COMBINED
INSURANCE

# Combined Insurance Company of America

**111 Wacker Drive, Suite 700 • Chicago, Illinois 60601**
**Administrator's Office: 4000 Luxottica Place; Mason, OH 45040**

## GROUP VISION INSURANCE CERTIFICATE

| | |
|---|---|
| **POLICY NUMBER:** | 1007428 / 1007429 / 1008118 / 1008838 |
| **POLICYHOLDER:** | City of Los Angeles |
| **POLICY EFFECTIVE DATE:** | January 1, 2017 |
| **POLICY ANNIVERSARY DATE:** | January 1, 2018, and each January 1 thereafter |

Combined Insurance Company of America represents that the Insured Person is insured for the benefits described on the following pages, subject to and in accordance with the terms and conditions of the Policy.

The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.

The Certificate explains the plan of insurance. An individual identification card will be issued to the Insured containing the group name, group number and Insured's effective date. The Certificate replaces all certificates previously issued to the Insured under the Policy.

All periods of time under the Policy will begin and end at 12:01 A.M. Local Time at the Policyholder's business address.

The Policy is issued by Combined Insurance Company of America at Chicago, Illinois on the Policy Effective Date.

Signed for **Combined Insurance Company of America**

Brad Bennett, President

Carmine A. Giganti, Vice President and Secretary

**THIS IS A LIMITED BENEFIT CERTIFICATE**
***Please read the Certificate carefully.***

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## DEFINITIONS

Please note certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

**Benefit Frequency** means the period of time in which a benefit is payable.

The Benefit Frequency begins on the later of the Insured Person's effective date or last date services were provided to the Insured Person. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

**Co-payment** means the designated amount, if any, shown in the Schedule of Benefits each Insured Person must pay to a Provider before benefits are payable for covered Vision Examination and Vision Materials per Benefit Frequency.

**Comprehensive Eye Examination** means a comprehensive ophthalmological service that is needed for the diagnosis and treatment of substandard visual acuity. Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination, biomicroscopy, examination with cyclopedia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

**Dependent** means any of the following persons whose coverage under the Policy is in force and has not ended:

1. the Insured's lawful spouse or Domestic Partner;
2. each unmarried child from birth to age 19 who is primarily dependent upon the Insured for support and maintenance; or
3. each unmarried child at least 19 years of age to 25 years of age who is primarily dependent upon the Insured for support and maintenance and who is a full-time student; or
4. each unmarried child at least19 years of age who is primarily dependent upon the Insured for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap; who was so incapacitated and is an Insured Person under the Policy on his or her 19th birthday; and who has been continuously so incapacitated since his or her 19th birthday.

Child includes stepchild, legally adopted child, child legally placed in the Insured's home for adoption and child under the Insured's legal guardianship. A full-time student is one who is enrolled at least the minimum number of hours of class a week the school considers as full-time status.

**Domestic Partner** means an adult who has chosen to share his or her life in an intimate and committed relationship of mutual caring with the Insured Person.

A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division, and, at the time of filing, all of the following requirements are met:

1. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
2. The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
3. Both persons are at least 18 years of age, except a person under 18 years of age who, together with the person with whom he or she proposes to establish a domestic partnership, otherwise meets the requirements for a domestic partnership other than the requirement of being at least 18 years of age, is capable of consenting to and establishing a domestic partnership upon obtaining a court order granting permission to the underage person or persons to establish a domestic partnership.
4. Either of the following:
   A. Both persons are members of the same sex.
   B. One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in Section 402(a) of Title 42 of the United States Code for old-age insurance benefits or Title XVI of the Social Security Act as defined in Section 1381 of Title 42 of the United States Code for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over 62 years of age.
5. Both persons are capable of consenting to the domestic partnership.

The term "spouse," wherever used, will include a Domestic Partner.

**Fundus Photography Examination** means the recording of a portion(s) or complete retina surface and structures.

**Insured** means an employee of the Policyholder who meets the eligibility requirements as shown in the Policyholder's application, and whose coverage under the Policy is in force and has not ended.

**Insured Person** means the Insured. Insured Person will also include the Insured's Dependents, if enrolled.

**IntraLase Initiated LASIK** means a LASIK surgical procedure in which a special laser is used instead of a blade to create the stromal flap.

