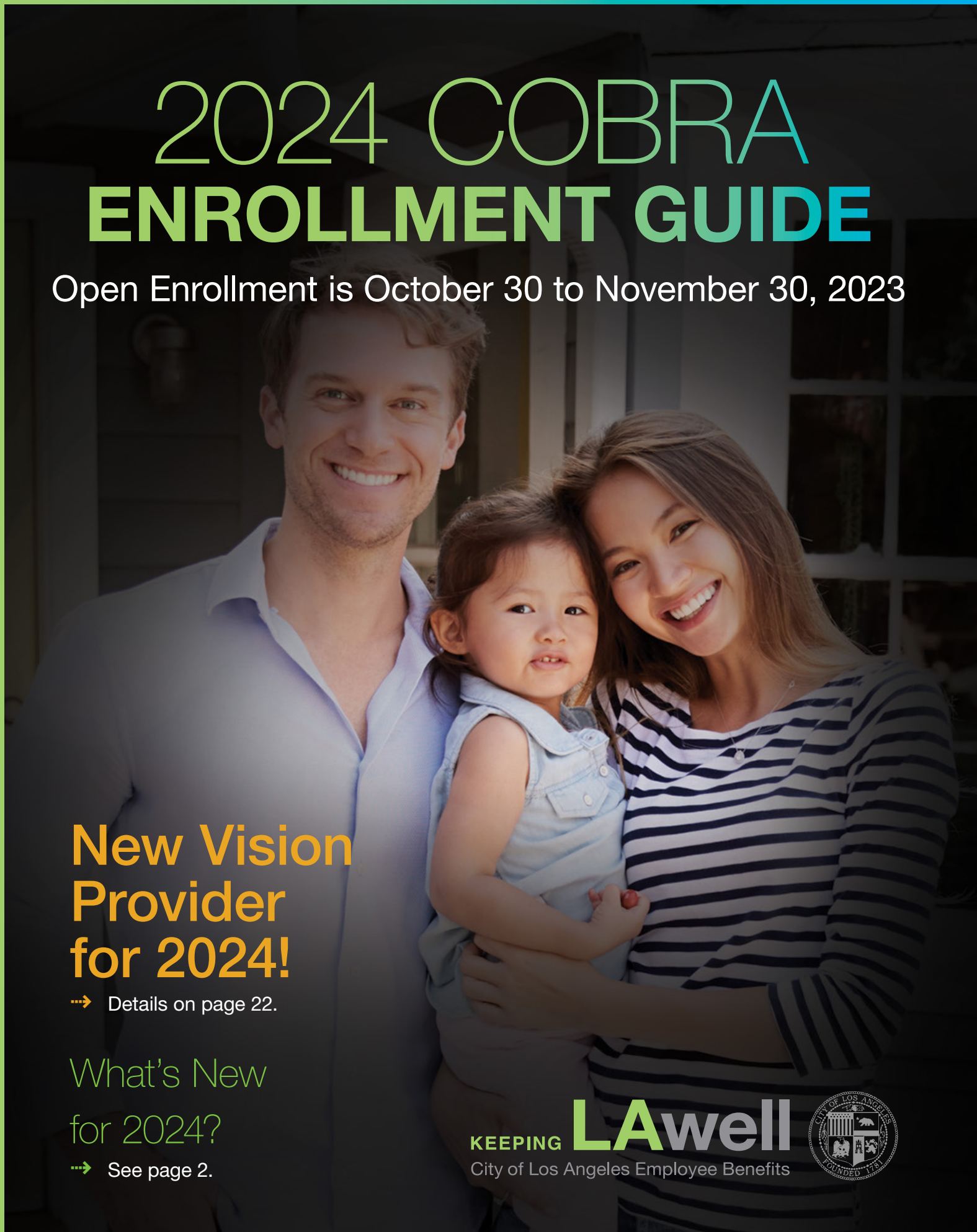
2024 COBRA ENROLLMENT GUIDE

Open Enrollment is October 30 to November 30, 2023



New Vision Provider for 2024!

Details on page 22.

What's New for 2024?

See page 2.

KEEPING LAwell

City of Los Angeles Employee Benefits

Open Enrollment 2024

What's New for 2024

New medical premium rates.

All medical plans will experience a rate change that goes into effect on January 1, 2024.

New dental premium rates.

All dental plans will experience a rate change that goes into effect on January 1, 2024.

New Vision provider for 2024.

Blue View Vision will be the vision provider starting January 1, 2024. The new 2024 plan provides the same benefits and network as the current (2023) vision plan. You will receive a Blue View Vision ID card in the mail. For complete details see page 22.

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Medical Coverage

Highlights

- Understanding **the difference between HMOs and PPOs** can help you determine which plan works best for you and your family. Read more about these differences on page 5. Then, compare plan benefits and the coverages they provide on pages 6-11.
- Your total medical plan costs include the **premium** (the monthly amount paid to the insurance company for your coverage) and **out-of-pocket costs** (deductibles, copays, and coinsurance) when you seek care. Read more about medical plan costs on page 12.
- Learn how to **log in to your medical plan online account** on page 15.

Your Medical Plan Choices

Medical Plans

1. Kaiser Permanente (HMO)
2. Anthem Narrow Network (Select) HMO
3. Anthem Full Network (CACare) HMO
4. Anthem Vivity (LA & Orange Counties) HMO
5. Anthem Preferred Provider Organization (PPO)

Understanding HMOs and PPOs

Insurance is a product that helps to cover your health expenses. Like auto insurance covers your car if you get into an accident, health insurance covers you if you get sick or injured. It also covers preventive care like doctor's visits, yearly eye exams, regular dental care, and annual screenings. Simply put, health insurance can help you maintain a healthy lifestyle, and protect you when you really need it. But remember, even if you don't use your insurance benefits, you still have to pay your monthly premiums — just like you do to keep your auto insurance current throughout the year.

