through Portability.
Not eligible to continue	Healthcare Flexible Spending (HCFSA) and Dependent Care Reimbursement Accounts (DCRA) are tax-advantaged spending accounts that provide for deductions to be taken through City payroll. Your ability to use these accounts will end when you terminate employment. You may only use any remaining balance toward eligible expenses that were incurred up to the last day of your City 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 Employee Benefits Division at **213-978-1655** 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 receive a confirmation statement in the mail and will have a period of time to make corrections/changes to their reinstated benefits.

* Minimum 40 compensated hours for full-time employees; minimum 20 compensated hours for half-time employees. See page 47 for more information on eligibility. Returning to City employment may not be considered as new hire employment status for benefits purposes.

Benefits While on Leave or in Non-Pay Status

HCFSA and DCRA contributions and disability coverage 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 six months.

How Benefits Can Be Affected During a Leave of Absence

Leaves Of Absence			
Type of Leave	**What is it?**	**Can my Benefits continue?**	**Can my City subsidy continue?**
Family and Medical Leave	FMLA is approved protected leave for qualified employees that falls under the provisions of the Family and Medical Leave Act (FMLA). Your department must approve an FMLA absence.	Yes – Most of your 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.*
Disability Leave	An approved leave for a non-work related disability, and you are receiving a disability benefit from Standard Insurance Company.	Yes – Most of your benefits can continue. Continuation Method: Direct Bill	City Subsidy will only apply to the employee only level of coverage, unless there has been no coverage break, for employees approved for the Benefit Protection Plan (BPP). See page 39 for more information on BPP.
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 benefits can continue. Continuation Method: Direct Bill or COBRA** (depends on situation)	***Only*** if your approved leave is supplemented with the **minimum** number of compensated hours: Full-Time: 40 hrs Half-Time: 20 hrs
Military Leave	An approved leave to actively serve in a branch of the military.	Yes – Most of your 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.
Catastrophic Illness	An approved leave that receives donated hours (see Catastrophic Illness Leave Donation Program on page 40).	Yes – Most of your benefits can continue. Continuation Method: Direct Bill	City Subsidy will only apply for the time you retain the minimum number of compensated hours: Full-Time: 40 hrs Half-Time: 20 hrs
Reduction of Hours, and Non-paid Leaves	During any two-week pay period, you **do not** meet the minimum number of compensated hours: Full-Time: 40 hrs Half-Time: 20 hrs ***Note:*** *Compensated hours include hours worked, banked sick or vacation time, and other qualifying hours for which you receive approved pay from the City. See page 47 for more information on eligibility.*	Yes – Most of your benefits can continue. Continuation Method: Direct Bill or COBRA (depends on situation)	**No,** you must pay the full unsubsidized premium for your benefits to continue.
Termination	You end employment with the City, either voluntarily or through City action.	Your 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 benefit, plus any COBRA administrative fees.
Retirement	You end employment due to your start of retirement benefits through LACERS. ***Note:*** A non-LACERS retirement is considered a "termination"	Your benefits will end the last day of the month in which you retire or transfer to DWP. You can only continue benefits through COBRA.	
Transfer to DWP	You accept and begin employment at the Department of Water and Power (DWP).		

** Most active payroll Workers' Compensation statuses that are supplemented with the minimum compensated hours can be continued through payroll or direct bill. However, Workers' Compensation statuses that are not supplemented with the minimum compensated hours can only be continued through COBRA.

Important Legal Notices

Binding Arbitration

Anthem Narrow Network (Select HMO), Anthem Full Network (CACare HMO), Anthem Vivity (LA & Orange Counties) HMO, 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 as to whether any medical services rendered by the health care providers 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. Both you and the health care provider agree to give up your/their constitutional right to have any such dispute decided in a court of law before a jury, and instead accept the use of arbitration, except as otherwise required by law.

It is further 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).

