

# OPEN ENROLLMENT 2019

2019 CHOOSEwell  
Enrollment Guide

October 1–31, 2018

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



# How to use this CHOOSEwell Enrollment Guide

First  
**1**

Review your current enrollment and your 2019 costs and options using your Personal Enrollment Fact Sheet or by logging into your account at [keepingLAWell.com](http://keepingLAWell.com).



Second  
**2**

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



Review your **CHOOSEwell** Highlights for a quick overview of 2019 benefits.



Third  
**3**

Make your 2019 enrollment elections by **October 31, 2018!** Go to [keepingLAWell.com](http://keepingLAWell.com) or call **800-778-2133** to make elections.



# Why Should You CHOOSEwell?

Your benefit choices are important in supporting the health and wellbeing of you and your dependents. Open Enrollment benefit elections will be in effect for all of 2019 unless you experience a qualifying life event. Choose wisely, and **CHOOSEwell!** For additional details about these benefits, please visit [keepingLAWell.com](http://keepingLAWell.com).

## Your Detailed Enrollment Checklist

- Review your Personal Enrollment Fact Sheet (PEFS).
- Review your options in the CHOOSEwell Enrollment Guide and [keepingLAWell.com](http://keepingLAWell.com).
- Review your dependent information and eligibility rules (on page 45) to verify current dependents, add new dependents, or remove ineligible dependents.
- Document your dependents by **December 10, 2018**; adding a dependent does not entitle that individual to coverage unless the City receives the appropriate documentation of eligibility.
- Provide Social Security numbers or Taxpayer Identification numbers for your dependents, if you have not already done so, by calling **800-778-2133** (this is for federal tax reporting purposes).
- Review the eligibility section and other pertinent sections of the CHOOSEwell Enrollment Guide to understand plan rules and successfully manage your benefits over time.
- Make your 2019 enrollment elections!
- Review your confirmation statement when you receive it in mid November.

## Your Enrollment Resources

- ✓ **Enroll or make changes online or on the phone, visit [keepingLAWell.com](http://keepingLAWell.com)** or contact the Benefits Service Center at **800-778-2133** (for TDD or TTY service, call **800-735-2922**). Representatives are available 8 a.m. to 5 p.m., Pacific Time, Monday – Friday.
- ✓ **Extended phone hours are provided on Tuesday, October 30 and Wednesday, October 31: 8 a.m. to 7 p.m.** On Saturday and Sunday, October 27 and 28, the Benefits Service Center will **NOT** be available via phone; however you can still enroll online.

## Attend a weekly event and learn more:

Date	Event Type	Duration	Location
Oct 3	Benefits Onsite	10:00 am – 3:00 pm	Marvin Braude Building 6262 Van Nuys Blvd. Room MB-1B (1st Floor)
Oct 4	Benefits Onsite	10:00 am – 3:00 pm	Garland Building 1200 W 7th Street 9th floor lunchroom
	Lunchtime Seminar/Webinar – Vision Benefits	11:30 am – 12:00 pm	Garland Building*
	Lunchtime Seminar/Webinar – Vision Benefits (repeat)	12:45 – 1:15 pm	Garland Building*
Oct 10	Benefits Onsite	10:00 am – 3:00 pm	Public Works Bldg 1149 S Broadway St 9th Flr Admin Conference Rm
Oct 11	Lunchtime Seminar/Webinar – Employee Assistance Program	11:30 am – 12:00 pm	City Hall East 200 N Main Street Controller Conf Rm 351
	Lunchtime Seminar/Webinar – Employee Assistance Program (repeat)	12:45 – 1:15 pm	
Oct 16	Nighttime Seminar/Webinar – Benefit Overview	5:00 – 6:00 pm	City Hall East 200 N Main Street Controller Conf Rm 351
Oct 18	Benefits Onsite	10:00 am – 3:00 pm	Harbor Dept 425 S. Palos Verdes St Harbor Dept Board Rm
	Lunchtime Seminar/Webinar – Anthem PPO Benefits	11:30 am – 12:00 pm	
	Lunchtime Seminar/Webinar – Anthem PPO Benefits (repeat)	12:45 – 1:15 pm	
Oct 23	Benefits Onsite	11:00 am – 5:30 pm	Airports 7407 1/2 World Way West, Building M2, 90045
	Lunchtime Seminar/Webinar – Benefit Overview/Q&A	12:15 – 12:45 pm	
	Nighttime Seminar – Benefit Overview/Q&A (repeat)	6:00 – 7:00 pm	
Oct 25	Benefits Onsite	10:00 am – 3:00 pm	Figueroa Plaza 221 North Figueroa St 5th Floor
	Lunchtime Seminar/Webinar – Dental Benefits	11:30 am – 12:00 pm	
	Lunchtime Seminar/Webinar – Dental Benefits (repeat)	12:45 – 1:15 pm	
Oct 30	Lunchtime Seminar/Webinar – Benefit Overview/Q&A	11:30 am – 12:00 pm	City Hall East 200 N Main Street Controller Conf Rm 351
	Lunchtime Seminar/Webinar – Benefit Overview/Q&A (repeat)	12:45 – 1:15 pm	

Visit at [keepingLAWell.com](http://keepingLAWell.com) for more information about attending a weekly event. Webinars will be recorded and available for viewing at [keepingLAWell.com](http://keepingLAWell.com).

## Meet a Member Advocate

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

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

## Important Dates

**Open Enrollment:**  
**October 1 – October 31, 2018**

**Events:** Webinars, lunchtime, and nighttime seminars, and Benefits Onsite meetings will be offered throughout Open Enrollment—check for updates at [keepingLAWell.com](http://keepingLAWell.com).

**Last day to make changes:**  
**October 31, 2018**

**Documentation deadline:**  
**December 10, 2018**

**Benefit changes take effect:**  
**January 1, 2019;** Health plan ID cards will be issued shortly thereafter.

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## Here are three top things you should know:

1. Open Enrollment is your only opportunity to make coverage elections for yourself and your dependents for 2019 (unless you experience a qualifying life event change in 2019).
2. Generally, your previously elected 2018 benefit elections will automatically roll over to 2019 unless you make a change during Open Enrollment.
3. Enrollment in either the Dependent Care Reimbursement Account (DCRA) and/or the Healthcare Flexible Spending Account (HCFSA) **does not automatically roll over** – if you wish to continue participating in 2019 or become a new participant in one of these accounts for 2019, you will need to elect to do so during Open Enrollment.



## How do I enroll during Open Enrollment?

Call **800-778-2133** or log on to **keepingLAwell.com**. The deadline to enroll or make changes is October 31!

See your Detailed Enrollment Checklist on page 3.

# CHOOSEwell Benefit Overview

## Here are some important questions and the answers:

### When do my Benefits Start?

- Open Enrollment elections are effective January 1, 2019.
- Newly hired employee elections are effective the date you enroll.
- Employees who are rehired or have their benefits reinstated will have varied effective dates of coverage. See page 51 for more information.

### How do I make a change during the year?

The benefit choices you make during Open Enrollment will stay in effect through December 31 2019.

You cannot change your choices during the year unless you have a life event as described by federal rules. **Common qualifying life events** include:

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

(See page 48 for more information on Life Events.)

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

You must notify the Plan within **30 days** of the qualifying life event by contacting the Benefits Service Center. A confirmation statement will be sent to you that documents your request and outlines any additional requirements. You will be requested to provide documents showing proof of the qualifying life event within **60 days** of the date on the confirmation statement reflecting such change. If you do not provide the required documents by the deadline, your requested changes will not be implemented. See page 48 for more information.



## Important questions and answers *continued*:

### What are my Benefit options and costs?

Your Benefit Options		Provider	Your Cost*	See Page
Medical	HMO health plans PPO health plan	Anthem and Kaiser	Cost varies based on coverage level elected and your MOU	8-21
	Cash-in-Lieu	City	None. Pays you up to \$100** each month.	9
	Dental	PPO dental plan DHMO dental plan	Delta Dental	Cost varies based on coverage level elected
Preventive Only plan		None. Pays you up to \$5** each month.		22-25
Vision	In-Network	EyeMed	Included at no cost	26-28
	Out-of-Network reimbursements			
Employee Assistance Program	Employee Assistance counseling services	Optum*** New provider starting January 2019***	Included at no cost	29
Insurance	Disability – <b>Basic Coverage</b> (up to 50% of earnings for a maximum of 2 years)	Standard Insurance Company	Included at no cost	30-38
	Life – <b>Basic Coverage</b> (\$10,000 for full-time, \$5,000 for half-time).		Included at no cost	
	Disability – <b>Supplemental Coverage</b> (up to 66 2/3% of earnings until retirement age)		Cost varies based on coverage level elected and is calculated by age and income. See your Personal Enrollment Fact Sheet or log into your account at <a href="http://keepingLAWell.com">keepingLAWell.com</a> for your specific cost details.	
	Life – <b>Supplemental Coverage</b> (up to 5x your annual salary)			
	Life – Spouse/Domestic Partner Coverage (up to \$100,000)			
	Life – Child Coverage (\$5,000 per child)			
	Accidental Death & Dismemberment (AD&D) (up to \$500,000)			
Tax-Advantaged Spending Accounts	Healthcare Flexible Spending Account	WageWorks	You elect voluntary contributions up to maximum limit	39-42
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\*Your personal cost options are detailed in your Personal Enrollment Fact Sheet. They are also available by logging into your account at [keepinglawell.com](http://keepinglawell.com).

\*\* Amounts represent full-time employment status. For half-time employees, the benefit is reduced 50%.

\*\*\*Managed Health Network (MHN) provides Employee Assistance Program services through December 31, 2018.

### Who can I cover and what is required?

Generally, any person who is your legal dependent is eligible to be added to your coverage. Supporting documentation to prove your relationship will be required to keep your dependent on your benefits. See page 45 for detailed eligibility information.

### When does my coverage end?

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

For more information see pages 47 and 53.

### What happens if I go on leave?

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

For more information see pages 50-53.

### Why should I update my beneficiary(ies)?

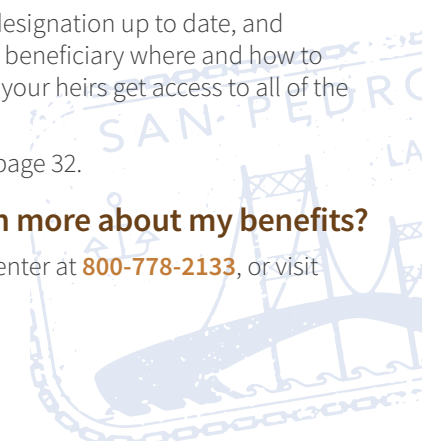
Beneficiaries for your insurance coverage elections are unique to your **LAWell** benefits. Your beneficiary elections for your LACERS retirement, Deferred Compensation Plan, or other City benefits are separate from the beneficiaries you designate for your **LAWell** Life and AD&D Insurance options.

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

For more information see page 32.

### Who do I call to learn more about my benefits?

Call the Benefits Service Center at **800-778-2133**, or visit [keepingLAWell.com](http://keepingLAWell.com).





# Medical Coverage & Cash-in-Lieu

## Your Medical Plan Choices

### Anthem

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

### Kaiser

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

### Cash-in-Lieu

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



### The Affordable Care Act (ACA)

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

## Understanding HMO and PPO Plans

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

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

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

	Anthem Narrow Network (Select) HMO/Anthem Full Network (CACare) HMO	Anthem Vivity (LA & Orange Counties) HMO	Kaiser Permanente HMO	Anthem PPO
<b>In-network care</b>	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.
<b>Out-of-network care</b>	Not covered unless you need care for a serious medical emergency outside of your HMO’s network service area.			You may visit any licensed provider you choose, and no primary care physician or specialist referrals are required. However, you will receive a lower level of benefits for out-of-network care.



## How Do I Enroll in Cash-in-Lieu?

### For first-time elections:

1. Select Cash-in-Lieu during Open Enrollment.
2. Complete the **Cash-In-Lieu Affidavit**, providing required supporting documentation of your eligible health coverage, by the **December 10, 2018** deadline.

Download the Affidavit at [keepingLAWell.com](http://keepingLAWell.com). You will also receive a copy along with your confirmation statement.

### **Additional first-time enrollment rules:**

*If you enroll during Open Enrollment for 2019, participation is effective January 1, 2019 and your current LAWell health coverage will terminate December 31, 2018. Your first "Cash-In-Lieu" payment will be reflected in your gross wages on the paycheck you receive on January 2, 2019, for the pay period ending December 22, 2018. If you do not submit a Cash-In-Lieu Affidavit by December 10, 2018 for 2019 Open Enrollment or within 60 days of a qualifying life event change that you have in 2019, your participation in Cash-In-Lieu will be canceled and you will be enrolled in employee-only health coverage. If you have no prior coverage elections in our records, you will be enrolled into the default health coverage plan for that year. Approval of your Cash-in-Lieu Affidavit is subject to review and verification by the Employee Benefits Division and your participation in the Cash-in-Lieu program may also be canceled based on the information you provide on your Affidavit.*

### For continuing elections:

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

## Questions?

### **ONLINE:**

**Anthem Blue Cross**  
[anthem.com/ca/cityofla](http://anthem.com/ca/cityofla)

**Kaiser Permanente**  
[my.kp.org/ca/cityofla](http://my.kp.org/ca/cityofla)

### **CALL:**

**Anthem PPO**  
833-597-2362

**Anthem HMO (Narrow or Full)**  
844-348-6111

**Anthem Vivity**  
844-348-6110

**Kaiser Permanente**  
800-464-4000

### **IN PERSON:**

**Member Advocates at City Hall Room 867**

**Anthem Blue Cross**  
Mon-Fri, 8:00 am-4:00 pm

**Kaiser Permanente**  
Tue-Thurs, 8:00 am-4:00 pm

If you have further questions, please contact the Employee Benefits Division at **213-978-1655**.

Si tiene preguntas adicionales, por favor llame a la División de Beneficios para Empleados: **213-978-1655**.



## What is Cash-in-Lieu?

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

### **What coverage is eligible for Cash-in-Lieu?**

The eligible medical coverage options include:

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

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

### **How much does Cash-in-Lieu pay?**

- Full-time employees receive an additional \$50 in taxable income in your paycheck each pay day, up to \$100 per month.
- Half-time employees receive \$25 per paycheck, up to \$50 per month.



