



Eligibility, Making Changes & Supplemental Plan Information

KEEPING LAwell
City of Los Angeles Employee Benefits



About this Guide

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

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Eligibility for You and Your Dependents

FULL-TIME EMPLOYEES

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

Changes in Employment Status

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

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

Eligible Children

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

HALF-TIME EMPLOYEES

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

FAMILY MEMBERS OF EMPLOYEES

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

Ineligible Dependents

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

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

Dependent Eligibility Criteria

Dependent Type	Age	Eligibility Definition	Documents Required for Verifying Eligibility
Spouse	N/A	Person of the opposite or same sex to whom you are legally married	Marriage certificate
Domestic Partner	N/A	Meet City's domestic partner eligibility requirements. See Domestic Partnership Information Sheet and Affidavit form at per.lacity.org/bens/docforms.htm	City of Los Angeles Affidavit of Domestic Partnership, or Declaration of Partnership filed with the California Secretary of State
Biological Child	Up to age 26*	Minor or adult child(ren) of employee who is under age 26	Child's birth certificate, hospital verification of birth or court document that verifies your relation to the child (an abstract document is not sufficient in most cases)
Step Child	Up to age 26*	Minor or adult child of employee's spouse who is under age 26	Child's birth certificate and certificate showing spouse/domestic partner as parent
Child Legally Adopted/Ward	Up to age 26*	Minor or adult child legally adopted/ward by employee who is under age 26	Child's birth certificate and court documentation
Child of Domestic Partner	Up to age 26*	Minor or adult child of employee's domestic partner who is under age 26	Child's birth certificate and City of Los Angeles Domestic Partner Affidavit or Declaration of Partnership filed with the California Secretary of State
Disabled Child	Up to age 26*	Child as defined in the child categories above	Same as the child requirements listed above
Disabled Child	Over age 26	Disabled child over the age of 26 who is dependent on you for support and was disabled before age 18. To be eligible, your child must remain unmarried, dependent on you for financial support and disabled as determined by your health plan.	Birth certificate and disability application from your health plan completed by your child's doctor and returned to your health plan for approval each year as requested by the insurance company
Grandchildren Legal Custody	Up to age 26*	Your grandchildren up to age 26 if you show proof of legal custody	Child's birth certificate and court documentation
Grandchildren	Up to age 26*	Your grandchildren can be added to the plan if their parent is your child who <ul style="list-style-type: none"> • is under age 19, unmarried, and financially dependent on you or • is age 19-26 and meets the full-time student status, is unmarried, and financially dependent on you If coverage for your child ends, coverage for your grandchildren will end.	Child's and grandchild's birth certificates; valid proof of dependent status and/or full-time student certification for your child

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

SPECIAL ENROLLMENT

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

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

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

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

Changing Your Benefit Choices

WHEN YOUR CHOICES WILL APPLY

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

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

WHEN YOU CAN MAKE CHANGES

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

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

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

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

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

Important Deadline

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

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

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

Limited Time Period for Making Benefit Changes after a Life Event

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

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

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

Documents Are Required

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

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

LIFE EVENTS

Your Benefits Can Be Affected When...

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

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

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

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

Your Work Schedule Changes

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

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

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

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

About Continuation Coverage

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

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

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

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

You Are Disabled

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

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

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

Benefits While on Leave or in Non-Pay Status

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

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

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

For your medical benefits, please contact the Employee Benefits Division at **213-978-1655** to understand your coverage options and costs. If you pay the cost of coverage

with after-tax dollars, **LAWell** disability coverage can continue while you are in a non-pay status for up to six months. After six months, you can choose to continue:

