OPEN ENROLLMENT 2017
OCTOBER 1–31, 2016

CHOOSE well

KEEPING **LAwell**

City of Los Angeles Employee Benefits

> HEALTH > DENTAL
> VISION > LIFE
> DISABILITY > EAP
> TAX-SAVINGS ACCOUNTS

Why Should You **CHOOSEwell**?

Your benefit choices are important to supporting the health and wellbeing of you and your dependents. Open Enrollment benefit elections will be in effect for all of 2017 unless you experience a qualifying life event. Choose wisely, and **CHOOSEwell!**

For complete details about these benefits, please visit

keepingLAwell.com

Your Enrollment Checklist

1. **Review your annual personal enrollment fact sheet.** If your personal/address information is incorrect, contact your department's personnel section to make updates.
2. **Review your options and coverage costs** in this **CHOOSEwell Guide** and at **keepingLAwell.com**.
3. **Review your dependent information and eligibility** rules to verify current dependents, add new dependents, or remove ineligible dependents.
4. **Document your dependents** by **December 12, 2016**; adding a dependent does not entitle that individual to coverage unless the City receives the appropriate documentation of eligibility.
5. **Provide Social Security numbers or Taxpayer Identification Numbers** for your dependents, if you have not already done so, by calling **800-778-2133**. (This is for federal tax reporting purposes).
6. **Review** the **Eligibility, Making Changes & Supplemental Plan Information Guide** to understand plan rules and successfully manage your benefits over time.
7. **Make your 2017 enrollment elections!** Go to **keepingLAwell.com** or call **800-778-2133** to make elections.
8. **Review your confirmation statement** when you receive it in early November.

What's Inside?

Health Coverage

YOUR HEALTH PLAN CHOICES

- **Kaiser Permanente HMO Plan**
- **Anthem Narrow Network (Select HMO)**
- **Anthem Full Network (CACare HMO)** *(not available to MOUs 22, 23, and 24)*
- **Anthem PPO**
- **NEW! Anthem Vivity (LA & Orange Counties)**

You can also decline health coverage – and receive a payment each pay period called Cash-in-Lieu – if you have coverage through your spouse's or domestic partner's employer or a second employer, or if you have retiree health coverage from a former employer. See "Cash-in-Lieu of Health or Dental Benefits" on page 41 for details.

THE AFFORDABLE CARE ACT (ACA)

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

ENROLLMENT ELECTIONS & DEFAULTS

- Open Enrollment is your only opportunity to make coverage elections for yourself and your dependents for 2017 (unless you experience a life event change in 2017).
- Generally, your previously elected 2016 benefit elections will automatically roll over to 2017 unless you make a change during Open Enrollment. **If you are currently enrolled in a Blue Shield plan and do not make an election during Open Enrollment, you will be automatically enrolled in the Anthem equivalent plan.**
- Enrollment in Dependent Care Reimbursement and Healthcare Flexible Spending Accounts does not automatically roll over – if you wish to continue participating or become a new participant in one of these accounts, you will need to elect to do so during Open Enrollment.

UNDERSTANDING HMO AND PPO PLANS

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

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

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

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

About Kaiser HMO

Kaiser Permanente is an HMO Plan. Kaiser operates seven regional HMO entities located in nine states. Kaiser Southern California is one of those entities and includes over 4 million members. Members may access Kaiser services through Permanente Medical Groups and Kaiser Foundation Hospitals located throughout the Southern California region. Kaiser members are not required to designate Primary Care Physicians to seek services but are encouraged to do so. Kaiser has an integrated medical recordkeeping system so that member records can be accessed by medical professionals throughout the organization as members seek services.

About Anthem Full Network

Anthem's Full Network is an HMO Plan. The Full Network provides a broad network of physicians, hospital and medical service providers throughout the State of California. Anthem Full Network members must designate and work through a Primary Care Physician when seeking services. Medical records are not integrated among Full Network service providers.

About Anthem Narrow Network

Anthem's Narrow Network is an HMO Plan. The Narrow Network provides a smaller, select group of physicians, hospitals and other medical service providers throughout the State of California. Anthem Narrow Network members must designate and work through a Primary Care Physician when seeking services. Medical records are not integrated among Full Network service providers.

About Anthem Vivity

Anthem's Vivity is an HMO Plan. Vivity is a regional network of seven major hospital systems including physicians, hospitals and medical service providers offering services in Los Angeles and Orange Counties. Anthem Vivity members must designate and work through a Primary Care Physician when seeking services. When you want care from a specialist in another Vivity medical group, your PCP can refer you to that group. The chart on page 6 provides further details regarding Anthem Vivity hospital systems, locations, and medical group affiliations.

About Anthem PPO

Anthem's PPO Plan includes a national network of physicians, hospital and medical service providers. Anthem PPO members are not required to designate a Primary Care Physician when seeking services. Anthem PPO members may seek both in-network as well as out-of-network services, but discounts only apply to in-network providers. Medical records are not integrated among in-network PPO service providers.

Open Enrollment is your only opportunity to make coverage elections for yourself and your dependents for 2017 (unless you experience a life event change in 2017).

ONLINE:

Anthem Blue Cross
anthem.com/ca/cityofla

Kaiser Permanente
my.kp.org/ca/cityofla

CALL:

Anthem Blue Cross
844-497-5954

Kaiser Permanente
800-464-4000

For help finding a PCP, you may call the Anthem Blue Cross Member Services Concierge at 844-497-5954 Monday through Friday, 8 a.m. to 8 p.m. or visit anthem.com/ca/cityofla

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

ANTHEM VIVITY HOSPITAL SYSTEMS/MEDICAL GROUPS

Hospital System	Medical Group Affiliations	Hospital Location(s)
Cedars-Sinai	• Cedar-Sinai Health Associates & Medical Group	Los Angeles Marina Del Rey
Good Samaritan	• Good Samaritan Medical Practice • Korean American Medical Group	Downtown Los Angeles
Huntington Memorial	• Vivity Huntington Memorial/ HCP Network	Pasadena
MemorialCare/ UC Irvine	• Edinger Medical Group • Greater Newport Physicians • MemorialCare	**Long Beach:** • Community Hospital • Long Beach Memorial • Miller Children's & Women's Hospital **Fountain Valley:** Orange Coast Memorial
	• Greater Newport Physicians • MemorialCare	**Laguna Hills:** Saddleback Memorial
	• UC Irvine Medical Group • UC Irvine Health Affiliated	**Irvine:** UC Irvine Medical Center
PIH Health	• PIH Health Physicians	Whittier Downey
Torrance Memorial	• Torrance Hospital IPA Medical Group	Torrance
UCLA	• UCLA Medical Group	**Santa Monica** • Santa Monica UCLA Medical Center **Westwood** • Ronald Reagan UCLA Medical Center • Mattel Children's Hospital • Resnick Neuropsychiatric Hospital

FINDING NETWORK PROVIDERS

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

- Go to **anthem.com/ca/cityofla**
- Select **Find a Doctor** and **Search as a Guest**
- Identify your plan type and profile information, as required, then select one of the following plans:
  - **Anthem Narrow Network (Select HMO)**
  - **Anthem Full Network (CACare HMO) – Large Group**
  - **Vivity**
  - **Blue Cross PPO (Prudent Buyer) – Large Group**

For help finding a PCP, you may call the Anthem Blue Cross Member Services Concierge at **844-497-5954** Monday through Friday, 8 a.m. to 8 p.m. or visit **anthem.com/ca/cityofla.**

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

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

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

ABOUT YOUR PRIMARY CARE PHYSICIAN
(HMO PLANS ONLY)

Anthem – Members in an Anthem HMO Plan will choose a Primary Care Physician (PCP) or medical group. You and your family members do not have to enroll with the same PCP or medical group, but a PCP designation is required to see a doctor. For help finding a PCP, you may search online at **anthem.com/ca/cityofla** or call the Anthem Blue Cross Member Services Concierge at **844-497-5954** Monday through Friday, 8 a.m. to 8 p.m.

If you enroll into an Anthem plan for the first time, you and your family will be automatically assigned a PCP. You may call the Anthem Blue Cross Customer Service number on the back of your ID card, or Member Concierge Services at **844-497-5954**, to change your PCP assignment. Anthem members are typically allowed to change their PCP designation no more than once a month.

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

For details on prescription drug coverage, see "Prescription Drug Coverage" on page 12.

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, all the health coverage options available in this guide are available to City of Los Angeles work addresses.

If you select HMO coverage and you reside outside of the Los Angeles City limits, **ensure that you and your dependents are able to receive Primary Care Physician services in or near your area of residence** or that you are capable and willing to travel into the Los Angeles area every time you seek care. To review PCP availability in other areas, review the "Finding Network Providers" section of this guide. (Page 7)

UNDERSTANDING OUT-OF-POCKET COSTS

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

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

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

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

For details on prescription drug coverage, see "Prescription Drug Coverage" on page 12.

CHOOSEwell – A HEALTH COVERAGE COMPARISON

	Anthem Narrow Network (Select HMO)/Anthem Full Network (CACare HMO)	Anthem Vivity (LA & Orange Counties)	Kaiser Permanente HMO
Calendar Year Deductible	$0	$0	$0
Calendar Year Out-of-Pocket Limit	$500/person, $1,500/family	$500/person; $1,500/family	$1,500/person; $3,000/family
Choice of physicians and facilities (hospital, etc.)	Access covered services through the Anthem Blue Cross network of physicians and facilities as directed by your PCP, except for emergencies***	Access covered services through the Anthem Blue Cross network of physicians and facilities as directed by your PCP, except for emergencies***	Access covered services through the Kaiser network of physicians and facilities, except for emergencies
Routine Office Visits	Plan pays 100% after $15 copay/ visit	Plan pays 100% after $15 copay/ visit	Plan pays 100% after $15 copay/ visit
Pediatric Office Visits	Plan pays 100% after $15 copay/ visit up to age 5	Plan pays 100% after $15 copay/ visit up to age 5	Plan pays 100% up to age 5
Preventive Care*	Plan pays 100%	Plan pays 100%	Plan pays 100%
Inpatient Hospitalization	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient Surgery	Plan pays 100%	Plan pays 100%	Plan pays 100% after $15 copay/ procedure
Maternity Care (Office Visits)	Plan pays 100% if preventive. Plan pays 100% after $15 copay/visit if non-preventive.	Plan pays 100% if preventive. Plan pays 100% after $15 copay/visit if non-preventive.	Plan pays 100%
Diagnostic Lab Work and X-rays	Plan pays 100%	Plan pays 100%	Plan pays 100% at a Kaiser facility
Emergency Room Care for True Emergencies (such as severe chest pains or breathing difficulties, severe bleeding, poisoning)	Plan pays 100% after $100 copay/ visit; copay waived if admitted	Plan pays 100% after $100 copay/ visit; copay waived if admitted	Plan pays 100% after $100 copay/ visit; copay waived if admitted
MENTAL HEALTH			
Inpatient**	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient**	Plan pays 100% for facility-based care; 100% after $15 copay/visit for physician visits	Plan pays 100% for facility-based care; 100% after $15 copay/visit for physician visits	Plan pays 100% after $15 copay/ visit for individual visit, $7 copay/visit for group session
CHEMICAL DEPENDENCY TREATMENT			
Inpatient**	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient**	Plan pay s 100% for facility-based care; 100% after $15 copay/visit for physician visits	Plan pays 100% for facility-based care; 100% after $15 copay/visit for physician visits	Plan pays 100% after $15 copay/ visit for individual visit; $5 copay/visit for group session
Hearing Aid Benefit	Plan pays for one hearing aid per ear every 24 months after $15 copay/visit	Plan pays for one hearing aid per ear every 24 months after $15 copay/visit	Plan pays for one device per ear every 36 months; covers all visits for fitting, counseling, adjustment, cleaning and inspection
Prescription Drugs	See “Prescription Drug Coverage” on page 12 for details		

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

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

*** *To find a provider or verify physicians, contact Anthem at* ***844-497-5954.***

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

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

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

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

**** *You or your doctor must contact Anthem for preauthorization and approval at a non-participating provider before a hospital stay or you will be responsible for a penalty of $500.*

Anthem PPO, continued		
	IN-NETWORK	**OUT-OF-NETWORK**
MENTAL HEALTH		
Inpatient**	Plan pays 90% after deductible. Prior authorization is required.****	Plan pays 70% of allowed charges*** after deductible, up to $1,500 per day maximum allowed charge. You are responsible for all charges in excess of $1,500. Prior authorization is required.****
Outpatient**	Plan pays 90% after deductible for facility-based care; 100% after $30 copay/visit for physician office visit	Plan pays 70% of allowed charges*** after deductible, up to $350 per day maximum allowed charge. You are responsible for all charges in excess of $350 for facility based care. For physician office visit, Plan pays 70% of allowed charges.
CHEMICAL DEPENDENCY TREATMENT		
Inpatient**	Plan pays 90% after deductible. Prior authorization is required.****	Plan pays 70% of allowed charges*** after deductible, up to $1,500 per day maximum allowed charges. You are responsible for all charges in excess of $1,500. Prior authorization is required.****
Outpatient**	Plan pays 90% after deductible for facility-based care; 100% after $30 copay/visit for physician office visit	Plan pays 70% of allowed charges*** after deductible, up to $350 per day maximum allowed charges. You are responsible for all charges in excess of $350 for facility based care. Plan pays 70% of allowed charges for physician office visit.
Hearing Aid Benefit	Plan pays 80% after deductible every 24 months for hearing aid and ancillary equipment	

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

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

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

**** *You or your doctor must contact Anthem for preauthorization and approval at a non-participating provider before a hospital stay or you will be responsible for a penalty of $500.*

SUCCESSFULLY MANAGING DEPENDENT COVERAGE

- Not everyone who lives with you is a dependent. Check the eligibility rules listed in the **Eligibility, Making Changes & Supplemental Plan Information Guide** before you enroll.
- **Document any added dependents** (e.g., birth certificates, marriage license, etc.) by **December 12, 2016**; adding a dependent does not entitle that individual to coverage unless the City receives the appropriate documentation of eligibility.
- To **add a new dependent** during the year you must do so within 30 days of the date he or she becomes your eligible dependent. If you do not act in a timely manner, you will not be able to enroll that dependent until the following year.
- To **remove an ineligible dependent** during the year you must do so within 30 days of the date he or she no longer meets the City's eligibility requirements. If you do not act in a timely manner, you may be subject to paying the cost of dependent coverage for periods of ineligibility. See pages 2–9 of the **Eligibility, Making Changes & Supplemental Plan Information Guide** for more information.

WHAT IS A DRUG FORMULARY?