**Open Enrollment is your only opportunity to make coverage elections for yourself and your dependents for 2019 (unless you experience a qualifying life event change in 2019).**



## Finding Network Providers

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

- Go to [anthem.com/ca/cityofla](http://anthem.com/ca/cityofla)
- Select Find a Doctor , Hospital, or Urgent Care
- Identify your plan:
  - Narrow Network (Select HMO)
  - Full Network (CACare HMO) – Large Group
  - Vivity HMO (LA and Orange Counties)
  - Vivity Behavioral Health (LA and Orange Counties)
  - PPO

For help finding a PCP, you may call Anthem (Narrow, Full) **844-348-6111** or Anthem Vivity **844-348-6110** Monday through Friday, 8 a.m. to 8 p.m. or visit [anthem.com/ca/cityofla](http://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](http://my.kp.org/ca/cityofla).
  - Choose Find a Doctor
  - Choose Southern California
- For help finding a PCP, you may call Kaiser Member Services at **800-464-4000**.

### For help finding a PCP, you may call:

Anthem (Narrow, Full) at **844-348-6111** or Anthem Vivity at **844-348-6110** Monday through Friday, 8 a.m. to 8 p.m. or visit [anthem.com/ca/cityofla](http://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](http://my.kp.org/ca/cityofla).

## About Your Primary Care Physician (HMO Plans only)

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

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

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

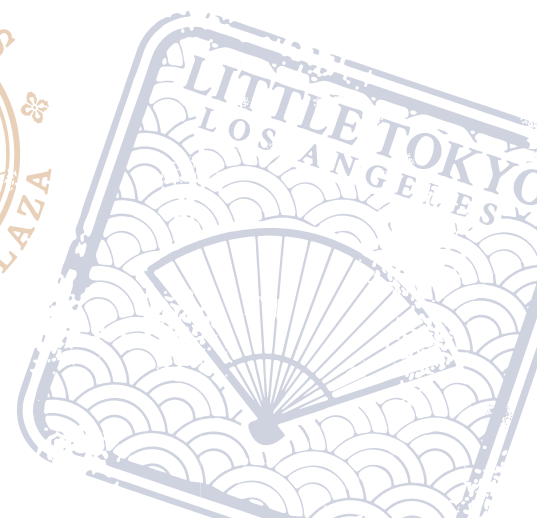
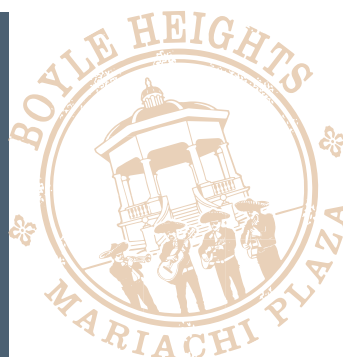
### Health Plan Member Advocates

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

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

## Medical services via phone or web

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



## Residence/Worksite Proximity to Service Providers

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

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

## Understanding Your Out-of-Pocket Costs

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

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

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

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

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



## Medical Plan Costs and Coverage Levels

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

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

See page 46 for more information on eligible dependents.

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

The amount of premium you are responsible for depends on your employment status (full-time or half-time), the Memorandum of Understanding (MOU) that applies to you, the number of dependents you cover (if any), and the specific plan you choose. There are two contribution structures: **LAwell Plan** and **LAwell Pay Plan**.

**LAwell Plan:** Pays up to the City’s maximum subsidy without additional premium cost-sharing. Covered MOUs include 02, 03, 04, 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, 05, 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 (\$1,590.36 per month) for full-time employees and the Kaiser Permanente HMO employee-only rate (\$611.70 per month) for half-time employees, subject to any premium sharing requirements as provided for by the employee’s MOU.

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

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

\*Domestic partnerships are not recognized under federal tax law and enrollment of domestic partner dependents may result in different taxable income treatment. See page 44 for more information.

For details on prescription drug coverage, see page 17.



# LAWell Plan

## Your 2019 Medical Plan Coverage Costs Per Pay Period (Every Two Weeks)

Coverage Level	Full-Time Employees (MOUs 02, 03, 04, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 34, 36 and 37)		Half-Time Employees (MOUs 02, 03, 04, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 34, 36 and 37)		Total Cost of Coverage Bi-Weekly (per Pay Period)
	City Pays...	Employee Pays...	City Pays...	Employee Pays...	
<b>Kaiser HMO</b>					
Employee Only	\$305.85	\$0.00	\$305.85	\$0.00	\$305.85
Employee & Spouse/DP*	\$672.81	\$0.00	\$305.85	\$366.96	\$672.81
Employee + Child(ren)*	\$611.70	\$0.00	\$305.85	\$305.85	\$611.70
Employee + Family*	\$795.18	\$0.00	\$305.85	\$489.33	\$795.18
<b>Anthem Narrow Network (Select) HMO</b>					
Employee Only	\$326.75	\$0.00	\$305.85	\$20.90	\$326.75
Employee & Spouse/DP*	\$718.88	\$0.00	\$305.85	\$413.03	\$718.88
Employee + Child(ren)*	\$620.85	\$0.00	\$305.85	\$315.00	\$620.85
Employee + Family*	\$795.18	\$54.41	\$305.85	\$543.74	\$849.59
<b>Anthem Full Network (CACare) HMO</b>					
Employee Only	\$326.75	\$134.65	\$305.85	\$155.55	\$461.40
Employee + Spouse/DP*	\$718.88	\$296.19	\$305.85	\$709.22	\$1,015.07
Employee + Child(ren)*	\$620.85	\$255.80	\$305.85	\$570.80	\$876.65
Employee + Family*	\$795.18	\$404.47	\$305.85	\$893.80	\$1,199.65
<b>Anthem Vivity (LA &amp; Orange Counties) HMO</b>					
Employee Only	\$274.29	\$0.00	\$274.29	\$0.00	\$274.29
Employee + Spouse/DP*	\$603.46	\$0.00	\$305.85	\$297.61	\$603.46
Employee + Child(ren)*	\$521.16	\$0.00	\$305.85	\$215.31	\$521.16
Employee + Family*	\$713.17	\$0.00	\$305.85	\$407.32	\$713.17
<b>Anthem PPO</b>					
Employee Only	\$525.45	\$0.00	\$305.85	\$219.60	\$525.45
Employee + Spouse/DP*	\$795.18	\$360.83	\$305.85	\$850.16	\$1,156.01
Employee + Child(ren)*	\$795.18	\$203.18	\$305.85	\$692.51	\$998.36
Employee + Family*	\$795.18	\$571.01	\$305.85	\$1,060.34	\$1,366.19

\*Domestic partnerships are not recognized under federal tax law and enrollment of domestic partner dependents may result in different taxable income treatment. See page 44 for more information.



# LAWELL Pay Plan

## Your 2019 Medical Plan Coverage Costs Per Pay Period (Every Two Weeks)

Coverage Level	Full-Time Employees (MOUs 00, 01, 05, 19, 20, 21, 26, 27, 28, 29, 30, 31, 32, 38, 39, 40, 61 and 63)		Half-Time Employees (MOUs 00, 01, 05, 19, 20, 21, 26, 27, 28, 29, 30, 31, 32, 38, 39, 40, 61 and 63)		Total Cost of Coverage Bi-Weekly (per Pay Period)
	City Pays...	Employee Pays...	City Pays...	Employee Pays...	
<b>Kaiser HMO</b>					
Employee Only	\$275.27	\$30.58	\$275.27	\$30.58	\$305.85
Employee & Spouse/DP*	\$605.53	\$67.28	\$275.27	\$397.54	\$672.81
Employee + Child(ren)*	\$550.53	\$61.17	\$275.27	\$336.43	\$611.70
Employee + Family*	\$715.66	\$79.52	\$275.27	\$519.91	\$795.18
<b>Anthem Narrow Network (Select) HMO</b>					
Employee Only	\$294.08	\$32.67	\$275.27	\$51.48	\$326.75
Employee + Spouse/DP*	\$646.99	\$71.89	\$275.27	\$443.61	\$718.88
Employee + Child(ren)*	\$558.77	\$62.08	\$275.27	\$345.58	\$620.85
Employee + Family*	\$715.66	\$133.93	\$275.27	\$574.32	\$849.59
<b>Anthem Full Network (CACare) HMO</b>					
Employee Only	\$294.08	\$167.32	\$275.27	\$186.13	\$461.40
Employee + Spouse/DP*	\$646.99	\$368.08	\$275.27	\$739.80	\$1,015.07
Employee + Child(ren)*	\$558.77	\$317.88	\$275.27	\$601.38	\$876.65
Employee + Family*	\$715.66	\$483.99	\$275.27	\$924.38	\$1,199.65
<b>Anthem Vivity (LA &amp; Orange Counties) HMO</b>					
Employee Only	\$246.86	\$27.43	\$246.86	\$27.43	\$274.29
Employee + Spouse/DP*	\$543.12	\$60.34	\$275.27	\$328.19	\$603.46
Employee + Child(ren)*	\$469.05	\$52.11	\$275.27	\$245.89	\$521.16
Employee + Family*	\$641.86	\$71.31	\$275.27	\$437.90	\$713.17
<b>Anthem PPO</b>					
Employee Only	\$472.91	\$52.54	\$275.27	\$250.18	\$525.45
Employee + Spouse/DP*	\$715.66	\$440.35	\$275.27	\$880.74	\$1,156.01
Employee + Child(ren)*	\$715.66	\$282.70	\$275.27	\$723.09	\$998.36
Employee + Family*	\$715.66	\$650.53	\$275.27	\$1,090.92	\$1,366.19

\*Domestic partnerships are not recognized under federal tax law and enrollment of domestic partner dependents may result in different taxable income treatment. See page 44 for more information.



# CHOOSEwell—A Medical Plan Coverage Comparison

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

	Anthem Narrow Network (Select HMO)/Anthem Full Network (CACare HMO)	Anthem Vivity (LA & Orange Counties)	Kaiser Permanente HMO
<b>Calendar Year Deductible</b>	\$0		\$0
<b>Calendar Year Out-of-Pocket Limit</b>	\$500/person, \$1,500/family		\$1,500/person; \$3,000/family
<b>Choice of Physicians and Facilities (hospital, etc.)</b>	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
<b>Routine Office Visits (including pediatric visits)</b>	Plan pays 100% after \$15 copay/visit ****		Plan pays 100% after \$15 copay/visit ****
<b>Preventive Care,* Maternity Care (Office Visits) &amp; Inpatient Hospitalization</b>	Plan pays 100%		Plan pays 100%
<b>Outpatient Surgery</b>	Plan pays 100%		Plan pays 100% after \$15 copay/procedure
<b>Diagnostic Lab Work and X-rays</b>	Plan pays 100%		Plan pays 100% at a Kaiser facility
<b>Emergency Room Care for True Emergencies (such as severe chest pains or breathing difficulties, severe bleeding, poisoning)</b>	Plan pays 100% after \$100 copay/visit; copay waived if admitted		Plan pays 100% after \$100 copay/visit; copay waived if admitted
<b>Hearing Aid Benefit</b>	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
<b>Prescription Drugs * see additional information on page 17</b>	See "Prescription Drug Coverage" on page 17 for details		
Mental Health & Substance Abuse Treatment			
<b>Inpatient**</b>	Plan pays 100%		Plan pays 100%
<b>Outpatient**</b>	Plan pays 100% for facility-based care; 100% after \$15 copay/visit for physician visits****		Plan pays 100% after \$15 copay/visit for individual visit, \$5-7 copay/visit for group session****

\*Preventive care coverage includes preventive services rated A or B by the U.S. Preventive Services Task Force and federal regulations. Go to the website for your health plan or call your health plan if you have questions about coverage.  
 \*\*The mental health inpatient and outpatient benefits shown here are general benefit provisions. Consult with your plan for specific information regarding benefits available.  
 \*\*\* To find a provider or verify physicians, contact **Anthem PPO at 833-597-2362, Anthem HMO (Narrow, Full) at 844-348-6111, or Anthem Vivity at 844-348-6110.**  
 \*\*\*\* Copay varies by office visit type. See the Evidence Of Coverage for more details.





# CHOOSEwell—A Medical Plan Coverage Comparison

Anthem PPO		
	In-Network	Out-of-Network
<b>Calendar Year Deductible</b>	\$750/person; \$1,500/family	\$1,250/person; \$2,500/family
<b>Calendar Year Out-of-Pocket Limit</b>	\$2,000/person; \$4,000/family, in-network and out-of-network combined	
<b>Choice of Physicians and Facilities (hospitals, etc.)</b>	Access covered services through Prudent Buyer PPO preferred providers	Access covered services through any provider
<b>Routine Office Visits</b>	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
<b>Online Office Visits</b>	Plan pays 100% after \$30 copay	N/A
<b>Pediatric Office Visits Well Baby &amp; Well-Child Care</b>	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
<b>Preventive Care*</b>	Plan pays 100%, no deductible	Plan pays 70% of allowed charges*** after deductible
<b>Inpatient Hospitalization</b>	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.****
<b>Outpatient Surgery</b>	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.
<b>Maternity Care (office visits)Pregnancy &amp; Maternity Care Office Visits</b>	Prenatal and postnatal office visits for ACA mandated services: 100%; no copay, no deductible. Other prenatal and postnatal office visits: Plan pays 100% after \$30 copay/visit with no deductible. Other services: Plan pays 90% after deductible	Plan pays 70% of allowed charges*** after deductible
<b>Diagnostic Lab Work and X-Rays</b>	Plan pays 90% after deductible	Plan pays 70% of allowed charges*** after deductible
<b>Emergency Room Care for True Emergencies (such as severe chest pains or breathing difficulties, severe bleeding, poisoning)</b>	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
<b>Hearing Aid Benefit</b>	Plan pays for one hearing aid per ear every 24 months after \$15 copay/visit	Plan pays for one device per ear every 24 months; covers all visits for fitting, counseling, adjustment, cleaning and inspection
<b>Prescription Drugs * see additional information on page 17</b>	See "Prescription Drug Coverage" on page 17 for details	

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

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

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

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



# CHOOSEwell—A Medical Plan Coverage Comparison

## Anthem PPO, continued

	In-Network	Out-of-Network
<b>Mental Health</b>		
<b>Inpatient**</b>	Plan pays 90% after deductible. Prior authorization is required.****	Plan pays 70% of allowed charges*** after deductible. Prior authorization is required.****
<b>Outpatient**</b>	Plan pays 90% after deductible for facility-based care; 100% after \$30 copay/visit for physician office visit	Plan pays 70% of allowed charges*** after deductible. For physician office visit, Plan pays 70% of allowed charges.
<b>Substance Abuse Treatment</b>		
<b>Inpatient**</b>	Plan pays 90% after deductible. Prior authorization is required.****	Plan pays 70% of allowed charges*** after deductible. Prior authorization is required.****
<b>Outpatient**</b>	Plan pays 90% after deductible for facility-based care; 100% after \$30 copay/visit for physician office visit	Plan pays 70% of allowed charges*** after deductible. Plan pays 70% of allowed charges for physician office visit.