HMOs

Health Maintenance Organizations (HMOs) provide health care through a network of doctors, hospitals, and other health care providers. With an HMO plan, you must access covered services through a network of physicians and facilities as directed by your primary care physician (PCP), except for emergencies. **LAwell** provides coverage where most City employees live.

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 PCP 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 the provider you are interested in.

PPOs

Preferred Provider Organizations (PPOs) are nationwide networks of doctors, hospitals, and other health care 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:

	Kaiser Permanente HMO	**Anthem Plans**		
		Narrow Network (Select HMO) **Full Network** (CACare HMO)	**Vivity** (LA & Orange Counties HMO)	**PPO**
In-Network Care	You may visit any Kaiser Permanente facility; a primary care physician is recommended but not required.	You designate a primary care physician; you must see this physician first when you need specialty care.		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 or urgent care 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.

Medical Plan Coverage Comparisons

The tables on the following pages display 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 keepingLAwell.com, anthem.com/ca/cityofla or my.kp.org/cityofla/.

Benefit Highlights

	Kaiser Permanente HMO	**Anthem Narrow Network** (Select HMO) **Anthem Full Network** (CACare HMO)	**Anthem Vivity** (LA & Orange Counties HMO)
Calendar Year Deductible	$0	$0	
Calendar Year Out-of-Pocket Limit	$1,500/person; $3,000/family	$500/person; $1,500/family	
Routine Office Visits (including pediatric visits)	Plan pays 100% after $15 copay/visit[2]	Plan pays 100% after $15 copay/visit[2]	
Virtual Visits	Plan pays 100%	Plan pays 100% after $15 copay/visit[2]	
Preventive Care[1]	Plan pays 100%	Plan pays 100%	
Maternity Care (Office Visits) **& Pregnancy**	Plan pays 100%	Plan pays 100%	
Inpatient Hospitalization	Plan pays 100%	Plan pays 100%	
Outpatient Surgery	Plan pays 100% after $15 copay/procedure	Plan pays 100%	
Diagnostic Lab Work and X-rays	Plan pays 100% at a Kaiser facility	Plan pays 100%	
Emergency Room Care for True Emergencies (severe chest pains, breathing difficulties, severe bleeding, poisoning, etc.)	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 up to $2,000 for one device per ear every 36 months; covers all visits for fitting, counseling, adjustment, cleaning, and inspection	Plan pays for one hearing aid per ear every 24 months	

1 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.
2 Copay varies by office visit type. See the Evidence of Coverage for more details.

Preventive Care

Your LAwell medical benefits offer no-cost or low-cost preventive care services. For more information on accessing preventive care services, visit keepingLAwell.com or call your health care provider.

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	
Routine Office Visits (including pediatric visits)	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[2] after deductible
Online Doctor Visits	Plan pays 100% after $30 copay	N/A
Preventive Care[1]	Plan pays 100%, no deductible	Plan pays 70% of allowed charges[2] after deductible
Maternity Care (Office Visits) **& Pregnancy**	**Prenatal and postnatal office visits for services mandated by the Affordable Care Act (ACA):** Plan pays 100%; no copay, no deductible **Other prenatal/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[2] after deductible
Inpatient Hospitalization	Plan pays 90% after deductible; prior authorization needed[3]	Plan pays 70% of allowed charges[2] after deductible, up to $1,500 per day maximum. You are responsible for all charges in excess of $1,500 per day. Prior authorization is needed.[3]
Outpatient Surgery	Plan pays 90% after deductible	Plan pays 70% of allowed charges[2] after deductible, up to $350 per day maximum. You are responsible for all charges in excess of $350 per day.
Diagnostic Lab Work and X-rays	Plan pays 90% after deductible	Plan pays 70% of allowed charges[2] after deductible
Emergency Room Care for True Emergencies (severe chest pains, breathing difficulties, severe bleeding, poisoning, etc.)	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	Plan pays 80% of allowed charges[2] after deductible for one hearing aid per ear every 24 months

1 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.
2 When members use non-preferred providers, they must pay the applicable copay 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.
3 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.