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

PRESCRIPTION DRUG COVERAGE

Participating Pharmacy

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

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

Your copayment when you enroll is:

	Anthem Plans	Kaiser Permanente HMO
PHARMACY		
Generic Copay	$10 for up to 30-day supply	$10 for up to 30-day supply
Brand-name Copay	**Formulary Drug:** $20 for up to 30-day supply **Non-Formulary** Drug: $40 for up to 30-day supply	$20 for up to 30-day supply
MAIL ORDER		
Generic Copay	$20 for up to 90-day supply	$20 for up to 100-day supply
Brand-name Copay	**Formulary Drug:** $40 for up to 90-day supply **Non-Formulary Drug:** $80 for up to 90-day supply	$40 for up to 100-day supply
FOR QUESTIONS		
Pharmacies or Mail Order	**844-497-5954 or anthem.com/ca/cityofla**	**800-464-4000** or **kp.org**

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

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

VISION CARE THROUGH YOUR HEALTH PLAN

Your health plan will no longer cover comprehensive vision care. EyeMed will be the single full-service vision care provider for all City employees starting January 1, 2017. Eye exams are still available under Kaiser or Anthem Blue Cross. See pages 24 and 25 for more details.

CHIROPRACTIC CARE AND ACUPUNCTURE

Anthem – Anthem plans include coverage for chiropractic care and acupuncture, with some limitations on the number of visits covered each year. You can visit any participating chiropractor from the network without a referral from your primary care physician. Simply call a participating provider to schedule an initial exam. Contact Anthem Member Services at **844-497-5954** or go to **anthem.com/ca/cityofla** if you have questions about coverage for chiropractic care and acupuncture.

Kaiser – **Kaiser Permanente HMO** does not cover chiropractic care, but member discounts on these services are available. Physician-referred acupuncture is covered at a $15 per visit copay. For more information, go to **kp.org/healthyroads**.

SPECIAL COVERAGE SITUATIONS

Special health coverage situations include:

- Travel outside of your network and/or outside the U.S.
- Dependents that do not reside with you (e.g. a child attending college away from home).

For additional information on these services, please review the **Eligibility, Making Changes & Supplemental Plan Information Guide**.

Dental Coverage

YOUR DENTAL COVERAGE CHOICES

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

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

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

Delta Dental Preventive Only covers preventive dental care only. It does not cover other services such as fillings, crowns and orthodontia. Those who choose this option receive additional pre-tax **LAwell** dollars of $5.00 per month (or $2.50 per month for regular half-time employees hired after 07/24/89).

Dentists who are not part of Delta's PPO network may still be Delta dentists and agree to accept Delta's reasonable and customary (R&C) fee. In California, 92% of dentists belong to a Delta network.

CHOOSEwell – A DENTAL PLAN COMPARISON

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

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

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

DELTA DENTAL NETWORK PROVIDERS

If you enroll in the DeltaCare USA DHMO option, you must use network providers to receive benefits. With the Preventive Only option and the Delta Dental PPO, you can choose a network or non-network provider each time you need care. Following is general information regarding how using the network relates to each plan option:

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

Finding a Network Provider

You can request a provider directory for the Preventive Only, DeltaCare USA DHMO or PPO option by:

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

HOW TO REGISTER FOR A DELTA ONLINE ACCOUNT

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

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

CHOOSING A PRIMARY CARE DENTIST (PCD)

If you enroll in DeltaCare USA DHMO, you must select a PCD from the DeltaCare USA network to receive benefits. When you enroll yourself or a dependent for the first time, you'll be prompted to select a PCD. During Open Enrollment, you can change your PCD effective January 1, 2017 by going online at keepingLAwell.com or calling the Benefits Service Center. If you want to change your PCD at any other time during the year, call Delta Dental Customer Service at 800-422-4234. Because the DeltaCare USA DHMO option does not cover care that is not coordinated by your PCD, it is important that you do not go to another dentist without first contacting Delta Dental Customer Service.

CHOOSEwell – A DENTAL COVERAGE COMPARISON

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

How Benefits Are Paid	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% of R&C* (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). 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.

How Benefits Are Paid	Preventive Only	DeltaCare USA DHMO	Delta Dental PPO	
			IN-NETWORK	OUT-OF-NETWORK
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				
Crown	Not covered	Your copay is $55–$195 per procedure**	Plan pays 80%	Plan pays 50% of R&C*
Dentures	Not covered	Your copay is $80–$170 per procedure	Plan pays 50%	Plan pays 50% of R&C*
Implants	Not covered	Not covered	Plan pays 50%	Plan pays 50% of R&C*
ORTHODONTIA				
Children under age 19	Not covered	Your copay is $1,000 plus start up fees of $300	Plan pays 50%	Plan pays 50% of R&C*
Children age 19 to age 26	Not covered	Your copay is $1,350 plus start up fees of $300	Plan pays 50%	Plan pays 50% of R&C*
Adults	Not covered	Your copay is $1,350 plus start up fees of $300	Not covered	Not covered
PLAN MAXIMUMS				
Annual maximum benefit (does not include diagnostic and preventive services)	Not applicable	None	$1,500/person***	$1,500/person***
Lifetime orthodontia maximum benefit	Not covered	None	$1,500/child	$1,500/child

** R&C is the reasonable and customary charge – the usual charge for specific services in the geographic area where you are treated.*

*** When there are more than six crowns in the same treatment plan, an enrollee may be charged an additional $100 per crown beyond the sixth unit.*

**** If you use both in-network and out-of-network dentists, your total annual maximum benefit will never be more than $1,500 per person.*

Vision Coverage

YOUR VISION COVERAGE

Beginning in 2017, City employees will receive vision care benefits through a single vision plan, offered through EyeMed, the largest vision network in the United States. This will mean improved coverage on eye exams, glasses and contact lenses. **The City provides this benefit at no cost to you,** and you will be enrolled automatically[1]. Your benefits through EyeMed include exams, frames, and lenses every 12 months.

To access benefits, you just need to provide your name and date of birth. No ID cards are needed, but can be printed on EyeMed.com and will be included in welcome packets mailed to your home.

THE EYEMED NETWORK

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

Out-of-Network Providers

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

[1] *Employees and their dependents covered under a health plan election for 2017 will be automatically enrolled into vision coverage. Employees electing Cash-in-Lieu for 2017 will be automatically enrolled in the Employee-Only level of vision coverage.*

IN- AND OUT-OF-NETWORK VISION BENEFITS

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

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

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

+ Tier levels reflect Name Brand categories.

RETINAL SCREENING EXAMS

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

HOW EYEMED BENEFITS WORK WITH HEALTH PLAN VISION BENEFITS

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

The Employee Assistance Program

The Employee Assistance Program (EAP) is designed to help you manage life challenges and improve your quality of life. The City of Los Angeles EAP is administered by Managed Health Network (MHN). Your EAP program is completely confidential and voluntary.

How It Works

The EAP offers telephone, web-video and face-to-face counseling by licensed providers. You can call the EAP anytime – 24 hours a day, 7 days a week – toll-free at **800-213-5813**. English and Spanish-speaking counselors are available. Any of your household family members can also use the EAP. This includes dependents who are away from home at college.

When you call, an EAP intake specialist will ask questions to assess your needs. You are eligible for five face to face, telephonic, and web-video consultations, per person, per incident, per benefit period at no cost to you. **EAP sessions must be pre-authorized by MHN.**

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

Issues for Which the EAP Provides Help

- Marriage, family and relationship problems, including domestic violence
- Stress and anxiety
- Alcohol and drug dependency
- Depression, grief or loss
- Legal concerns related to family law, divorce, real estate, wills and contracts, estate planning, criminal law, personal injury and consumer law
- Financial and credit issues, including budgeting, saving and pre-retirement planning
- Preparing for a baby's arrival, including special "Baby Kits"
- Child care and elder care assistance, including referrals to providers
- Federal tax consultation and representation related to an audit, late return or other IRS problem
- Referrals for travel, event planning and more
- Issues around identity theft

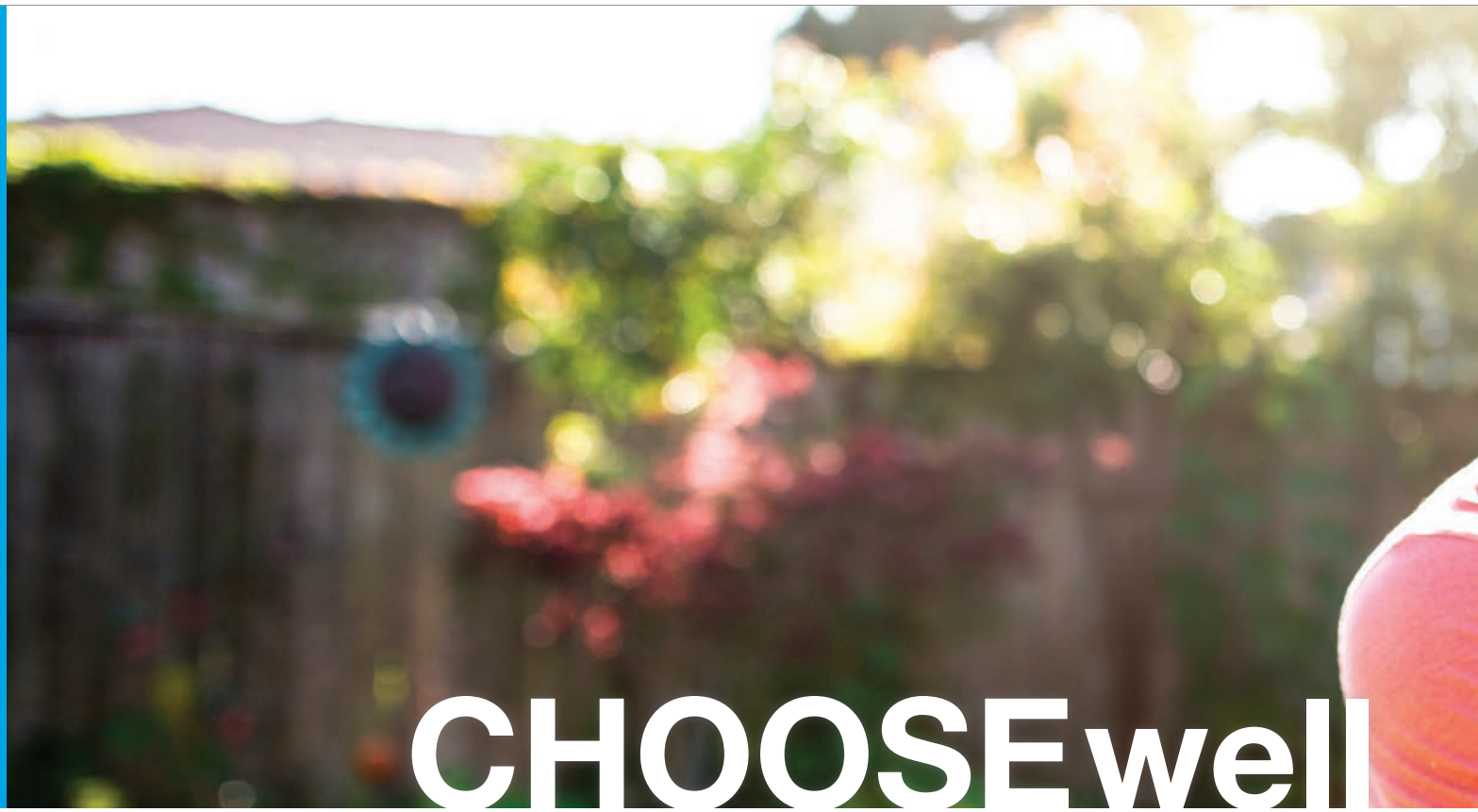
Harbor Department Employees

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

ONLINE RESOURCES

On the web, go to members.mhn.com and type "cityoflosangeles" as the company code. You can:

- **Search for an MHN counselor and get a referral**
- **Ask experts questions**
- **Use self-help programs for stress, depression, anxiety, and more**
- **Use estate planning tools**
- **Search child and elder care databases**



Life, AD&D and Disability Insurance

LIFE INSURANCE

Life insurance offers important financial protection for you and your family. **LAwell** provides basic life insurance at no cost to you and gives you options for supplemental and dependent life insurance.

Here is an overview:

	Amount	Your Cost
Basic Life Insurance for You	$10,000 for full-time employees $5,000 for regular half-time employees hired after July 24, 1989 (see MOU if hired before that date)	None – City paid
Dependent Life Insurance for your spouse or domestic partner See page 32 for details	$10,000, $25,000, $50,000, $75,000 or $100,000	You pay for coverage at group rates
Dependent Life Insurance for your children See page 33 for details	$5,000 per child	You pay for coverage at group rates

ONLINE CALCULATOR

Use the online calculator to help you determine how much insurance you need. From keepingLAwell.com, click on Enroll in Benefits or Make Changes.

Supplemental Life

Your supplemental life insurance amount will be the multiple of annual base pay you choose – one times pay up to five times pay – rounded up to the nearest $1,000. Here is an example for an employee who chooses coverage of four times pay:

Employee's pay	$43,552
multiplied by	× 4
equals	$174,208
	Rounded to $175,000 coverage amount

You buy any supplemental life insurance you choose with pre-tax dollars from your pay. While supplemental life insurance rates are staying the same for 2017, your cost for coverage may change because of a change in your age or salary. See "Your Monthly Cost for Supplemental Life Insurance" on page 29 for life insurance rates.

EXAMPLE:

An employee is 46 years old and wants supplemental insurance up to $150,000. The employee's cost will be:

$150,000 ÷ $1,000 = $150
$150 x $0.126 = $18.90

Reductions Based on Age

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

PORTABILITY AND CONVERSION

Information about Portability and Conversion of your life insurance can be found on page 13 of the Eligibility, Making Changes & Supplemental Plan Information Guide.

Your Monthly Cost for Supplemental Life Insurance

Here are the 2017 monthly rates for supplemental life insurance for each $1,000 in coverage. The personal fact sheet you receive for enrollment or as a new hire shows your coverage cost.

Age on 9/1/16	Rate per $1,000 of coverage
Under 20	$0.046
20 – 24	$0.046
25 – 29	$0.054
30 – 34	$0.072
35 – 39	$0.082
40 – 44	$0.090
45 – 49	$0.126
50 – 54	$0.198
55 – 59	$0.370
60 – 64	$0.540
65 – 69	$1.101
70 or above	$1.786

About Life Insurance and Imputed Income

Under federal tax law, you are taxed on the value of employer-provided life insurance over $50,000. If this situation occurs, imputed income will be reflected on your paystub and included in your W-2 statement as taxable income. Members should consult their tax advisors for more information. Please also refer to page 14 of the **Eligibility, Making Changes & Supplemental Plan Information Guide** for additional information.