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

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

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

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



## Successfully Managing Dependent Coverage

Not everyone who lives with you is a dependent. Check the eligibility rules listed on pages 45-47 before you request enrollment of a dependent.

Document any added dependents (e.g., birth certificates, marriage license, etc.) by December 10, 2018; adding a dependent does not entitle that individual to coverage unless the City receives the appropriate documentation of eligibility.

To add a new dependent during the year through a qualified life event you must do so within **30 days** of the date he or she becomes your eligible dependent. If you do not act in a timely manner, you will not be able to enroll that dependent until the following year. See Life Events on page 48 for more information.

To remove an ineligible dependent during the year you must do so within **30 days** of the date he or she no longer meets the City's eligibility requirements. If you do not act in a timely manner, you may be subject to paying the cost of dependent claims for periods of ineligibility. See Life Events on page 48 for more information.



## Prescription Drug Coverage Details

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

### Participating Pharmacy

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

- You do not have to submit claim forms.
- For all Anthem plans**, you can fill prescriptions at any retail pharmacy that participates in the Anthem pharmacy network. Prescriptions from non-participating pharmacies are also covered, but the member's cost share is significantly higher. To find a participating pharmacy, go to [anthem.com/ca/cityofla](http://anthem.com/ca/cityofla) and select Find a Doctor, Hospital, or Urgent Care. Select your plan, then select "Pharmacy" from the drop-down menu.
- For the Kaiser Permanente HMO**, you must fill prescriptions at a Kaiser pharmacy. Prescriptions from non-participating pharmacies are not covered unless they are associated with covered emergency services. To find a Kaiser pharmacy, **visit [kp.org](http://kp.org)**.

### 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](http://anthem.com/ca/cityofla) and selecting Find a Doctor, Hospital, or Urgent Care. Select your plan, then select "Pharmacy" from the drop-down menu. You can access the Kaiser drug formulary by going to [kp.org/formulary](http://kp.org/formulary).

	Anthem Plans	Kaiser Permanente HMO
<b>Pharmacy</b>		
<b>Generic Copay</b>	\$10 for up to 30-day supply	\$10 for up to 30-day supply
<b>Brand-name Copay</b>	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
<b>Mail Order (Home Delivery) Service</b>		
<b>Generic Copay</b>	\$20 for up to 90-day supply	\$20 for up to 100-day supply
<b>Brand-name Copay</b>	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
<b>For Questions</b>		
<b>Pharmacies or Mail Order</b>	Anthem PPO at <b>833-597-2362</b> , Anthem HMO (Narrow, Full) at <b>844-348-6111</b> , Anthem Vivity at <b>844-348-6110</b> or <a href="http://anthem.com/ca/cityofla">anthem.com/ca/cityofla</a> or visit a member advocate (see pg. 10)	<b>800-464-4000</b> or <a href="http://my.kp.org/ca/cityofla">my.kp.org/ca/cityofla</a> or visit a member advocate (see pg. 10)

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

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

### Chiropractic Care and Acupuncture

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

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

# Special Health Coverage

## 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 <b>800-225-8883</b> 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 BlueCross BlueShield Global Core Service Center is available 24 hours a day, seven days a week toll free at <b>800-810-BLUE</b> or by calling collect at <b>804-673-1177</b> . An assistant coordinator, along with a medical professional, will arrange doctor or hospitalization needs.		Go to the nearest emergency facility and call <b>800-225-8883</b> if you receive treatment. Request an itemized bill (in English) and save your receipt to file a claim for reimbursement.
Urgent Care	<p><b>In-Area:</b> 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.</p> <p><b>Out-of-Area:</b> 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.</p>	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, <b>anthem.com/ca</b> to locate the nearest in-network facility.	<p>Within the service area, call for an appointment or contact the advice nurse at the number listed in Your Guidebook.</p> <p>Outside service area, but in California, call <b>800-225-8883</b> for assistance.</p>
Prescription Coverage	<p><b>In the U.S.:</b> Call Anthem Blue Cross Customer Service at the number listed on your member ID card or visit <b>anthem.com/ca/cityofla</b> to find a participating pharmacy that accepts your coverage.</p> <p><b>Outside the U.S.:</b> Request an itemized bill (in English) and save your receipt to file a claim for reimbursement.</p>		<p>Within the service area, go to any Kaiser pharmacy.</p> <p>Outside the service area, only emergency/urgent prescriptions are covered; ask for an itemized bill (in English) and save your receipt to file a claim for reimbursement.</p>

## Care for Dependents Who Do Not Live with You

Type of Care	Anthem Narrow Network (Select) HMO Anthem Full Network (CACare) HMO Anthem Vivity (LA & Orange Counties) HMO	Anthem PPO	Kaiser Permanente HMO
Routine care for a dependent who does not live with you	<ul style="list-style-type: none"> <li><b>In California:</b> Select a primary care physician by calling Anthem Blue Cross Customer Service at the number listed on your member ID card or by visiting <a href="http://anthem.com/ca/cityofla">anthem.com/ca/cityofla</a>.</li> <li><b>Outside California:</b> 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.</li> </ul>	Contact Anthem Blue Cross Customer Service at the number listed on your member ID card or visit <a href="http://anthem.com/ca/cityofla">anthem.com/ca/cityofla</a> 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 <a href="http://kp.org">kp.org</a> or call <b>800-464-4000</b> . If no Kaiser facility is available, only emergency care is covered.

### Special Coverage Situations for Dependents

Eligible dependents under your plan may fall under special coverage situations that could affect their ability to remain on your coverage. See **Dependent Coverage Rules for Special Situations** on page 43.





## Wellness Program

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

LIVEwell, our wellness program, launched in 2018. See more information about LIVEwell on page 66. Additional wellness resources presently offered by our health plans are shown in the table below:

	Anthem Plans <a href="http://anthem.com/ca/cityofla">anthem.com/ca/cityofla</a>	Kaiser Permanente HMO <a href="http://my.kp.org/ca/cityofla">my.kp.org/ca/cityofla</a>
<b>Annual Checkups</b>	Annual physical and other in-network preventive care is generally covered at 100% in-network	
<b>Nurse Help Line</b> 24 hours a day, 7 days a week	Call the 24/7 Nurseline at the number listed on your member ID card	<b>888-576-6225</b>
<b>Weight Management and Nutrition Counseling</b>	<ul style="list-style-type: none"> <li>• Solera Diabetes Prevention Program for pre-diabetics (in-person and online)</li> <li>• Diet and nutrition advice</li> <li>• Diabetic Care self-management training (after copay)</li> <li>• Active&amp;Fit Direct™ – provides discounted gym memberships</li> <li>• Discounts on weight loss products and programs, including Jenny Craig, Living Lean, Lindora Clinic, nutrition bars and drinks</li> </ul>	<p>Nutrition counseling available with doctor referral; copay applies</p> <ul style="list-style-type: none"> <li>• Lifestyle Weight Management Course plus other health education programs</li> <li>• Free online personalized Weight Management Program</li> <li>• Weight Watcher discounts</li> </ul>
<b>Smoking/Tobacco Cessation</b>	<p>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:</p> <ul style="list-style-type: none"> <li>• Smoking/tobacco cessation support</li> <li>• Over-the-counter nicotine replacement medications with no copayment</li> <li>• Prescription smoking cessation medications</li> </ul>	<p>Nicotine patches at regular drug copayment for up to six months when registered for a smoking cessation class</p> <ul style="list-style-type: none"> <li>• Stop smoking classes offered at no fee to members</li> <li>• Members can meet with a Clinical Health Educator for one-on-one counseling at regular office copay</li> <li>• Free, online personalized Stop Smoking Program</li> <li>• Quit smoking with Breathe™</li> </ul>

	Anthem Plans <a href="http://anthem.com/ca/cityofla">anthem.com/ca/cityofla</a>	Kaiser Permanente HMO <a href="http://my.kp.org/ca/cityofla">my.kp.org/ca/cityofla</a>
<b>Health Coaching</b>	Contact Anthem Concierge support for resources and wellness services.	Offers a phone-based Health Coaching program available to all members focused on health habits, like managing weight, quitting tobacco, reducing stress, becoming more active, and eating healthier.
<b>Exercise</b>	Offers a web-based walking program that allows members to earn points and join an online community supporting their walking goals.	Exercise videos and fitness widgets
<b>Chronic Care Management</b>	Call <b>800-552-5560</b> 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 <b>800-464-4000</b> .
<b>Other Online Tools</b>	Go to <b><a href="http://anthem.com/ca/cityofla">anthem.com/ca/cityofla</a></b> and select Health & Wellness to find: <ul style="list-style-type: none"> <li>• Preventive health guidelines for men, women, children and seniors</li> <li>• Videos on a range of wellness topics</li> <li>• Articles on alternatives to Western medicine</li> <li>• First aid information</li> <li>• Comprehensive health library</li> <li>• LiveHealth Online doctors</li> </ul>	Total Health Assessment with Succeed™ <ul style="list-style-type: none"> <li>• Physical and mental health quizzes and calculators</li> <li>• Downloadable podcasts</li> <li>• Interactive “Kid Wisdom” site geared for child health</li> </ul>





# Your Dental Coverage

## Dental Coverage Choices

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

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

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

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

Dentists who are not part of Delta's PPO network may still be Delta dentists and agree to accept Delta's reasonable and customary (R&C) fee. In California, 89.9% of dentists belong to a Delta network.



### Choosing A Primary Care Dentist (PCD)

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



## CHOOSEwell – A Dental Plan Comparison

	Delta Dental Preventive Only	DeltaCare USA DHMO	Delta Dental PPO
Features a network of providers	Yes	Yes	Yes
Offers flexibility to use non-network providers	Yes	No	Yes – paid at out-of-network level
Covers preventive care	Yes	Yes	Yes
Covers services other than preventive care – such as basic and major services	No	Yes	Yes
Has a calendar year deductible	No	No	Yes
Has an annual maximum benefit	No	No	Yes

## CHOOSEwell – A Dental Plan Comparison *continued*

	Delta Dental Preventive Only	DeltaCare USA DHMO	Delta Dental PPO
Includes set copayments for most services	No	Yes	No
Requires you to choose a primary care dentist	No	Yes	No
Covers emergency care outside the provider network*	No	Yes – up to \$100 per incident after any copay**	Yes – paid at out-of-network level

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

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

### Delta Dental Network Providers

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

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

### Finding a Network Provider

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

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

### How to Register for a Delta Dental Online Account

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

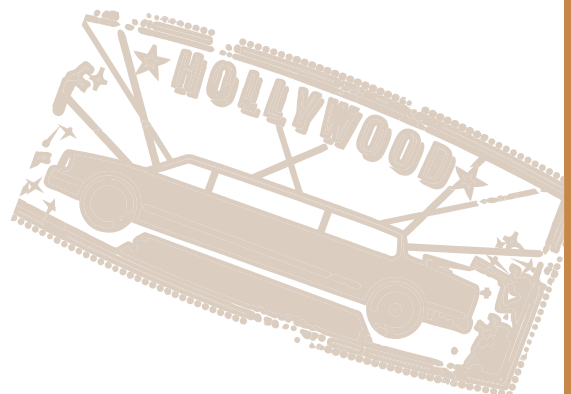
1. Go to [deltadentalins.com/enrollees/index.html](http://deltadentalins.com/enrollees/index.html)
2. Select "Register for an Online Account" from the right side of the page
3. Select "Enrollee /Adult Dependent" from the pull-down menu
4. Enter your personal information

### Dental Coverage Costs and Coverage Levels

The majority of employee-only coverage dental insurance premium costs are paid by the City's subsidy. The **LAwell** Plan offers the same four coverage level options for Dental plans as for medical enrollment (see page 11). For more information on eligible dependents, see page 45.

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

For 2019, the maximum DHMO dental plan subsidy is \$16.78 per month for all employees. The maximum PPO dental plan subsidy is \$44.60 per month for full-time employees and \$26.24 per month for half-time employees.