Accessing Care

	Kaiser Permanente HMO	Anthem Narrow Network (Select HMO) Anthem Full Network (CACare HMO)	Anthem Vivity (Los Angeles & Orange Counties HMO)
Choice of Physicians and Facilities (hospital, etc.)	Access covered services through the Kaiser network of physicians and facilities, except for emergencies	Access covered services through the Anthem Blue Cross network of physicians and facilities as directed by your PCP, except for emergencies[1]	
Location of Doctors and Providers	Regionally located in nine states	**Select HMO:** Throughout California **CACare HMO:** Throughout California	Throughout select locations in Los Angeles and Orange Counties
Primary Care Physician (PCP) Designation	Members will not automatically be assigned a PCP, but may choose and switch PCPs at any time. Members can receive urgent or emergency care services without selecting a PCP.	A PCP designation is required to see a doctor. Members and their dependents may choose their own PCP or medical group, and they do not have to enroll with the same PCP or medical group. New members will automatically be assigned a PCP, but may change their PCP assignment by calling the Anthem Blue Cross Customer Service numbers below. Anthem members are typically allowed to change their PCP designation no more than once a month.	
Changing or Finding a PCP or Network Provider	• Go to my.kp.org/ca/cityofla, choose "Find a Doctor," then choose "Southern California" • Call **800-464-4000** – Open 24 hours a day, 7 days a week • Contact an onsite member advocate	• Go to anthem.com/ca/cityofla, choose "Find Care," then identify your plan • Call Anthem (Narrow or Full) at **844-348-6111**, Monday through Friday, 8:00 a.m. to 8:00 p.m. • Contact an onsite member advocate	• Go to anthem.com/ca/cityofla, choose "Find Care," then identify your plan • Call Anthem Vivity at **844-348-6110**, Monday through Friday, 8:00 a.m. to 8:00 p.m. • Contact an onsite member advocate
Onsite Member Advocates	A Kaiser member advocate is available[2] at: **Los Angeles City Hall** **200 N. Spring Street, Room 867** **Los Angeles, CA 90012** 8:00 a.m. – 4:00 p.m. Tuesday – Thursday Phone: **323-219-6704** Email: LACity.Advocate@kp.org	An Anthem member advocate is available[2] at: **Los Angeles City Hall** **200 N. Spring Street, Room 867** **Los Angeles, CA 90012** 8:00 a.m. – 4:00 p.m., Monday – Friday Phone: **213-200-2987** Email: Lorena.Gomez@anthem.com	
Telemedicine	Kaiser provides phone and video appointments at no additional cost to you. Get quick guidance from a Kaiser Permanente provider, including some prescriptions and 24/7 self-care advice. For more information, visit kp.org/getcare.	Anthem offers LiveHealth Online video visits through the web and the Sydney Health mobile app. • LiveHealth Online lets you visit a doctor, 24/7, through a smartphone, tablet, or computer with a webcam; no appointment is needed. • Anthem's Sydney Health app connects you to everything you need to know about your medical plan. Download the free app via the iPhone App Store or Google Play Store.	
Acupuncture & Chiropractic Care (for assistance in finding a provider, use the Changing or Finding a PCP or Network Provider information above)	Physician-referred acupuncture is covered at a $15 copay per visit. Chiropractic care is not covered, but member discounts are available. For more information, go to kp.org/choosehealthy or call **877-335-2746** Monday – Friday, 5:00 a.m. to 6:00 p.m.	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.	
LGBTQIA Health Care Providers (for assistance in finding an LGBTQIA provider, use the Changing or Finding a PCP or Network Provider information above)	Kaiser can offer care that is personalized to your sexual orientation, gender identity, or gender expression. You and your provider can decide what information to add to your medical record. For more information, call the Transgender Care line at **323-857-3818**, Monday – Friday, 8:00 a.m. to 5:00 p.m.	Anthem can offer care that is personalized 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.	

1 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**.
2 In-person availability may vary due to periods of COVID-19 closures.

	Anthem PPO In-Network	Anthem PPO Out-of-Network
Choice of Physicians and Facilities (hospital, etc.)	Access covered services through Prudent Buyer PPO preferred providers	Access covered services through any provider
Location of Doctors and Providers	Available nationally	
Physicians	Members in the Anthem PPO Plan may visit any licensed provider, in or out of network; primary care physician or specialist referrals are not required. However, you will receive a lower level of benefits for out-of-network care.	
Changing or Finding Providers	• Go to anthem.com/ca/cityofla, choose "Find Care," then identify your plan • Call Anthem PPO at **833-597-2362**, Monday through Friday, 8:00 a.m. to 8:00 p.m. • Visit an onsite member advocate	
Onsite Member Advocates	An Anthem member advocate is available[1] at: **Los Angeles City Hall** **200 N. Spring Street, Room 867** **Los Angeles, CA 90012** 8:00 a.m. – 4:00 p.m., Monday – Friday Phone: **213-200-2987** Email: Lorena.Gomez@anthem.com	
Telemedicine	Anthem offers LiveHealth Online video visits through the web and the Sydney Health mobile app. • LiveHealth Online lets you visit a doctor, 24/7, through a smartphone, tablet, or computer with a webcam; no appointment is needed. • Anthem's Sydney Health app connects you to everything you need to know about your medical plan — all in one place. To get started, download the app for free via the iPhone App Store or Google Play Store.	
Acupuncture & Chiropractic Care (for assistance in finding a provider, use the Changing or Finding Providers information above)	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.	
LGBTQIA Health Care Providers (for assistance in finding an LGBTQIA provider, use the Changing or Finding a Providers information above)	Anthem 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.	

1 In-person availability may vary due to periods of COVID-19 closures.

Mental Health and Substance Abuse Treatment Highlights

The mental health inpatient and outpatient benefits shown here are general benefit provisions. For more information about your coverage, or to get a copy of the complete terms of coverage, visit my.kp.org/cityofla/ or anthem.com/ca/cityofla.

	Kaiser Permanente HMO	Anthem Plans			
		Narrow Network (Select HMO) **Full Network** (CACare HMO)	**Vivity** (Los Angeles & Orange Counties HMO)	**PPO** In-Network	**PPO** Out-of-Network
Inpatient[1]	Plan pays 100%	Plan pays 100%		Plan pays 90% after deductible; prior authorization needed.[3]	Plan pays 70% of allowed charges[2] after deductible; prior authorization needed.[3]
Outpatient[1]	Plan pays 100% after $15 copay/visit for individual visit, $5 – $7 copay/visit for group session[2]	Plan pays 100% for facility-based care; 100% after $15 copay/visit for physician visits[2]		Plan pays 90% after deductible for facility-based care; 100% after $30 copay/visit for physician office visit.	Plan pays 70% of allowed charges[4] after deductible. Plan pays 70% of allowed charges for physician office visit.

1 The mental health inpatient and outpatient benefits shown here are general benefit provisions. Consult with your plan for specific information regarding benefits available.
2 Copay varies by office visit type. See the Evidence of Coverage for more details.
3 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.
4 When members use non-preferred providers, they must pay the applicable copay 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.