**In-Network Provider** means a Provider who has signed a Preferred Provider Agreement with the PPO.

**LASEK** (Laser Assisted Epithelium Keratomileusis) means a surgical procedure that utilizes a trephine to create an epithelial flap and an alcohol solution to preserve the epithelial cells. Once the epithelial flap is created and lifted, the treatment proceeds as for traditional PRK, with light smoothing at its conclusion. The epithelial flap is then repositioned with a small spatula.

**Laser Vision Correction Procedures** means surgical procedures which permanently alter the focusing power of the eye(s) in order to change refractive errors.

**LASIK** (Laser Assisted In-Situ Keratomileusis) means a surgical procedure involving the use of a computer-controlled excimer laser to reshape the cornea (epithelium) without invading the adjacent cell layers. An automated microkeratome is used to create a stromal flap of the cornea that is lifted, and the exposed surface is reshaped using the laser. After altering the cornea curvature, the stromal flap is replaced and is adhered without stitches.

**Medically Necessary Contact Lenses** means:

1. Keratoconus where the Insured Person is not correctable to 20/30 in either or both eyes using standard spectacle lenses, or the Provider attests to the specified level of visual improvement;
2. High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;
3. Anisometropia of 3D in spherical equivalent or more; or
4. vision for an Insured Person can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle.

**Out-of-Network Provider** means a Provider, located within the PPO Service Area, who has not signed a Preferred Provider Agreement with the PPO.

**Policy** means the Policy issued to the Policyholder.

**Policyholder** means the Employer named as the Policyholder in the face page of the Policy.

**PPO Service Area** means the geographical area where the PPO is located.

**Preferred Provider Agreement** means an agreement between the PPO and a Provider that contains the rates and reimbursement methods for services and supplies provided by such Provider.

**Preferred Provider Organization ("PPO")** means a network of Providers and retail chain stores within the PPO Service Area that has signed a Preferred Provider Agreement.

**Provider** means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing optician.

The term "spouse", wherever used, will include a Registered Domestic Partner.]

**Vision Examination** means any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

**Vision Materials** means those materials shown in the Schedule of Benefits.

## EFFECTIVE DATES

**Effective Date of Insured's Insurance.** The Insured's insurance will be effective as follows:

1. if the Policyholder does not require the Insured to contribute towards the premium for this coverage, the Insured's insurance will be effective on the date the Insured became eligible;
2. if the Policyholder requires the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured became eligible, provided;
   a. the Insured has given the Company the Insured's enrollment form (if required) on, prior to, or within 30 days of the date the Insured became eligible; and
   b. the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 a) and 2 b) within 30 days after becoming eligible, the Insured's coverage will not become effective until the Company has verified that the Insured has met these requirements. The Insured will then be advised of the Insured's effective date.

**Effective Date of Dependents' Insurance.** Coverage for Dependents becomes effective on the later of:

1. the date Dependent coverage is first included in the Insured's coverage; or
2. the premium due date on or after the date the person first qualifies as the Insured's Dependent. If an enrollment form is required, the Insured must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

If the Insured and the Insured's spouse are both Insureds, one Insured may request to be a Dependent spouse of the other. A Dependent child may not be covered by more than one Insured.

**Newborn Children.** A Dependent child born while the Insured's coverage is in force will be covered from the moment of birth for 90 days or greater, if elected. In order to continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period.

**Adopted Children.** If a Dependent child is placed with the Insured for adoption while the Insured's coverage is in force, this child will be covered from the date of placement for 90 days or greater, if elected. In order to continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period. If proper notice has been given, coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.

## BENEFITS

Benefits are payable for each Insured Person as shown in the Schedule of Benefits for expenses incurred while this insurance is in force.

**Comprehensive Eye Examination.** An Insured Person is eligible for one Comprehensive Eye Examination in each Benefit Frequency.

**In-Network Provider Benefits.** The Insured Person must pay any Co-payment or any cost above the allowance shown in the Schedule of Benefits at the time the covered service is provided. Benefits will be paid to the In-Network Provider who will file a claim with the Company.

**Out-of-Network Provider Benefits.** The Insured Person must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the Company. The Company will reimburse the Insured Person for the Out-of-Network Provider benefits up to the maximum dollar amount shown in the Schedule of Benefits.

**Vision Materials.** If a Vision Examination results in an Insured Person needing corrective Vision Materials for the Insured Person's visual health and welfare, those Vision Materials prescribed by the Provider will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

- *Lenses* provided one time in each Benefit Frequency.
- *Frame(s)* provided one time in each Benefit Frequency.
- *Contact Lenses* provided one time in each Benefit Frequency in lieu of lenses.