# LAWell Dental Pay Plan

## Your 2019 Dental Coverage Costs Per Pay Period (Every Two Weeks)

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

\*Additional LAWell dollars credited to employee

\*\*Domestic partnerships are not recognized under Federal tax law and enrollment of domestic partner dependents may result in different taxable income treatment. See page 44 for more information

### What Is Reasonable And Customary (R&C)?

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

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







# CHOOSEwell – Dental Plan Coverage Comparison

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

How Benefits Are Paid	Delta Dental Preventive Only	DeltaCare USA DHMO	Delta Dental PPO	
			In-Network	Out-of-Network
<b>Calendar year deductible</b>	None	None	\$25/person; \$75/family	\$50/person; \$150/family
<b>Diagnostic and Preventive Care</b>				
<ul style="list-style-type: none"> <li>Two cleanings and exams/year</li> <li>Two sets of bitewing X-rays/year for children up to age 18; one set/year for adults</li> <li>Two fluoride treatments/year for children up to age 19 (not covered by Preventive Only)</li> </ul>	Plan pays 100% In-Network or 100% of R&C* Out-of-Network (includes an additional oral exam and routine cleaning during pregnancy)	Plan pays 100% – Covers one series of four bitewing X-rays in any six-month period for children or adults	Cleanings, X-rays and exams; Plan pays 100% with no deductible (includes an additional oral exam and a routine cleaning during pregnancy). Diagnostic and Preventive Care charges are not applied to the annual maximum.	Cleanings, X-rays and exams; Plan pays 80% of R&C* with no deductible (includes an additional oral exam and a routine cleaning during pregnancy). Diagnostic and Preventive Care charges are not applied to the annual maximum.
<b>Basic Services</b>				
<b>Amalgam fillings, extractions</b>	Not covered	Plan pays 100% for fillings; you pay up to \$90 for extractions	Plan pays 80%	Plan pays 80% of R&C*
<b>Root canal</b>	Not covered	Your copay is \$45–\$220 per procedure	Plan pays 80%	Plan pays 80% of R&C*
<b>Periodontal scaling and root planing</b>	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
<b>Major Services</b>				
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*
<b>Orthodontia</b>				
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
<b>Plan Maximums</b>				
Annual maximum benefit (does not include diagnostic and preventive services)	Not applicable	None	\$1,500/person***	
Lifetime orthodontia maximum benefit	Not covered	None	\$1,500/child	

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

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

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



# Vision Coverage

## Your Vision Coverage

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



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

No ID cards are needed, but can be printed on [eyemedvisioncare.com/cityofla](http://eyemedvisioncare.com/cityofla).

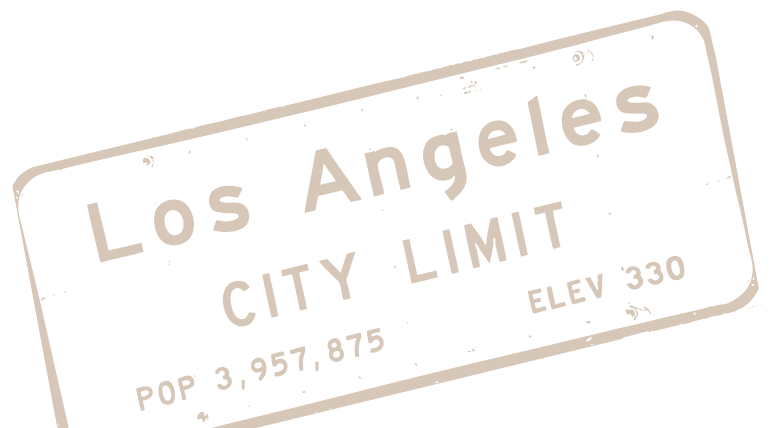
## The EyeMed Network

EyeMed provides care through a network of vision care specialists who have agreed to offer covered services at discounted rates. The EyeMed Insight network has over 98,000 providers, including 50,000 independent providers plus national retail chains such as LensCrafters®, Sears Optical®, Target Optical®, JCPenney Optical® and most Pearle Vision® locations. To find a provider near you and schedule an appointment, visit [eyemedvisioncare.com/cityofla](http://eyemedvisioncare.com/cityofla) or download the EyeMed mobile app (available in the Apple App Store and Google Play) and choose the Insight network from the list of network options.

## Out-of-Network Providers

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

Annual Benefit to Purchase Eyeglasses & Contacts		
	Covered	Not Covered
<b>Option 1</b>	\$150 Contact Lens Allowance + \$150 Frame ONLY Allowance	Eyeglass lens
<b>Option 2</b>	\$150 Frame Allowance + Eyeglass lens copay	Contact lenses





## In- and Out-of-Network Vision Benefits

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

Benefits	EyeMed In-Network Provider What you pay	Out-of-Network Provider What the Plan reimburses
<b>Routine Eye Exam<sup>1</sup></b>	\$10 copay	\$45 reimbursement maximum*
<b>Exam Options:</b> 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*
Frames <sup>2</sup>	\$150 Allowance, 80% of balance over \$150	\$104 reimbursement maximum*
<b>EyeGlass Lenses<sup>2</sup></b>		
<b>Lenses<sup>2</sup></b> Single Vision Bifocal Trifocal Standard Progressive <sup>†</sup> Premium Progressive Tier 1 <sup>†</sup> Premium Progressive Tier 2 <sup>†</sup> Premium Progressive Tier 3 <sup>†</sup> Premium Progressive Tier 4 <sup>†</sup>	\$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*
<b>Contact Lenses</b>		
<b>Lens Options<sup>2</sup></b> UV Treatment Tint (Solid & Gradient) Standard Plastic Scratch Coating Standard Polycarbonate – Adults Standard Polycarbonate – Kids under 19 Standard Anti-Reflective Coating <sup>†</sup> Premium Anti-Reflective Tier 1 <sup>†</sup> Premium Anti-Reflective Tier 2 <sup>†</sup> Premium Anti-Reflective Tier 3 <sup>†</sup> Polarized Photochromic/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
<b>Contact Lenses<sup>2</sup></b> 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

<sup>†</sup> Tier levels reflect Name Brand categories.

<sup>1</sup> Eye Exam coverage through EyeMed applies to a routine eye exam for a vision prescription. Medical eye exams are typically covered through your health care provider. See the chart on page 28 and visit [keepinglawell.com](http://keepinglawell.com) for more information.

<sup>2</sup> The Frame allowance can be used with either the Contact Lenses allowance OR the Lenses/Lens Options copay options during a calendar year. Contact Lenses and Eyewear Lens benefits cannot be used together in the same calendar year. Visit [keepinglawell.com](http://keepinglawell.com) for more information.

## Retinal Imaging

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



## How EyeMed Benefits Work with Medical Plan Vision Benefits

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

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

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



## Vision Plan Costs and Coverage Levels

All vision insurance premium costs are paid by the City.

Enrollment in the vision plan will match your elected enrollment into medical coverage. For more information on eligible dependents, see page 45.

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

# The Employee Assistance Program

The Employee Assistance Program (EAP), a service that provides you and your family with professional and confidential counseling support, is designed to help you manage life challenges and improve your quality of life.

**Your EAP program is completely confidential and voluntary.**

## How It Works

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

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

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



## New Provider, Same Service

Starting on January 1, 2019, Optum will be the City's provider for EAP services.

The phone number for your EAP will not change. Call **800-213-5813** to seek services at any time in 2018 and 2019.

Starting January 1 2019, your online access to EAP services will change under Optum.

You and your dependents can access your EAP services in 2018 and 2019 in the following ways:

	Through December 31, 2018	Starting January 1, 2019
EAP Provider	Managed Health Network	Optum
Website	<b>members.mhn.com</b>	<b>Liveandworkwell.com</b>
Access Code	cityoflosangeles	CityofLA
Phone	<b>800-213-5813</b>	

## 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**.



## Benefits for All Employees and their Family Members

- **Consultation and Counseling:** Receive unlimited 24/7 access to EAP Specialists over the phone. In addition, you are eligible for five face to face and web-video consultations, per person, per incident, per benefit period at no cost to you. EAP sessions will be coordinated by Optum.

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

- **Liveandworkwell.com:** Reliable, trusted website with resources to address all life's challenges.
- **Work-Life Support:** Concierge-like services including eldercare, referral services and convenience services. More than 100 services areas covered.
- **Legal assistance and financial counseling:** consultations on specific legal and financial issues at no initial cost and other discounted fees for attorneys retained through EAP.



# Life Insurance

## Life Insurance

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

### Life Insurance Options Overview:

Insurance for Yourself	Coverage Amount	Your Cost
<b>Basic Life Insurance</b>	\$10,000 for full-time employees; \$5,000 for regular half-time employees	\$0.00 This is a City paid benefit.
<b>Supplemental Life Insurance</b>	Up to 5 times your annual base salary rounded up to the nearest \$1,000	Varies – See page 32.

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

Under Federal law, you may be taxed on the value of coverage, called imputed income, over a certain dollar amount. See page 32 for more information on imputed income.



## Supplemental Life Insurance

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

Supplemental Life Insurance Example:	
<b>Employee Annual Base Pay</b>	\$43,552
<b>Coverage Level Selected</b>	4 times
<b>Subtotal</b>	\$174,208
<b>New Subtotal</b> (round up to nearest \$1,000)	\$175,000
<b>Actual coverage purchased</b>	<b>\$175,000</b>

You buy supplemental life insurance you choose with pre-tax dollars from your pay. See “Your Monthly Cost for Supplemental Life Insurance” on page 32 for life insurance rates. Below is the per pay period cost for the previous employee choosing supplemental life coverage of four times pay, assuming the employee is 46 years old.

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

\*See chart on page 32. Example assumes employee is 46 years old.

### Online Calculator

Use the online calculator to help you determine how much insurance you need. From [keepingLAwell.com](http://keepingLAwell.com), access the calculator directly through the Standard Insurance Company, or through the Benefits Central Portal when you make an election change.



## Requirements to Enroll into Life Insurance Coverage

### Active Work Requirement

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

### Medical History Statement Requirement

Some life insurance coverage levels available to you will require you and/or your dependent to complete a Medical History Statement. A Medical History Statement (“MHS”), available at [keepingLAWell.com](http://keepingLAWell.com), asks a series of questions (about five) regarding your current and past medical condition. Once received, the Standard Insurance Company will review your statement and determine if any additional information or action is required of you or your dependent before an approval of coverage determination can be made. You must complete and return the MHS before your submission deadline **and** it must be approved by the Standard Insurance Company before your coverage can take effect. If you or your dependents’ MHS has not been provided by the deadline, any pending coverage will be removed from your benefits account and the City will send a confirmation statement of this change to you. If the MHS is submitted before your deadline, but the Standard Insurance Company requires additional information/ action before an approval determination can be made, your coverage will become effective on the date of approval. The City will not take payroll deductions until the insurance company provides a date of approval.

### When is MHS Required?

#### For your coverage:

There are many situations when a MHS is required. View offer options on your Personal Employee Fact Sheet or in your online account at [keepingLAWell.com](http://keepingLAWell.com) to see if your election will require you to complete a MHS. However, in general, current **LAWell** members choosing to increase their current coverage by more than one level or choosing coverage over the amount of \$750,000 or three times your annual earnings will be required to complete the MHS.

For new hire employees, the MHS requirement may be waived if enrollment occurs by the new hire enrollment offer deadline.

#### For your dependent spouse/domestic partner coverage:

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

For new hire employees, the MHS requirement may be waived if enrollment occurs by the new hire enrollment offer deadline.

#### For your dependent child coverage:

Not applicable

### What is the MHS submission deadline?

After your enrollment in a plan that requires a MHS, you will receive a confirmation statement that provides you a deadline for submitting the MHS. Typically, the deadline is 60 days from the date of your confirmation statement.

However, you can complete the form at anytime online. The MHS form is available at [keepingLAWell.com](http://keepingLAWell.com).

### Reductions Based on Age

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

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

### Dependent Life Coverage Level and Eligibility Requirements

#### Spouse/Domestic Partner

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

The spouse/domestic partner you purchase coverage for must be a named dependent for your **LAWell** coverage. Eligibility rules apply to your dependents (see pages 45-47).

#### Child

The child you purchase coverage for must be a named dependent for your **LAWell** coverage. Eligibility rules apply to your dependents; see page pages 45-47.

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

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

## Claiming Life Insurance Benefits— Things to Consider

### Designating a Beneficiary

#### For your life coverage (Basic and Supplemental):

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

It is important to name a beneficiary so death benefits can be paid to the person of your choice if you were to die. To name or update your beneficiary information, go to [keepinglawell.com](http://keepinglawell.com). You can also call the Benefits Service Center at **800-778-2133**.

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

You will be the beneficiary for dependent life insurance.

### Accelerated Benefit

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

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

## Claims Process

To receive a life insurance benefit, the beneficiary must complete and submit a beneficiary statement with required documentation. If you have designated multiple beneficiaries, each beneficiary must complete and submit their own. The City and its life insurance provider, Standard Insurance Company, will not notify beneficiaries of any eligibility. **It is the responsibility of the beneficiary to initiate the life insurance claim process.** Ensure your beneficiary is informed of their designation as your beneficiary and the process to initiate a claim. View more information at [keepinglawell.com](http://keepinglawell.com), including the Checklist For Surviving Family Members, or call the Benefits Service Center at **800-778-2133**.

## Funeral Planning Services

The Funeral Planning service option allows for your beneficiary to designate a funeral home assignment, which allows the insurance company to pay the funeral home directly from your life insurance policy. Additional funeral planning services may be available. Review more information on funeral planning services at [keepingLAWell.com](http://keepingLAWell.com).

## Coverage Costs & Imputed Income



### Your Monthly Cost for Supplemental Life and Dependent Insurance

#### Insurance for yourself

Here are the 2019 monthly rates for supplemental life insurance for each \$1,000 in coverage. The Personal Enrollment Fact Sheet you receive shows your coverage cost.

Age on 9/1/18	Rate per \$1,000 of coverage
Under 25	\$0.044
25 – 29	\$0.051
30 – 34	\$0.068
35 – 39	\$0.078
40 – 44	\$0.086
45 – 49	\$0.120
50 – 54	\$0.188
55 – 59	\$0.352
60 – 64	\$0.513
65 – 69	\$1.046
70 or above	\$1.697

#### Insurance for your dependents

Dependent coverage costs are based on a group rate by coverage level. Here are the 2019 monthly group rates for dependent coverage:

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



## About Life Insurance and Imputed Income

### Insurance for yourself

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

### Insurance for your dependents

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

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

### Example of Imputed Income

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

<b>Supplemental life insurance</b> (\$45,000 × 3)		\$135,000
<b>Plus</b> Core life insurance	+	\$10,000
<b>Equals</b> Total life insurance	=	\$145,000
<b>Minus</b> Amount that's not taxed	-	\$50,000
<b>Equals</b> Taxable amount above \$50,000	=	\$95,000
<b>Divided</b> by 1,000	÷	1,000
<b>Equals</b> Units of coverage	=	95
<b>Times</b> Imputed income from IRS table for age 30 (see table below)	x	.08
<b>Equals</b> 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

### Salary Changes and Supplemental Life

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

## Continuing Coverage After Your City Employment ends

### Portability and Conversion

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

#### Portability

##### For your life coverage (Basic and Supplemental)

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

##### For your Dependents life coverage (Spouse/DP and Child)

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

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

#### Conversion

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

#### What You Need to Do

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



## Accidental Death & Dismemberment Insurance

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

### AD&D Insurance Option Overview:

Insurance	Coverage Amount	Your Cost
Employee Only	\$50,000 to \$500,000 (\$50,000 increments)	Varies – See page 35
Family Coverage	\$50,000 to \$500,000 (\$50,000 increments)	Varies – See page 35

### Requirements to Enroll into Coverage

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



### Active Work Requirement

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

# Accidental Death & Dismemberment (AD&D) Insurance

## Claiming AD&D Benefits – Things to Consider

The **Designating a Beneficiary and Claims Process** for Life Insurance all apply to AD&D. See page 32 for more information.