Prescription Drug Coverage Highlights

	Kaiser Permanente HMO	Anthem Plans		
		Narrow Network (Select HMO) **Full Network** (CACare HMO)	**Vivity** (Los Angeles & Orange Counties HMO)	**PPO** In-Network/ Out-of-Network
Prescription Drug Coverage	You must fill prescriptions at a Kaiser pharmacy. Simply show your member ID card and pay a copay when you go to a participating Kaiser pharmacy. You do not have to submit claim forms. Prescriptions from non-participating pharmacies are not covered unless they are associated with covered emergency services.	You must 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 have a prescription filled, simply show your member ID card and pay a copay when you go to a participating Anthem pharmacy. You do not have to submit claim forms. If an Anthem member requests a brand-name drug and a generic equivalent is available, the member is responsible for paying the generic drug copay 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 be used for experimental or investigative indications		
Finding a Pharmacy	To find a Kaiser pharmacy, go to kp.org.	To find a participating pharmacy, go to anthem.com/ca/cityofla.		
Finding the Drug Formulary	To find the Kaiser drug formulary, go to kp.org/formulary.	To find the Anthem drug formulary, go to anthem.com/ca/cityofla. Select "Drug Lists (Formularies)" at the bottom of the page, then select "Anthem National Drug List."		
Pharmacy				
Generic Copay[1]	$10 for up to 30-day supply	$10 for up to 30-day supply		
Brand-name Copay[1]	$20 for up to 30-day supply	Formulary Drug: $20 for up to 30-day supply Non-Formulary Drug: $40 for up to 30-day supply		
Pharmacy Mail Order (Home Delivery Service)				
Generic Copay[1]	$20 for up to 100-day supply	$20 for up to 90-day supply		
Brand-name Copay[1]	$40 for up to 100-day supply	Formulary Drug: $40 for up to 90-day supply Non-Formulary Drug: $80 for up to 90-day supply		

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

Drug Formulary

Your out-of-pocket costs are lower when you use a drug on the 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.

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, see the "Changing or Finding a PCP or Network Provider" on the "Accessing Care" charts on page 8.

Medical Plan Costs

When choosing a plan, it's a good idea to think about your total health care costs, not just the premium (the monthly amount paid to the insurance company for your coverage). You may also have to pay out-of-pocket costs — deductibles, copays, and coinsurance — when you seek medical care. While health plan options generally cover the same types of care, the differences in what they pay for covered care have a big impact on out-of-pocket costs and your total spending on health care — sometimes more than the premium itself.

COBRA premium costs

2024 COBRA Monthly Costs					
Enrollment Tier	**Anthem Narrow Network HMO (Select HMO)**	**Anthem Full Network HMO (CACare HMO)**	**Anthem Vivity HMO (LA & Orange County Regional HMO)**	**Anthem PPO**	**Kaiser Permanente HMO**
Employee or Individual	$796.44	$1,124.62	$668.56	$1,324.06	$777.92
Employee & Spouse/DP	$1,752.22	$2,474.18	$1,470.88	$2,912.96	$1,709.03
Employee or Spouse/DP and Child(ren)	$1,513.28	$2,136.78	$1,270.30	$2,515.68	$1,553.85
Employee & Family	$2,070.82	$2,924.06	$1,738.34	$3,442.58	$2,019.40

Out-of-Pocket (OOP) 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 deductibles, copays, and coinsurance before your plan begins to pay 100% of eligible medical expenses.

Compare the plans' out-of-pocket costs on pages 6-7.

Care While Traveling

Type of Care	Kaiser Permanente HMO	Anthem Plans	
		Narrow Network (Select HMO) **Full Network** (CACare HMO) **Vivity** (LA & Orange Counties HMO)	**PPO**
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 copay will be waived if you are admitted.		
	Call **800-225-8883** immediately if you are admitted to a non-participating hospital.	Within 48 hours of admission, contact Anthem Blue Cross Customer Service at the number listed on your member ID card.	
Emergency Care Outside the U.S.	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.	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, 7 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.	
Urgent Care	**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 **1-833-574-2273 (TTY 711)**. **Out-of-Area:** Go to the nearest urgent care facility, Concentra urgent care center, MinuteClinic, or The Little Clinic. Members can use their Kaiser Permanente ID card at Concentra, MinuteClinic, or The Little Clinic locations and only pay their standard copay. You may also access emergency and urgent care through Cigna's network of physicians and providers nationwide. Visit kp.org/travel for more information.	**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/cityofla to locate the nearest in-network facility.
Prescription Coverage	**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.	**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.	

Care for Dependents Who Do Not Live with You*

Type of Care	Kaiser Permanente HMO	Anthem Plans	
		Narrow Network (Select HMO) **Full Network** (CACare HMO) **Vivity** (LA & Orange Counties HMO)	**PPO**
Routine care for a dependent who does not live with you	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 and urgent care is covered.	**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.

* Employees in HMO coverages, who move outside of California, are only able to access care as outlined in these sections. Moving outside of a coverage area in California, may be a qualified life event if reported within 30 days. Contact the Benefit Service Center for more information.

Health and Wellbeing

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.