## LIMITATIONS

Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy.

Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

If payment for claims exceeds the amount for which the Insured Person is eligible under any benefit provision or rider of the Policy, the Company has the right to recover the excess of such payment from the Provider or the Insured.

The Policy is not a Workers' Compensation policy. The Policy does not satisfy any requirement for coverage by Workers' Compensation Insurance.

## EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from:

1. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
2. medical and/or surgical treatment of the eye, eyes or supporting structures;
3. any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
4. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5. plano (non-prescription) lenses;
6. non-prescription sunglasses;
7. two pair of glasses in lieu of bifocals;
8. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; and:
9. lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit the Company from providing insurance, including, but not limited to, the payment of claims.

## TERMINATION OF INSURANCE

The Policyholder or the Company may terminate or cancel the Policy as shown in the Policy.

**For All Insureds.** The Insureds' insurance will cease on the earliest of the following dates:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
   a. does so without individual selection between Insureds; and
   b. continues to pay any premium contribution for those individuals.

**For Dependents.** A Dependent's insurance will cease on the earlier of:

1. on the date the Insured's coverage ends;
2. the date on which the Dependent ceases to be an eligible Dependent as defined in the Policyholder's application; or
3. the end of the last period for which any required premium contribution has been made.

A Dependent child will not cease to be a Dependent solely because of age if the child is:

1. not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company may ask for proof of the eligible Dependent child's incapacity and dependency two months prior to the date the Dependent child would otherwise cease to be covered.

The Company may require the same proof again, but will not ask for it more than once a year after this coverage has been continued for two years. This continued coverage will end:

1. on the date the Policy ends;
2. on the date the incapacity or dependency ends;
3. on the end of the last period for which any required premium contribution for the Dependent child has been made; or
4. 60 days following the date the Company requests proof and such proof is not provided to the Company.

## CLAIMS AND GENERAL PROVISIONS

**Entire Contract; Changes.** The Policy, the application of the Policyholder, and the individual applications, if any, of the individuals insured constitute the entire contract between the parties, and all statement made by the Policyholder, or by any individuals insured shall, in the absence of fraud, be deemed a representation and not warranties, and that no such statement be used in defense to a claim under the Policy, unless it is contained in a written application.

No change in the Policy shall be valid unless approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or waive any of its provisions.

**Time Limit on Certain Defenses.** After three years from the date of issue of the Policy, no misstatement of the Policyholder except a fraudulent misstatement, made in his application shall be used to void the Policy; and after three years from the effective date of the coverage with respect to which any claim is made no misstatement of any Insured eligible for coverage under the Policy, except a fraudulent misstatement, made in an application under the Policy shall be used to deny a claim for loss incurred or disability as defined in the Policy commencing after expiration of such three years.

**Grace Period.** A grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which Grace Period the policy shall continue in force, but the Policyholder shall be liable to the Company for the payment of the premium accruing for the period the policy continues in force.

**Reinstatement.** There shall be no provision in a group disability Policy relative to reinstatement of the Policy after lapse because of default in the payment of premium nor shall there be any provision therein prior to the reinstatement relative to when the insurance coverage becomes effective again after such lapse and reinstatement.

**Notice of claim.** Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the insurer at Administrator's Office: 4000 Luxottica Place; Mason, OH 45040, or to any authorized agent of the Company, with information sufficient to identify the insured, shall be deemed notice to the Company.

**Claims forms.** The Company, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

**Proofs of Loss.** Written proof of loss must be furnished to the Company, in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the Company is liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the employee, later than one year from the time proof is otherwise required.

**Time of Payment of Claim.** Subject to due written proof of loss, all indemnities for loss for which the Policy provides payment will be paid to the Insured as they accrue and any balance remaining unpaid at termination of the period of liability will be paid to the Insured immediately upon receipt of due written proof.

**Payment of Claims.** If any indemnity of the Policy shall be payable to the estate of the Insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity up to an amount not exceeding $1,000 to any relative by blood or connection by marriage of the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

**Legal Actions.** No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

**Misstatement of Age.** If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of the premium for the Policy so that there shall be paid to the Company the premium for the coverage of such individual at his correct age, and the amount of the insurance coverage shall not be affected.