Proof of Good Health

If you choose coverage that requires proof of good health, you will receive an Evidence of Insurability form with the confirmation statement you receive in the mail. You must complete and return this form immediately and it must be approved by the insurance company before your coverage can takes effect. For details on when proof of good health is required, see page 15 of the **Eligibility, Making Changes & Supplemental Plan Information Guide**.

If proof of good health has not been provided by **March 1, 2017** – or within **60 days** of your enrollment as a new hire – for any coverage requiring it, any pending coverage will be removed from your benefits account and the City will send a confirmation statement of this change to you. If the insurance company approves coverage for you after **March 1, 2017** – or after the 60-day period if you enroll as a new hire – your coverage will become effective on the date of approval. The City will not make payroll deductions until the insurance company provides a date of approval. The Evidence of Insurability form is available at **per.lacity.org/bens/docforms.htm**.

YOUR BENEFICIARY

You can name anyone as the beneficiary of your basic and supplemental life insurance. If you have had a recent change in your family status – such as marriage or divorce – you may need to update your beneficiary. Keep in mind that if you have not done so, you should consider naming a beneficiary for the basic life insurance coverage the City provides – even if you do not choose supplemental coverage. It is important to name a beneficiary so benefits can be paid to the person of your choice if you were to die. To name or update your beneficiary information, go to keepingLAwell.com. You can also call the Benefits Service Center at 800-778-2133.

IMPUTED INCOME

For 2017, you may be taxed on the value of life insurance coverage for your dependent(s) above $2,000.

Imputed income depends on the ages of your dependents and will generally apply only if you cover a spouse over age 55 or more than one child.

Dependent Life Insurance

If you choose supplemental life insurance for yourself, you can choose to purchase dependent life insurance coverage for your spouse/domestic partner, your children, or both. You will be the beneficiary for dependent life insurance.

Under California law, the spouse/domestic partner coverage you choose cannot be more than your total life insurance coverage (basic plus supplemental). So, if you want to purchase $50,000 in spouse/domestic partner life insurance, you must have at least $50,000 in **LAwell** life insurance.

- If you are currently enrolled in **LAwell,** you will have to provide proof of good health – or evidence of insurability – for your spouse/domestic partner if you are purchasing spouse/domestic partner life insurance for the first time or increasing coverage during Open Enrollment.
- If you are enrolling for the first time as a new hire within the time shown on your personal fact sheet, proof of good health is not required for spouse/domestic partner life insurance. During future enrollments, proof of good health will be required to enroll in spouse/domestic partner life insurance for the first time or to increase coverage.
- For coverage changes during the year because of a family life event, proof of good health is required for spouse/domestic partner insurance – unless you are adding a spouse/domestic partner within 30 calendar days of marriage or beginning a domestic partner relationship.

DEPENDENT LIFE INSURANCE COVERAGE LIMITS

Dependent life insurance coverage for your spouse/domestic partner cannot be more than your total life insurance coverage (basic and supplemental). If your life insurance coverage is reduced based on your age, coverage for your spouse/domestic partner will be reduced.

If you choose coverage that requires proof of good health, you'll receive an Evidence of Insurability form with the confirmation statement you receive in the mail. When you receive the form, you must complete and return it. This form must be approved by the insurance company before your coverage change takes effect. You can also download the form from **per.lacity.org/bens/docforms.htm**.

For your spouse/domestic partner	For your children
A choice of: • $10,000 • $25,000 • $50,000 • $75,000 • $100,000	• $5,000 per child • A newborn dependent child becomes eligible for life insurance at birth. Children are eligible up to age 26.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Accidental Death and Dismemberment (AD&D) Insurance is available at an additional cost to you. AD&D insurance pays a benefit to you if you suffer a covered loss or to your beneficiary if you die in an accident. **LAwell** gives you a choice of AD&D insurance for yourself only, or for you and your family.

If you want coverage for yourself, you can choose any amount between $50,000 and $500,000, in multiples of $50,000. AD&D pays a percentage of your total coverage amount for injuries, depending on the type of injury. For your accidental death, AD&D pays 100% of your coverage amount, plus an additional $3,000 – up to a maximum of $503,000.

The AD&D insurance certificate of coverage is available online at **per.lacity.org/bens/docforms.htm** or from the Employee Benefits Division. It provides a detailed list of covered losses, benefit amounts and additional features.

If you cover yourself, you can also cover your family. Coverage amounts for your family members will depend on the amount of coverage you choose for yourself and on your family make-up. If you choose family coverage, you will be covering all **LAwell**-eligible persons in your family, not just those who are covered as dependents under your benefits.

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

From age 65 to 69, your AD&D coverage will be reduced to 65% of your selected coverage amount. At age 70, your AD&D coverage will be reduced to 35% of your selected coverage amount.

If your coverage or your employment with the City ends, you have the option to continue AD&D coverage. To select this portability continuation coverage, you have 60 days from the date your employment ends to complete a form available online at **per.lacity.org/bens/docforms.htm** or from the Employee Benefits Division and submit it to Standard Insurance Company.

BENEFITS FOR YOUR SPOUSE AND CHILDREN

If you die by accidental means due to either an on-the-job accident or a non-occupational accident, your AD&D insurance provides special benefits to your family in addition to your coverage amount. These may include education benefits for your spouse and child and childcare benefits in some cases. For more information, contact Standard Insurance Company at 800-524-0450.

BENEFICIARY FOR AD&D INSURANCE

- **Your beneficiary for AD&D will be the same as your life insurance beneficiary.**
- **You will automatically be the beneficiary of any family AD&D insurance you choose.**
- **To name or update your beneficiary, go to keepingLAwell.com. You can also call the Benefits Service Center.**

DISABILITY COVERAGE

Basic and Supplemental Disability Coverage

Disability coverage provides replacement income to you in the event of a qualified disability. Basic disability coverage is provided at no cost to you. Additional supplemental coverage can be purchased. Supplemental coverage pays a higher monthly benefit than basic coverage, and pays beyond the 24-month limit (short-term and long-term disability combined) if you remain disabled. While rates for supplemental disability coverage are not changing, your cost may increase because of your age and your annual salary at the time that enrollment costs are calculated.

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

	Benefit	When Benefits Begin	How Long Benefits Last	Cost to You
Basic short term disability coverage	50% of the first $1,462 of your weekly pre-disability earnings (up to $731 per week)*	When 100% and 75% sick leave is completely used and you apply for benefits and are approved	180 days or the date long term disability benefits become payable to you, whichever occurs first	$0
Supplemental short term disability coverage	66 2/3% of the first $4,157 of your weekly pre-disability earnings (up to $2,771 per week)*	When 100% and 75% sick leave is completely used and you apply for benefits and are approved	180 days or the date long term disability benefits become payable to you, whichever occurs first	Varies (refer to your personal enrollment worksheet)
Basic long term disability coverage	50% of the first $6,332 of your pre-disability earnings*	180 days, plus the period for which you receive 100% or 75% sick leave pay under the Employer's sick leave plan	Determined by your age when disability begins, up to 1 year and 6 months if age 67 or younger at onset of disability	$0
Supplemental long term disability coverage	66 2/3% of the first $18,000 of your pre-disability earnings*	180 days, plus the period for which you receive 100% or 75% sick leave pay under the Employer's sick leave plan	Determined by your age when Disability begins, up to the longer of 1) until age 65 or 2) 3 years and 6 months, if age 61 or younger at onset of disability**	Varies (refer to your personal enrollment worksheet)

** Benefits may be reduced by income you receive from other sources.*

*** LTD benefits last up to 18 months during your entire lifetime for disabilities related to a mental disorder, alcohol use, alcoholism or drug use or drug addiction.*

Definition of Disability

For short-term disability (STD) benefits – your first 180 days of disability after exhausting 100% and 75% sick leave – you are disabled if:

- You are unable to perform with reasonable continuity the material duties of your own occupation because of sickness, injury or pregnancy, or
- You are working and unable to earn more than 80% of your pre-disability earnings because of sickness, injury or pregnancy.

For long-term disability (LTD) benefits – the benefits you receive after you have exhausted all sick leave and been disabled for 180 days beyond the exhaustion of your 100% and 75% sick leave – you are disabled if because of physical disease, injury, pregnancy or mental disorder:

- For the first 24 months of LTD benefits:
  - You are unable to perform with reasonable continuity the material duties of your own occupation, or

  - You are working in your own occupation and unable to earn at least 80% of your pre-disability earnings.
- After 24 months:
  - You are unable to perform with reasonable continuity the substantial and material acts of any gainful occupation for which you are reasonably fitted due to physical disease, injury, pregnancy or mental disorder.

For more details, see your Certificate of Insurance, available from the Employee Benefits Division or online at **per.lacity.org/bens/docforms.htm**.

Proof of Good Health

If you are currently enrolled in **LAwell** and are choosing supplemental disability coverage for the first time during Open Enrollment, you will have to provide proof of good health to become insured. Proof of good health is not required if you are enrolling for the first time as a new hire within the time shown on your personal fact sheet, but it will be required to enroll in disability coverage for the first time during future enrollments. For coverage changes during the year because of an eligible family life event, proof of good health is not required.

To provide proof of good health, you will receive a Medical History Statement after enrollment. This Medical History Statement is also available online at **per.lacity.org/bens/docforms.htm**. Your completed form must be approved by the insurance company before your coverage takes effect. If any required proof of good health has not been provided by **March 1, 2017** – or within 60 days of your enrollment as a new hire – any pending coverage will be removed from your benefits account, and the City will send a confirmation statement of this change to you. If Standard Insurance Company approves coverage for you after **March 1, 2017** – or after the 60-day period if you enroll as a new hire – your coverage will become effective on the date of approval. The City will not make payroll deductions and your supplemental coverage will not become effective until the insurance company provides a date of approval.

For more information regarding STD and LTD benefits, please review pages 13–18 of the Eligibility, Making Changes & Supplemental Plan Information Guide.

Health and Dependent Care Tax-Savings Accounts

TYPES OF ACCOUNTS

The City offers accounts for tax savings on eligible expenses:

- A **Healthcare Flexible Spending Account** for eligible healthcare expenses
- A **Dependent Care Reimbursement Account** for dependent day care expenses

When You Can Enroll

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

How the Accounts are Different

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

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

ADMINISTRATIVE FEE

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

Information about Commuter Spending Accounts can be found in the Wellness, Retirement & Commuter Benefits Guide, pages 5–6.

ABOUT THE HEALTHCARE FLEXIBLE SPENDING ACCOUNT

Use the Healthcare Flexible Spending Account to pay for eligible healthcare expenses that are not covered by any medical, dental, or vision coverage.

How Much You Can Set Aside

You can set aside from $300 up to $2,550 (maximum amounts subject to Federal law revision) annually in a Healthcare Flexible Spending Account. Your contributions are deducted from your paycheck each pay period.

Examples of Eligible and Ineligible Expenses

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

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

About Eligible Dependents

IRS rules determine who is an eligible dependent. You may use a Healthcare Flexible Spending Account for healthcare expenses of:

- Your spouse and any child you claim as a dependent on your tax return.
- Anyone who is your "health plan tax dependent" as defined by the IRS.

Filing Claims

Generally, you pay eligible healthcare expenses out of your pocket first, then file a claim with documentation of your expenses in order to be reimbursed from your account. You may be reimbursed the full amount of your claim (including tax) when you file a claim for an eligible expense, up to the amount you have chosen to put into your account. This applies even if your account does not yet have enough in it to cover the expense. However, you will be reimbursed only for expenses you or an eligible family member have while you are contributing to the account.

As long as you file claims regularly, you can receive reimbursement promptly. Generally, you receive a reimbursement check within two weeks for a paper claim or one to two days for an

DEBIT CARD

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

You will automatically receive a debit card to use for eligible healthcare expenses at any provider or retailer that accepts debit cards.

online claim. For claim forms, go to **per.lacity.org/bens/docforms.htm.** You can submit claims and upload receipts online and pay your provider directly for some services.

Important Deadline and Restrictions

The Healthcare Flexible Spending Account is not a savings account. You can use the money you set aside in 2017 only for eligible expenses you have during the 2017 plan year while you are contributing to the account. If you have unused contributions at the end of the plan year, those contributions will not carry forward and will be forfeited.

Also, if you leave your employment with the City mid-year – including transfers to the Department of Water and Power (DWP) – you can file claims and receive reimbursement only for expenses you had up to your date of termination or transfer, and you will forfeit any additional amount left in your account. You may be able to continue a Healthcare Flexible Spending Account under COBRA if your employment ends, with some limitations.

Estimate Expenses Carefully

It is important to estimate expenses carefully and set aside only the amount you think you will need while you are contributing to the account during 2017. **You must file claims for 2017 expenses by April 30, 2018. If you do not file claims by this deadline, you forfeit any money left in your account.** This is an Internal Revenue Code rule and the **LAwell** program cannot make exceptions.

You may be able to change the amount elected if you have a qualifying family life event (see "When You Can Make Changes" in the **Eligibility, Making Changes & Supplemental Plan Information Guide** on page 5–6 for more on family life events).

ABOUT THE DEPENDENT CARE REIMBURSEMENT ACCOUNT

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

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

See "Domestic Partner Coverage and Pre-Tax Benefits" on page 50 for a definition of "health plan tax dependent."

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

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

DEFINITION

See "Domestic Partner Coverage and Pre-Tax Benefits" on page 46 for a definition of "health plan tax dependent."

ESTIMATING EXPENSES AND TAX SAVINGS

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

LEARN MORE

Go to wageworks.com and savesmartspendhealthy.com to learn more about the benefits of using a Healthcare Flexible Spending Account. Get tips and guidance to help you decide whether to participate in a Healthcare FSA. You can learn how to stretch your budget if you choose to participate.

How Much You Can Set Aside

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

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

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

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

About the Reimbursement Account and Taxes

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

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

- You are eligible for the Earned Income Tax Credit. You are eligible for the credit if you have less than $3,400 in investment income and your income (or the income of you and your spouse, if you are married filing jointly) is less than the amount set forth for 2017 in the following table depending on your number of children:

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

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

Dollar amounts are based on federal tax law effective for 2017 federal income taxes. These are just guidelines and do not take into account state taxes.

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

Filing Claims

Generally, you pay eligible dependent care expenses out of your pocket first – then file a claim to be reimbursed from your account, including documentation of your expenses described on the claim form.

You may be reimbursed up to the amount in your account at the time of the claim. Any unpaid claims will remain in "pending" status and will be reimbursed as you make additional contributions to your account through payroll deduction.