NOTICE: BY ENROLLING IN A HEALTH CARE PLAN YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHTS TO A JURY OR COURT TRIAL AND TO ASSERT OR PARTICIPATE IN A CLASS ACTION. (Such enrollment serves as your electronic signature for agreement to the above provisions for the purposes of California Health and Safety Code Section 1361.1 and Code of Civil Procedure Section 1295.)

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).

MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under the Medical Plan options available to you are or are not creditable with (as valuable as) Medicare's prescription drug coverage.

To find out whether the prescription drug coverage under the medical plan options offered by the City are or are not creditable, you should review the Plan's Medicare Part D Notice of Creditable Coverage available on page 63.

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. 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 **keepingLAwell.com**.

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**.

Designation of a Primary Care Provider (PCP) and Direct Access to OB/GYN Providers:

The Anthem PPO and Kaiser HMO medical plans offered by LAwell do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any in-network (or non-network) health care provider; however, payment by the Plan may be less for the use of a non-network provider. To locate an in-network provider, contact your medical plan.

You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology (OB/GYN), contact the you medical plan.

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 **www.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 **1-877-KIDS NOW** or **www.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 **www.askebsa.dol.gov** or call **1-866-444-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 July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://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+ Website: https://www.colorado.gov/pacific/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: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

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/Hawki
Phone: 1-800-257-8563

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

KENTUCKY – Medicaid
Website: https://chfs.ky.gov
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: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.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://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 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://medicaid.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
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: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://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: https://www.coverva.org/medicaid/
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/famis/
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

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

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA(3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext.61565

California residents may also be eligible for premium assistance. Contact the California Department of Health Care Services' voluntary Health Insurance Premium Payment (HIPP) program by email at **HIPP@dhcs.ca.gov** or by fax at **916-440-5677**, or visit **https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx**.

Other California Premium Assistance Resources:

Medi-Cal Website
www.dhcs.ca.gov

Medi-Cal Phone:
1-800-541-5555

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

CHIP Phone:
(800) 880-5305

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

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 **833-4LA-WELL** or **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 share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

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 51) 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 **https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra**.

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% (or, in the case of an extension of continuation coverage due to a disability, 150%) 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**.

CalCOBRA Coverage for Medical Benefits Only

In certain circumstances a COBRA Qualified Beneficiary may continue coverage under CalCOBRA after federal COBRA coverage is exhausted. You are not eligible for CalCOBRA if you have Medicare, you have or get coverage under another group health plan, or you are eligible for or covered under federal COBRA. If you are entitled to elect CalCOBRA coverage, you will be notified by the insurance company. You can add eligible family members to your Cal COBRA. You may have to pay the whole cost of the CalCOBRA coverage you elect. For more information on CalCOBRA, contact your medical insurance company.

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 **keepingLAwell.com** or contact the Benefits Service Center at **833-4LA-WELL** to get a free copy.

To request special enrollment or obtain more information, contact the Benefits Service Center, at **833-4LA-WELL**, 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 Benefits Service Center at **833-4LA-WELL**, Monday – Friday, 8 a.m. to 5 p.m. Pacific Time.

Notice Regarding The Wellness Program

The LIVEwell Wellness Program is a voluntary wellness program available to all employees and is designed to **promote health or prevent disease**. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the LIVEwell Wellness Program you will be asked to complete a biometric screening, which will include a blood test for cholesterol and blood glucose levels, among other things. You are not required to participate in the blood test or other medical examinations.

The results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information.

Information collected from Wellness Program participants will only be received by your employer in aggregate form. Although the Wellness Program and the City may use aggregate information it collects to design a program based on identified health risks in the workplace, LIVEwell will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the Wellness Program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the Wellness Program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Wellness Program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Wellness Program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the Wellness Program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a health coach in order to provide you with services under the Wellness Program.

In addition, all medical information obtained through the Wellness Program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the Wellness Program will be used in making any employment decision. Appropriate precautions will be taken the City to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the Wellness Program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the Wellness Program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Benefits Service Center at **833-4LA-WELL**.

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 2020

Medicare and the City

If you are an active City 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 LACERS at **800-779-8328** 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 **800-MEDICARE** (**800-633-4227**). TTY users should call **877-486-2048**.