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

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

You Begin Receiving Workers' Compensation (State Rate) Benefits

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

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

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

You Retire from the City

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

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

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

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

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

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

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

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

Your LAwell Benefits and Changes

HEALTH COVERAGE DETAILS

Coverage for Special Circumstances

Care While Traveling

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

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

Care for Dependents Who Do Not Live with You

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

IRS FORMS TO BE PROVIDED TO YOU ANNUALLY

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

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

HEALTH PLAN DOCUMENTS

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

Life, AD&D, and Disability Insurance Details

LIFE INSURANCE

Portability and Conversion

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

Portability

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

Conversion

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

What You Need to Do

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

Accelerated Benefit

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

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

Active Work Requirement

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

About Life Insurance and Imputed Income

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

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

Example of Imputed Income

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

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

IRS Table for Calculating Imputed Income

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

SUPPLEMENTAL LIFE INSURANCE

Proof of Good Health

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

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

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

DEPENDENT LIFE INSURANCE

About Portability and Conversion

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

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

Selecting Portable or Conversion Coverage

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

AD&D Insurance

Continuing AD&D Coverage

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

Disability Coverage

About Your Basic and Supplemental Disability Benefits

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

Disability Retirement Income

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

Disability Benefits Require Approval

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

Taxes and Your Disability Benefits

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

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

Benefit Protection Plan

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

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

Active Work Requirement

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

Definition of Pre-Disability Earnings for Disability Coverage

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

Disability Coverage and Pre-Existing Conditions

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

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

Other Benefits to Consider

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

Benefit Exclusions

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

Filing a Disability Claim

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

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

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

Sick Leave and Disability – What's the Difference?

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

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

Important Legal Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

ABOUT HOSPITAL STAYS FOR MOTHERS AND NEWBORNS

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

PRIVACY AND YOUR HEALTH COVERAGE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AVAILABILITY OF SUMMARY HEALTH INFORMATION

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

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

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

IMPORTANT NOTICE FROM THE CITY OF LOS ANGELES FOR LAwell-ELIGIBLE EMPLOYEES AND DEPENDENTS ABOUT PRESCRIPTION DRUG COVERAGE FOR PEOPLE WHO ARE ALREADY MEDICARE-ELIGIBLE OR MAY BECOME MEDICARE-ELIGIBLE DURING 2017

Your Prescription Drug Coverage and Medicare

As the sponsor of an active group medical plan, the City of Los Angeles' **L**Awell Plan is required to provide all Medicare-eligible participants with the following notice from the federal government in conjunction with the Medicare Prescription Drug Improvement and Modernization Act of 2003. This notice has information about your current prescription drug coverage with the City of Los Angeles and about your options under Medicare's prescription drug coverage.

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

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

Medicare prescription drug coverage for Medicare-eligible people is available through Medicare Prescription Drug Plans or a Medicare Advantage Plans (like an HMO or PPO) that offer prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

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

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

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

REMEMBER TO KEEP THIS NOTICE

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

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

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

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

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

If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. Having dual prescription drug coverage under this Plan and Medicare means that this Plan will coordinate its drug payments with Medicare, as follows:

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

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

If You Decide To Join A Medicare Drug Plan

You may decide to join a Medicare drug plan while still an active City employee with benefits. Please refer to the 2017 **CHOOSEwell Guide** regarding your prescription and medical benefits with the City. Having dual prescription drug coverage under the City's Plan and Medicare means that the City's Plan will coordinate its drug payments with Medicare, as follows:

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

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

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

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

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

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

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

When Can You Join a Medicare Drug Plan?

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

1. when you first become eligible for Medicare,
2. each year during Medicare's annual election period (from October 15th through December 7th), and/or
3. if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible to join a Part D plan for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan while still an active City employee with benefits, you will continue to receive the City's **LAWell** coverage as your primary insurance provider. Please be aware that enrolling in Medicare simultaneously with the City's **LAWell** Plan may cause payment errors and in most cases will not increase your benefits. Please refer to the 2017 **CHOOSEwell Guide** regarding your prescription and medical benefits with the City **LAWell** Plan. If you had Medicare prior to becoming eligible for **LAWell** Benefits, then you may receive Cash-in-Lieu and disenroll from your **LAWell** medical coverage. If you are a Medicare-eligible dependent of an active City employee, you may discontinue participation in the City of Los Angeles **LAWell** Plan and enroll in Medicare Part B and Part D based upon Medicare's guidelines.

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

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

If you drop or lose your coverage with the City of Los Angeles and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join. City employees and their federally recognized eligible dependents will not be subject to higher premiums if they maintain creditable coverage with the City.

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

Your Right to Receive a Notice

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

For More Information about Your Options under Medicare's Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

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

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

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

Date: 10/01/2016

Name of Entity/Sender: City of Los Angeles, Personnel Department

Contact—Position/Office: Employee Benefits Division

Address: 200 North Spring Street, City Hall, Room 867

Phone Number: 213-978-1655

E-Mail: per.empbenefits@lacity.org

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

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

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

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

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 Residence/Worksite Proximity to Service Providers: C8

S

Spouse: E3

T

Transit Spending Account (TSA): W5
 Transit Reimbursement Program: W6

V

Vanpool/Carpool Program: W6
 Vision Benefits: C21–C23

W

Wellness: W2
 Women's Health & Cancer Rights Act: E19
 Workers' Compensation (State Rate) Benefits: E9

NOTES

NOTES

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

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

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



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City of Los Angeles Employee Benefits