**Conformity With State Statutes.** Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statute.

## GRIEVANCES AND COMPLAINTS

**If you are not satisfied with any aspect of service or claim resolution relating to the coverage under the Policy, you may file a grievance or complaint with Us at the address or telephone number shown below:**

**Combined Insurance Company of America**
**C/O 4000 Luxottica Place**
**Mason, OH 45040**
**866-939-3633**

**If you are not satisfied with the resolution of your grievance or complaint, you may file a complaint with the Consumer Services Division of the California Department of Insurance at the address or telephone numbers shown below. The Department of Insurance should be contacted only after discussions with Us have failed to produce a satisfactory resolution to the problem.**

**California Department of Insurance**
**Claims Services Bureau, 11th Floor**
**300 South Spring Street**
**Los Angele, CA 90013**
**800-927-4357 (within CA)**
**213-897-8921 (outside CA)**
**800-482-4833 (TDD)**

# SCHEDULE OF BENEFITS

Policyholder: City of Los Angeles

An Insured Persons has the right to obtain vision care from the Provider of his or her choice. Benefits are payable as shown in the following Schedule of Benefits:

| **Benefit** | **In-Network Cost Benefit Amount** | **Out-of-Network Reimbursement Benefit Amount** | **Benefit Frequency** |
|---|---|---|---|
| **VISION EXAMINATION** | | | |
| **Comprehensive Eye Examination** | $10 Co-payment | up to $45 | 12 months |
| **Fundus Photography Benefits** | $10 Co-payment | up to $21 | 12 months |
| **VISION MATERIALS** | | | |
| ***Standard Plastic Lenses*** | | | 12 months |
| Single Vision | $10 Co-payment | up to $35 | |
| Bifocal | $10 Co-payment | up to $50 | |
| Trifocal | $10 Co-payment | up to $65 | |
| Lenticular | $10 Co-payment | up to $65 | |
| ***Frames*** | $150 retail allowance | up to $104 | 12 months |
| ***Contact Lenses (only one option available per Benefit Frequency)*** | | | 12 months |
| Conventional | $0 Co-payment up to $150 allowance | up to $120 | |
| Disposable | $0 Co-payment up to $150 allowance | up to $120 | |
| Medically Necessary | $0 Co-payment Paid in full | up to $210 | |
| ***Lens Options*** | | | 12 months |
| Standard Polycarbonate (For covered Dependent children under 19 years of age.) | $0 Co-payment | up to $28 | |
| Standard Progressive Lenses (add on to Bifocal) "Brand Names" | $75 Co-payment | up to $70 | |
| Premium Progressive Lenses (add on to Bifocal) "Brand Names" | Tier 1 - $95 Co-payment<br>Tier 2 - $105 Co-payment<br>Tier 3 - $120 Co-payment<br>Tier 4 - $75 Co-payment, less $120 allowance | up to $70 | |

# Group Application Addendum Memo

## Eligibility for LAwell Benefits

### Full-Time Employees

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

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

### Half-Time Employees

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

### Family Members of Employees

Employees eligible for LAwell may also enroll their eligible family members if their dependents meet the dependent eligibility criteria (see Page 2) and the required documentation is submitted by the deadlines. Employees MUST review their dependent elections and verify that each dependent enrolled – and dependents that are added – continue to meet the LAwell eligibility criteria at all time. Examples of ineligible dependents is provided below.