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

Terms and Conditions

The Terms and Conditions of the LAwell Program are subject to change without notice and are provided in their entirety at keepingLAwell.com.

To complete your enrollment, you must provide any you must provide any required paperwork to the LAwell Benefits Service Center at PO Box 534077 St. Petersburg, FL 33747-4077 or to the Personnel Department, Employee Benefits Division **within 60 days of the date on the confirmation statement** you receive after enrolling.

By enrolling, you consent to the following:

- You have read, agreed to, and will abide by the full Terms and Conditions for LAwell Program members as follows:
  - Making changes to your elections and dependent information requires you to provide an electronic signature of the choices you enter. If you prefer not to make changes electronically, call the Benefits Service Center at 1-833-4-LA-WELL (1-833-452-9355) Monday to Friday from 8:00 am to 5:00 pm PST for assistance.
  - If you are required to complete any forms, like a Cash-in-Lieu Affidavit or Affidavit of Domestic Partnership, be sure to return your forms by the deadline on your confirmation statement. You can find forms at keepingLAwell.com.
  - Documentation, such as a birth certificate, is required to enroll dependents. If LAwell coverage is canceled because you do not provide information by the deadline, any expenses your child or spouse/domestic partner has after coverage is canceled, including expenses incurred before your cancellation notice, will be your responsibility. Go to keepingLAwell.com or view the CHOOSEwell Enrollment Guide to confirm dependent enrollment requirements.
  - Only the dependent relationships identified by the LAwell program are permissible eligible dependents and can only be added/removed to LAwell coverage as specified by the LAwell program rules, or by specific court order.
  - You will not be able to re-enroll your dropped dependent until the next annual enrollment period or within 30 days of another qualifying life event.
  - If you decide to make changes electronically, completion of an event will serve as your consent.
  - You agree that your information, and the information you provided for your eligible dependents is true and accurate. You must drop coverage for any 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 may be subject to disciplinary action.
  - 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.
  - Dual LAwell coverage by LAwell employees in a relationship with or as a parent of another LAwell employee is not permissible.
  - Your eligibility for LAwell benefits is evaluated on a biweekly basis per pay period as outlined in the CHOOSEwell enrollment guide and on keepingLAwell.com. Not meeting eligibility requirements will result in either the discontinuation of the City subsidy applied to your LAwell benefits or the termination of your LAwell benefits.
- All the information you provided is accurate and true, to the best of your knowledge;
- My enrollment, and the enrollment of my dependents, is conditional and may require further action;
- Clicking the box above and completing this event will also serve as your electronic signature of the information you enter. By law, this electronic signature will have the same effect as a signature on a paper form.

City of Los Angeles Dependent Care Reimbursement Account (DCRA), Health Care Flexible Spending Account (HCFSA), and HCFSA Debit Card Terms and Conditions

By participating in the HCFSA and DCRA, I understand that:

- the annual amount I have elected is irrevocable;
- my per pay period deduction may be adjusted to meet my annual election amount if I miss any payroll contributions during the calendar year;
- the funds I deposit for HCFSA can only be used to pay for eligible medical, dental, and vision care expenses that are not covered by my insurance plan or elsewhere;
- the funds I deposit for DCRA can only be used for eligible dependent care expenses;
- the funds I deposit must be used by the end of the calendar year or I will forfeit any unclaimed balance that is not used by December 31;
- I have until April 30 to file a claim for expenses made in the prior calendar year;

- the HCFSA is not a Health Savings Account, and I cannot use the account to pay for premiums;
- the available HCFSA debit card is an optional convenience to me, and not all eligible expenses are available to purchase through the debit card. I may still need to file a paper claim in certain expense situations;
- I abide by all of the rules of the LAwell Program and the applicable rules of the HCFSA and DCRA administered by the City's flexible spending accounts administrator Wageworks.
- I will receive a HCFSA debit card with stored credit in the amount elected by me. Regarding the use of this debit card, I understand and agree to the following:
  - I will only use the debit card to pay for medical expenses, otherwise eligible under IRS rules, for myself or my spouse and dependents;
  - I will not use the debit card for any medical expense that has already been reimbursed by this HCFSA or under another health plan;
  - I will not seek reimbursement under any other health plan for any expenses paid for with a debit card; and
  - I will keep sufficient documentation (such as invoices and receipts) for all expenses paid with the card and will provide it