	Kaiser Permanente HMO my.kp.org/ca/cityofla	Anthem Plans anthem.com/ca/cityofla
Annual Checkups	Annual physical and other in-network preventive care is generally covered at 100% in-network.	
Nurse Help Line (available 24/7)	**1-833-574-2273 (TTY 711)**	**800-977-0027**
Weight Management and Nutrition Counseling	Visit kp.org/health-wellness to explore wellness resources, including: • Weight loss tools and resources • Healthy Balance Program • Ideas to make exercise enjoyable • Healthy recipes and more	• Diabetes Prevention Program for pre-diabetics. For more information on this free program, call your Anthem plan at the number in the "Learn More" section on page 26. • Online tools and resources to support your diet, fitness, and weight management goals. Log in to your member account at anthem.com/ca/cityofla and select "My Health Dashboard" to get started. • Discounts on gym memberships through Active&Fit Direct™, and weight loss products and programs, including Jenny Craig, Living Lean, nutrition bars, and drinks. Log in to anthem.com/ca/cityofla and select "Discounts" to learn more.
Smoking/Tobacco Cessation	Access Quit Smoking Services: • Contact your doctor • Call Wellness Coaching by phone at **866-862-4295** • Attend an in-person workshop, "Freedom From Tobacco" — visit kp.org/centerforhealthyliving for more information.	• Online smoking/tobacco cessation support. Log in to your member account at anthem.com/ca/cityofla and select "My Health Dashboard" to learn more. • Coverage for FDA-approved, over-the-counter nicotine replacement medications with no copay, when obtained with a doctor's prescription. • Coverage for FDA-approved prescription smoking cessation medications with no copay. Contact your Anthem provider for more information.
Health Coaching	A phone-based Wellness Coaching program is 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**.	Anthem offers an array of support programs to help manage your condition(s). Contact Anthem at the numbers shown below for assistance with finding the program that's right for you. • Anthem PPO: **833-597-2362** • Anthem Vivity: **844-348-6110** • Anthem Narrow Network (Select HMO) and Full Network (CACare) HMO: **844-348-6111**
Exercise	Visit kp.org/exercise for more information about: • Active&Fit Direct™ — provides discounted gym memberships to adult members. • ClassPass — provides on-demand video workouts and reduced rates on in-person workouts to adult members.	Active&Fit Direct™ — provides discounted gym memberships. Log in to your member account at anthem.com/ca/cityofla and select "Discounts" to learn more.
Chronic Care Management	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**.	Call the 24/7 Nurse Line at **800-977-0027** for access to a nurse care manager who can enroll you and your dependents in valuable health management programs for certain health conditions. Extra Support for PPO Members — Contact My Medical Ally powered by Alight at **888-361-3944** to receive personalized, one-on-one support from an expert team to understand your medical conditions and available treatment options.
Other Online Tools	Total Health Assessment (THA) begins with a series of questions about your health. You will then be provided personalized recommendations to help reach your health goals. Visit kp.org/tha to get started. To participate, you need to be registered at kp.org/registernow. In addition, adult members have access to the myStrength app, Calm app and Ginger at no cost. Visit kp.org/selfcareapps to create an account.	Log in to your member account at anthem.com/ca/cityofla and select "My Health Dashboard" 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

COVID-19 Information

Access updated information on COVID-19, including vaccine information, through the following websites:

- **Kaiser Permanente:** kp.org/coronavirus
- **Anthem:** anthem.com/ca/coronavirus
- **Keeping LAwell:** keepingLAwell.com/covid-19

Managing Your Medical Plan Online Account

Kaiser Permanente Online Account

You can go online to view most lab results, refill most prescriptions, email your doctor, schedule and cancel routine appointments, and print vaccination records. Here's how to register online:

1. Go to kp.org/registernow.
2. Select the blue "Create my account" button.
3. Enter your personal information.

Anthem Online Account

You can go online to find doctors and hospitals in your plan, view or update your primary care physician (PCP), review payments and billing, and order and manage prescriptions. Here's how to register online:

1. Go to anthem.com/ca/cityofla.
2. Select the blue profile button on the top right side of the page.
3. Select "Registration" from the drop-down menu.
4. Enter your personal information.

Learn More

Find more information on each of the plans:

- **Kaiser Permanente HMO:** Visit my.kp.org/ca/cityofla or call **800-464-4000**
- **Anthem Narrow Network (Select) HMO and Full Network (CACare) HMO:** Visit anthem.com/ca/cityofla or call **844-348-6111**
- **Anthem Vivity:** Visit anthem.com/ca/cityofla or call **844-348-6110**
- **Anthem PPO:** Visit anthem.com/ca/cityofla or call **833-597-2362**
- **All plans:** Visit keepingLAwell.com for information and plan documents like Summaries of Benefits and Coverage (SBCs) and Evidence of Coverage (EOCs), or call **833-4LA-WELL**.

Dental Coverage

Highlights

- You may choose from three dental plan options administered by Delta Dental. Compare plan benefits and the coverages they provide on pages 16-19.
- Your total dental plan costs include the **premium** (the monthly amount paid to the insurance company for your coverage) and **out-of-pocket costs** (deductibles and copays) when you seek care. Read more about dental plan costs on pages 20.
- Learn how to log in to your Delta Dental online account on page 20.

Your Dental Plan Choices

1. **Delta Dental Preventive Only** provides preventive dental care only. It does not cover other services such as fillings, crowns, and orthodontia. You can visit any licensed dentist each time you need care; however, you'll save the most when you choose a dentist in the Delta Dental PPO network.
2. **DeltaCare USA DHMO** is a dental HMO. In order to receive benefits, you must use the primary care dentist (PCD) you have on file with Delta Dental whenever you need care.
3. **Delta Dental PPO** provides care through a network of dentists who have agreed to offer covered services at discounted rates. You can visit any licensed dentist each time you need care; however, you'll save the most when you choose a dentist in the Delta Dental PPO network.

Dental Plan Coverage Comparisons

The tables that follow display only a few highlights of your dental benefit options. For more information about your coverage, or to get a copy of the complete terms of coverage, log in to your Delta Dental account at **deltadentalins.com** and view "Benefit Details." Additional information is available through **keepingLAwell.com**.

Dental Plan Highlights

	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 copays 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.

Preventive Care

Your LAwell dental benefit offers no-cost or low-cost preventive care services.

For more information on accessing preventive care services, visit **keepingLAwell.com** or call your dental care provider.