### Additional Benefit Payout Rules

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

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

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

<sup>1</sup>This benefit includes loss of life due to exposure or disappearance

<sup>2</sup> This benefit is payable whether or not the hand or foot is surgically reattached

<sup>3</sup> No AD&D benefit will be paid for loss of function of a hand or foot if an AD&D benefits is payable for Quadriplegia or Paraplegia

## AD&D Family Coverage

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

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



### AD&D Coverage Costs

Here are the 2019 monthly rates for supplemental life insurance for each \$1,000 in coverage. The Personal Enrollment Fact Sheet you receive shows your coverage cost.

AD&D Coverage Option	Rate per \$1,000 of coverage
Employee Only	\$0.011
Family Coverage	\$0.026

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

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

### Reductions Based on Age

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

## Continuing AD&D Coverage After Your City Employment Ends

### Portability and Conversion: What You Need to Do

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

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





# Disability Coverage

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



## Basic and Supplemental Disability Overview:

	Benefit*	When Benefits Begin	How Long Can Benefits Last?	Your Cost
<b>Basic Disability Coverage</b>	<b>50%* of your salary up to a maximum of \$3,268 a month</b>	After all the following are met:	Up to 2 Years (STD: 180 days + LTD: 1 year+6 months)	\$0.00 – This is a City paid benefit
<b>Supplemental Disability Coverage</b>	<b>66 2/3%* of your salary up to a maximum of \$12,000 a month</b>	<ul style="list-style-type: none"> <li>All sick leave is used; <i>and</i></li> <li>An application for disability is filed; <i>and</i></li> <li>Benefits are approved</li> </ul>	Generally, until you are no longer disabled, or age 65, whichever is earlier.  (STD: 180 days + LTD**: up to max benefit age)	Varies (refer to your personal enrollment worksheet)

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

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

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

Supplemental coverage pays a higher monthly benefit than basic disability coverage, and pays beyond the 24-month limit (short-term and long-term disability combined) if you remain disabled. Supplemental disability coverage costs are calculated based on your age and your annual salary at the time of enrollment. See Disability Definitions on page 38 for more details.

### Sick Leave and Disability – What’s the Difference?

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

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



## Requirements to Enroll into Disability Coverage

### Active Work Requirement

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

## Medical History Statement (MHS) Requirement

In most situations, enrolling in supplemental disability coverage for the first time will require you to complete a Medical History Statement. A Medical History Statement (“MHS”), available at [keepingLAWell.com](http://keepingLAWell.com), asks a series of questions (about five) about your current and past medical condition. Once received, the Standard Insurance Company will review your statement and determine if any additional information or action is required of you or your dependent before an approval of coverage determination can be made.

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

### What is the MHS Submission Deadline?

After your enrollment in a plan that requires a MHS, you will receive a confirmation statement that provides a deadline for submitting the MHS. Typically, the deadline is **60 days** from the date of your confirmation statement. However, you can complete the form at anytime online. The MHS form is available at [keepingLAWell.com](http://keepingLAWell.com).

### Filing a Disability Claim

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

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

### Disability Benefits Require Approval

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

## Disability Benefits and Other Income Sources

If your disability is work-related and you have filed a Workers’ Compensation claim, you should **also** file a claim with The Standard Insurance Company. 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.

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

### Benefit Protection Plan

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

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

### Taxes and Your Disability Benefits

If you receive Short-Term Disability (STD) benefits, state and/or federal income taxes 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.

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

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





## Disability Definitions

### Definition of Disability

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

- You are required to be totally disabled or partially disabled from your own occupation.
- You are totally disabled from your own occupation if, as a result of physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the substantial and material acts necessary to pursue your own occupation and you are not working in your own occupation.
- You are partially disabled from your own occupation if you are not totally disabled and you are actually working in your own occupation but, as a result of physical disease, injury, pregnancy or mental disorder, you are unable to earn 80% or more of your indexed predisability earnings.

For more details, see your Certificate of Insurance, available from the Employee Benefits Division or online at [keepingLAWell.com](http://keepingLAWell.com).

### Definition of Pre-Disability Earnings for Disability Coverage

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

### Disability Coverage and Pre-Existing Conditions

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

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

### Benefit Exclusions

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

### Other Benefits to Consider

#### Disability Retirement

The opportunity to file for disability retirement is limited to individuals who were paid by their employing department within the last 12 months prior to filing. Please contact 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 Insurance Company.

**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 [keepingLAWell.com](http://keepingLAWell.com) to view the application.



# Health and Dependent Care Tax-Advantaged Spending Accounts

## Types of Accounts

The City offers accounts for tax savings on eligible expenses:

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

## When You Can Enroll

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

### Debit Card

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

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

The debit card is an additional convenience option and is not intended to replace the traditional claim process. Some eligible healthcare expenses may not be available through the debit card and will only be eligible through filing a traditional claim.

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

### Administrative Fee

If you choose to contribute to one of these accounts, a per pay period administrative fee of \$1.50 will automatically be deducted from your paycheck each pay period.

Only one administrative fee applies if you contribute to more than one account.



## How the Accounts are Different

Healthcare Flexible Spending Account (HCFSA)	Dependent Care Reimbursement Account (DCRA)
<ul style="list-style-type: none"><li>• Use it to reimburse yourself for eligible healthcare expenses for you and your eligible dependents</li><li>• Eligible healthcare expenses include medically necessary expenses that are not covered by any medical, dental or vision plan</li></ul>	<ul style="list-style-type: none"><li>• Use it to reimburse yourself for day care expenses for your eligible dependents</li><li>• Eligible dependents generally include your dependent children under age 13 and a disabled spouse or dependent who is incapable of self-care</li></ul>

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

## About the Healthcare Flexible Spending Account

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

### How Much You Can Set Aside

You can set aside from **\$300 up to \$2,650** (maximum amounts subject to Federal law revision) annually in a Healthcare Flexible Spending Account. Your contributions are deducted from your paycheck (pre-tax) each pay period.



## Examples of Eligible and Ineligible Expenses

The Healthcare Flexible Spending Account Can Be Used To Pay For:	The Healthcare Flexible Spending Account <b>CANNOT</b> Be Used To Pay For:
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Chiropractic services</li> <li>• Crutches and wheel chairs</li> <li>• Eye exams, eyeglasses</li> <li>• Laser eye surgery</li> <li>• Hearing aids</li> <li>• Lamaze classes</li> <li>• Mental health and substance abuse treatment</li> <li>• Orthodontia</li> <li>• Copayments, coinsurance and deductibles you pay out of your pocket for medical, prescription drug, dental and vision care</li> <li>• Over-the-counter medications with a doctor's prescription and insulin</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic surgery or procedures, including teeth whitening or bleaching</li> <li>• Your bi-weekly premium contributions for health and dental insurance</li> <li>• Procedures or expenses not medically necessary</li> <li>• Weight loss programs not prescribed by a doctor</li> <li>• Exercise equipment and health club dues not prescribed by a doctor</li> <li>• Nutritional supplements not prescribed by a doctor, such as vitamins taken for general health</li> <li>• Most over-the-counter medications and products without a prescription such as cosmetics, soaps and toiletries</li> </ul>

Go to [wageworks.com/employees/support-center/healthcare-fsa-eligible-expenses-table/](https://wageworks.com/employees/support-center/healthcare-fsa-eligible-expenses-table/) to view a searchable list of HCFSAs-eligible expenses.

### Learn More

Go to [wageworks.com](https://wageworks.com) and [savesmartspendhealthy.com](https://savesmartspendhealthy.com) to learn more about the benefits of using an HCFSAs. Get tips and guidance to help you decide whether to participate in an HCFSAs. You can learn how to stretch your budget if you choose to participate.

### Healthcare Flexible Spending Accounts (FSA) and Healthcare Savings Accounts (HSA)

The **LAWell** program does not offer a high-deductible health plan and the Flexible Spending Account offered through the **LAWell** program is not established as a HSA-compatible option. If you are enrolled in a high-deductible health plan with your spouse/domestic partner, former employer, or other organization and are enrolled (or plan to enroll) into a Health Savings Account (HSA) for 2019, you should consult with your tax advisor before enrolling into **LAWell's** HCFSAs. Enrolling in a FSA account is considered an irrevocable election; see "Important Deadlines and Restrictions" for more information.

### About Eligible Dependents

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

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

See page 41 for a definition of "health plan tax dependent."

### Estimate Expenses Carefully

It is important to estimate HCFSAs expenses carefully and set aside only the amount you think you will need while you are contributing to the account during 2019. **You must file claims for 2019 expenses by April 30, 2020.** If you do not file claims by this deadline, you forfeit any money left in your account. This is an Internal Revenue Code rule and the **LAWell** program cannot make exceptions.

You may be able to make a limited change if you have a qualifying life event (see pages 48-49 for more on life events). For the DCRA, certain changes to your day care provider or the cost of care may also qualify as an eligible change event, subject to approval of the **LAWell** benefits program.

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



## About the Dependent Care Reimbursement Account

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

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

See the shaded box below for a definition of “health plan tax dependent.”

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

### Who Is A “Health Plan Tax Dependent”?

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

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



## How Much You Can Set Aside

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

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

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

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

## About the Dependent Care Reimbursement Account and Taxes

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

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

- You are eligible for the Earned Income Tax Credit. You are eligible for the credit if you have less than \$3,400 in investment income and your income (or the income of you and your spouse, if you are married filing jointly) is less than the amount set forth for 2019 in the table on the next page depending on your number of children.





# Dependent Coverage Rules for Special Situations



## Dependent Coverage Rules for Special Situations

### Important Information about Eligibility Criteria for Disabled Child Over Age 26

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

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

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

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

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

### Children Who Are City Employees

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





### Domestic Partner Coverage and Pre-Tax Benefits

The City of Los Angeles offers domestic partners of City employees, and domestic partners’ children, equal access to its employee benefit programs, including medical, dental and vision plans. To obtain these benefits, you must enroll your dependents during the specified times and provide the required dependent eligibility documentation. Please refer to pages 45-47 for more information on enrolling dependents.

### Federal Taxes vs State Taxes

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

Based on **California state law**, if you provide **LAwell** coverage for a domestic partner, and/or their dependents, you can purchase health or dental coverage with pre-tax dollars as long as your domestic partnership meets eligibility requirements and is registered with the State of California. The amount the City of Los Angeles pays toward coverage cost will be excluded from your reported State income. You must provide a copy of the approved State certificate to receive this tax benefit. For more information on the California income tax benefit, including how to register a domestic partner, contact the City’s Domestic Partnership coordinator at **213-978-1591**.

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

Your additional bi-weekly taxable income in 2019 when you enroll yourself and these dependents:

	Kaiser Permanente HMO		Anthem Narrow Network (Select HMO) Anthem Full Network (CACare HMO)		Anthem Vivity (LA & Orange Counties HMO)		Anthem PPO		Delta Dental
	LAwell Plan	LAwell Pay Plan	LAwell Plan	LAwell Pay Plan	LAwell Plan	LAwell Pay Plan	LAwell Plan	LAwell Pay Plan	Preventative, DHMO, PPO
Domestic Partner	\$366.96	\$330.26	\$392.13	\$352.91	\$329.17	\$296.26	\$269.73	\$242.75	\$0.00
Domestic Partner’s Children	\$305.85	\$275.26	\$294.10	\$264.69	\$246.87	\$222.19	\$269.73	\$242.75	\$0.00
Your Children + Domestic Partner’s Children	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Domestic Partner + Your Children	\$366.96	\$330.26	\$392.13	\$352.91	\$329.17	\$296.26	\$269.73	\$242.75	\$0.00
Domestic Partner + Domestic Partner’s Children	\$489.33	\$440.39	\$468.43	\$421.58	\$439.88	\$395.00	\$269.73	\$242.75	\$0.00
Domestic Partner + Your and Domestic Partner’s Children	\$366.96	\$330.26	\$392.13	\$352.91	\$329.17	\$296.26	\$269.73	\$242.75	\$0.00

# Eligibility



## Who is Eligible for Benefits?

### Employees

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

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

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

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

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

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



## Family Members of Employees

If you are eligible for **LAWell** benefits, you can also enroll your eligible family members if your dependents meet the criteria listed on page 46 and you submit the required documentation by the deadlines. You **MUST** review your dependent elections and verify that each dependent enrolled—and dependents you add—continue to meet the **LAWell** eligibility criteria at all times. You must provide the required documentation to confirm your dependents, as determined by the Employee Benefits Division. Restrictions apply to family members who are also City employees, see page 43 for details.

### Ineligible Dependents

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

**You must drop coverage for your enrolled dependent within 30 days of the date he or she loses eligibility.**

See requirement and more information on page 47.

### Eligible Dependents

Your dependents are eligible if they meet the requirements listed on page 46.