City of Los Angeles Transit Spending Account (TSA) and Parking Spending Account (PSA), and Commuter Card Terms and Conditions

You can begin using your PSA once you have a balance in your *WageWorks* account at **https://www.wageworks.com**.

- In certain instances, parking passes can be purchased directly through *WageWorks*, at 10th of the month . Purchase your parking pass by the **10th of the month** to have your name added to the list of authorized users at the chosen lot for the following month. **Your PSA will automatically be debited** the amount you select. You may also use your debit or credit card to cover the costs of a purchase if you have not yet accumulated enough in your PSA.
- You can also make your parking purchases at a garage/lot directly and file a claim in order to receive reimbursement from your PSA. However, you must **notify WageWorks before the 10th of the month how much you plan to spend in the following month**. File your claim up to six months after your purchases(s) through WageWorks. Your PSA will be debited and a reimbursement check will be mailed to you.
- A **$1.50 administrative fee** will be deducted from each paycheck. This is a flat fee for any combination of WageWorks accounts – you will see only one fee whether you have a PSA and/or a Healthcare Flexible Spending Account, Dependent Care Reimbursement Account, or Transit Spending Account.

Things to Remember:

- This account **cannot be used for parking provided by the City of Los Angeles to its employees** at City owned or leased lots (City Hall East, Fig. Plaza, Police Admin. Building, etc.).
- **Employees of LADWP, Airports and Harbor are not eligible to join this program**.
- You are not required to make your purchases in the month you make your contributions. **Funds can be accumulated and used whenever you wish**.
- There are **no "use it or lose it" provisions at year-end. However, you cannot keep more than $1,500 in either your WageWorks account or Parking Card at any given time**. Funds are rolled over to subsequent years until you terminate from the City or transfer to DWP, at which point, any unused PSA funds will be forfeited.
- You can take advantage of an additional tax-savings opportunity – remember to check out the **Transit Spending Account (TSA)** if you are taking public transit for any portion of your commute!

IMPORTANT: You must keep your records up-to-date. Immediately inform your employer if your mailing address or other personal information changes.

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 Standard of living you had while working. At the City of Los Angeles, you have two resources for creating retirement income security:

- Los Angeles City Employees Retirement System (LACERS) — Benefits are determined based on factors such as how long you work for the City and your salary near retirement. They are also based on your retirement Tier (Tier 1 for employees hired prior to February 21, 2016; Tier 3 for employees hired on or after February 21, 2016) and the benefit formulas that apply to each Tier. For most employees, this benefit will not replace 100% of their working income.
- 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 LACERS 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. The Plan helps you with easy-to-use investment options, convenient saving via payroll deduction, and a robust retirement calculator that will give you a projection of your retirement income needs.

Would you like to learn more?

You can enroll today or learn more 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.commuteoptions@lacity.org**.

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

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 $265 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 $265 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 during the year, including during Open Enrollment.
- The minimum contribution to either account is $10 per pay period.
- 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 or transfer to the Department of Water and Power).
- 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.
- TSA/PSA is not available to employees of the Airport Department or Harbor Department.

LIVEwell

The City's LIVEwell Wellness Program (LIVEwell) offers a variety of practical wellness tools, activities, and resources to inspire, support, and empower members in achieving health lifestyles, both at work and at home.

LIVEwell provides a new, free, online resource for building your personal wellness **LIVEwell.la**.

LIVEwell.la

With **LIVEwell.la** you can create and support all of your personal wellness goals through:

- Tools for creating personal health goals
- Team challenges
- Social support
- Updates for City wellness events and activities
- A broad array of informational resources and tools

How does it work?