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

Important Deadlines and Restrictions

The Dependent Care Reimbursement Account is not a savings account. You can use the money you set aside in 2017 only for eligible expenses you have during the 2017 plan year while you are contributing to the account. If you have unused contributions at the end of the plan year, those contributions will not carry forward and will be forfeited.

Also, if you leave your employment with the City mid-year – including transfers to the Department of Water and Power (DWP) – you can file claims and receive reimbursement only for expenses you had up to your date of termination or transfer, and you will forfeit any additional amount left in your account.

Estimate Expenses Carefully

It is important to estimate expenses carefully and set aside only the amount you think you will need while you are contributing to the account during 2017. You must file claims for 2017 expenses by **April 30, 2018**. If you do not file claims by this deadline, you forfeit any money left in your account. This is an IRS rule and the **LAwell** program cannot make exceptions.

You may be able to change the amount elected if you have a family life event (see "When You Can Make Changes" in the **Eligibility, Making Changes & Supplemental Plan Information Guide** on page 5–6 for more on family life events) or if you have a change in day care providers or a change in the cost of day care.

Paying for Coverage

PAYING FOR COVERAGE BENEFIT OPTIONS

Cash-in-Lieu of Health or Dental Benefits

For health and dental coverage, the City pays a part or all of the cost of coverage depending on the option and level of coverage you choose.

You are eligible to opt out of health and/or dental coverage under certain circumstances and receive a cash benefit in lieu of the coverage as follows:

Cash-In-Lieu Benefits		
	If you decline health coverage with required proof of other coverage and choose Cash-in-Lieu	If you choose employee-only dental coverage under the Preventive Only option
If you are a full-time employee	$50 per pay period	$2.50 per pay period
If you are a regular half-time employee hired after July 24, 1989*	$25 per pay period	$1.25 per pay period
Cash-in-lieu benefits are paid up to a maximum of 24 pay periods in a calendar year.		

** If you are a regular half-time employee hired after July 24, 1989, please see your MOU's Benefits Section for details on your **LAwell** options and the amount of **LAwell** dollars available to you.*

If you take Cash-in-Lieu and your spouse/domestic partner later loses health coverage through his or her employer, this constitutes a family life event. You may enroll yourself and any eligible dependents in **LAwell** coverage within 30 calendar days after you lose other coverage. See "When You Can Make Changes" in the **Eligibility, Making Changes & Supplemental Plan Information Guide** on page 5–6.

TO SELECT CASH-IN-LIEU...

You must have the option to enroll in health coverage as a dependent through your spouse's or domestic partner's employer. You may also be eligible for Cash-in-Lieu if you have retiree health coverage from a former employer, if you have health coverage through a second employer or if you are enrolled in Medicare when you become eligible for LAwell. Contact the Employee Benefits Division at 213-978-1655 if you have questions.

LAwell CREDITS

Some MOUs provide for LAwell credits based upon negotiations. LAwell credits are additional dollars you can use for pre-tax benefits or take as taxable cash in your paycheck. Please refer to your MOU for specifics.

Selecting Cash-in-Lieu

If you select Cash-in-Lieu for the first time during Open Enrollment or as a new hire, you must complete and return the Cash-in-Lieu affidavit you receive with your confirmation statement by the following deadlines:

- By **December 12, 2016** if you select Cash-in-Lieu during Open Enrollment. If your Cash-in-Lieu affidavit is received after the deadline, you will not receive payments for any pay periods missed.
- Within **60 days** of the date on your confirmation statement if you enroll as a new hire. If you do not return the affidavit, Cash-in-Lieu will be canceled effective the 61st day.

If you were enrolled in Cash-in-Lieu for 2016 and do not make an election for 2017, you are not required to resubmit another Cash-in-Lieu affidavit.

HEALTH COVERAGE COSTS

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

The amount of premium you are responsible for depends on your employment status (full-time or half-time), the MOU that applies to you, the number of dependents (if any) covered, and the specific plan you choose.

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

PRE-TAX DOLLARS... A SAVINGS ADVANTAGE

State and federal income taxes are not withheld from those pre-tax dollars when you purchase additional pre-tax benefits with money from your paycheck.

LAwell PLAN HEALTH COSTS

The City has two contribution structures for its health plans:

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

LAwell Pay Plan: Pays up to the City's maximum subsidy with additional premium cost-sharing of 10%. Covered MOUs include 00, 01, 19, 20, 21, 26, 27, 28, 29, 30, 31, 32, 38, 39, 40, 61 and 63.

The City's **maximum subsidy** is an amount equal to the Kaiser Permanente HMO family premium ($1,560.64 per month) for full-time employees and the Kaiser Permanente HMO employee-only rate ($600.28 per month) for half-time employees, subject to any premium sharing requirements as provided for by the employee's MOU.

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

LAwell DENTAL COSTS

The City offers one contribution structure for its dental plans. Page 46 shows 2017 dental coverage costs for these plans.

YOUR 2017 COSTS PER PAY PERIOD

LAwell PLAN

2017 Costs Per Pay Period (Every Two Weeks)

	Full-Time Employees (MOUs 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 34, 36 and 37)		Half-Time Employees (MOUs 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 34, 36 and 37)		
Coverage Level	City Pays…	Employee Pays…	City Pays…	Employee Pays…	Total Cost of Coverage Bi-Weekly
Kaiser HMO					
Employee Only	$300.14	$0.00	$300.14	$0.00	$300.14
Employee & Spouse/DP	$660.24	$0.00	$300.14	$360.10	$660.24
Employee + Child(ren)	$600.27	$0.00	$300.14	$300.13	$600.27
Family	$780.32	$0.00	$300.14	$480.18	$780.32
Anthem Narrow Network (Select HMO)					
Employee Only	$283.02	$0.00	$283.02	$0.00	$283.02
Employee + Spouse/DP	$622.65	$0.00	$300.14	$322.51	$622.65
Employee + Child(ren)	$537.75	$0.00	$300.14	$237.61	$537.75
Family	$735.86	$0.00	$300.14	$435.72	$735.86
Anthem Full Network (CACare HMO) (Not available to MOUs 22, 23, or 24)					
Employee Only	$283.02	$116.62	$283.02	$116.62	$399.64
Employee + Spouse/DP	$622.65	$256.55	$300.14	$579.06	$879.20
Employee + Child(ren)	$537.75	$221.56	$300.14	$459.17	$759.31
Family	$735.86	$303.20	$300.14	$738.92	$1039.06
Anthem Vivity (LA & Orange Counties HMO)					
Employee Only	$280.19	$0.00	$280.19	$0.00	$280.19
Employee + Spouse/DP	$616.43	$0.00	$300.14	$316.29	$616.43
Employee + Child(ren)	$532.37	$0.00	$300.14	$232.23	$532.37
Family	$728.51	$0.00	$300.14	$428.37	$728.51
Anthem PPO					
Employee Only	$434.60	$0.00	$300.14	$134.46	$434.60
Employee + Spouse/DP	$780.32	$175.81	$300.14	$655.99	$956.13
Employee + Child(ren)	$780.32	$45.43	$300.14	$525.61	$825.75
Family	$780.32	$349.65	$300.14	$829.83	$1,129.97

LAwell PAY PLAN

2017 Costs Per Pay Period (Every Two Weeks)

	Full-Time Employees (MOUs 00, 01, 19, 20, 21, 26, 27, 28, 29, 30, 31, 32, 38, 39, 40, 61 and 63)		Half-Time Employees (MOUs 00, 01, 19, 20, 21, 26, 27, 28, 29, 30, 31, 32, 38, 39, 40, 61 and 63)		
Coverage Level	City Pays…	Employee Pays…	City Pays…	Employee Pays…	Total Cost of Coverage Bi-Weekly
Kaiser HMO					
Employee Only	$270.13	$30.01	$270.13	$30.01	$300.14
Employee & Spouse/DP	$594.22	$66.02	$270.13	$390.11	$660.24
Employee + Child(ren)	$540.25	$60.02	$270.13	$330.14	$600.27
Family	$702.29	$78.03	$270.13	$510.19	$780.32
Anthem Narrow Network (Select HMO)					
Employee Only	$254.72	$28.30	$254.72	$28.30	$283.02
Employee + Spouse/DP	$560.39	$62.26	$270.13	$352.52	$622.65
Employee + Child(ren)	$483.98	$53.77	$270.13	$267.62	$537.75
Family	$662.28	$73.58	$270.13	$465.73	$735.86
Anthem Full Network (CACare HMO) (Not available to MOUs 22, 23, or 24)					
Employee Only	$254.72	$144.92	$254.72	$144.92	$399.64
Employee + Spouse/DP	$560.39	$318.81	$270.13	$609.07	$879.20
Employee + Child(ren)	$483.98	$275.33	$270.13	$489.18	$759.31
Family	$662.28	$376.78	$270.13	$768.93	$1039.06
Anthem Vivity (LA & Orange Counties HMO)					
Employee Only	$252.17	$28.02	$252.17	$28.02	$280.19
Employee + Spouse/DP	$554.79	$61.64	$270.13	$346.30	$616.43
Employee + Child(ren)	$479.14	$53.23	$270.13	$262.24	$532.37
Family	$655.66	$72.85	$270.13	$458.38	$728.51
Anthem PPO					
Employee Only	$391.14	$43.46	$270.13	$164.47	$434.60
Employee + Spouse/DP	$702.29	$253.84	$270.13	$686.00	$956.13
Employee + Child(ren)	$702.29	$123.46	$270.13	$555.62	$825.75
Family	$702.29	$427.68	$270.13	$859.84	$1129.97

LAwell DENTAL PAY PLAN

2017 Costs Per Pay Period

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

Domestic Partner Coverage and Pre-Tax Benefits

The City of Los Angeles offers domestic partners of City employees, and domestic partners' children, equal access to its employee benefit programs, including health, dental and vision plans. To obtain these benefits, you must enroll your dependents during the specified times and provide the required dependent eligibility documentation. Please refer to pages 2–4 in the **Eligibility, Making Changes & Supplemental Plan Information Guide** for more information on enrolling dependents.

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

This chart shows the dollar value of domestic partner coverage paid by **LAwell** that will be reported as additional bi-weekly taxable income for full-time employees.

Your additional bi-weekly taxable income in 2017 when you enroll yourself and these dependents:

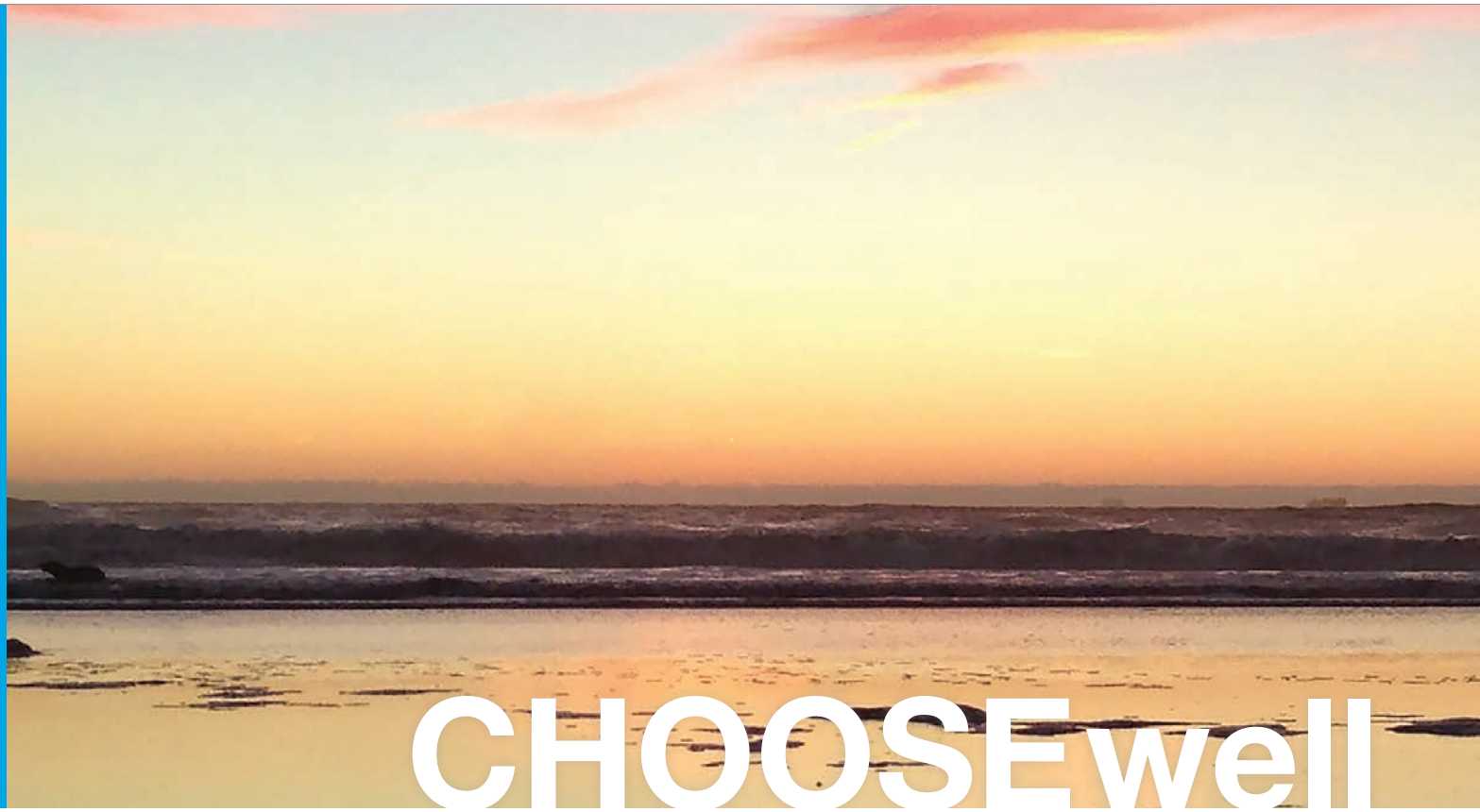
	Kaiser Permanente HMO		Anthem Narrow Network (Select HMO) Anthem Full Network (CACare HMO)		**Anthem Vivity** (LA & Orange Counties HMO)		Anthem PPO	
	LAwell Plan	**LAwell Pay Plan**	**LAwell Plan**	**LAwell Pay Plan**	**LAwell Plan**	**LAwell Pay Plan**	**LAwell Plan**	**LAwell Pay Plan**
Domestic Partner	$360.10	$324.09	$339.63	$305.67	$336.24	$302.62	$345.72	$311.15
Domestic Partner's Children	$300.13	$270.12	$254.73	$229.26	$252.18	$226.97	$345.72	$311.15
Your Children + Domestic Partner's Children	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Domestic Partner + Your Children	$360.10	$324.09	$339.63	$305.67	$336.24	$302.62	$345.72	$311.15
Domestic Partner + Domestic Partner's Children	$480.18	$432.16	$452.84	$407.56	$448.32	$403.49	$345.72	$311.15
Domestic Partner + Your and Domestic Partner's Children	$360.10	$324.09	$339.63	$305.67	$336.24	$302.62	$345.72	$311.15

If You Marry Your Domestic Partner

You have **30 days** from the date of marriage to change your domestic partner's status to spouse. You must call the Benefits Service Center at **800-778-2133** to make this change. You must also submit a copy of your marriage certificate. If you don't make this change, you will continue to pay taxes on your domestic partner's coverage and any coverage for his or her children.

