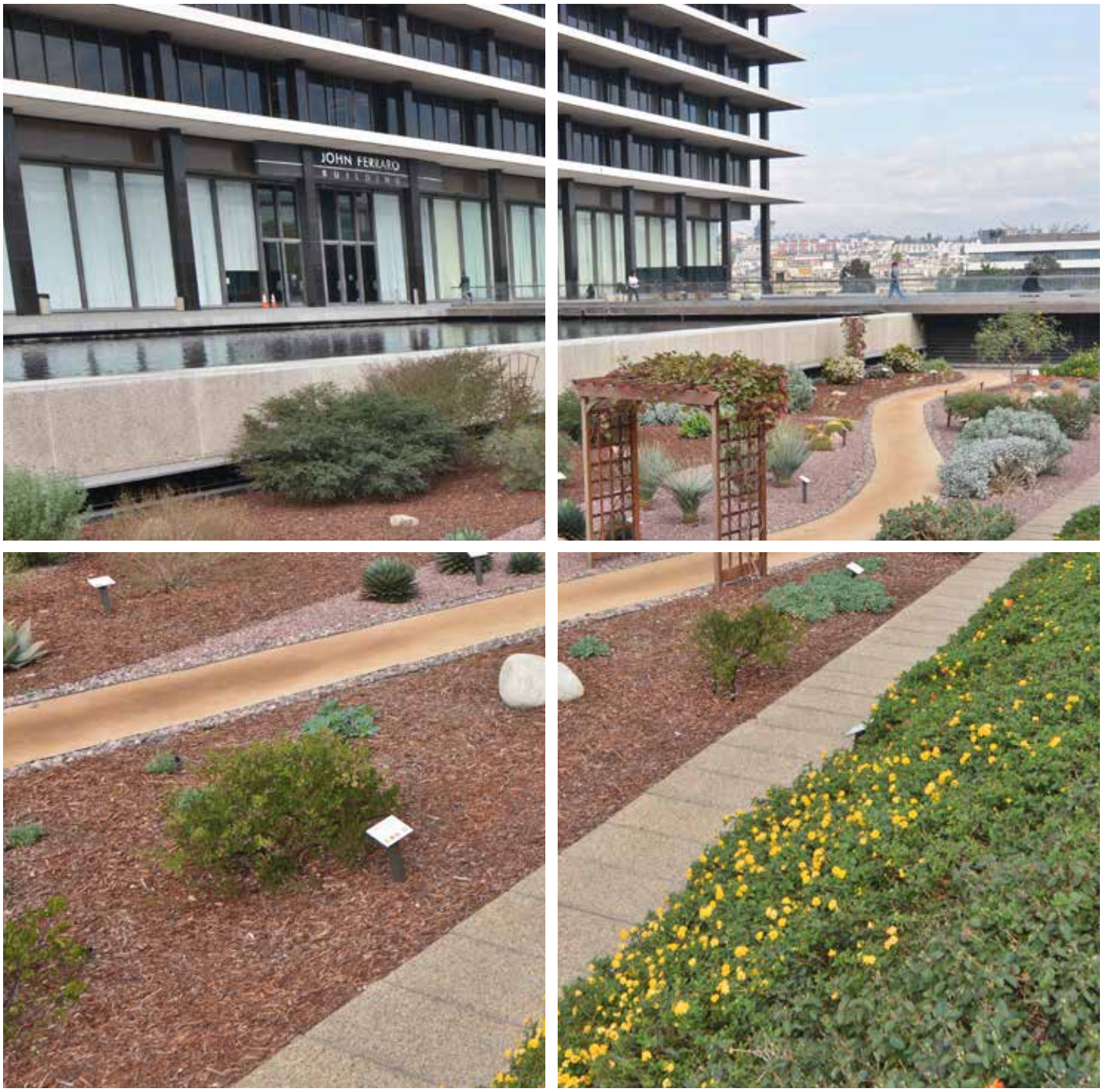
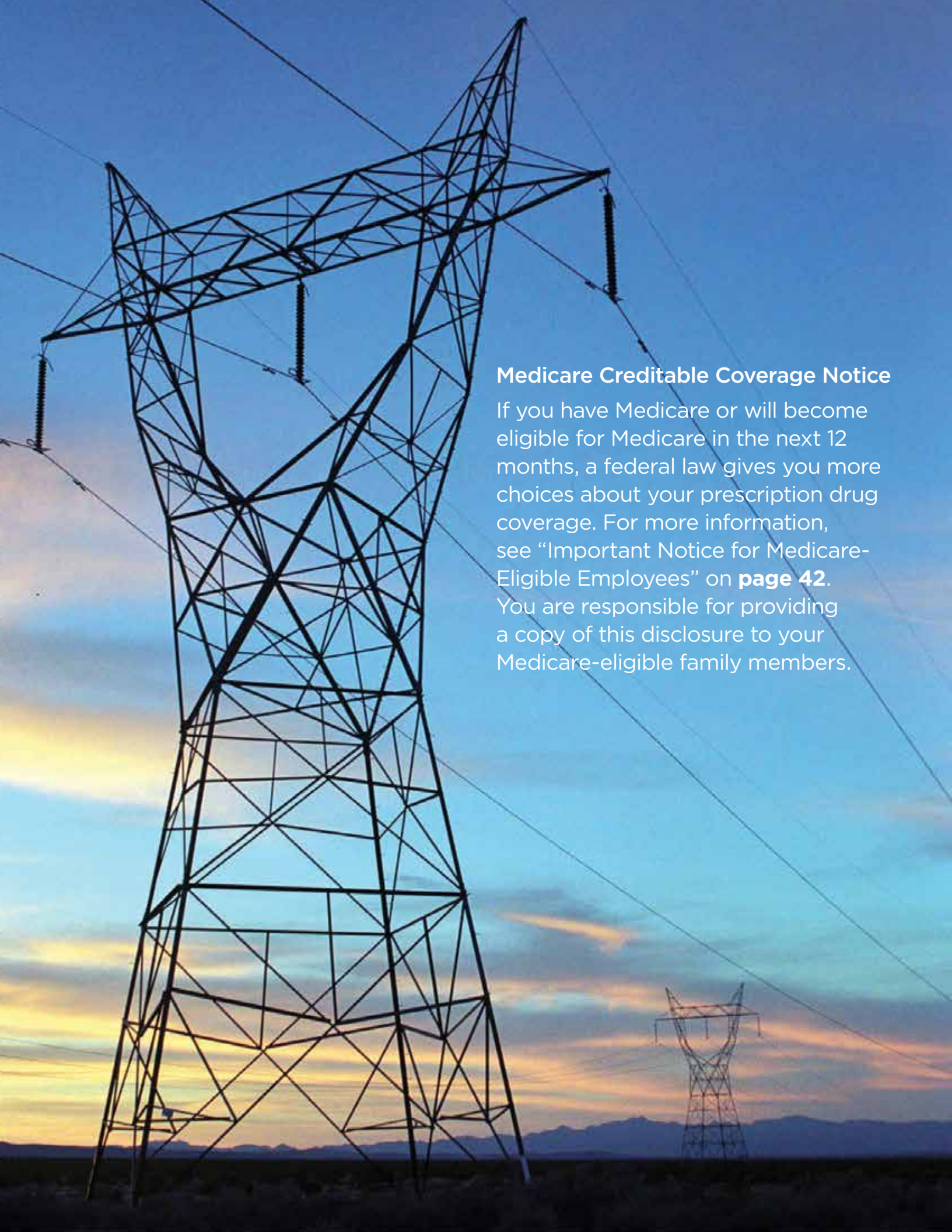
2018-2019 Employee Benefit Guide