- **Motivation and inspiration, all in one place**
  - **LIVEwell.la** is your online resource for all your wellness needs. Use it to discover your personal strengths and set personal wellness goals.
- **Personalized plan, just for you**
  - Once you establish your account and take the WellCheck questionnaire, **LIVEwell.la** will provide you with activities and content based on your specific interests, allowing you to personalize and self-direct your wellness goals.
- **Challenge yourself**
  - Participate in challenges and activities that appeal to you. There are dozens to choose from, such as "Exhale Your Worries," "Walk and Talk," "Use Your Desk as a Workout Zone," and "No Sad Desk Lunches."
- **Share and celebrate wins together**
  - Share updates, photos, and comments with fellow City employees using the **LIVEwell.la** Community Feed. Give virtual high-fives to show support and cheer victories. Share your own achievements to inspire your peers on their wellness journeys. By connecting with your peers, you can give and feel support.
- **Achieve rewards and recognition**
  - Collect points by creating your **LIVEwell.la** account, taking the WellCheck questionnaire, and completing activities you select. There are four point levels to achieve, each with their own rewards and recognition!

Level 1

The Adventurer: Badge of Honor Pin & Lanyard, Badge Holder

Level 2

The Explorer: Badge of Honor Pin & Telescopic Stainless Steel Straw

Level 3

The Trailblazer: Badge of Honor Pin & Exercise Running Belt

Level 4

The Titan: Badge of Honor Pin & Backpack Cooler

Register Your Free Account

- Visit **LIVEwell.la** and click on "Get Started"

3. Enter:
   - Your email address
   - Your employee ID number
   - Your last name and date of birth (MM/DD/YYY)
4. From your homepage, complete the *WellCheck* questionnaire.
5. Review your *WellCheck* results to understand your personal strengths and opportunities.
6. Browse the activities available under "Other Things to Do." Choose one or more that appeal to you, then join your first challenge!

CHOOSEwell Enrollment Guide Section Details

CHOOSEwell Benefit Overview 6
When do my Benefits Start? 6
How do I make a change during the year? 6
What is required to make a qualifying life event change during the year? 6
What are my Benefit options and costs? 7
Who can I cover and what is required? 7
When does my coverage end? 7
What happens if I go on leave? 7
Why should I update my beneficiary(ies)? 7
Who do I call to learn more about my beefits? 7

Online Open Enrollment 8
Online Account Registration 8
Easy-to-Use Navigation 9
Make Open Enrollment Elections 10

Medical Coverage & Cash-in-Lieu. 12
Your Medical Plan Choices 12
Understanding HMO and PPO Plans 12
What is Cash-in-Lieu? 13
What coverage is eligible for Cash-in-Lieu? 13
How much does Cash-in-Lieu pay? 13
How Do I Enroll in Cash-in-Lieu? 13
Finding Network Providers. 14
About Your Primary Care Physician (HMO Plans only) 14
Residence/Worksite Proximity to Service Providers. 15
Understanding Your Out-of-Pocket Costs. 15
Medical Plan Costs and Coverage Levels 15
CHOOSEwell – A Medical Plan Coverage Comparison 18
Prescription Drug Coverage Details 21
Chiropractic Care and Acupuncture 21
Special Health Coverage 22
Care While Traveling 22
Care for Dependents Who Do Not Live with You 22
Dental Coverage **24**
Dental Coverage Choices 24
CHOOSEwell – Dental Plan Comparison 24
Delta Dental Network Providers 25
How to Register for a Delta Dental Online Account 25
Dental Coverage Costs and Coverage Levels. 25
CHOOSEwell – A Dental Plan Coverage Comparison. 27

Vision Coverage **28**
Your Vision Coverage 28
The EyeMed Network 28
In- and Out-of-Network Vision Benefits 29
Retinal Imaging 29
How EyeMed Benefits Work with Medical Plan Vision Benefits. 30
Vision Plan Costs and Coverage Levels 30