The Delta Dental Network

In California, 79% of dentists belong to a Delta network. 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.

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 providers only	Plan pays highest level of benefit when you use in-network PPO providers
Network providers offer discounted fees	You must visit your assigned primary care dentist (PCD) from the DeltaCare USA network. You can change your PCD up to once a month by contacting Delta Dental customer service.	Network providers offer discounted fees. No charges above reasonable and customary (R&C) limits

To find a Delta Dental network provider near you:

- Search Delta's online provider directories by visiting **deltadentalins.com** and selecting "Find a Dentist." From the drop-down menu, choose Delta Dental PPO for the Delta Dental Preventive Only or PPO option, or DeltaCare USA for the DHMO option.
- Request a provider directory (at no cost) by calling **800-765-6003** for the Delta Dental Preventive Only and Delta Dental PPO options or **800-422-4234** for the DeltaCare USA DHMO option.

Teledentistry

Your dentist can determine through consultation whether you have an emergency dental problem, and can provide instructions on how to treat conditions.

Follow these simple steps to explore teledentistry as a care option with your dentist:

1. Contact your dental office to find out if teledentistry services are offered.
2. Ensure that you have the technology used by your dentist office.
3. Fill out any required paperwork, such as patient consent forms, and understand your patient rights.

Dental Benefit Highlights

This table shows a brief summary of how the three dental options pay for certain services. If you have questions about how a specific service is covered, call **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 ages 18 and under	Not covered	Your copay is $1,000 plus start-up fees of $300	Plan pays 50%	Plan pays 50% of R&C*
Children ages 19 to 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.
**** Employees accessing out-of-network services may be required to pay for services in full and submit claims directly to Delta Dental for reimbursement. The employee is also required to ensure their payments for services are accurate.

Dental Plan Costs

Premium Costs

2024 COBRA MONTHLY COSTS				
Coverage Level	**Employee or Individual**	**Employee & Spouse/DP**	**Employee or Spouse/DP and Children**	**Employee & Family**
DeltaCare USA DHMO	$16.26	$27.19	$30.31	$35.12
Delta Dental PPO	$54.51	$100.14	$96.59	$134.33
Delta Dental Preventive Only	$7.57	$15.54	$13.87	$22.46

Learn More

Find more information on each of the plans:

- **Delta Dental Preventive Only** or **Delta Dental PPO:** Visit deltadentalins.com or call **800-765-6003**.
- **DeltaCare USA DHMO:** Visit deltadentalins.com or call **800-422-4234**.
- **All plans:** Visit keepingLAwell.com for plan information and Evidence of Coverage (EOC) documents, or call **833-4LA-WELL**.

Managing Your 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. You can also use Delta Dental's Cost Estimator tool to check out-of-pocket expenses and find the average submitted costs for dental procedures.

Here's how to register online:

1. Go to deltadentalins.com.
2. Select "Log in" at the top right side of the page.
3. Select "Create an account."
4. Select "Enrollee/Adult Dependent" from the drop-down menu. Then select "Next."
5. Enter your personal information.

Dental Coverage

Vision Coverage

Blue View Vision will be the vision provider for all LAwell members starting January 1, 2024. The new plan provides the same benefits and network as the current (plan year 2023) vision plan. You and your eligible dependents will receive a new vision coverage ID card in the mail.

Highlights

- The **Blue View Vision network** has over 42,000 providers, but you can visit a vision care provider who does not participate in the Blue View Vision network. Read this page for more about the Blue View Vision network and out-of-network providers.
- Your total vision insurance plan costs include the **premium** (the monthly amount paid to the insurance company for your coverage) and **out-of-pocket costs** (copays) when you seek care. See page 23 for vision plan costs.
- Your benefits through Blue View Vision, including exams, frames, and either eyeglass lenses or contact lenses, are available to you and your covered dependents **once every 12 months**. See page 24 for details.

Vision Coverage Levels

Enrollment in vision coverage is automatic:

- Employees and their eligible dependents enrolled in **LAwell** medical coverage will automatically be enrolled in the vision plan.

Dual Vision Coverage

Dual coverage is not allowed within the **LAwell** plan, meaning two City employees cannot cover each other as dependents.

Dual vision coverage is permitted with outside, non-**LAwell** plans under certain circumstances. For more information about using dual vision benefits, contact the Blue View Vision Customer Care Center at **877-635-6403**.

Vision Plan Costs

2024 COBRA MONTHLY COSTS	
	Blue View Vision
Employee or Individual	$9.26
Employee & Spouse/DP	$9.26
Employee or Spouse/DP and Child(ren)	$9.26
Employee & Family	$9.26

The Blue View Vision Network

Blue View Vision provides care through a network of vision care specialists who have agreed to offer covered services at discounted rates. The Blue View Vision network has over 42,000 providers, at over 32,000 locations including independent providers plus national retail chains such as LensCrafters®, Target Optical®, and most Pearle Vision® locations.

To access benefits, just provide your name and date of birth to an in-network Blue View Vision PLUS provider. ID cards are not needed, but you can print an ID card by visiting LAwellvision.org

Network Providers

To find a network provider near you:

- Visit LAwellvision.org and click the “Find Care” button.
- Download the Sydney Health mobile app (available in the App Store and Google Play).
- Call the Blue View Vision Customer Care Center at **877-635-6403**.

Out-of-Network Providers

You can visit a vision care provider who does not participate in the Blue View Vision network and still receive benefits for covered services. You will be reimbursed up to a maximum dollar amount if you provide Blue View Vision with an itemized receipt and a completed claim form. Claim forms are available at LAwellvision.org or by calling the Blue View Vision Customer Care Center at **877-635-6403**.