**Ineligible Dependents**

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

## Dependent Eligibility Criteria

| Dependent Type | Age | Eligibility Definition | Documents Required for Verifying Eligibility |
|---|---|---|---|
| Spouse | N/A | Person of the opposite or same sex to whom you are legally married | Marriage certificate |
| Domestic Partner | N/A | Meet City's domestic partner eligibility requirements. See Domestic Partnership Information Sheet and Affidavit form at **myflexla.com** in "Forms and Documents." | City of Los Angeles Affidavit of Domestic Partnership, or Declaration of Partnership filed with the California Secretary of State |
| Biological Child | Up to age 26* | Minor or adult child(ren) of employee who is under age 26 | Child's birth certificate, hospital verification of birth or court document that verifies your relation to the child (an abstract document is not sufficient in most cases) |
| Step Child | Up to age 26* | Minor or adult child of employee's spouse who is under age 26 | Child's birth certificate and certificate showing spouse/domestic partner as parent |
| Child Legally Adopted/ Ward | Up to age 26* | Minor or adult child legally adopted/ ward by employee who is under age 26 | Child's birth certificate and court documentation |
| Child of Domestic Partner | Up to age 26* | Minor or adult child of employee's domestic partner who is under age 26 | Child's birth certificate and City of Los Angeles Domestic Partner Affidavit or Declaration of Partnership filed with the California Secretary of State |
| Disabled Child | Up to age 26* | Child as defined in the child categories above | Same as the child requirements listed above |
| Disabled Child | Over age 26 | Disabled child over the age of 26 who is dependent on you for support and was disabled before age 18. To be eligible, your child must remain unmarried, dependent on you for financial support and disabled as determined by your health plan. | Birth certificate and disability application from your health plan completed by your child's doctor and returned to your health plan for approval each year as requested by the insurance company. See the Disabled Child Criteria on **page 53** for more information. |
| Grandchildren Legal Custody | Up to age 26* | Your grandchildren up to age 26 if you show proof of legal custody | Child's birth certificate and court documentation |
| Grandchildren | Up to age 26* | Your grandchildren can be added to the plan if their parent is your child who<br>• is under age 19, unmarried, and financially dependent on you ***or***<br>• is age 19-26 and meets the full-time student status, is unmarried, and financially dependent on you<br>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<br>Please call the Employee Benefits Division for more information. |

* Eligibility continues up to the end of the month in which your dependent turns age 26 effective January 1, 2016.

**Terminations:**

Terminations will be effective as follows:

- If an employee leaves on his/her own (resignation) or is terminated from City service, coverage ends on the last day of service.
- If an employee retires, coverage ends at the end of the month.
- If an employee transfers to DWP, coverage ends at the end of the month.

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INSURANCE
**Combined Insurance Company of America**
**111 Wacker Drive, Suite 700 • Chicago, Illinois 60601**
**Administrator's Office: 4000 Luxottica Place; Mason, OH 45040**

## DEPENDENT DEFINITION ENDORSEMENT

The rider is attached to and made part of Policy No. 1007428 / 1007429 / 1008118 / 1008838 issued by **Combined Insurance Company of America** to **City of Los Angeles.**

Effective **January 1, 2017,** this Policy and Certificate as issued is amended as follows:

**Dependent Definition Endorsement is being amended as follows:**

**Dependent means any of the following persons whose coverage under the Policy is in force and has not ended:**

**1. the Insured's lawful spouse or Domestic Partner;**

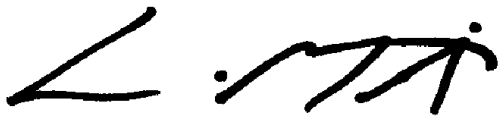
**2. each child from birth to age 26; or**

**3. each unmarried child at least 26 years of age who is primarily dependent upon the Insured for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap; and who has been continuously so incapacitated and primarily dependent upon the Insured for support and maintenance since his or her 26 birthday.**

**Child includes the Insured's biological child, stepchild, foster child, legally adopted child, ward, child of domestic partner, child legally placed in the Insured's home for adoption, child under the Insured's legal guardianship, grandchild for whom the Insured has legal custody and grandchild if the unmarried parent of the grandchild is financially dependent on the Insured and under age 19, or age 19-26 and a full time student, provided the parent is an Insured Person on the policy.**

Signed for **Combined Insurance Company of America**

Brad Bennett, President



Carmine A. Giganti, Vice President and Secretary

# ACE GROUP OF COMPANIES
# U.S. PRIVACY NOTICE

| FACTS | WHAT DOES THE ACE GROUP OF COMPANIES DO WITH YOUR PERSONAL INFORMATION? |
|---|---|
| **Why?** | Insurance companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal and state law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do. |
| **What?** | The types of personal information we collect and share depend on the product or service you have with us. This information can include:<br><br>▪ Social Security number and payment history<br>▪ insurance claim history and medical information<br>▪ account transactions and credit scores<br><br>When you are no longer our customer, we continue to share information about you as described in this notice. |
| **How?** | All insurance companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons insurance companies can share their customers' personal information; the reasons the ACE Group chooses to share; and whether you can limit this sharing. |

| Reasons we can share your personal information | Does ACE share? | Can you limit this sharing? |
|---|---|---|
| **For our everyday business purposes** – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus | Yes | No |
| **For our marketing purposes** – to offer our products and services to you | Yes | No |
| **For joint marketing with other financial companies** | Yes | No |
| **For our affiliates' everyday business purposes** – information about your transactions and experiences | Yes | No |
| **For our affiliates' everyday business purposes** – information about your creditworthiness | No | We don't share |
| **For our affiliates to market to you** | No | We don't share |
| **For nonaffiliates to market to you** | No | We don't share |