Support Plus: Employee and Family Assistance Program **31**
How It Works. 31
Benefits for All Employees and their Family Members 31
Harbor Department Employees 31

Life Insurance 32
Life Insurance Options Overview 32
Requirements to Enroll into Life Insurance Coverage 33
Active Work Requirement 33
Medical History Statement Requirement 33
What is the MHS submission deadline? 33
Reductions Based on Age 33
Dependent Life Coverage Level and Eligibility Requirements 33
Claiming Life Insurance Benefits – Things to Consider 34
Designating a Beneficiary 34
Accelerated Benefit 34
Claims Process 34
Funeral Planning Services 34
Coverage Costs & Imputed Income 34
Continuing Coverage After Your City Employment Ends 35

Accidental Death & Dismemberment (AD&D) Insurance 36
AD&D Insurance Option Overview 36
Requirements to Enroll into Coverage 36
Claiming AD&D Benefits – Things to Consider 36
AD&D Coverage Costs 37
Continuing AD&D Coverage After Your City Employment Ends 37

Disability Coverage 38
Basic and Supplemental Disability Overview 38
Requirements to Enroll into Disability Coverage 38
Active Work Requirement 38
Medical History Statement (MHS) Requirement 39
What is the MHS Submission Deadline 39
Filing a Disability Claim 39
Disability Benefits Require Approval 39
Disability Benefits and Other Income Sources 39
Benefit Protection Plan 39
Taxes and Your Disability Benefits 39
Definition of Disability 40
Other Benefits to Consider 40

Health and Dependent Care Tax-Advantaged Spending Accounts 41
Types of Accounts 41
When You Can Enroll 41
How the Accounts are Different 41
About the Healthcare Flexible Spending Account 41
How Much You Can Set Aside 41
Examples of Eligible and Ineligible Expenses 42
About Eligible Dependents 42
Estimate Expenses Carefully 42
About the Dependent Care Reimbursement Account 43
How Much You Can Set Aside 43
About the Dependent Care Reimbursement Account and Taxes 43
Important Deadline and Restrictions 44
Filing Claims 44

Dependent Coverage Rules for Special Situations 45
Dependent Coverage Rules for Special Situations 45
Eligibility Criteria for Disabled Child Over Age 26 45
When Two **LAwell**-Eligible City Employees Are Married, Are Domestic Partners or Have Dependent Children Together 45
Children Who Are City Employees 45
Domestic Partner Coverage and Pre-Tax Benefits 46
Federal Taxes vs. State Taxes 46

Eligibility 47
Who Is Eligible for Benefits 47
Family Members of Employees 47
Dependent Eligibility Criteria 48
Dependent Documentation Information is Required 49
Removing Ineligible Dependents 49

Life Events 50
When Your Choices Will Apply 50
When You Can Make **LAwell** Benefit Changes 50
Qualifying Life Event Requirements 50
What Benefits Can Change for a Life Event 51
Leaves of Absence 52
How Benefits Can Be Affected During a Leave of Absence 54

Important Legal Notices 55
Binding Arbitration 55
Women's Health and Cancer Rights Act 55
About Hospital Stays for Mothers and Newborns 55
Privacy and Your Health Coverage 56
Personal Physician Designations and OB/GYN Visits in the Anthem Blue Cross HMOs 56
Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) 56
Health Insurance Marketplace 58
Important Information About Your COBRA Continuation Coverage Rights 59
Availability of Summary Health Information 61
Taxpayer Identification Number (TIN) or Social Security Number (SSN) Reminder 62
Important Notice about Prescription Drug Coverage and Medicare 63

Terms and Conditions 65

RETIREwell 67
Deferred Compensation Plan 67

COMMUTEwell 68
Commuter Spending Accounts 68
Transit Spending Account (TSA) and Parking Spending Account (PSA) 68