Annual Benefit Details

The benefits through Blue View Vision including exams, frames, and either lenses or contacts, are available to you and your covered dependents **once every 12 months**.

Your Blue View Vision Plan Benefits	In-Network	Out-of-Network	Frequency
Routine Eye Exam			
A comprehensive eye examination	$10 copay	Up to $45 reimbursement	Once every 12 months
A comprehensive eye examination at a PLUS Provider	$0 copay	Not Covered	
Eyeglass Frames			
One pair of eyeglass frames	$150 allowance, then 20% off any remaining balance	Up to $104 reimbursement	Once every 12 months
One pair of eyeglass frames at a PLUS Provider	$200 allowance, then 20% off any remaining balance	Not Covered	
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses:			
Single vision lenses	$10 copay	Up to $35 reimbursement	Once every 12 months
Bifocal lenses	$10 copay	Up to $70 reimbursement	
Trifocal lenses	$10 copay	Up to $65 reimbursement	
Lenticular lenses	$10 copay	Up to $65 reimbursement	
Eyeglass Lens Enhancements When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.			
Transitions Lenses (for a child under age 19)	$0 copay	Not Covered	Same as covered eyeglass lenses
Standard polycarbonate (for a child under age 19)	$0 copay	Up to $28 reimbursement	
Factory scratch coating	$0 copay	Not Covered	
Retinal imaging (obtained during covered eye exam)	$10 copay	Up to $21 reimbursement	
Contact Lenses *(instead of eyeglass lenses)* Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.			
Elective conventional (non-disposable)	$150 allowance, then 15% off any remaining balance	Up to $120 reimbursement	Once every 12 months
OR			
Elective disposable	$150 allowance (no additional discount)	Up to $120 reimbursement	
OR			
Non-elective (medically necessary)	Covered in full	Up to $210 reimbursement	

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

This page is intended to be a summary only, for additional benefits covered by the plan, please review plan information at LAwellvision.org

Eyeglasses & Contacts Benefit

Your benefits through Blue View Vision include either eyeglass lenses or contact lenses every 12 months. You may select one of the two options below.

Annual Benefit to Purchase Eyeglasses & Contacts		
	Covered	**Not Covered**
Option 1	$150 contact lens allowance + $150 frame allowance	Eyeglass lenses
Option 2	Eyeglass lens copay benefit options + $150 frame allowance	Contact lenses

Retinal Imaging Benefit

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.

Managing Your Blue View Vision Online Account

You can go online to locate an in-network provider, check claim status, view benefit coverage details, download an ID card, and check your service level eligibility (such as your $150 allowance). You can also view special offers and additional resources.

Here's how to register online:

1. Visit LAwellvision.org.
2. Select "Login & Register Now."
3. Follow the registration steps and provide all required personal information.

Preventive Care

Your **LAwell** vision benefits offer no-cost or low-cost preventive care services. For more information on accessing preventive care services, visit **keepingLAwell.com** or call your vision care provider.

How Blue View Vision 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 Blue View Vision for reimbursement as an out-of-network provider. Members may also visit a Blue View Vision in-network provider using their medical plan provider prescription and purchase eyewear using their Blue View Vision materials benefit.

The table below outlines how your Blue View Vision benefit can be used with your medical plan. Note that allowances may vary per specific benefit, based on the type of benefit item purchased, and do not apply to all benefits.

Description	Blue View Vision	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) Additional allowance for PLUS Providers, see page 35.	Not covered (Partial reimbursement available from Blue View Vision if member files an out-of-network claim.)	
Medical Eye Exams (e.g., screening for medical vision conditions like glaucoma and cataracts)	Check with Blue View Vision 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 and cataracts)	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.

Learn More

For more information about Blue View Vision:

- Visit LAwellvision.org.
- Call the Blue View Vision Customer Care Center at **877-635-6403**.
- Visit keepingLAwell.com for plan information and the Certificate of Insurance document, or call **833-4LA-WELL.**

Important Legal Notices

The included legal notices apply to plan year 2024 and are valid as of the date of print. Any changes to this legal notices section made after the date of print will be distributed separately and be made available online at keepingLAwell.com.

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 35.

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 (Kaiser Foundation Health Plan, Inc. and any contracted provider) 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 (except for Small Claims Court cases and any other claim that cannot be subject to binding arbitration under governing 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

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided for by the **LAwell** medical plan in which you may be enrolled. For questions about mastectomy-related benefits, contact your medical plan (see your ID card).

About Hospital Stays for Mothers and Newborns

Medical plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section (C-section). However, federal law generally does not prohibit the plan from paying for a

shorter stay when the mother's or newborn's attending provider, after consulting with the mother, discharges 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 health care 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 health care information.

The **LAwell** privacy notice explains your rights and the plan's 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 plan's 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. For children, you may designate a pediatrician as the primary care provider. 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 health care 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 Anthem 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. For children, you may designate a pediatrician as the primary care 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 medical plan.

LAwell Plan Document

This enrollment guide is published by the City of Los Angeles Personnel Department. It provides only highlights of the **LAwell** program, and supplements the program rules identified in the **LAwell** Plan Document. This guide does not change the terms of your benefits or the official documents that control them. Copies of the **LAwell** Plan Document and official benefit documents are available at **keepingLAwell.com**.