Los Angeles Department of Water & Power



Medicare Creditable Coverage Notice

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. For more information, see "Important Notice for Medicare-Eligible Employees" on **page 42**. You are responsible for providing a copy of this disclosure to your Medicare-eligible family members.

Inside

Welcome

Health and Dental

Wellness Resources, Flex Plan, Dependents and Leave of Absence

Additional Information

4 Exploring Your Health Benefits

Your health benefits are a vital part of your personal financial security program. LADWP benefits are designed to give you the resources and information you need to live well and stay healthy. We want you to select the plan that works best for you and your family.

During our annual Open Enrollment period, you have the opportunity to review your health and/or dental plans and make any needed changes. In this guide, you will find your options for enrollment, details on coverage, tips on how to enroll and more about your benefits. Explore this guide so you can understand all that is available to you and make your best decision for coverage.

2018-2019 Open Enrollment: April 23 – May 4, 2018

Time: 8:00 a.m. to 3:00 p.m., Monday through Friday
Location: JFB 111 North Hope Street, A-Level, Los Angeles 90012

Preparing for Enrollment or Enrollment Changes

Update your personal information: Make sure your address and other personal information is updated. If your address has changed, please update eBenefits at **https://eBenefits.ladwp.com** to reflect your current information.

- **Note:** Employees enrolled in an IBEW Local 18-sponsored health or dental plan should contact the IBEW Local 18 Benefit Service Center, or update their address online at **www.mybenefitchoices.com/local18**.

Review your dependents: Take a look at your current dependent coverage to ensure accuracy and to verify they still meet the eligibility criteria.

- You must update your dependents (such as a new spouse, domestic partner or a new child) within 31 days from a qualifying event, or you will not be able to add your dependent until the next Open Enrollment period in 2019. See **page 12** for details.

Gather all of your documents: When you enroll, make sure you have all of the required documents. You will need to provide each eligible dependent's Social Security number for verification purposes along with copies of any other supporting documentation (birth certificate, marriage certificate, domestic partnership). See **pages 12-13**.

Plan to keep proof of enrollment: Print or keep a copy of your form as proof of enrollment. Enrolling in and/or changing your benefits can't be done verbally.