### Changes in Employment Status

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



The following chart describes eligible dependents for medical, vision, and dental coverage. See “About Eligible Dependents” on page 40 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
<b>Spouse</b>	N/A	Person of the opposite or same sex to whom you are legally married	Marriage certificate
<b>Domestic Partner</b>	N/A	Meet City’s domestic partner eligibility requirements. See Domestic Partnership Information Sheet and Affidavit form at <a href="http://keepingLAWell.com">keepingLAWell.com</a>	City of Los Angeles Affidavit of Domestic Partnership, or Declaration of Partnership filed with the California Secretary of State
<b>Biological Child (Natural child)</b>	Up to age 26*	Employee’s married or unmarried child(ren) under age 26	Child’s birth certificate, hospital verification of birth or court document that verifies your relation to the child (an abstract document is not sufficient in most cases)
<b>Stepchild</b>	Up to age 26*	Employee’s spouse’s married or unmarried child(ren) under age 26	Child’s birth certificate and certificate showing spouse/domestic partner as parent
<b>Adopted child or child placed for adoption</b>	Up to age 26*	Minor or adult child legally adopted by employee under age 26 (married or unmarried)	Child’s birth certificate and court documentation
<b>Child of Domestic Partner</b>	Up to age 26*	Minor or adult child of employee’s domestic partner under age 26 (married or unmarried)	Child’s birth certificate and City of Los Angeles Domestic Partner Affidavit or Declaration of Partnership filed with the California Secretary of State
<b>Disabled Child</b>	Age 26 and older	Disabled child over the age of 26 who is dependent on you for support and was disabled before age 26. To be eligible, your child must remain unmarried, dependent on you for financial support and disabled as determined by your health plan.	Birth certificate and disability application from your health plan completed by your child’s doctor and returned to your health plan for approval each year as requested by the insurance company
<b>Child under a legal guardianship</b>	Up to age 26*	Child (unmarried) up to age 26 if you show proof of legal custody	Child’s birth certificate and court documentation
<b>Grandchildren</b>	Up to age 26*	Your grandchildren can be added to the plan if their parent is your child who <ul style="list-style-type: none"> <li>• is under age 19, unmarried, and financially dependent on you or</li> <li>• is age 19-26 and meets the full-time student status, is unmarried, and financially dependent on you</li> </ul> If coverage for your child ends, coverage for your grandchildren will end.	Child’s and grandchild’s birth certificates; valid proof of dependent status and/or full-time student certification for your child

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

For information on income tax treatment of your eligible Domestic Partner(s) dependent(s), see page 44. For other eligibility, such as Medicare, Medicaid, etc., see the Important Legal Notices section starting on page 54.



## Dependent Documentation Information Is Required

Documentation is required to enroll dependents. If you do not provide required proof of dependent status information, your dependent will be ineligible for coverage. Contact the Employee Benefits Division at **213-978-1655** with any questions.

If You Added Your Dependent During...	Deadline	Important Considerations
Open Enrollment (October 1- October 31)	<b>If you enroll your dependent who is not currently covered during Open Enrollment (October 1- October 31, 2018), documents must be received by December 11, 2018.</b>	If you fail to provide the required documentation to the Personnel Department Benefits Division by the deadline, your dependent coverage will not take effect for your added dependent enrolled during Open Enrollment on January 1, 2019. You will not be able to re-enroll your dropped dependent until the next Open Enrollment period or within <b>30 days</b> of a qualifying life event.
Outside Open Enrollment	<b>If you enroll your dependent during the year, documents must be received within 60 days of the date on the confirmation statement you receive after enrolling the dependent.</b>	If you fail to provide the required documentation to the Personnel Department Benefits Division by the deadline, your dependent coverage will not take effect. You will not be able to re-enroll your dependent until the next Open Enrollment period or within <b>30 days</b> of a qualifying life event.

### Removing Ineligible Dependents

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

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

### Where to Send Required Documents

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

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

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

\*Documents listed serve as examples. Other documents may apply. See page 46 or call **800-778-2133** or email **per.empbenefits@lacity.org** to ask what documents apply to your specific life event.



# Life Events

## When You Can Make LAwell Benefit Changes

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

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

## Qualifying Life Event Requirements

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

Some common Life Events and their reporting requirements are shown in the table below. This is not an exhaustive list and is subject to change. View more information on [keepinglawell.com](http://keepinglawell.com).

## 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 pages 64-65 for more information about these benefits.

Life Event	Report the Life Event within 30 days of the...	Where to Report	Supporting Documents* required 60 days from date on Confirmation Statement?
Marriage	...date of the marriage	Online: <b>keepingLAwell.com</b> OR Phone: <b>800-778-2133</b>	Yes: Marriage Certificate
Domestic Partnership, start or end	...effective date		Yes: <b>LAwell</b> Domestic Partnership Affidavit
Divorce	...date divorce is final		Yes: Signed Divorce Judgment
Additions due to Birth, Adoption, Legal Custody, etc	...date of birth ...date of legal custody		Yes: Birth Certificate
Dependent loses non-City or COBRA coverage	...last day of coverage		Yes: Confirmation letter of loss of coverage
Death of a Dependent	...date of the death	Phone Only: <b>800-778-2133</b>	Yes: Death Certificate
Entitled to or lose eligibility for Medicare or Medicaid	...first day of coverage		Yes: Medicare/Medicaid proof
Move outside Medical or Dental plan's service area	...day you move		May be required: Change of Address
Half-time to Full-time (Employee)	- Not Applicable -		Depends on benefit change requested
Go on leave (see Direct Bill, page 50), or Return to work after leave	- Not Applicable -		Depends on benefit change requested

\*Documents listed serve as examples. Other documents may apply. See page 46 or call **800-778-2133** or email [per.empbenefits@lacity.org](mailto:per.empbenefits@lacity.org) to ask what documents apply to your specific life event.



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

- cause coverage of a dependent to not start or to end, and
- result in your liability to repay the Plan if any benefits are paid to an ineligible person.

### What Benefits Can Change For A Life Event?

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

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

For more information on your benefit change options, call the Benefits Services Center at **800-778-2133**.

### Documents Are Required

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

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



### About Continuation Coverage

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

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

**Life insurance may be continued through portability and/or conversion and AD&D coverage may be continued through portability continuation. You have 60 days from the date coverage ends to submit the required form to Standard Insurance Company. See page 30 for more information on life insurance, page 34 for more information on AD&D insurance.**

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



Los Angeles



## Leaves Of Absence

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

#### What benefits does the City subsidize?

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

The amount of the subsidy will vary based on your MOU and employment status. You must have minimum compensated hours\* (40 hours for full-time employees and 20 hours for half-time employees) per pay period for the City to continue to pay the subsidy for your benefits.

\*Compensated hours include hours worked, banked sick or vacation time, and other qualifying hours for which you received approved pay from the City. See page 45 for more information.

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

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

Method of Continuing LAwell Benefits	
Direct Bill	<ul style="list-style-type: none"> <li>City employees receiving benefits while on any of the type of leaves of absence listed on pages 52-53 may not be able to pay their share of benefits cost(s) through City payroll and must pay their cost(s) (or the full premium if City Subsidy no longer applies) to the Personnel Department.</li> <li>If on direct bill you will receive a bill for outstanding benefits cost(s) due from the Personnel Department, Direct Billing Section. Your payment must be received within <b>15 days</b> of the date of the billing letter or benefits will end.</li> </ul> <p>Call <b>213-978-1655</b> for more information on Direct Bill.</p>
COBRA	City employees receiving a COBRA offer pay the full premium cost of the benefit plus any administration fee.



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



## Which LAwell benefits can continue?

Continue Benefits?	Direct Bill	COBRA
Continue with payment	<ul style="list-style-type: none"> <li>• Medical insurance</li> <li>• Dental insurance</li> <li>• Vision insurance</li> <li>• Basic &amp; Supplemental Life insurances (including AD&amp;D)</li> <li>• Basic &amp; Supplemental Disability insurance</li> </ul>	<ul style="list-style-type: none"> <li>• Medical insurance</li> <li>• Dental insurance</li> <li>• Vision insurance</li> </ul>
Continue through other action	N/A	Basic and Supplemental Life insurances can only continue through Portability or Conversion. AD&D insurance can only continue through Portability.
Not eligible to continue	Healthcare Flexible Spending and Dependent Care Reimbursement Accounts are tax-advantaged spending accounts that provide for deductions to be taken through City payroll. Your ability to use these accounts will end when you terminate employment. You may only use any remaining balance toward eligible expenses that were incurred up to the last day of your City employment.	

## Returning to City Employment

Employees who terminate City employment and subsequently return to City employment in a different plan year, are considered “Rehire” employees and will receive a new benefits package in the mail when they become benefit eligible.\* Contact the Employee Benefits Division at **213-978-1655** if you do not receive a benefits package within four to six weeks after returning to work.

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

\*Minimum 40 compensated hours for full-time employees; minimum 20 compensated hours for half-time employees. See page 45 for more information on eligibility. Returning to City employment may not be considered as new hire employment status for benefits purposes.

### Benefits While on Leave or in Non-Pay Status

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



## How Benefits Can Be Affected During A Leave Of Absence

Leaves Of Absence			
Type of Leave	What is it?	Can my Benefits continue?	Can my City subsidy continue?
<b>Family Medical Leave</b>	FMLA is approved protected leave for qualified employees that falls under the provisions of the Family Medical Leave Act (FMLA).  Your department must approve a FMLA absence.	Yes – Most of your benefits can continue.  <u>Continuation Method:</u> Direct Bill	Yes. City Subsidy can continue for a maximum of 9 pay periods* within a 12-month period, regardless of the number of incidents. A 12-month period shall begin on the first day of leave.  <i>*Exception: Maternity Leave – up to 9 pay periods for childbirth disability and up to an additional 9 pay periods for purposes of bonding. The aggregate period for parents who both work for the City is limited to the time allowed for one employee.</i>
<b>Disability Leave</b>	An approved leave for a non-work related disability, and you are receiving a disability benefit from Standard Insurance Company.	Yes – Most of your benefits can continue.  <u>Continuation Method:</u> Direct Bill	City Subsidy will only apply to the <b>employee only level</b> of coverage, unless there has been no coverage break, for employees approved for the Benefit Protection Plan (BPP). See page 37 for more information on BPP.
<b>Workers' Compensation Leave</b>	An approved leave for a work related injury or illness, and you are receiving injury or disability "IOD" pay through the City's payroll or State Rate from Workers' Compensation.	Yes – Most of your benefits can continue.  <u>Continuation Method:</u> Direct Bill or COBRA** (depends on situation)	<b>Only</b> if your approved leave is supplemented with the <b>minimum</b> number of compensated hours:  Full-Time: 40 hrs Half-Time: 20 hrs
<b>Military Leave</b>	An approved leave to actively serve in a branch of the military.	Yes – Most of your benefits can continue.  <u>Continuation Method:</u> Direct Bill	<b>Only</b> if your approved leave qualifies for the City Subsidy. Military leave types vary. Ask your human resources or personnel division for more information.
<b>Catastrophic Illness</b>	An approved leave that receives donated hours (see Catastrophic Illness Leave Donation Program on page 38).	Yes – Most of your benefits can continue.  <u>Continuation Method:</u> Direct Bill	City Subsidy will only apply for the time you retain the minimum number of compensated hours:  Full-Time: 40 hrs Half-Time: 20 hrs

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



## How Benefits Can Be Affected During A Leave Of Absence *continued*

Leaves Of Absence			
Type of Leave	What is it?	Can my Benefits continue?	Can my City subsidy continue?
<b>Reduction of hours, and non-paid leaves</b>	<p>During any two-week pay period, you <b>do not</b> meet the minimum number of compensated hours:</p> <p>Full-Time: 40 hrs Half-Time: 20 hrs</p> <p><b>Note:</b> <i>Compensated hours include hours worked, banked sick or vacation time, and other qualifying hours for which you receive approved pay from the City. See page 45 for more information on eligibility.</i></p>	<p>Yes – Most of your benefits can continue.</p> <p><u>Continuation Method:</u> Direct Bill or COBRA (depends on situation)</p>	<b>No</b> , you must pay the full unsubsidized premium for your benefits to continue.
<b>Termination</b>	You end employment with the City, either voluntarily or through City action.	Your benefits will end the day your employment ends. You can only continue benefits through COBRA.	<b>No</b> , COBRA enrollment requires you to pay the full cost of your benefit, plus any COBRA administrative fees.
<b>Retirement</b>	<p>You end employment due to your start of retirement benefits through LACERS.</p> <p><b>Note:</b> A non-LACERS retirement is considered a "termination"</p>	Your benefits will end the last day of the month in which you retire or transfer to DWP. You can only continue benefits through COBRA.	
<b>Transfer to DWP</b>	You accept and begin employment at the Department of Water and Power (DWP).		





## Binding Arbitration

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

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

# Important Legal Notices

## Women’s Health and Cancer Rights Act

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

## About Hospital Stays for Mothers and Newborns

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

## Privacy and Your Health Coverage

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

give you additional rights concerning control of your own healthcare information.

The **LAWell** privacy notice explains your rights and the plans' legal duties with respect to personal health information and how the **LAWell** plan may use or disclose your personal health information. To obtain a copy of the **LAWell** privacy notice or for any questions about the plans' privacy policies, please contact the Plan's Privacy Officer in the Employee Benefits Division at **213-978-1655**. You can also go online to **keepingLAWell.com**.