WHO IS A "HEALTH PLAN TAX DEPENDENT"?

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



Required Documents, Special Dependent Rules, & Contact Information

REQUIRED DOCUMENTS

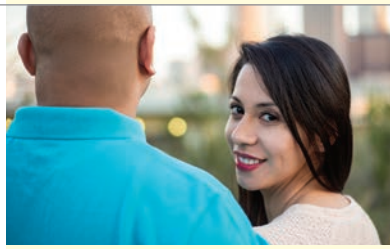
Documentation is required to enroll dependents. If you fail to provide required documentation by the deadline, your dependent coverage will be canceled. You will not be able to re-enroll your dropped dependent until the next Open Enrollment period or within 30 days of a qualifying life event. If coverage is canceled because you do not provide documentation, any expenses your child or spouse/domestic partner incurred or incurs after the preliminary effective date of coverage will be your financial responsibility, which may include expenses incurred before your cancellation notice. Contact the Employee Benefits Division at **213-978-1655** with any questions.

DEPENDENT COVERAGE RULES FOR SPECIAL SITUATIONS

Important Information about Eligibility Criteria for Disabled Child Over Age 26

You can enroll a disabled child age 26 or older who is dependent on you for support if that child was disabled before age 18. To be eligible, your child must remain unmarried, dependent on you for financial support and disabled as determined by your health plan.

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



Documentation is required to enroll dependents. If you fail to provide required documentation by the deadline, your dependent coverage will be canceled.

Contact the Employee Benefits Division at 213-978-1655 with any questions.

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

- For health, dental and vision coverage, you cannot enroll as both an employee and as a dependent of your spouse/domestic partner. Only one spouse/domestic partner can cover dependent children.
  - Health and vision coverage: If your spouse/domestic partner chooses family coverage, you must choose Cash-in-Lieu and you can be covered as a dependent of your spouse/ domestic partner.
  - Dental coverage: Each employee must enroll in his/her own dental plan. Your spouse/ domestic partner cannot cover you as a dependent.
- For life insurance, each of you can purchase supplemental life insurance as an employee, or one of you can purchase supplemental life insurance for yourself and dependent life insurance for your spouse/domestic partner. Only one of you can cover dependent children.
- For AD&D insurance, your spouse/domestic partner cannot cover you as a dependent. Each of you can purchase employee only coverage. Only one of you can cover dependent children.

If you have dependent children with another City employee who is not currently your spouse/ domestic partner, only one parent can purchase health coverage, dental coverage, life or AD&D insurance for the dependent children.

CHILDREN WHO ARE CITY EMPLOYEES

Your children who are benefits-eligible employees of the City cannot be covered as dependents; however, they may be beneficiaries of life insurance.

Extended Coverage For Child on Medical Leave From Post-Secondary Educational Institution

Effective January 1, 2010, the **LAwell** Plan added a special provision to comply with Michelle's Law. This provision applies only to a dependent child who is enrolled because of full-time student status. If the dependent child has a serious illness or injury resulting in a medically necessary leave of absence or change in enrollment (such as reduction in hours) that causes a loss of student status, the **LAwell** Plan will extend coverage to the child for up to a year. This maximum one-year extension of coverage begins on the first day of the medically necessary leave of absence (or other change in enrollment) and ends on the date that is the earlier of one year later or the date on which coverage would otherwise terminate under the terms of the Plan. Beginning January 1, 2011, the **LAwell** Plan does not require full-time student status as a condition of coverage for eligible dependents (except certain conditions for grandchildren – see page 3 of the **Eligibility, Making Changes & Supplemental Plan Information Guide**).

IMPORTANT WEBSITES AND PHONE NUMBERS

Plan/Program	Website	Phone Number
Anthem Narrow Network (Select HMO)	**anthem.com/ca/cityofla**	**844-497-5954**
Anthem Full Network (CACare HMO)	**anthem.com/ca/cityofla**	**844-497-5954**
Anthem Vivity (LA & Orange Counties HMO)	**anthem.com/ca/cityofla**	**844-497-5954**
Anthem PPO	**anthem.com/ca/cityofla**	**844-497-5954**
Kaiser Permanente HMO	**my.kp.org/ca/cityofla**	**800-464-4000**
Delta Dental PPO or Preventive Only	**deltadentalins.com/enrollees/index.html**	**800-765-6003**
DeltaCare USA DHMO	**deltadentalins.com/enrollees/index.html**	**800-422-4234**
EyeMed Vision Care	**eyemed.com**	**855-695-5418**
Employee Assistance Program	**members.mhn.com** (company code "cityoflosangeles")	**800-213-5813**
EAP for Harbor Employees Only		**800-367-7474**
Healthcare Flexible Spending Account or Dependent Care Reimbursement Account	**wageworks.com**	**877-924-3967**
Commuter Spending Accounts	**wageworks.com**	**877-924-3967**
Standard Insurance Company: Life Insurance, AD&D and Disability Insurance	**keepingLAwell.com**	**800-524-0450** for general questions **800-843-7979** for evidence of insurability **800-527-0218** for travel assistance
Benefits Service Center	**keepingLAwell.com** to enroll or make changes to your **LAwell** benefits	**800-778-2133** and immediately press "0#" two times to speak with a representative or **800-735-2922** if hearing or speech impaired (Monday – Friday, 8 a.m. to 5 p.m. Pacific time)
Employee Benefits Division	**keepingLAwell.com** or send e-mail to **per.EmpBenefits@lacity.org**	**213-978-1655** (Monday through Friday, 8 a.m. to 4 p.m. Pacific time)
City Retirement Benefits	**lacers.org**	**800-779-8328**
Deferred Compensation Plan	**cityofla457.com**	**888-466-0381** (Empower) or **213-978-1636** (Employee Benefits Division)
Parking/Transit Reimbursement/Rideshare Programs	**per.lacity.org/bens/commuteoptions.htm**	**213-978-1655**
City Employees Club of Los Angeles	**cityemployeesclub.com**	**213-620-0388**
All City Employees Benefits Services Association	**acebsa.org**	**213-485-2485**
City MOUs	**cao.lacity.org/MOUS**	**213-978-7676**

INDEX

This Index will direct you to the sections of your Enrollment Kit guides and brochures where you can find the information you're looking for. If you still have questions regarding any of your benefits, contact the Benefits Service Center at **800-778-2133**, Monday – Friday, 8 a.m. to 5 p.m. Pacific.

C = CHOOSEwell Guide
E = Eligibility, Making Changes & Supplemental Plan Information Guide
W = Wellness, Retirement & Commuter Benefits Guide
H = Enrollment Highlights Brochure

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

*By enrolling in, and/or accepting services under the **LAwell** Plan, you agree to abide by all terms, conditions and provisions stated in the 2017* **LAwell CHOOSEwell Guide**.

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

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

KEEPING LAwell

City of Los Angeles Employee Benefits

Eligibility, Making Changes & Supplemental Plan Information

KEEPING **LAwell**

City of Los Angeles Employee Benefits

About this Guide

This Guide includes additional details about your 2017 **LAwell** benefits that are not covered in the **CHOOSEwell Guide**, as well as legally required information. For an overview of your 2017 Open Enrollment choices, see the **CHOOSEwell Guide**.

What's Inside?

Eligibility for You and Your Dependents

FULL-TIME EMPLOYEES

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

- Eligible for membership in one of the employee representation units for which the civilian benefits program (**LAwell** program) has been negotiated in an MOU
- Not represented by an employee representation unit
- Port Police Officer member (MOU 27 or MOU 38) and a member of Tier 5 and Tier 6 of the Fire & Police Pension System
- Elected Official of the City or a full-time Member of the Board of Public Works.

Changes in Employment Status

If you change from regular full-time or regular half-time to part-time/intermittent status, you are not eligible for **LAwell** even if you continue to be a member of the Los Angeles City Employees' Retirement System.

Eligible Children

Your children may include legally adopted children or children placed with you for adoption, children for whom you have legal custody or guardianship, foster children placed in your home pending a permanent placement with you, and stepchildren. These children are eligible if they meet the age requirements listed on page 3.

HALF-TIME EMPLOYEES

Regular half-time civilian employees are eligible for **LAwell** benefits if paid at least 20 hours per pay period. Employees in part-time/intermittent or similar positions are not eligible.

FAMILY MEMBERS OF EMPLOYEES

If you are eligible for **LAwell**, you can also enroll your eligible family members if your dependents meet the criteria listed on page 3 and you submit the required documentation by the deadlines.

Ineligible Dependents

The following are examples of individuals who are not considered eligible dependents: your spouse following a divorce; someone else's child such as your nieces, nephews, or ineligible grandchildren (see page 3), unless you have been awarded legal custody or guardianship; or parents, parents-in-law, or grandparents, regardless of their IRS dependent status. **You must drop coverage for your enrolled dependent within 30 days of the date he or she loses eligibility** (e.g., within **30 days** of a divorce). If you fail to remove ineligible dependents, you will be required to pay all costs for any benefits that were paid on their behalf and may be subject to disciplinary action.

The following chart describes eligible dependents for health coverage, vision coverage, dental coverage, life insurance and AD&D coverage. See "About Eligible Dependents" on page 36 of the **CHOOSEwell Guide** for information on eligible dependents for the Healthcare Flexible Spending Account and Dependent Care Reimbursement Account.

Dependent Eligibility Criteria

Dependent Type	Age	Eligibility Definition	Documents Required for Verifying Eligibility
Spouse	N/A	Person of the opposite or same sex to whom you are legally married	Marriage certificate
Domestic Partner	N/A	Meet City's domestic partner eligibility requirements. See Domestic Partnership Information Sheet and Affidavit form at **per.lacity.org/bens/docforms.htm**	City of Los Angeles Affidavit of Domestic Partnership, or Declaration of Partnership filed with the California Secretary of State
Biological Child	Up to age 26*	Minor or adult child(ren) of employee who is under age 26	Child's birth certificate, hospital verification of birth or court document that verifies your relation to the child (an abstract document is not sufficient in most cases)
Step Child	Up to age 26*	Minor or adult child of employee's spouse who is under age 26	Child's birth certificate and certificate showing spouse/domestic partner as parent
Child Legally Adopted/Ward	Up to age 26*	Minor or adult child legally adopted/ward by employee who is under age 26	Child's birth certificate and court documentation
Child of Domestic Partner	Up to age 26*	Minor or adult child of employee's domestic partner who is under age 26	Child's birth certificate and City of Los Angeles Domestic Partner Affidavit or Declaration of Partnership filed with the California Secretary of State
Disabled Child	Up to age 26*	Child as defined in the child categories above	Same as the child requirements listed above
Disabled Child	Over age 26	Disabled child over the age of 26 who is dependent on you for support and was disabled before age 18. To be eligible, your child must remain unmarried, dependent on you for financial support and disabled as determined by your health plan.	Birth certificate and disability application from your health plan completed by your child's doctor and returned to your health plan for approval each year as requested by the insurance company
Grandchildren Legal Custody	Up to age 26*	Your grandchildren up to age 26 if you show proof of legal custody	Child's birth certificate and court documentation
Grandchildren	Up to age 26*	Your grandchildren can be added to the plan if their parent is your child who • is under age 19, unmarried, and financially dependent on you **or** • is age 19-26 and meets the full-time student status, is unmarried, and financially dependent on you If coverage for your child ends, coverage for your grandchildren will end.	Child's and grandchild's birth certificates; valid proof of dependent status and/or full-time student certification for your child

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

SPECIAL ENROLLMENT

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the **LAwell** plan if you or your dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within **30 days** after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the **LAwell** plan. However, you must request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption.

IF YOU LOSE MEDICAID OR CHIP COVERAGE OR BECOME ELIGIBLE FOR PREMIUM ASSISTANCE

Employees and dependents who are eligible for, but not enrolled in a City health coverage option may enroll if they lose Medicaid or Children's Health Insurance Program (CHIP) coverage because they are no longer eligible, or they become eligible for a state's premium assistance program. You have **60 days** from the date of the Medicaid/CHIP eligibility change to request enrollment under the Plan. If you request this change, coverage will be effective the first of the month following your request for enrollment. See page 20 for details on CHIP.

Changing Your Benefit Choices

WHEN YOUR CHOICES WILL APPLY

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

Exceptions: You can enroll in or change your participation in the **Deferred Compensation Plan** or **Commuter Spending Accounts** at any time. See the **Wellness, Retirement & Commuter Benefits Guide** for more information about these benefits.

WHEN YOU CAN MAKE CHANGES

You cannot change your choices during the year unless you have a life event in compliance with federal rules. A life event can include:

- You get married or divorced
- You begin or end a domestic partnership
- You add or lose an eligible dependent
- Your spouse/domestic partner's employment status, work schedule, or residence changes, significantly changing eligibility or coverage under the other employer's plan
- There is a significant change in the health or dental coverage your spouse/domestic partner has through his or her employer
- You move outside your health or dental plan's service area
- You or your dependent loses COBRA or other health coverage
- Coverage of a child due to a Qualified Medical Child Support Order (QMCSO)
- Entitlement or loss of entitlement to Medicare or Medicaid
- Changes consistent with Special Enrollment rights and FMLA leaves

You must notify the Plan within **30 days** of the life event by contacting the Benefits Service Center. The **LAwell** program will determine if your change request is permitted. You will receive confirmation of the benefit change by mail within two weeks of completing the change online or by phone. You will be asked to provide documents showing proof of the life event within **60 days** of the date on the confirmation statement reflecting such change. If you do not provide the required documents by the deadline, **LAwell** coverage changes will be canceled.

Important Deadline

You must make changes to your benefit choices **within 30 calendar days** of an eligible life event or you will have to wait until the next Open Enrollment.

Failure to give **LAwell** timely notice (as noted above) may:

- cause coverage of a dependent child to end when it otherwise might continue because of a disability and
- result in your liability to repay the Plan if any benefits are paid to an ineligible person.