LIVEwell 69
LIVEwell Activities 69

Important Websites and Phone Numbers

	Plan/Program	Pages	Website	Phone Number
LAwell Program Benefit Contacts	Anthem PPO Anthem HMO (Narrow, Full) Anthem Vivity (LA & Orange Counties HMO)	12-23	**anthem.com/ca/cityofla**	**Anthem PPO: 833-597-2362** **Anthem HMO (Narrow, Full): 844-348-6111** **Anthem Vivity: 844-348-6110**
	Kaiser Permanente HMO	12-23	**my.kp.org/ca/cityofla**	**800-464-4000**
	Delta Dental PPO or Preventive Only	24-27	**deltadentalins.com/enrollees/index.html**	**800-765-6003**
	DeltaCare USA DHMO	24-27	**deltadentalins.com/enrollees/index.html**	**800-422-4234**
	EyeMed Vision Care	28-30	**eyemedvisioncare.com/cityofla**	**855-695-5418**
	Support Plus: Employee and Family Assistance Program	31	**liveandworkwell.com**	**800-213-5813**
	Healthcare Flexible Spending Account or Dependent Care Reimbursement Account	41-44	**wageworks.com**	**877-924-3967**
	Commuter Spending Accounts	66	**wageworks.com**	**877-924-3967**
	Standard Insurance Company: Life Insurance, AD&D and Disability Insurance	32-40	**https://www.standard.com/employee-benefits/city-los-angeles**	**844-505-6025** for general questions **800-843-7979** for evidence of insurability **800-527-0218** for travel assistance **FILE A CLAIM** 844-505-6025 – Disability Insurance 213-978-1591 – Life or AD&D Insurance
Direct	**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**
	Benefits Service Center		**keepingLAwell.com** to enroll or make changes to your **LAwell** benefits	**833-4LA-WELL** ***(800-735-2922 if hearing or speech impaired)*** Monday – Friday, 8:00 a.m. to 5:00 p.m. Pacific time
	Employee Benefits Division		**keepingLAwell.com** or send e-mail to **per.EmpBenefits@lacity.org**	**213-978-1655** Monday – Friday, 8:00 a.m. to 4:00 p.m. Pacific time
Other City Benefit Contacts	EAP for Harbor Employees Only			**800-367-7474**
	Los Angeles Employees' Retirement System		**lacers.org**	**800-779-8328**
	Deferred Compensation Plan		**LA457.com**	**844-523-2457** (Voya) or **213-978-1601** (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**

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. This Guide outlines the insured plan benefits provided by the Insurance Companies whose names and contact information are listed on the Important Websites and Phone Numbers section of this document. Where this Guide deviates from the certificate of coverage and summary of benefits produced by the insurance company, the insurance company documents will prevail. Contact the Benefits Service Center for a copy of insurance coverage documents.*

*By enrolling in, and/or accepting services under the **LAwell** Plan, you agree to abide by all terms, conditions and provisions stated in the 2020 **LAwell** CHOOSEwell 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.*

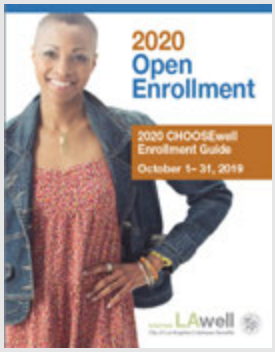
How to use this CHOOSEwell Enrollment Guide

First 1

Review your current enrollment and your 2020 costs and options using your Personalized Benefit Statement or by logging into your account at **keepingLAwell.com**.

Second 2

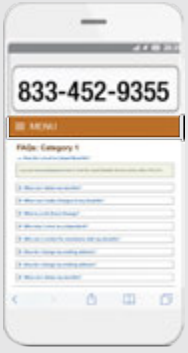
Review the **CHOOSEwell** Enrollment Guide to learn more about **using your benefits,** and any **rules/restrictions** that may apply.



Review your **CHOOSEwell** Highlights for a quick overview of 2020 benefits.

Third 3

Make your 2020 enrollment elections by October 31, 2019! Go to **keepingLAwell.com** or call **833-4LA-WELL (833-452-9355)** to make elections.



KEEPING **LAwell**
City of Los Angeles Employee Benefits