| Questions? | Call 1-800-352-4462 or go to www.acegroup.com/us-en/contact-us/general-inquiry-form.aspx |
|---|---|

| Who we are | |
|---|---|
| **Who is providing this notice?** | The ACE Group of Companies. A list of these companies is located at the end of this document. |

| What we do | |
|---|---|
| **How does ACE Group protect my personal information?** | To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings.<br><br>We restrict access to personal information to our employees, affiliates' employees, or others who need to know that information to service the account or to conduct our normal business operations. |
| **How does ACE Group collect my personal information?** | We collect your personal information, for example, when you<br><br>▪ apply for insurance or pay insurance premiums<br>▪ file an insurance claim or provide account information<br>▪ give us your contact information<br><br>We also collect your personal information from others, such as credit bureaus, affiliates, or other companies. |
| **Why can't I limit all sharing?** | Federal law gives you the right to limit only<br><br>▪ sharing for affiliates' everyday business purposes – information about your creditworthiness<br>▪ affiliates from using your information to market to you<br>▪ sharing for nonaffiliates to market to you<br><br>State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law. |

| Definitions | |
|---|---|
| **Affiliates** | Companies related by common ownership or control. They can be financial and nonfinancial companies.<br><br>▪ Our affiliates include those with an ACE name and financial companies, such as Westchester Fire Insurance Company and ESIS, Inc. |
| **Nonaffiliates** | Companies not related by common ownership or control. They can be financial and nonfinancial companies.<br><br>▪ ACE does not share with nonaffiliates so they can market to you. |
| **Joint Marketing** | A formal agreement between nonaffiliated financial companies that together market financial products or services to you.<br><br>▪ Our joint marketing partners include categories of companies such as banks. |

## Other important information

**For Insurance Customers in CA, CT, GA, IL, MA, ME, MN, MT, NC, NJ, OH, OR, and VA only:** Under state law, you have the right see the personal information about you that we have on file. To see your information, write ACE US Customer Services, P.O. Box 1000, 436 Walnut Street, WA04B, Philadelphia, PA 19106. ACE USA may charge a reasonable fee to cover the costs of providing this information. If you think any of the information is wrong, you may write us. We will let you know what actions we take. If you do not agree with our actions, you may send us a statement. If you want a full description of privacy rights that we will protect in accordance with the law in your home state, please contact us and we will provide it. We may disclose information to certain third parties, such as law enforcement officers, without your permission.

**For Nevada residents only:** We may contact our existing customers by telephone to offer additional insurance products that we believe may be of interest to you. Under state law, you have the right to opt out of these calls by adding your name to our internal do-not-call list. To opt out of these calls, or for more information about your opt out rights, please contact our customer service department. You can reach us by calling **1-800-352-4462**, emailing us at info@acegroup.com, or writing to P.O. Box 1000, 436 Walnut Street, WA04B, Philadelphia, PA 19106. You are being provided this notice under Nevada state law. In addition to contacting ACE, Nevada residents can contact the Nevada Attorney General for more information about your opt out rights by calling 775-684-1100, emailing bcpinfo@ag.state.nv.us, or by writing to: Office of the Attorney General, Nevada Department of Justice, Bureau of Consumer Protection: 100 North Carson Street, Carson City, NV 89701.

**For Vermont residents only:** Under state law, we will not share information about your creditworthiness within our corporate family except with your authorization or consent, but we may share information about our transactions or experiences with you within our corporate family without your consent.

## ACE Group of Companies legal entities

ACE Group of Companies use the names: ACE American Insurance Company, ACE Fire Underwriters Insurance Company, ACE Insurance Company of the Midwest, ACE Property and Casualty Insurance Company, Atlantic Employers Insurance Company, Bankers Standard Fire and Marine Company, Bankers Standard Insurance Company, Century Indemnity Company, Illinois Union Insurance Company, Indemnity Insurance Company of North America, Insurance Company of North America, Pacific Employers Insurance Company, Westchester Fire Insurance Company, Westchester Surplus Lines Insurance Company, ESIS, Inc., Combined Insurance Company of America, Combined Life Insurance Company of New York, Penn Millers Insurance Company, Agri General Insurance Company