In general, the new benefit choices you make after an eligible life event must be consistent with that change. For instance, if your spouse/domestic partner begins working and becomes eligible for health coverage, you could drop him or her from your health coverage because he or she gained eligibility for coverage from another source. There is an exception to the rule that requires benefit changes to be consistent with the type of life event. The exception allows you to make any changes to your benefit choices if you get married, begin a domestic partnership, add an eligible dependent by birth, adoption or placement for adoption, or you or your dependent loses COBRA or other health or dental coverage.

Important Deadline for Making Changes to Benefit Choices with a Life Event

Limited Time Period for Making Benefit Changes after a Life Event

If you have a life event, you must call the Benefits Service Center or go online **within 30 calendar days** after the life event to make new benefit choices.

- Call the Benefits Service Center at **800-778-2133** to make new benefit choices for any life event (see "When You Can Make Changes" on page 5). You will be asked to enter your Employee ID number and PIN (the last four digits of your Social Security number unless you've changed it). If you want to bypass the menu and speak to a representative, press "0#" two times.
- If your life event is marriage, birth or adoption of a child, divorce, or beginning or ending a domestic partnership, you can change your benefit choices by visiting **keepingLAwell.com**. For any other types of life events, you must call the Benefits Service Center.

Keep in mind that if you have or adopt a child during the year, you must enroll that child for coverage within **30 calendar days** of the birth or adoption. You can enroll the child by calling the Benefits Service Center or going to **keepingLAwell.com**. If you do not go online or call **within 30 calendar days**, you must wait until the next Open Enrollment to enroll that child. For example, if your child is born on June 1, 2017, you must call or go online to enroll your child by June 30, 2017. If you do not enroll your child within that time, you must wait until the next Open Enrollment, and your child will not have coverage under **LAWell** until January 2018.

Documents Are Required

You have **60 days from the date on your confirmation statement** to provide any required documentation listed on your confirmation statement. If you do not submit the required documents by the deadline, any change you made online or by calling the Benefits Service Center will be canceled. For example, if you add a dependent to your health coverage and fail to provide the required documentation within **60 days** of the date on your confirmation statement, that dependent's coverage will be canceled **effective the 61st day. Any health, vision or dental expenses your dependent has after coverage is canceled will be your financial responsibility, which may include expenses incurred before your cancellation notice.**

Contact the Employee Benefits Division at **213-978-1655** if you have questions about life events**.**

LIFE EVENTS

Your Benefits Can Be Affected When...

You Leave the City (other than retirement or transfer to DWP)

Your **LAwell** benefits end on the day after your last compensated day of City service. You may be able to continue:

- Health, dental, and vision benefits and Healthcare Flexible Spending Account contributions through COBRA continuation coverage
- Life insurance, including dependent life, through portability or by converting to an individual whole life policy
- AD&D coverage through portability continuation.

You will receive information on continuation coverage at the time your employment ends. Dependent Care Reimbursement Account contributions and disability coverage cannot be continued once you have terminated employment with the City. Access to the EAP ends on the last day of the month your City employment ends.

Your Work Schedule Changes

You may be eligible for **LAwell** benefits if your work schedule falls below 40 hours a pay period if you are a full-time employee – or below 20 hours a pay period or the amount specified in your MOU if you are a half-time employee. You are no longer eligible, however, to receive the City subsidy toward health, dental, and vision coverage, basic life insurance or basic disability.

You can continue non-medical **LAwell** benefits by paying the entire cost. In this case, you will be billed by the Employee Benefits Division. Your payment must be received within 15 days of the date of the billing letter or benefits will end.

You can continue medical **LAwell** benefits by contacting the Employee Benefits Division at **213-978-1655** to discuss your coverage options and costs.

If, in the same calendar year, you return to working the required number of hours, you will need to contact the Employee Benefits Division to request reinstatement of your **LAwell** coverage. If, in a different calendar year, you return to working the required number of hours, you must re-enroll for **LAwell** coverage. A benefits package will be mailed to you. You may contact the Employee Benefits Division if you do not receive a package within four to six weeks after returning to work.

About Continuation Coverage

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

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

Life insurance may be continued through portability and/or conversion and **AD&D coverage** may be continued through portability continuation. You have **60 days** from the date coverage ends to submit the required form to Standard Insurance Company. See page 13 for more information on life insurance, page 16 for more information on AD&D insurance, and the **CHOOSEwell Guide** for insurance coverage information.

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

You Are Disabled

Your **LAwell** disability coverage will continue if you are out for a disability approved by Standard Insurance Company. If you are on an approved disability, the **Benefit Protection Plan** (see page 17) allows you to continue the **LAwell** health, dental, vision and basic life insurance you had as an active employee for up to two years of disability. While you are covered by the Benefit Protection Plan, the City subsidy continues, so you pay only the coverage cost you paid as an active employee.

Participation in the Benefit Protection Plan ends if you retire or leave City service for any reason. After Benefit Protection Plan coverage ends, contact the Employee Benefits Division at **213-978-1655** to understand your coverage options and costs.

For other **LAwell** benefits not included in the Benefit Protection Plan, you can continue coverage by paying the full cost of coverage with after-tax dollars. Healthcare Flexible Spending Account and Dependent Care Reimbursement Account contributions cannot be continued while you are on approved disability.

Benefits While on Leave or in Non-Pay Status

Healthcare Flexible Spending Account and Dependent Care Reimbursement Account contributions and disability coverage cannot be continued while you are on leave or in non-pay status.Some benefits can continue through COBRA after 6 months.

You Go On Leave, Non-Pay Status or Have Insufficient Hours Worked

You are considered in a non-pay status if you take a leave of absence that does not include a Family Medical Leave (FMLA) or Catastrophic Leave. You can choose to continue your non-medical **LAwell** benefits by paying the entire cost of coverage with after-tax dollars. You will not be eligible for the City subsidy toward health, vision and dental coverage, basic life insurance or basic disability.

For your medical benefits, please contact the Employee Benefits Division at **213-978-1655** to understand your coverage options and costs. If you pay the cost of coverage with after-tax dollars, **LAwell** disability coverage can continue while you are in a non-pay status for up to six months. After six months, you can choose to continue:

- Health, dental, and vision benefits and Healthcare Flexible Spending Account contributions through COBRA continuation coverage.

- Life insurance, including dependent life, through portability or by converting to an individual whole life policy.
- AD&D coverage through portability continuation.

You Begin Receiving Workers' Compensation (State Rate) Benefits

Once you begin receiving State Rate benefits from Workers' Compensation, the City will no longer pay the subsidy for health, dental and vision coverage, basic life insurance or basic disability. At this time, you may continue:

- Health, dental, and vision benefits and Healthcare Flexible Spending Account contributions through COBRA continuation coverage.
- Life insurance, including dependent life, through portability or by converting to an individual whole life policy.
- AD&D coverage through portability continuation.

Dependent Care Reimbursement Account contributions and disability coverage cannot be continued once you begin receiving State Rate benefits. If you became disabled while still actively at work, you may be eligible for long-term disability benefits.

If the State Rate is supplemented with at least 40 hours of sick, vacation or overtime (CTO) in a two-week pay period (20 hours of compensation in a two-week pay period for half-time employees), the City will continue to pay the subsidy for benefits. Please contact the Employee Benefits Division at **213-978-1655** to understand your coverage options and costs.

You Retire from the City

Your **LAwell** benefits end on the last day of the month in which you retire. Make sure to:

- Confirm with LACERS if/when your retiree health and dental benefits begin
- Contact the Employee Benefits Division immediately if there is a gap between when your **LAwell** benefits end and LACERS benefits begin.

You may be able to continue life insurance by converting to an individual whole life policy and continue AD&D coverage through portability continuation.

You Transfer to the Department of Water & Power (DWP)

Your **LAwell** benefits end on the last day of the month in which City employment ends for you and any enrolled dependents. To avoid a break in health coverage, contact:

- DWP Health Plans Office at **213-367-2023** to enroll in health and/or dental coverage; you must enroll within **30 days** of the effective date of your transfer or you will have no coverage
- Employee Benefits Division immediately if you will have a break in coverage; in this case, **LAwell** health coverage may be extended on a limited basis until DWP coverage begins. You will have to pay for your extended coverage by check since you will no longer be able to pay through payroll deductions.

The DWP offers a Healthcare Flexible Spending Account and a Dependent Care Reimbursement Account. Contact the DWP program coordinator for more information.

Your **LAwell** Benefits and Changes

HEALTH COVERAGE DETAILS

Coverage for Special Circumstances

Care While Traveling

Type of Care	Anthem Vivity (LA & Orange Counties HMO) Anthem Narrow Network (Select HMO) Anthem Full Network (CACare HMO)	Anthem PPO	Kaiser Permanente HMO
Emergency Care in the U.S.	Covered 24 hours a day, 7 days a week Call 911 or go immediately to the closest emergency facility for medical attention Emergency room copayment will be waived if you are admitted		
	Within 48 hours of admission, contact Anthem Blue Cross Customer Service at the number listed on your member ID card		Call **800-225-8883** immediately if you are admitted to a non-participating hospital
Emergency Care outside the U.S.	Before traveling, contact Anthem Blue Cross Customer Service at the number listed on your member ID card for a list of participating hospitals Always go to the closest emergency facility; request an itemized bill (in English) before leaving to file a claim for reimbursement The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll free at **800-810-BLUE** or by calling collect at **804-673-1177**. An assistant coordinator, along with a medical professional, will arrange doctor or hospitalization needs.		Go to the nearest emergency facility and call **800-225-8883** if you receive treatment. Request an itemized bill (in English) and save your receipt to file a claim for reimbursement.
Urgent Care	**In-Area:** If you are in-area (15 miles or 30 minutes or less from your medical group), call your primary care physician or medical group and follow their instructions **Out of Area:** If you can't wait to return for an appointment with your primary care physician, get the medical help you need right away. If you are admitted, call Anthem Customer Service within 48 hours at the number listed on your member ID card.	Go to the closest urgent care or emergency facility. Contact Anthem Blue Cross Customer Service at the number listed on your member ID card or look up a provider on the anthem website, **anthem.com/ca** to locate the nearest in-network facility.	Within the service area, call for appointment or contact the advice nurse at the number listed in Your Guidebook Outside service area but in California call **800-225-8883** for assistance

Type of Care	Anthem Vivity (LA & Orange Counties HMO) Anthem Narrow Network (Select HMO) Anthem Full Network (CACare HMO)	Anthem PPO	Kaiser Permanente HMO
Prescription Coverage	**In the U.S.:** Call Anthem Blue Cross Customer Service at the number listed on your member ID card or visit **anthem.com/ca/cityofla** to find a participating pharmacy that accepts your coverage **Outside the U.S.:** Request an itemized bill (in English) and save your receipt to file a claim for reimbursement		Within the service area, go to any Kaiser pharmacy Outside the service area, only emergency/ urgent prescriptions covered; ask for an itemized bill (in English) and save your receipt to file a claim for reimbursement

Care for Dependents Who Do Not Live with You

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

IRS FORMS TO BE PROVIDED TO YOU ANNUALLY

Under the Affordable Care Act, starting in early 2016, employers (and in some cases insurance companies) are required to provide full-time employees, as well as other employees enrolled in a medical plan, with IRS Form 1095. Form 1095 should be provided to you by early February.

If you receive Form 1095, you should consult with your tax advisor or the IRS at **irs.gov** to understand how this form may affect your annual tax filing for the calendar year.

HEALTH PLAN DOCUMENTS

For a copy of documents related to the medical, dental, vision and other plan benefits, go to the employee benefits website at **per.lacity.org/bens/docforms.htm**. If you need a hard copy of these documents, please contact the Employee Benefits Division at **213-978-1655**.

Life, AD&D, and Disability Insurance Details

LIFE INSURANCE

Portability and Conversion

If your City employment ends, there are two ways you can take your life insurance with you – portability and conversion. Different rules apply. Here is an overview.

Portability

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

Conversion

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

What You Need to Do

To select portable coverage or to convert coverage, you must complete a form available online at **per.lacity.org/bens/docforms.htm**. Call **213-978-1655** for more information.

Accelerated Benefit

The Accelerated Benefit option can provide financial assistance if you become terminally ill and have a life expectancy of 12 months or less. In this case, you may have the right to receive during your lifetime a portion of your insurance as an Accelerated Benefit. You must have at least $10,000 of insurance in effect to be eligible.

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

Active Work Requirement

If you cannot work because of sickness, injury or pregnancy on the day before your life insurance takes effect, including any increases in coverage, that coverage will not become effective until the day after you complete one full day of active work as an eligible employee.

About Life Insurance and Imputed Income

For 2017, you may be taxed on the value of coverage above $2,000 under federal law, called imputed income. Imputed income depends on the ages of your dependents and will generally apply only if you cover a spouse over age 55 or more than one child.

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

Example of Imputed Income

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

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

IRS Table for Calculating Imputed Income

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

SUPPLEMENTAL LIFE INSURANCE

Proof of Good Health

Here is an overview of when proof of good health – or evidence of insurability – is required to enroll in **LAwell** supplemental life insurance or make changes in your coverage level. There may be other situations where proof of good health is required for future changes.

If you are a current employee...	Proof of good health required...
Enrolling in supplemental life insurance for the first time during Open Enrollment to a level of more than three times annual base pay or $750,000	Yes
Increasing your coverage by more than one level during Open Enrollment – for instance, from one to three times annual base pay – or to a level of more than three times annual base pay or $750,000	Yes
Keeping the same coverage or increasing your coverage by one level during Open Enrollment (three times annual base pay or less)	No
If you are a new hire enrolling within the time shown on your personal enrollment fact sheet...	
Enrolling for coverage of up to three times annual base pay or $750,000	No
Enrolling for coverage of four or five times annual base pay – or an amount above $750,000	Yes
If you have a qualified life event during the year...	
Increasing your coverage by more than one level	Yes
Choosing coverage of more than three times annual base pay – or an amount above $750,000	Yes

If your supplemental life coverage increases to more than $750,000 because of a salary increase resulting from a change in job class or pay grade, you will have to provide proof of good health for any amount over $750,000.

DEPENDENT LIFE INSURANCE

About Portability and Conversion

Portability: If you choose portable coverage for your basic and supplemental life insurance when your City employment ends, you may also take any dependent coverage with you as portable coverage if your dependents meet the age requirements. Your children are eligible up to age 26.

Conversion: If dependent coverage ends for any reason, your dependent can convert coverage to an individual whole life policy.

Selecting Portable or Conversion Coverage

To select portable or conversion coverage, you have **60 days** from the date your employment or dependent coverage ends to complete a form available online at **per.lacity.org/bens/docforms.htm** or from the Employee Benefits Division and submit it to Standard Insurance Company.

