

Important Legal Notices

The included legal notices apply to plan year 2023 and are valid as of the date of print. Any changes to this legal notices section made after the date of print will be distributed separately and be made available online at keepingLAwell.com.

Medicare Notice of Creditable Coverage Reminder

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

To find out whether the prescription drug coverage under the medical plan options offered by the City are or are not creditable, you should review the Plan's Medicare Part D Notice of Creditable Coverage available on page 82.

Binding Arbitration

Anthem Narrow Network (Select HMO), Anthem Full Network (CACare HMO), Anthem Vivity (LA & Orange Counties) HMO, Anthem PPO (Prudent Buyer), and Kaiser Permanente HMO (Kaiser Foundation Health Plan, Inc. and any contracted provider) health plans use binding arbitration to settle disputes, including benefit claims, medical malpractice claims and disputes relating to the delivery of service under the plan. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered by the health care providers were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law (except for Small Claims Court cases and any other claim that cannot be subject to binding arbitration under governing law) and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both you and the health care provider agree to give up your/their constitutional right to have any such dispute decided in a court of law before a jury, and instead accept the use of arbitration, except as otherwise required by law.

It is further understood that this agreement to arbitrate shall apply and extend to any dispute for medical malpractice relating to the delivery of service under the plan, and to any claims in tort, contract or otherwise, between the individuals seeking services under the plan, whether referred to as a member, subscriber, dependent, enrollee, or otherwise (whether a minor or adult), or the heirs-at-law or personal representatives of any such individual(s), as the case may be, and the health plan (including any of their agents, successors- or predecessors-in-interest, employees, or providers).

NOTICE: BY ENROLLING IN A HEALTH CARE PLAN, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHTS TO A JURY OR COURT TRIAL AND TO ASSERT OR PARTICIPATE IN A CLASS ACTION.

(Such enrollment serves as your electronic signature for agreement to the above provisions for the purposes of California Health and Safety Code Section 1361.1 and Code of Civil Procedure Section 1295.)

Women's Health and Cancer Rights Act

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

About Hospital Stays for Mothers and Newborns

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

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

Privacy and Your Health Coverage

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

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

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

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

You do not need prior authorization from the Anthem Blue Cross HMO or from any other person (including a Personal Physician) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however,

may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

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

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

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

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

LAWell Plan Document

This enrollment guide is published by the City of Los Angeles Personnel Department. It provides only highlights of the **LAWell** program, and supplements the program rules identified in the **LAWell** Plan Document. This guide does not change the terms of your benefits or the official documents that control them. Copies of the **LAWell** Plan Document and official benefit documents are available at [keepingLAWell.com](https://www.keepingLAWell.com).



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

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [healthcare.gov](https://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, call **877-KIDS-NOW**, or visit [insurekidsnow.gov](https://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 [askebsa.dol.gov](https://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your state for more information on eligibility.

Contact Information by State

ALABAMA – Medicaid

Website: myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid

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

ARKANSAS – Medicaid

Website: myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

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

COLORADO – Health First Colorado

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

FLORIDA – Medicaid

Website: flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

A HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 1-678-564-1162, Press 1
GA CHIPRA Website: medicaid.georgia.gov/programs/third-partyliability/childrens-health-insurance-program-reauthorizationact-2009-chipra
Phone: 1-678-564-1162, Press 2

Contact Information by State

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: in.gov/fssa/hip
Phone: 1-877-438-4479
All other Medicaid
Website: in.gov/medicaid
Phone 1-800-457-4584

IOWA – Medicaid and CPHP (Hawki)

Medicaid Website: dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: kancare.ks.gov
Phone: 1-800-792-4884

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

MAINE – Medicaid

Enrollment Website: maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

Contact Information by State

<p>MASSACHUSETTS – Medicaid and CHIP Website: www.mass.gov/masshealth/pa Phone: 1-800-862-4840</p>
<p>MINNESOTA – Medicaid Website: mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739</p>
<p>MISSOURI – Medicaid Website: dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p>MONTANA – Medicaid Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>
<p>NEBRASKA – Medicaid Website: ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178</p>
<p>NEVADA – Medicaid Medicaid Website: dhcfnv.gov Medicaid Phone: 1-800-992-0900</p>
<p>NEW HAMPSHIRE – Medicaid Website: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>
<p>NEW JERSEY – Medicaid and CHIP Medicaid Website: state.nj.us/humanservices/dmahs/clients/medicaid Medicaid Phone: 609-631-2392 CHIP Website: www.njfamilycare.org/default.aspx CHIP Phone: 1-800-701-0710</p>
<p>NEW YORK – Medicaid Website: health.ny.gov/health_care/medicaid Phone: 1-800-541-2831</p>
<p>NORTH CAROLINA – Medicaid Website: medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>
<p>NORTH DAKOTA – Medicaid Website: nd.gov/dhs/services/medicalserv/medicaid Phone: 1-844-854-4825</p>
<p>OKLAHOMA – Medicaid and CHIP Website: insureoklahoma.org Phone: 1-888-365-3742</p>
<p>OREGON – Medicaid Website: healthcare.oregon.gov/Pages/index.aspx or oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>
<p>PENNSYLVANIA – Medicaid Website: dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462</p>
<p>RHODE ISLAND – Medicaid Website: eohhs.ri.gov Phone: 855-697-4347, or 401-462-0311 (Direct Rlts Share Line)</p>
<p>SOUTH CAROLINA – Medicaid Website: scdhhs.gov Phone: 1-888-549-0820</p>
<p>SOUTH DAKOTA - Medicaid Website: dss.sd.gov Phone: 1-888-828-0059</p>
<p>TEXAS – Medicaid Website: gethipptexas.com Phone: 1-800-440-0493</p>