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **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 January 31, 2023. 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:
https://health.alaska.gov/dpa/Pages/default.aspx

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

CALIFORNIA — Medicaid
Website: Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: **hipp@dhcs.ca.gov**

COLORADO – Health First Colorado
Health First Colorado Website: **www.healthfirstcolorado.com/**
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: **https://hcpf.colorado.gov/child-health-plan-plus**
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: 678-564-1162, Press 1
GA CHIPRA Website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**
Phone: (678) 564-1162, Press 2

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: **https://www.in.gov/medicaid/**
Phone 1-800-457-4584

IOWA – Medicaid and CPHP (Hawki)
Medicaid Website: **https://dhs.iowa.gov/ime/members**
Medicaid Phone: 1-800-338-8366
Hawki Website: **http://dhs.iowa.gov/Hawki**
Hawki Phone: 1-800-257-8563
HIPP Website: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: **https://www.kancare.ks.gov/**
Phone: 1-800-792-4884
HIPP Phone: 1-800-766-9012

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx**
Phone: 1-855-459-6328
Email: **KIHIPP.PROGRAM@ky.gov**
KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx**
Phone: 1-877-524-4718
Kentucky Medicaid Website: **https://chfs.ky.gov**

LOUISIANA – Medicaid
Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp**
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: **https://www.mymaineconnection.gov/benefits/s/?language=e n_US**
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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

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

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
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: 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 or http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, 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: dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp
Medicaid/CHIP Phone: 1-800-432-5924

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

WEST VIRGINIA – Medicaid
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
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 dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx.

Other California Premium Assistance Resources:

- Medi-Cal Website: dhcs.ca.gov
- Medi-Cal Phone: **800-541-5555**
- CHIP Website: https://www.insurekidsnow.gov/coverage/ca/index.html
- CHIP Phone: **877-KIDS-NOW** (**877-543-7669**)

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 (expires 1/31/2026)

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.

California Healthcare Mandate (CHM)

Under the CHM, everyone is required to have medical coverage or pay a tax penalty; some exemptions apply. This is called the personal healthcare mandate. If you enroll in LAwell medical benefits, you meet the personal healthcare mandate. If you plan to enroll in coverage through another plan, it's a good idea to confirm that other coverage meets CHM requirements for the personal healthcare mandate.

To learn more, visit **www.ftb.ca.gov/about-ftb/newsroom**.

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. Above is 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. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, **Children's Health Insurance Program (CHIP)**, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." 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 copays), 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 **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 **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 continuation 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 may affect the right to extend the period of continuation coverage.

Disability

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. 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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event 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 may 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 qualified beneficiary 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

The month after your employment ends; or The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit **https://www.medicare.gov/medicare-and-you**.

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 **HealthCare.gov** or **CoveredCA.com**.

CalCOBRA Coverage for Medical Benefits Only

In certain circumstances, a COBRA qualified beneficiary may continue coverage under Cal-COBRA after federal COBRA coverage is exhausted. You are not eligible for Cal-COBRA 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 Cal-COBRA 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 Cal-COBRA coverage you elect. For more information on Cal-COBRA, 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 of Benefits and Coverage (SBC)

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, 8:00 a.m. to 5:00 p.m.

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 an SSN: **http://www.socialsecurity.gov/online/ss-5.pdf**. Applying for a social security number is FREE.

The SSN will also be used to help fulfill mandatory reporting requirements to the Centers for Medicare and Medicaid (CMS) for the purposes of permitting Medicare to coordinate benefits for individuals enrolled in both an employer-sponsored medical plan and Medicare.

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 the Benefits Service Center at **833-4LA-WELL**, Monday – Friday, 8:00 a.m. to 5:00 p.m.

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 2024

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 can 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 in 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.
- Reimbursements of Medicare Part B premiums for actively employed members are subject to the provisions of the Los Angeles Administrative Code and the policies of the **LAwell** Program.

Important Notice from the 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 the 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 HMO (LA & Orange Counties), Anthem Narrow Network (Select HMO), Anthem Full Network (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 and is 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 15 to December 7.

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 copays;
- 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 midyear 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 19 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 the 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 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 Medicare at **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 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).

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Kaiser Permanente and Anthem Blue Cross. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims, and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact **the Plan Administrator** for more details.

No Surprises Act Notice

Our medical plans are subject to the No Surprises Act, which limits the amount covered persons may have to pay for certain out-of-network surprise medical bills. More information about surprise billing requirements included under the No Surprises Act and similar state laws, can be found on the medical insurance company's website or the Plan Sponsor's website. Additional information may be found in your Explanation of Benefits for any affected claims.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

- **Emergency services:** If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- **Certain services at an in-network hospital or ambulatory surgical center:** When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, the federal phone number for information and complaints is 1-800-985-3059.

Visit cms.gov/nosurprises/consumers for more information about your rights under federal law.

Important Websites and Phone Numbers

Employee Benefits Division

keepingLAwell.com

per.empbenefits@lacity.org

213-978-1655
Phone hours:
Monday – Friday,
8:00 a.m. to 4:00 p.m.

City Hall office hours: Visit keepingLAwell.com/contacts for availability.

Health Plan Member Advocates

Anthem: Monday – Friday
8:00 a.m. to 4:00 p.m.

213-200-2987
Lorena.Gomez@anthem.com

Kaiser: Tuesday – Thursday
8:00 a.m. to 4:00 p.m.

323-219-6704
LACity.Advocate@kp.org

LAwell Program Benefit	Pages	Website	Phone Number
Anthem PPO **Anthem HMO (Narrow & Full)** **Anthem Vivity**	12 – 27	anthem.com/ca/cityofla	Anthem PPO: **833-597-2362** Anthem HMO (Narrow & Full): **844-348-6111** Anthem Vivity: **844-348-6110**
Kaiser Permanente HMO		my.kp.org/ca/cityofla	**800-464-4000**
Delta Dental PPO or Preventive Only	28 – 33	deltadentalins.com	**800-765-6003**
DeltaCare USA DHMO		deltadentalins.com	**800-422-4234**
Blue View Vision Care	34 – 37	LAwellvision.org	**877-635-6403**

*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 this 2024 LAwell Enrollment 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.*