AD&D Insurance

Continuing AD&D Coverage

If your coverage or your employment with the City ends, you have the option to continue AD&D coverage. To select this portability continuation coverage, you have **60 days** from the date your employment ends to complete a form available online at **per.lacity.org/bens/docforms.htm** or from the Employee Benefits Division and submit it to Standard Insurance Company.

Disability Coverage

About Your Basic and Supplemental Disability Benefits

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

Disability Retirement Income

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

Disability Benefits Require Approval

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

Taxes and Your Disability Benefits

If you receive Short-Term Disability (STD) benefits, state and/or federal income taxes will not be withheld from your basic disability payment. You will be responsible for paying any taxes owed on these basic benefits. If you become eligible for Long-Term Disability (LTD) benefits, tax-withholding forms will be sent to you. Because the full cost of basic disability coverage is paid by the **LAwell** program, any basic disability benefits you receive are taxable at the time they are paid to you under IRS rules.

Benefits under the supplemental plan are less than 100% taxable. The explanation of benefits you receive with your disability check will reflect the amount of benefits that are considered taxable.

Benefit Protection Plan

You are eligible for the Benefit Protection Plan for an approved disability. This plan allows you to continue any **LAwell** health, dental, vision and basic life insurance coverage you had as an active employee for up to two years of disability. You can also continue coverage for any dependents who are enrolled when you become disabled. The City subsidy continues, so you pay only the coverage cost you paid as an active employee, if any. If you become disabled, you will receive more information.

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

Active Work Requirement

If you cannot work because of sickness, injury or pregnancy on the day before your disability coverage (or any coverage increase) becomes effective, your coverage, including any increases, will not become effective until the day after you complete one full day of active work as an eligible employee.

Definition of Pre-Disability Earnings for Disability Coverage

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

Disability Coverage and Pre-Existing Conditions

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

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

Other Benefits to Consider

- **Family Medical Leave (FMLA)** – While you are on FMLA, the City may continue to pay your health, vision and dental subsidies. Contact the Personnel Section of your department or refer to your MOU for more information on FMLA.
- **Catastrophic Illness Leave Donation Program** – If you are a regular full-time or half-time employee and have passed probation, this program allows you to apply for up to 480 hours of leave to be paid at a 40-hour maximum per pay period. You may use the program once during your City career if you have used all of your 100% and 75% sick time and vacation time, as well as all basic and supplemental disability benefits, and you continue to need time off for your own illness or to care for an eligible family member. Contact the Employee Benefits Division at **213-978-1655** for more information. Go to **per.lacity.org/bens/docforms.htm** to view the application.

Benefit Exclusions

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

Filing a Disability Claim

If you have a disabling condition that may use up your 100% and 75% sick leave, contact the Employee Benefits Division as early as possible to find out what you will need to do to file a claim. It takes a minimum of one week to process a disability claim so approved payments can begin.

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

If your disability is work-related and you have filed a Workers' Compensation claim, you should also file a claim with The Standard. You may be entitled to disability benefits while waiting for Workers' Compensation to decide on your claim – and you may receive LTD benefits along with Workers' Compensation benefits after 180 days. Workers' Compensation benefits would reduce your LTD benefit.

Sick Leave and Disability – What's the Difference?

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

Disability – Disability insurance may replace part of your income if you are disabled because of sickness, injury or pregnancy. Disability benefits begin when you exhaust your 100% and 75% leave banks. To receive disability benefits, your condition must be approved as a disability by The Standard, which requires information from you, your doctor and the City. While you are receiving disability benefits, you do not accumulate retirement credit because you are no longer being paid by the City.

Important Legal Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

ABOUT HOSPITAL STAYS FOR MOTHERS AND NEWBORNS

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

PRIVACY AND YOUR HEALTH COVERAGE

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require that the **LAwell** health plans comply with privacy rules and periodically remind you about the availability of the privacy notice and how to obtain that notice. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

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

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

PERSONAL PHYSICIAN DESIGNATIONS AND OB/GYN VISITS IN THE ANTHEM BLUE CROSS HMOs

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

You do not need prior authorization from the Anthem Blue Cross HMO or from any other person (including a Personal Physician) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For information on how to select a Personal Physician, and for a list of the participating Personal Physician and health care professionals who specialize in obstetrics or gynecology, contact the Anthem Blue Cross Member Services Concierge at **844-497-5954**.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your state for more information on eligibility.

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447	**GEORGIA – Medicaid** Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Medicaid Eligibility Phone: 404-651-9982 HIPP Information Phone: 678-564-1162 ext 2131
ALASKA – Medicaid Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	**INDIANA – Medicaid** Healthy Indiana Plan for low-income adults 19-64 Website: www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid Medicaid Website: www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	**IOWA – Medicaid** Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid Website: http://flmedicaidtplrecovery.com/hipp Phone: 1-877-357-3268 HIPP Phone: 844-449-3450	**KANSAS – Medicaid** Website: www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY – Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	**NEW HAMPSHIRE – Medicaid** Website: www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	**NEW JERSEY – Medicaid and CHIP** Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid Website: www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	**NEW YORK – Medicaid** Website: www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP Website: www.mass.gov/MassHealth Phone: 1-800-462-1120	**NORTH CAROLINA – Medicaid** Website: www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	**NORTH DAKOTA – Medicaid** Website: www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	**OKLAHOMA – Medicaid and CHIP** Website: www.insureoklahoma.org Phone: 1-888-365-3742

MONTANA – Medicaid Website: http://dphhs.mt.gov/MontanaHealthcare-Programs/HIPP Phone: 1-800-694-3084	**OREGON – Medicaid** Website: www.oregonhealthykids.gov www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	**PENNSYLVANIA – Medicaid** Website: www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEVADA – Medicaid Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	**RHODE ISLAND – Medicaid** Website: www.eohhs.ri.gov Phone: 401-462-5300
SOUTH CAROLINA – Medicaid Website: www.scdhhs.gov Phone: 1-888-549-0820	**VIRGINIA – Medicaid and CHIP** Medicaid Website: www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA – Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059	**WASHINGTON – Medicaid** Website: www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid Website: http://gethipptexas.com/ Phone: 1-800-440-0493	**WEST VIRGINIA – Medicaid** Website: www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	**WISCONSIN – Medicaid and CHIP** Website: www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid Website: www.greenmountaincare.org/ Phone: 1-800-250-8427	**WYOMING – Medicaid** Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

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

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565
OMB Control Number 1210-0137 (expires 10/31/2016)

AVAILABILITY OF SUMMARY HEALTH INFORMATION

LAwell offers a series of health coverage 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 health coverage option in a standard format, to help you compare across options. The SBC summarizes and compares important information including what is covered, what you need to pay for various benefits, what is not covered, and where to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC.

The most current SBC documents for the **LAwell** medical plan options are available online at **per.lacity.org/bens/docforms.htm** or contact the Benefits Service Center at **800-778-2133** to get a free copy.

This notice is for people with Medicare. Please read this notice carefully.

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 2017

Your Prescription Drug Coverage and Medicare

As the sponsor of an active group medical plan, the City of Los Angeles' **LAwell** Plan is required to provide all Medicare-eligible participants with the following notice from the federal government in conjunction with the Medicare Prescription Drug Improvement and Modernization Act of 2003. 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.

- If you and/or your family members are not now eligible for Medicare, and will not be eligible during the next 12 months, you may disregard this Notice.
- If, however, you and/or your family members are now eligible for Medicare or may become eligible for Medicare in the next 12 months, you should read this Notice very carefully and keep a copy of this Notice.

This announcement is required by law whether the group health plan's coverage is primary or secondary to Medicare. Because it is not possible for our Plan to always know when a Plan participant or their eligible spouse or children have Medicare coverage or will soon become eligible for Medicare we have decided to provide this Notice to all plan participants. Please read this notice carefully to determine if you will need to contact Medicare, Social Security, the Los Angeles City Employees' Retirement System (LACERS), or the Employee Benefits Division.

Medicare prescription drug coverage for Medicare-eligible people is available through Medicare Prescription Drug Plans or a Medicare Advantage Plans (like an HMO or PPO) that offer 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.

The City of Los Angeles has determined that the prescription drug coverage is "creditable" under the following medical plan options: Anthem Vivity (LA & Orange Counties HMO), Anthem Narrow Network (Select HMO), Anthem Full Network (CACare HMO), Anthem PPO, and Kaiser Permanente HMO.

"Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

Because the plan options noted above are, on average, at least as good as the standard Medicare prescription drug coverage, you can keep the prescription drug coverage under the Anthem Vivity (LA & Orange Counties HMO), Anthem Narrow Network (Select HMO), Anthem Full Network (CACare HMO), Anthem PPO, or Kaiser Permanente HMO and not pay a higher premium (a late enrollment penalty) if you later decide to join a Medicare drug plan.

REMEMBER TO KEEP THIS 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).

Please keep this notice as proof of having creditable coverage under the City's **LAwell** Plan.

In most cases, the City of Los Angeles' **LAwell** Plan is the primary insurance plan for employees and federally recognized dependents; Medicare is typically secondary. Active City employees and federally recognized dependents with **LAwell** coverage can choose to not enroll in Medicare Part B and Part D and continue their medical and prescription drug coverage through the City plan. The LAwell Plan is, on average, at least as good as the standard Medicare prescription drug coverage. City employees and federally recognized dependents that maintain City **LAwell** coverage will not pay a higher premium (a late enrollment penalty) if they decide to join a Medicare drug plan after they are first eligible.

If You Decide to Keep Your City Coverage and Also Join a Medicare Drug Plan

You can also decide to keep your current medical and prescription drug coverage with the above City Plans and also enroll in a Medicare prescription drug plan. If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket. Your current coverage pays for other health expenses in addition to prescription drugs.

If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. Having dual prescription drug coverage under this Plan and Medicare means that this 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.
- for Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and the group health plan 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.

If You Decide To Join A Medicare Drug Plan

You may decide to join a Medicare drug plan while still an active City employee with benefits. Please refer to the 2017 **CHOOSEwell Guide** regarding your prescription and medical benefits with the City. 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
- for Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and the group health plan pays secondary.

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

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

- PDPs may have different premium amounts;
- PDPs cover different brand name drugs at different costs to you;
- PDPs may have different prescription drug deductibles and different drug copayments;
- PDPs may have different networks for retail pharmacies and mail order services.

If you are an active City employee, you cannot discontinue participation in the City of Los Angeles Plan in order to enroll in Medicare Part B and Part D. If you had Medicare prior to becoming eligible for the City's Health Benefits, then you may receive Cash-in-Lieu and disenroll from your City medical coverage. If you are a Medicare-eligible dependent of an active City employee, you may discontinue participation in the City of Los Angeles Plan and enroll in Medicare Part B and Part D based upon Medicare's guidelines.

The federal government does not recognize domestic partners as eligible dependents of active City employees with group health coverage for Medicare purposes. If you are a domestic partner and you are eligible for Medicare, you may want to consider enrolling in Medicare and dropping **LAwell** coverage at the time of eligibility. If you do not enroll in Medicare Part B and Part D when you first become eligible, you will be charged a higher premium (a penalty) for your Medicare coverage.

You may contact LACERS at **800-779-8328** to discuss your retirement and to assist you with your Medicare enrollment, when appropriate.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan at one of the following three times:

1. when you first become eligible for Medicare,
2. each year during Medicare's annual election period (from October 15th through December 7th), and/or
3. if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible to join a Part D plan 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 while still an active City employee with benefits, you will continue to receive the City's **LAwell** coverage as your primary insurance provider. Please be aware that enrolling in Medicare simultaneously with the City's **LAwell** Plan may cause payment errors and in most cases will not increase your benefits. Please refer to the 2017 **CHOOSEwell Guide** regarding your prescription and medical benefits with the City **LAwell** Plan. If you had Medicare prior to becoming eligible for **LAwell** Benefits, then you may receive Cash-in-Lieu and disenroll from your **LAwell** medical coverage. If you are a Medicare-eligible dependent of an active City employee, you may discontinue participation in the City of Los Angeles **LAwell** Plan and enroll in Medicare Part B and Part D based upon Medicare's guidelines.

If you are a domestic partner and you are eligible for Medicare, you may want to consider enrolling in Medicare and dropping **LAwell** Benefits coverage at the time of eligibility (age 65). The federal government does not recognize domestic partners as eligible dependents of active group health coverage for Medicare purposes. If you do not enroll in Medicare Part B and Part D when you first become eligible, you will be charged a higher premium (a penalty) for your Medicare coverage.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

If you drop or lose your coverage with the City of Los Angeles and do not 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 prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join. City employees and their federally recognized eligible dependents will not be subject to higher premiums if they maintain creditable coverage with the City.

For more information about this notice or your current prescription drug coverage please contact the Employee Benefits Division at **213-978-1655**.

Your Right to Receive a Notice

You will receive this Notice at least every 12 months and at other times in the future such as if the creditable/non-creditable status of the prescription drug coverage through this plan changes. You may also request a copy of a Notice at any time.

For More Information about Your Options under Medicare's 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 when you become eligible. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

For people with limited income and resources. 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 whether or not you are required to pay a higher premium (a penalty).

For more information about this notice or your current prescription drug coverage contact:

Date: 10/01/2016
Name of Entity/Sender: City of Los Angeles, Personnel Department
Contact—Position/Office: Employee Benefits Division
Address: 200 North Spring Street, City Hall, Room 867
Phone Number: 213-978-1655
E-Mail: per.empbenefits@lacity.org

As in all cases, the City of Los Angeles, Kaiser Permanente, and Anthem Blue Cross reserve the right to modify benefits at any time, in accordance with applicable law. This document is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

NOTE: You will receive this notice each year. You may also request a copy if needed.

As a covered entity under Title II of the Americans with Disabilities Act, the City of Los Angeles does not discriminate on the basis of disability and, upon request, will provide reasonable accommodations to ensure equal access to its programs, services and activities.

INDEX

This Index will direct you to the sections of your Enrollment Kit guides and brochures where you can find the information you're looking for. If you still have questions regarding any of your benefits, contact the Benefits Service Center at **800-778-2133**, Monday – Friday, 8 a.m. to 5 p.m. Pacific.