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

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

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

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

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

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

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

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1- 877-KIDS NOW** or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

*If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility.*

### ALABAMA – Medicaid

Website: <http://myalhipp.com/>  
Phone: 1-855-692-5447

### ALASKA – Medicaid

The AK Health Insurance Premium Payment Program Website: <http://myakhipp.com/>  
Phone: 1-866-251-4861  
Email: [CustomerService@MyAKHIPP.com](mailto:CustomerService@MyAKHIPP.com)  
Medicaid Eligibility: <http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

### ARKANSAS – Medicaid

Website: <http://myarhipp.com/>  
Phone: 1-855-MyARHIPP (855-692-7447)

<p><b>COLORADO – Health First Colorado</b>                  (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)                  Health First Colorado Website:  <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a>                  Health First Colorado Member Contact Center:                  1-800-221-3943/ State Relay 711                  CHP+: <a href="http://Colorado.gov/HCPF/Child-Health-Plan-Plus">Colorado.gov/HCPF/Child-Health-Plan-Plus</a> CHP+ Customer Service: 1-800-359-1991/                  State Relay 711</p>
<p><b>FLORIDA – Medicaid</b>                  Website: <a href="http://flmedicaidtplrecovery.com/hipp/">http://flmedicaidtplrecovery.com/hipp/</a>                  Phone: 1-877-357-3268</p>
<p><b>GEORGIA – Medicaid</b>                  Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a> – Click on Health Insurance Premium Payment (HIPP)                  Phone: 404-656-4507</p>
<p><b>INDIANA – Medicaid</b>                  Healthy Indiana Plan for low-income adults 19-64                  Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a>                  Phone: 1-877-438-4479                  All other Medicaid                  Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a>                  Phone 1-800-403-0864</p>
<p><b>IOWA – Medicaid</b>                  Website: <a href="http://dhs.iowa.gov/hawk-i">http://dhs.iowa.gov/hawk-i</a>                  Phone: 1-800-257-8563</p>
<p><b>KANSAS – Medicaid</b>                  Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a>                  Phone: 1-785-296-3512</p>
<p><b>KENTUCKY – Medicaid</b>                  Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a>                  Phone: 1-800-635-2570</p>
<p><b>LOUISIANA – Medicaid</b>                  Website: <a href="http://dhh.louisiana.gov/index.cfm/ubhome/1/n/331">http://dhh.louisiana.gov/index.cfm/ubhome/1/n/331</a>                  Phone: 1-888-695-2447</p>
<p><b>MAINE – Medicaid</b>                  Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a>                  Phone: 1-800-442-6003                  TTY: Maine relay 711</p>
<p><b>MASSACHUSETTS – Medicaid and CHIP</b>                  Website: <a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">http://www.mass.gov/eohhs/gov/departments/masshealth/</a>                  Phone: 1-800-862-4840</p>
<p><b>MINNESOTA – Medicaid</b>                  Website:  <a href="https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a>                  Phone: 1-800-657-3739</p>
<p><b>MISSOURI – Medicaid</b>                  Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a>                  Phone: 573-751-2005</p>
<p><b>MONTANA – Medicaid</b>                  Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a>                  Phone: 1-800-694-3084</p>
<p><b>NEBRASKA – Medicaid</b>                  Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a>                  Phone: (855) 632-7633                  Lincoln: (402) 473-7000                  Omaha: (402) 595-1178</p>
<p><b>NEVADA – Medicaid</b>                  Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a> Medicaid                  Phone: 1-800-992-0900</p>
<p><b>NEW HAMPSHIRE – Medicaid</b>                  Website: <a href="https://www.dhhs.nh.gov/ombp/nhhpp/">https://www.dhhs.nh.gov/ombp/nhhpp/</a>                  Phone: 603-271-5218                  Hotline: NH Medicaid Service Center at 1-888-901- 4999</p>

<p><b>NEW JERSEY – Medicaid and CHIP</b>                  Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>                  Medicaid Phone: 609-631-2392                  CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>                  CHIP Phone: 1-800-701-0710</p>
<p><b>NEW YORK – Medicaid</b>                  Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a>                  Phone: 1-800-541-2831</p>
<p><b>NORTH CAROLINA – Medicaid</b>                  Website: <a href="https://dma.ncdhhs.gov/">https://dma.ncdhhs.gov/</a>                  Phone: 919-855-4100</p>
<p><b>NORTH DAKOTA – Medicaid</b>                  Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a>                  Phone: 1-844-854-4825</p>
<p><b>OKLAHOMA – Medicaid and CHIP</b>                  Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>                  Phone: 1-888-365-3742</p>
<p><b>OREGON – Medicaid</b>                  Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a>  <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a>                  Phone: 1-800-699-9075</p>
<p><b>PENNSYLVANIA – Medicaid</b>                  Website: <a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm</a>                  Phone: 1-800-692-7462</p>
<p><b>RHODE ISLAND – Medicaid</b>                  Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a>                  Phone: 855-697-4347</p>
<p><b>SOUTH CAROLINA – Medicaid</b>                  Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a>                  Phone: 1-888-549-0820</p>
<p><b>SOUTH DAKOTA - Medicaid</b>                  Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a>                  Phone: 1-888-828-0059</p>
<p><b>TEXAS – Medicaid</b>                  Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a>                  Phone: 1-800-440-0493</p>
<p><b>UTAH – Medicaid and CHIP</b>                  Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a>                  CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a>                  Phone: 1-877-543-7669</p>
<p><b>VERMONT– Medicaid</b>                  Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a>                  Phone: 1-800-250-8427</p>
<p><b>VIRGINIA – Medicaid and CHIP</b>                  Medicaid Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a>                  Medicaid Phone: 1-800-432-5924                  CHIP Website:  <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a>                  CHIP Phone: 1-855-242-8282</p>
<p><b>WASHINGTON – Medicaid</b>                  Website: <a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a>                  Phone: 1-800-562-3022 ext. 15473</p>
<p><b>WEST VIRGINIA – Medicaid</b>                  Website: <a href="http://mywwhipp.com/">http://mywwhipp.com/</a>                  Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
<p><b>WISCONSIN – Medicaid and CHIP</b>                  Website: <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a>                  Phone: 1-800-362-3002</p>
<p><b>WYOMING – Medicaid</b>                  Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a>                  Phone: 307-777-7531</p>



To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)

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

California residents may also be eligible for premium assistance. Contact the California Department of Health Care Services' voluntary Health Insurance Premium Payment (HIPP) program by email at

**HIPP@dhcs.ca.gov** or by fax at **916-440-5677**, or visit **[http://www.dhcs.ca.gov/services/Pages/TPLRD\\_CAU\\_cont.aspx](http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx)**.

#### **Other California Premium Assistance Resources:**

Medi-Cal Website  
**[www.dhcs.ca.gov](http://www.dhcs.ca.gov)**

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

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

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

## **Paperwork Reduction Act Statement**

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

## **Health Insurance Marketplace**

New Health Insurance Marketplace Coverage Options and Your Health Coverage.

### **PART A: General Information**

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

#### **What is the Health Insurance Marketplace?**

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

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

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

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

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

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

### How Can I Get More Information?

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

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

<sup>1</sup> An employer-sponsored health plan meets the “minimum value standard” if the plan’s

### PART B: Information About Health Coverage Offered by Your Employer

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

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

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

- **As your employer, we offer a health plan to:**
  - All employees. Eligible employees are:
  - Some employees. Eligible employees are: Full-time, Permanent, Half-Time, and Temporary Employees who work qualifying hours
- With respect to dependents:
  - We do offer coverage. Eligible dependents are: Spouse, Domestic Partners, and Children
  - We do not offer coverage.
- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.**

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

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

## Important Information About Your COBRA Continuation Coverage Rights

### What is continuation coverage?

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

### Who are the qualified beneficiaries?

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

### Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

### How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your medical and/or dental plan of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event (see additional information on page 48) may affect the right to extend the period of continuation coverage.



### Disability

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

### Second Qualifying Event

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

### How can you elect COBRA continuation coverage?

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

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

### How much does COBRA continuation coverage cost?

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

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

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

### First payment for continuation coverage

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

## Periodic payments for continuation coverage

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

## Grace periods for periodic payments

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

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

## For more information

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

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

## Keep Your Plan Informed of Address Changes

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

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

## Availability of Summary Health Information

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

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

To request special enrollment or obtain more information, contact the Benefits Service Center, at **800-778-2133**, Monday – Friday, 8 a.m. to 5 p.m. Pacific.

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

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

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

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact Benefits Service Center at **800-778-2133**, Monday – Friday, 8 a.m. to 5 p.m. Pacific Time.

## Important Notice from the City of Los Angeles for LAwell-Eligible Employees and Dependents about Prescription Drug Coverage for People who Are Already Medicare-Eligible or May Become Medicare-Eligible during 2019

### Medicare and the City

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

- If you have enough service credits you will receive Medicare Part A at age 65 at no cost. You will be contacted by Social Security and will receive a Medicare ID card. At this time you may be asked if you would like to enroll in Medicare Part B, C and/or D. If you are not retired or planning to retire at or around age 65, you may not want to purchase Medicare since you have City benefits.
- To prevent errors in coverage and payments, we recommend that you do not enroll in Medicare Part B or Part D as long as you have City of Los Angeles **LAwell** Benefits (active employee coverage). When you are planning to retire, please contact LACERS at **800-779-8328** so that they may help you sign up for Medicare and to ensure you do not experience a lapse in coverage. As long as you had the City's creditable active employee coverage beginning from the time you became eligible for Medicare (for most people, age 65) through the date your Medicare enrollment becomes effective (typically after age 65), you will not be charged a late-enrollment penalty for signing up after becoming eligible.
- If you do decide to enroll into Medicare as an active employee and you also retain your enrollment with **LAwell** coverage, it is important that you remember to use your Medicare coverage as a secondary insurance provider. Medicare will not pay primary insurer costs for individuals with dual coverage.
- If you have already signed up for Medicare and also have **LAwell** coverage, please inform your doctor(s) so that there are no issues with payments. Some doctors do not accept Medicare patients. When you are filling out your claim information, please provide the Employee Benefits Division address as your work location. Do not provide the address of your actual work location or that of your department's administrative office.
- The federal government does not recognize Domestic Partners as eligible dependents. Domestic Partners being covered under **LAwell** Benefits will receive a penalty for late-enrollment in Medicare if they do not sign-up when they become eligible. Domestic Partners should consider enrolling in Medicare when they become eligible.

## Important Notice from City of Los Angeles About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Los Angeles and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Los Angeles has determined that the prescription drug coverage offered by the Anthem Vivity (LA & Orange Counties HMO), Anthem Narrow Network (Select HMO), Anthem Full (CA Care), Anthem PPO, and Kaiser Permanente HMO, is **creditable** meaning that, on average for all plan participants, it is expected to pay out as much as standard Medicare prescription drug coverage pays are therefore considered Creditable Coverage. Because your existing medical plan coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

### When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

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

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

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

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

## When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the City and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

## For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the Employee Benefits Division at **213-978-1655**.

**NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan,



and if this coverage through City of Los Angeles, Personnel Department changes. You also may request a copy of this notice at any time.

## For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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



# RETIREwell

How do I enroll or find out more information?

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

## Deferred Compensation Plan

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

### Why Should I Consider Joining?

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

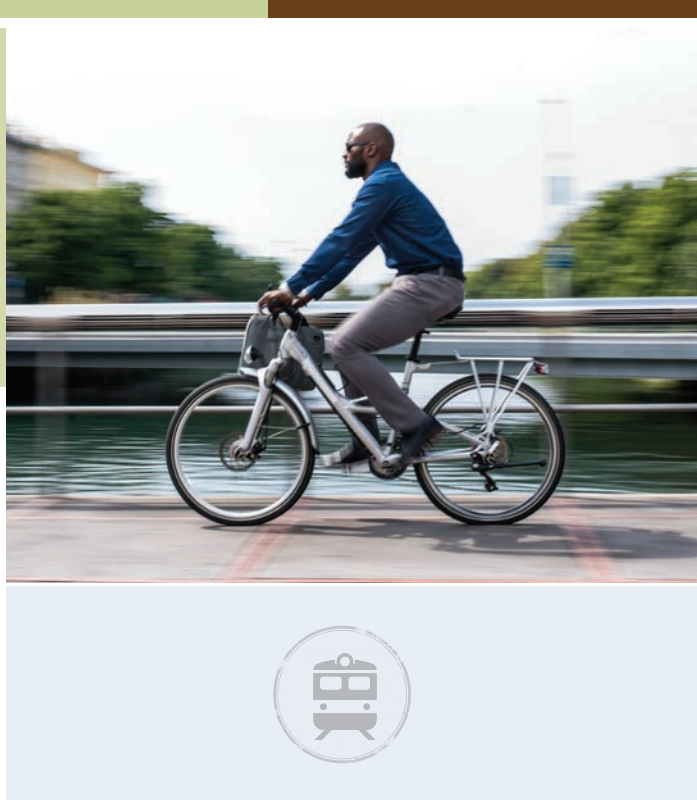
- **Los Angeles City Employees Retirement System (LACERS)** — Benefits are determined based on factors such as how long you work for the City and your salary near retirement. They are also based on your retirement Tier (Tier 1 for employees hired prior to February 21, 2016; Tier 3 for employees hired 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.





# COMMUTEwell



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

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

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

## Commuter Spending Accounts

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

- **Transit Spending Account (TSA) (includes City contribution match of up to \$50 per month)** – set aside up to \$260 per month on a pre-tax basis to pay for public transit expenses, including bus, rail, train and subway fares.
- **Parking Spending Account (PSA)** – set aside up to \$260 per month on a pre-tax basis to pay for parking expenses related to commuting from home to work. Note: cannot be used for parking provided by the City of Los Angeles to its employees at City owned or leased lots (e.g., lots at City Hall East, Figueroa Plaza, Police Administration Building, etc.).

Unlike other benefit programs, elections to participate in TSA and PSA may be modified throughout the year, not just during Open Enrollment. To enroll or make changes, go to [keepingLAWell.com](http://keepingLAWell.com).