Contact Information by State

<p>UTAH – Medicaid and CHIP Medicaid Website: medicaid.utah.gov CHIP Website: chip.health.utah.gov Phone: 1-877-543-7669</p>
<p>VERMONT– Medicaid Website: greenmountaincare.org Phone: 1-800-250-8427</p>
<p>VIRGINIA – Medicaid and CHIP Website: coverva.org/en/famis-select or coverva.org/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924</p>
<p>WASHINGTON – Medicaid Website: hca.wa.gov Phone: 1-800-562-3022</p>
<p>WEST VIRGINIA – Medicaid Website: dhr.wv.gov/bms/ www.mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
<p>WISCONSIN – Medicaid and CHIP Website: dhs.wisconsin.gov/badgercareplus/hipp.htm Phone: 1-800-362-3002</p>
<p>WYOMING – Medicaid Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269</p>

To see if any other states have added a premium assistance program since January 1, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
dol.gov/agencies/ebsa
 1-866-444-EBSA (3272)

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

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

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

Other California Premium Assistance Resources:

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



Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20220 or email ebbsa.opr@dol.gov and reference the OMB Control Number 1210-0137 (expires 1/31/2023).

Health Insurance Marketplace

New Health Insurance Marketplace Coverage Options and Your Health Coverage.

PART A: General Information

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

What Is the Health Insurance Marketplace?

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

Can I Save Money on My Health Insurance Premiums in the Marketplace?

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

Does Employer Health Coverage Affect Eligibility for Premium Savings Through the Marketplace?

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Benefits Service Center at **833-4LA-WELL** or keepingLAwell.com.

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

¹ An employer-sponsored health plan meets the “minimum value standard” if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

California Healthcare Mandate (CHM)



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

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

PART B: Information About Health Coverage Offered by Your Employer

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

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

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

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

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

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



Important Information About Your COBRA Continuation Coverage Rights

What is continuation coverage?

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

Who are the qualified beneficiaries?

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

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children’s Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” A “qualifying event” that results in a loss of coverage provides a “special enrollment period” that allows you **60 days** to enroll in an insurance plan on the Marketplace; otherwise, you must wait until regular Open Enrollment. You may be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions (including your out-of-pocket costs for deductibles, coinsurance, and copays), and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. You can access the Marketplace at [HealthCare.gov](#). You may also be eligible for Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period,” or through private health insurance exchanges. Legal residents of the State of California who do not have health insurance from their employer or another government program may be eligible to purchase health insurance through the State of California’s Health Insurance Marketplace called “Covered California.”

For more information, please visit [CoveredCA.com](#) or call **800-300-1506**. Some of these options may cost less than COBRA continuation coverage.

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

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

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

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

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

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your medical and/or dental plan of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event (see additional information on page 67) may affect the right to extend the period of continuation coverage.



Disability

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

Second Qualifying Event

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

How can you elect COBRA continuation coverage?

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

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within **30 days**

after your group health coverage ends. You also have special enrollment rights to enroll in the Health Insurance Marketplace within **60 days** after your group health coverage ends. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

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

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

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

First payment for continuation coverage

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

Periodic payments for continuation coverage

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

Grace periods for periodic payments

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

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

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

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

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

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

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

For more information

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

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

CalCOBRA Coverage for Medical Benefits Only

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

Keep Your Plan Informed of Address Changes

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

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

Availability of Summary of Benefits and Coverage (SBC)

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

The most current SBC documents for the **LAWell** medical plan options are available online at [keepingLAWell.com](https://www.keepingLAWell.com), or contact the Benefits Service Center at **833-4LA-WELL** to get a free copy.

To request special enrollment or obtain more information, contact the Benefits Service Center at **833-4LA-WELL**, Monday – Friday, 8:00 a.m. to 5:00 p.m.

Important Reminder to Provide the Plan with the Taxpayer Identification Number (TIN) or Social Security Number (SSN) of Each Enrollee in a Health Plan

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

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

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

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact the Benefits Service Center at **833-4LA-WELL**, Monday – Friday, 8:00 a.m. to 5:00 p.m.

Notice Regarding the Wellness Program

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

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

The results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

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

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

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

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

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



Important Notice from the City of Los Angeles for LAwell-Eligible Employees and Dependents About Prescription Drug Coverage for People Who Are Already Medicare-Eligible or May Become Medicare-Eligible During 2023

Medicare and the City

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

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

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

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

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

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

When Can You Join a Medicare Drug Plan?

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

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

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

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

- For Medicare-eligible active employees and their Medicare-eligible dependents, the group health plan pays primary and Medicare Part D coverage pays secondary.

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

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

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

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

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

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

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

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

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

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Los Angeles, Personnel Department changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

- Visit [medicare.gov](https://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 Medicare at **800-MEDICARE (800-633-4227)**. TTY users should call **877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [socialsecurity.gov](https://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).

Networks/Claims/Appeals

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



No Surprises Act Notice

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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

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

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

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

You're protected from balance billing for:

- **Emergency services:** If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

- **Certain services at an in-network hospital or ambulatory surgical center:** When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

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

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

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

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

Generally, your health plan must:

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

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

Visit [cms.gov/nosurprises/consumers](https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law.