C = CHOOSEwell Guide
E = Eligibility, Making Changes & Supplemental Plan Information Guide
W = Wellness, Retirement & Commuter Benefits Guide
H = Enrollment Highlights Brochure

NOTES

NOTES

*This Guide is published by the City of Los Angeles Personnel Department. By enrolling in, and/or accepting services under the **LAwell** Plan, you agree to abide by all terms, conditions and provisions stated in the 2017 **LAwell CHOOSEwell Guide**.*

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

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

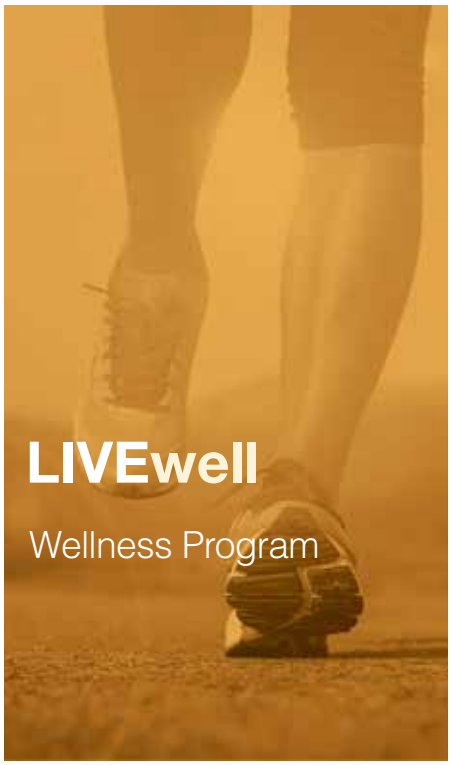
KEEPING LAwell

City of Los Angeles Employee Benefits

Wellness, Retirement & Commuter Benefits

KEEPING **LAwell**

City of Los Angeles Employee Benefits



LIVEwell

Wellness Program

SAVEwell

Deferred Compensation Plan

COMMUTEwell

Ridesharing & Parking Benefits

Understanding Your Full Benefits Package

To support your current and future health and wellbeing, **LAwell** includes many other benefits beyond those described in the **CHOOSEwell Guide**. This brochure summarizes these additional—and very important—parts of your benefits package.

LIVEwell

Our new wellness program, **LIVEwell**, will launch in late 2016. This program will give you and your family resources to support your current and future wellbeing. Be on the lookout for more information to come, and visit the keepingLAwell.com and the per.lacity.org/Bens websites for updates.

Please be aware of the following Wellness resources presently offered by our health plans:

Annual checkups
Nurse Help Line 24 hours a day, 7 days a week
Weight management and nutrition counseling
Smoking/tobacco cessation
Health Coaching
Exercise
Chronic Care Management
Other online tools

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

SAVEwell

Deferred Compensation Plan

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

WHY SHOULD I CONSIDER JOINING?

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

- **Los Angeles City Employees Retirement System (LACERS) —** Benefits are determined based on factors such as how long you work for the City and your salary near retirement. They are also based on your retirement Tier (Tier 1 for employees hired prior to February 21, 2016; Tier 3 for employees hired on or after February 21, 2016) and the benefit formulas that apply to each Tier.
- **Deferred Compensation Plan —** Benefits are based on the total balance (contributions + earnings) you accumulate in your account. You can begin drawing on your balance when you retire. You have several withdrawal options, although ideally you would convert your balance into a steady income stream over many years to supplement your LACERS income.

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

WHAT DECISIONS ARE REQUIRED TO ENROLL?

Enrolling in the Plan requires making a few basic decisions:

1. How much do I want to contribute each payday?

You can contribute as little as $15 per payday. Annual contribution limits as of 2016 are $18,000 for those below age 50, $24,000 for those age 50 or older, and $36,000 for participants eligible for Catch-Up. These limits are subject to increase by the federal government on an annual basis.

2. Do I want to save pre-tax or after-tax?

Pre-tax contributions are made before federal and state taxes are withheld. Earnings grow tax-deferred. You do not pay taxes on these amounts until you withdraw them from the Plan.

After-Tax (Roth) contributions are made after federal and state taxes are withheld. Earnings grow tax-free. No taxes are paid on distributions (if your account has been held for at least five years and you're at least age 59-1/2).

3. How do I want to invest my account?

The Plan offers a wide variety of investment options, ranging from interest-bearing savings accounts to stock and bond mutual funds. You can choose an investment profile that matches your risk tolerance and investment objective. In addition to a core menu of investment options, a brokerage window through Charles Schwab is available offering access to a wider universe of stocks, bonds and mutual funds.

4. What if I need to access my account while working?

Although generally these funds are not available to you until after you end employment with the City, there are a few exceptions. The Plan offers a loan program, which allows you to borrow from your account up to certain limits and then pay yourself back. In addition, if you experience a financial emergency and meet federal guidelines, you may be eligible for a hardship withdrawal.

5. How do I enroll?

You can obtain enrollment materials by visiting the Plan website at cityofla457.com; calling **888-457-9460;** or visiting the Plan Service Center located in the Employee Benefits Division, Room 867 City Hall, Monday through Friday from 8 a.m. to 4 p.m.

COMMUTEwell

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

- Commuter Spending Accounts
- Transit Reimbursement Program
- Vanpool/Carpool Program
- Parking Benefits
- Bike/Walk to Work
- Commute Options & Parking Administration

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

Commuter Spending Accounts

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

- Transit Spending Account (TSA) (including contribution match of up to **$50** per month)
- Parking Spending Account (PSA)

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

TRANSIT SPENDING ACCOUNT (TSA)

- Transit Spending Accounts allow you to set aside up to $255 (maximum amount subject to federal law revision) per month on a pre-tax basis to pay for public transit expenses, including bus, rail, train and subway fares.
- Transit media (e.g. passes, tickets, etc.) can, in most cases, be purchased directly through our service provider, WageWorks. Make your purchases by the 10th of the month and those media will then be mailed to your home prior to the month they will be used.
- The City offers up to $50 in the form of a "Transit Match" for eligible City employees who meet all requirements of the Transit Match program.

PARKING SPENDING ACCOUNT (PSA)

- Parking Spending Accounts allow you to set aside up to $255 (maximum amount subject to federal law revision) per month on a pre-tax basis to pay for parking expenses related to commuting from home to work. Note that these accounts cannot be used for parking provided by the City of Los Angeles to its employees at City owned or leased lots (e.g., lots at City Hall East, Figueroa Plaza, Police Administration Building, etc.).
- Parking passes can, in certain instances, be purchased directly through our service provider, WageWorks. Alternatively, you can make your parking purchases at a garage/lot and file a claim in order to receive reimbursement from your account.

IMPORTANT INFORMATION ABOUT THE TSA AND PSA

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

CONTINUED ON BACK COVER

Transit Reimbursement Program

- The Transit Reimbursement Program provides up to $50 per month to individuals who use public transportation to commute to work. Unlike Transit Spending Accounts, participants must submit monthly forms with proof of transit purchase in order to be eligible for reimbursement.

Vanpool/Carpool Program

- The City's Vanpool Program assists City employees in joining or forming vanpools as a means of commuting to common City work locations within the greater L.A. region. Approximately 90 vans are currently operating through this program.
- The Carpool Program facilitates employee carpooling as a means of commuting to work and may provide for carpool parking permits at City owned/leased lots based on meeting certain criteria and subject to space availability.

Parking Benefits

- The City provides employee parking at a variety of City-owned and leased lots near primary City work facilities. The cost of parking to the employee varies by type of permit. Please note the following:
  - A variety of different permit types (Individual, Night, Disabled, Electric, etc.) are issued based on the terms of the City's Special Memorandum of Understanding on Commute Options and Parking.
  - Permit availability is subject to space availability and upon meeting all program terms and conditions.

Bike/Walk to Work Programs

- The Bike to Work and Walk to Work Programs provide up to $50 per month to individuals who commute to work by bicycle or walking.

Commute Options & Parking Administration

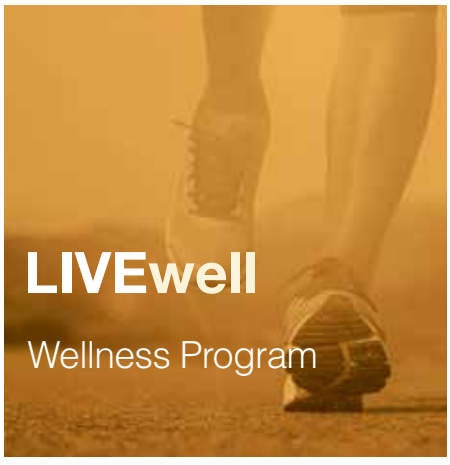
- Ridesharing and parking programs are administered by the Commute Options and Parking Section located at the Employee Benefits Division, City Hall, Room 867. The office is open from 8:00 a.m. to 4 p.m. You may contact a representative at **(213) 978-1634** or send an email to **per.commuteoption@lacity.org**.

Harbor Department and Los Angeles World Airports (LAWA) Employees

If you are a Harbor or LAWA employee, you are not eligible for these transit and parking benefits. Instead, your transit and parking benefits are provided directly by your Department. Please contact the appropriate departmental human resource section for more information about transit and parking benefits for these departments.

*Our Open Enrollment materials provide highlights of the **LAwell** program.*

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



Enrollment Highlights

KEEPING **LAwell**

City of Los Angeles Employee Benefits

What's in this Enrollment Kit

Open Enrollment October 1 – 31, 2016

Welcome to Open Enrollment! We're pleased to share significant improvements to the Civilian Benefits Program in 2017. We're also making efforts to better communicate benefits information. This year's enrollment materials include:

- **Personal Enrollment Fact Sheet:** Your personal information and benefits choices.
- **Enrollment Highlights:** Overview of what's changing and your Enrollment Checklist.
- New **CHOOSEwell Guide:** Key information for making your 2017 choices.
- New **Eligibility, Making Changes & Supplemental Plan Information Guide:** Guidelines for eligibility and making changes.
- New **Wellness, Retirement & Commuter Benefits Guide:** Highlights of other important benefits offered to City employees.

Announcing: Major Benefits Enhancements for 2017

- **New Health Plan Provider –** Anthem Blue Cross ("Anthem") will replace Blue Shield, becoming the new provider of our PPO and HMO Full Network and HMO Narrow Network plans.
- **New HMO Option: "Vivity" –** A new health plan option, called "Vivity," will be added to our health plan menu. Vivity is an affiliation of seven hospital systems and medical provider groups in Los Angeles and Orange counties— **Cedars-Sinai, UCLA, PIH Health, Huntington Memorial, Torrance, Memorial Care, and Good Samaritan**.
- **New Vision Plan –** A single vision plan, "EyeMed", for all members will be established to provide one point-of-service, increased eyewear benefit allowances, and on-site vision exam clinics and eyewear delivery. You will be automatically enrolled in this plan at no additional cost. Eyewear prescription benefits will no longer be bundled with the City's health plans.
- **Increased Dental PPO Benefits –** Improvements to the Delta Dental PPO Plan will help reduce member out-of-pocket costs.

Enrollment Elections & Defaults

- **Open Enrollment 2016 is your only opportunity to make coverage elections for yourself and your dependents for 2017** (unless you experience a life event change in 2017).
- Generally, your previously elected 2016 benefit elections will automatically roll over to 2017 unless you make a change during Open Enrollment. **If you are currently enrolled in a Blue Shield plan and do not make an election during Open Enrollment, you will be automatically enrolled in the equivalent (Anthem PPO, HMO Full Network, or HMO Narrow Network) plan.**
- Enrollment in our **Dependent Care Reimbursement and Flexible Spending Accounts** does not automatically roll over — if you wish to continue participating or become a new participant in one of these accounts, you will need to elect to do so during Open Enrollment.
- Employees without health coverage who do not elect a health plan during Open Enrollment will be automatically enrolled in the Employee Only level of the Anthem HMO Narrow Network plan.

ACCESS ON THE GO!

*You can access **keepingLAwell.com** and the enrollment site from any device:*

- *Computer*
- *Smartphone*
- *Tablet*

*To access the Benefits Service Center enrollment site from **keepingLAwell.com**, click **Enroll in Benefits** or **Make Changes**, then log in.*

Your Enrollment Checklist

1. **Review your annual personal enrollment fact sheet.** If your personal/address information is incorrect, contact your department's personnel section to make updates

2. **Review your options and coverage costs** in the **CHOOSEwell Guide** and at **keepingLAwell.com**.

3. **Review your dependent information and eligibility rules** to verify current dependents, add new dependents, or remove ineligible dependents.

4. **Document your dependents** by **December 12, 2016**; adding a dependent does not entitle that individual to coverage unless the City receives the appropriate documentation of eligibility.

5. **Provide Social Security numbers or Taxpayer Identification numbers** for your dependents, if you have not already done so, by calling **800-778-2133** (This is for federal tax reporting purposes).

6. **Review** the **Eligibility, Making Changes & Supplemental Plan Information Guide** to understand plan rules and successfully manage your benefits over time.

7. **Make your 2017 enrollment elections!** Go to **keepingLAwell.com** or call **800-778-2133** to make elections.

8. **Review your confirmation statement** when you receive it in early November.

Successfully Manage Your Dependents in 2017

- To **add a new dependent** during the year you must do so within **30 days** of the date he or she becomes your eligible dependent. If you do not act in a timely manner, you will not be able to enroll that dependent until the following year.
- To **remove an ineligible dependent** during the year you must do so within **30 days** of the date he or she no longer meets the City's eligibility requirements. If you do not act in a timely manner, you may be subject to paying the cost of dependent coverage for periods of ineligibility.

Important Dates

- **Open Enrollment:** **October 1 – October 31, 2016**
- **Webinars and Onsite Meetings:** Webinars and onsite meetings will be offered throughout Open Enrollment—check for updates at **keepingLAwell.com**.
- **Last day to make changes:** **October 31, 2016**
- **Documentation deadline:** **December 12, 2016**
- **Benefit changes take effect:** **January 1, 2017**; Health & Vision plan ID cards will be issued shortly thereafter.

*Our Open Enrollment materials provide highlights of the **LAwell** program.*

Questions?

- **Call the Benefits Service Center at** **800-778-2133** and immediately press "0#" two times to speak to a representative. For TDD or TTY service, call **800-735-2922**. Representatives are available 8 a.m. to 5 p.m., Pacific time, Monday – Friday.

  Extended hours are provided on Friday, October 28 and Monday, October 31: 8 a.m. to 7 p.m. On Saturday and Sunday, October 29 and 30, the Benefits Service Center will NOT be available via phone; however you can still enroll online.
- **Chat with the Benefits Service Center**— Live Chat with Benefits Service Center representatives is available from 8 a.m. to 5 p.m., Monday through Friday. Representatives can answer questions about the enrollment site and benefit options.
- **Meet a Member Advocate** — Member Advocates from our Health and Dental providers will provide personal, one-on-one assistance out of our office in City Hall, 200 N. Spring Street, Room 867, during Open Enrollment and throughout the year.

KEEPING LAwell
City of Los Angeles Employee Benefits