## Important Information About the TSA and PSA

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





# LIVEwell

## Activities

City employees are able to participate in LIVEwell program events and activities throughout the year at no additional cost. Activities and events include:

- Annual Wellness Festival
- Educational classes
- Informational webinars
- Team challenges
- Massage clinics
- Flu shots
- Health screenings
- Cooking demonstrations

LIVEwell events and activities are announced through Citywide email and also on the LIVEwell program's website at [per.lacity.org/bens/livewell.com](http://per.lacity.org/bens/livewell.com)



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

LIVEwell supports members by providing information and resources focused on four building blocks of wellness, including:





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# Important Websites and Phone Numbers

	Plan/Program	Pages	Website	Phone Number
LAWell Program Benefit Contacts	Anthem PPO Anthem HMO (Narrow, Full) Anthem Vivity (LA & Orange Counties HMO)	8-21	<a href="http://anthem.com/ca/cityofla">anthem.com/ca/cityofla</a>	<b>Anthem PPO: 833-597-2362</b> <b>Anthem HMO (Narrow, Full): 844-348-6111</b> <b>Anthem Vivity: 844-348-6110</b>
	Kaiser Permanente HMO	8-21	<a href="http://my.kp.org/ca/cityofla">my.kp.org/ca/cityofla</a>	<b>800-464-4000</b>
	Delta Dental PPO or Preventive Only	22-25	<a href="http://deltadentalins.com/enrollees/index.html">deltadentalins.com/enrollees/index.html</a>	<b>800-765-6003</b>
	DeltaCare USA DHMO	22-25	<a href="http://deltadentalins.com/enrollees/index.html">deltadentalins.com/enrollees/index.html</a>	<b>800-422-4234</b>
	EyeMed Vision Care	26-28	<a href="http://eyemedvisioncare.com/cityofla">eyemedvisioncare.com/cityofla</a>	<b>855-695-5418</b>
	Employee Assistance Program	29	<a href="http://liveandworkwell.com">liveandworkwell.com</a>	<b>800-213-5813</b>
	Healthcare Flexible Spending Account or Dependent Care Reimbursement Account	39-42	<a href="http://wageworks.com">wageworks.com</a>	<b>877-924-3967</b>
	Commuter Spending Accounts	65	<a href="http://wageworks.com">wageworks.com</a>	<b>877-924-3967</b>
	Standard Insurance Company: Life Insurance, AD&D and Disability Insurance	30-38	<a href="https://www.standard.com/employee-benefits/city-los-angeles">https://www.standard.com/employee-benefits/city-los-angeles</a>	800-524-0450 for general questions 800-843-7979 for evidence of insurability 800-527-0218 for travel assistance <b>FILE A CLAIM</b> 844-505-6025 – Disability Insurance 213-978-1591 – Life or AD&D Insurance
Direct	<b>Health Plan Member Advocates</b>		<b>Los Angeles City Hall 200 N. Spring Street Room 867 Los Angeles, CA 90012</b>	<b>Anthem: Monday - Friday 8:00 am - 4:00 pm</b> <b>Kaiser: Tuesday - Thursday 8:00 am - 4:00 pm</b>
	<b>Benefits Service Center</b>		<b>keepingLAwell.com to enroll or make changes to your LAwell benefits</b>	<b>800-778-2133</b> <i>(800-735-2922 if hearing or speech impaired)</i> <b>Monday – Friday, 8:00 a.m. to 5:00 p.m. Pacific time</b>
	<b>Employee Benefits Division</b>		<b>keepingLAwell.com or send e-mail to <a href="mailto:per.EmpBenefits@lacity.org">per.EmpBenefits@lacity.org</a></b>	<b>213-978-1655</b> <b>Monday – Friday, 8:00 a.m. to 4:00 p.m. Pacific time</b>
Other City Benefit Contacts	EAP for Harbor Employees Only			<b>800-367-7474</b>
	Los Angeles Employees' Retirement System		<a href="http://lacers.org">lacers.org</a>	<b>800-779-8328</b>
	Deferred Compensation Plan		<a href="http://LA457.com">LA457.com</a>	<b>844-523-2457</b> (Voya) or <b>213-978-1601</b> (Employee Benefits Division)
	Parking/Transit Reimbursement/ Rideshare Programs		<a href="http://per.lacity.org/bens/commuteoptions.htm">per.lacity.org/bens/commuteoptions.htm</a>	<b>213-978-1655</b>
	City Employees Club of Los Angeles		<a href="http://cityemployeesclub.com">cityemployeesclub.com</a>	<b>213-620-0388</b>
	All City Employees Benefits Services Association		<a href="http://acebsa.org">acebsa.org</a>	<b>213-485-2485</b>
	City MOUs		<a href="http://cao.lacity.org/MOUS">cao.lacity.org/MOUS</a>	<b>213-978-7676</b>

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 accommodation to ensure equal access to its programs.

*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 2019 **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 **LA**well  
City of Los Angeles Employee Benefits





# 2019 CHOOSEwell Highlights



## Open Enrollment Starts October 1st!

It's that time again! Time to make your benefits elections during this year's October 1-31, 2019 Open Enrollment for the new Plan Year beginning January 1, 2019.

Your benefit choices are important in supporting the health and wellbeing of you and your dependents. Open Enrollment benefit elections will be in effect for all of 2019 unless you experience a qualifying event. Use this 2019 CHOOSEwell Highlights as your quick reference guide to 2019 plan changes and your enrollment steps.

## What's New for 2019?

- **Optum** is your new Employee Assistance Program (EAP) provider.
  - **EAP Access by Phone:** The phone number for your EAP will not change. Call **800-213-5813** for assistance at any time in 2018 and 2019.
  - **EAP Access Online:** Starting January 1, 2019, your online access to EAP services will change under Optum. You and your dependents can access your EAP services in 2018 and 2019 through the following:

	Through December 31, 2018	Starting January 1, 2019
EAP Provider	Managed Health Network	Optum
Website	<b>members.mhn.com</b>	<b>LiveAndWorkWell.com</b>
Access Code	cityoflosangeles	CityofLA
Phone	<b>800-213-5813</b>	

- There are **new premium rates** for the Anthem PPO, Narrow, Full and Vivity Plans that go into effect on January 1, 2019. Review the new rates on pages 12-13 of the CHOOSEwell Enrollment Guide, or on your Personal Enrollment Fact Sheet.
- The **maximum contribution limit for the Healthcare Flexible Spending Account** has increased to \$2,650. See page 39 of the CHOOSEwell Enrollment Guide for more information.
- The **maximum benefit for Basic Disability Coverage** has increased to \$3,268 per month. See page 36 of the CHOOSEwell Enrollment Guide for more information.
- There are **new security enhancements for the Benefit Central Portal**. When you log onto the Benefits Central Portal at **www.keepingLAwell.com**, you may be asked to reset your username and password to help improve your account security.
- **Coming Soon:** Stay tuned for more changes to the member call center and web portal, coming in early 2019.



## Open Enrollment Ends October 31!

Don't wait. Make your elections by logging onto your account at **keepingLAwell.com** or contacting the Benefits Service Center at **800-778-2133**

If you do not make a change during Open Enrollment, your previously elected 2018 benefit elections will generally roll over to 2019. *(Healthcare and Dependent Care accounts require annual enrollment elections)*

## Attend a Weekly Event and Learn More:

Date	Event Type	Duration	Location
Oct 3	Benefits Onsite	10:00 am – 3:00 pm	Marvin Braude Building 6262 Van Nuys Blvd. Room MB-1B (1st Floor)
Oct 4	Benefits Onsite	10:00 am – 3:00 pm	Garland Building 1200 W 7th Street 9th floor lunchroom
	Lunchtime Seminar/Webinar – Vision Benefits	11:30 am – 12:00 pm	Garland Building*
	Lunchtime Seminar/Webinar – Vision Benefits (repeat)	12:45 – 1:15 pm	Garland Building*
Oct 10	Benefits Onsite	10:00 am – 3:00 pm	Public Works Bldg 1149 S Broadway St 9th Flr Admin Conference Rm
Oct 11	Lunchtime Seminar/Webinar – Employee Assistance Program	11:30 am – 12:00 pm	City Hall East 200 N Main Street Controller Conf Rm 351
	Lunchtime Seminar/Webinar – Employee Assistance Program (repeat)	12:45 – 1:15 pm	
Oct 16	Nighttime Seminar/Webinar – Benefit Overview	5:00 – 6:00 pm	City Hall East 200 N Main Street Controller Conf Rm 351
Oct 18	Benefits Onsite	10:00 am – 3:00 pm	Harbor Dept 425 S. Palos Verdes St Harbor Dept Board Rm
	Lunchtime Seminar/Webinar – Anthem PPO Benefits	11:30 am – 12:00 pm	
	Lunchtime Seminar/Webinar – Anthem PPO Benefits (repeat)	12:45 – 1:15 pm	
Oct 23	Benefits Onsite	11:00 am – 5:30 pm	Airport 7407 1/2 World Way West, Building M2, 90045
	Lunchtime Seminar/Webinar – Benefit Overview/Q&A	12:15 – 12:45 pm	
	Nighttime Seminar – Benefit Overview/Q&A (repeat)	6:00 – 7:00 pm	
Oct 25	Benefits Onsite	10:00 am – 3:00 pm	Figueroa Plaza 221 North Figueroa St 5th Floor
	Lunchtime Seminar/Webinar – Dental Benefits	11:30 am – 12:00 pm	
	Lunchtime Seminar/Webinar – Dental Benefits (repeat)	12:45 – 1:15 pm	
Oct 30	Lunchtime Seminar/Webinar – Benefit Overview/Q&A	11:30 am – 12:00 pm	City Hall East 200 N Main Street Controller Conf Rm 351
	Lunchtime Seminar/Webinar – Benefit Overview/Q&A (repeat)	12:45 – 1:15 pm	

### Benefits Onsite

Walk-in at any time during the posted hours to ask **LAWell** benefit questions and process some of your **LAWell** benefit transactions. Registration is not required.

Member Advocates from Anthem and Kaiser will also be available at each Benefits Onsite location.

### Seminars

Registration is not required to attend any lunchtime or nighttime seminar held October 11 – October 30.

\*Attendance at the Vision Benefits seminar held on October 4 at the Garland Building requires advance registration.

Visit [www.keepingLAWell.com](http://www.keepingLAWell.com) to register, subject to capacity.

### Webinars

Registration is not required to attend any webinar. Join a webinar event by clicking the link(s) provided on [www.keepingLAWell.com](http://www.keepingLAWell.com).

Webinars will be recorded and made available for viewing at [keepingLAWell.com](http://keepingLAWell.com).



## Important Dates to Remember

Here's what will happen between now and January 1, 2019:

- **Late September:** Open Enrollment Kit mailed to your home.
- **October 1-October 31:** Open Enrollment for 2019 benefits.
- **During October:** Webinars and on-site seminars. Check [keepingLAWell.com](http://keepingLAWell.com) for specific dates and times.
- **January 1, 2019:** New plan year; benefit changes take effect.

To learn more, please visit [keepingLAWell.com](http://keepingLAWell.com) for further information and updates. All Open Enrollment materials and important dates/events will be posted and updated as we move through Open Enrollment.

# Choose Wisely, and CHOOSEwell!

## What are My Benefit Options and Costs in 2019?

	Your Benefit Options	Provider	Your Cost*
Medical	HMO health plans PPO health plan	Anthem and Kaiser	Cost varies based on coverage level elected and your MOU.
	Cash-in-Lieu	City	None. Pays you up to \$100** each month.
Dental	PPO dental plan DHMO dental plan	Delta Dental	Cost varies based on coverage level elected.
	Preventive Only plan		None. Pays you up to \$5** each month.
Vision	In-Network	EyeMed	Included at no cost
	Out-of-Network reimbursements		
Employee Assistance Program	Employee Assistance counseling services	Optum*** New provider starting January 2019***	Included at no cost
Insurance	Disability – <b>Basic Coverage</b> (up to 50% of earnings for a maximum of 2 years)	Standard Insurance Company	Included at no cost
	Life – <b>Basic Coverage</b> (\$10,000 for full-time, \$5,000 for half-time).		Included at no cost
	Disability – <b>Supplemental Coverage</b> (up to 66 <sup>2</sup> / <sub>3</sub> % of earnings until retirement age)		Cost varies based on coverage level elected and is calculated by age and income. See your Personal Enrollment Fact Sheet or log into your account at <a href="http://www.keepingLAWell.com">www.keepingLAWell.com</a> for your specific cost details.
	Life – <b>Supplemental Coverage</b> (up to 5x your annual salary)		
	Life – Spouse/Domestic Partner Coverage (up to \$100,000)		
	Life – Child Coverage (\$5,000 per child)		
	Accidental Death & Dismemberment (up to \$500,000)		
Tax-Advantaged Spending Accounts	Healthcare Flexible Spending Account Dependent Care Reimbursement Account Parking & Commuter Accounts	WageWorks	You elect voluntary contributions up to maximum limit.

\* Your personal cost options are detailed in your Personal Enrollment Fact Sheet. They are also available by logging into your account at [www.keepinglawell.com](http://www.keepinglawell.com).

\*\* Amounts represent full-time employment status. For half-time employees, the benefit is reduced 50%.

\*\*\*Managed Health Network (MHN) provides Employee Assistance Program services through December 31, 2018.

Review the full details of these benefit options and costs in your Open Enrollment **CHOOSEwell** Guide or on your Personal Enrollment Fact Sheet.

## Key Things to Remember During Open Enrollment

- Open Enrollment will be your only opportunity to make coverage elections for yourself and your dependents for 2019 – unless you experience a qualifying life event.
- Unless you make a change during Open Enrollment, your previously elected 2018 benefit elections will generally roll over to 2019.
- However, your enrollment in either the Dependent Care Reimbursement Account or the Healthcare Flexible Spending Account **DOES NOT automatically roll over**. If you wish to continue participating in these accounts – or if you wish to enroll in either of these accounts for 2019, you'll need to make an election during Open Enrollment.
- Open Enrollment elections take effect January 1, 2019.

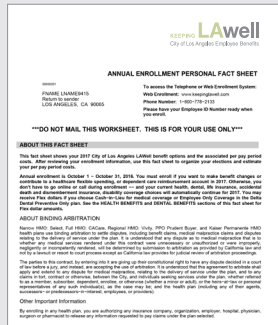
**Meet a Member Advocate** — Member Advocates from our health providers will provide personal, one-on-one assistance in our office in City Hall, 200 N. Spring Street, Room 867, 8:00 a.m. to 4:00 p.m. during Open Enrollment and throughout the year.

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

# How to Use the CHOOSEwell Enrollment Guide

Review your current enrollment and your 2019 costs and options using your Personal Enrollment Fact Sheet or by logging into your account at [keepingLAWell.com](http://keepingLAWell.com).

First  
**1**



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

Second  
**2**

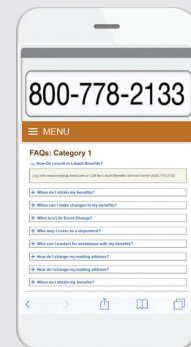


Review the 2019 CHOOSEwell Highlights for a quick overview of 2019 benefits.



Make your 2019 enrollment elections by **October 31, 2018!** Go to [keepingLAWell.com](http://keepingLAWell.com) or call **800-778-2133** to make elections.

Third  
**3**



## Your Enrollment Resources

To enroll or make changes, visit [keepingLAWell.com](http://keepingLAWell.com) or contact the Benefits Service Center at **800-778-2133** (for TDD or TTY service, call **800-735-2922**.) Representatives are available 8:00 a.m. to 5:00 p.m., Pacific Time, Monday –Friday.

**Extended hours are provided on Tuesday, October 30 and Wednesday, October 31: 8:00 a.m. to 7:00 p.m.** On Saturday and Sunday, October 28 and 29, the Benefits Service Center will NOT be available via phone; however you can still enroll online.