- For LADWP-sponsored plans, you can enroll online or by completing an enrollment form. See **page 8** for details.
- For IBEW Local 18-sponsored plans, you can enroll online. See **page 8** for details.

Please read this guide carefully to ensure you choose a health and dental plan that is best for you and your family. If you want to keep your current health and/or dental plans and coverage levels for you and the same eligible family members you cover today, you simply take no action. Your current coverage choices will continue automatically. However, please review this guide for any benefit coverage changes.

Note: Please review the subsidy and premium rate changes for the 2018-2019 plan year.

Important

You must remove dependents from your coverage if they no longer qualify as "eligible dependents." See **pages 12-13**.

6 Eligibility

Who can enroll in LADWP or IBEW Local 18-sponsored plans?

If You Are...	Then You Are Eligible For...
An employee of LADWP working 20 hours or more per week or A permanent half-time/ part-time employee who works 19 hours per week and is in an IBEW Local 18 bargaining unit	LADWP and/or IBEW Local 18-sponsored health and dental plans
An employee occupying positions in the class of Security Officer, Class Code 3181	▸ LADWP health plans ▸ LADWP Delta Dental Plan or ▸ Local 721 United Concordia Plus Dental Plan
A Construction exempt employee on Payroll 02, 06 or 72	LADWP and/or IBEW Local 18-sponsored health and dental plans; but you **are not** eligible for the LADWP subsidy
If You Are...	**Then You Are NOT Eligible For...**
Construction exempt employees on Payroll 03, 94 or 95	LADWP and/or IBEW Local 18-sponsored health and dental plans NOR the LADWP subsidy

Which Dependents Can You Cover?

- Your spouse or domestic partner
- Your children under age 26 — includes stepchildren and children of whom you are the legal guardian
- Your disabled children age 26 or older
- Your grandchildren who are the children of your *covered* children

Special rules and definitions apply to all dependents. It is your responsibility to remove dependents from coverage if they no longer qualify as "eligible dependents." See dependent eligibility details on **page 16**.

Enrolling in Coverage

If you are a new hire or you make a change in coverage due to a qualifying event, your coverage begins the first day of the month after you submit your enrollment/change form to the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center. You must complete your enrollment within your 31-day eligibility period and pay your portion of the cost, if any.

Note: For Open Enrollment, the effective date is July 1, 2018 for the 2018-2019 Plan Year (July 1, 2018 to June 30, 2019). However, the Health and Dental Plans are based on a calendar year. The benefits that have a specified number of visits per year, or amounts you pay for deductibles, coinsurance or copayments and when you reach your annual out-of-pocket maximum, these are all counted or accumulate on a calendar-year basis.

2018-2019 Open Enrollment: April 23 – May 4, 2018

8 How to Enroll

LADWP-Sponsored Plans

To enroll in a LADWP-sponsored plan, pick up your enrollment/change form from the LADWP Health Plans Administration Office. Once your form is completed, submit it and the supporting documentation to:

LADWP Health Plans Administration Office
John Ferraro Building (JFB)
111 North Hope Street, Room 564
Los Angeles, CA 90012

- You can enroll or download enrollment forms from the eBenefits website at **https://eBenefits.ladwp.com**. For questions or help with your enrollment/changes, call the LADWP Health Plans Administration Office at **(213) 367-2023** or **(800) 831-4778**.
- Forms and supporting documentation can be emailed to **HealthPlans@ladwp.com**.

Note: The original enrollment forms will still be required.

IBEW Local 18-Sponsored Plans

- Enroll online at **www.mybenefitchoices.com/local18**.
- For questions or help with your enrollment/changes, please call the IBEW Local 18 Benefit Service Center weekdays at **(818) 678-0040** or **(800) 842-6635** between the hours of 8:30 a.m. and 12:00 p.m., and 12:45 p.m. and 5:00 p.m., email **Local18@mybenefitchoices.com** or stop by:

  IBEW Local 18 Benefit Service Center
  9500 Topanga Canyon Boulevard
  Chatsworth, CA 91311

Reviewing Your Choices

If you enroll online, print your confirmation statement at the end of the enrollment process. If you enroll with a paper form, make a copy for your records. Check your enrollment carefully!

- **Coverage level** — did you elect individual or family coverage? Make sure all enrollment forms are signed correctly.
- **Dependents** — do you have the correct name and Social Security number listed for each dependent you want to cover? If you added a new dependent, did you submit the verification of eligibility information listed on **pages 12-13**?
- **Your contributions** — does your paycheck stub accurately reflect your benefit choices?

See pages 12-13 for details about which dependents you may enroll and when their coverage begins and ends.

Switching Between LADWP and IBEW Local 18-Sponsored Plans

Special rules apply if you switch from LADWP-sponsored plans to IBEW Local 18-sponsored plans, or vice versa. You must complete the plan termination form to cancel your current coverage to make the change effective. An electronic copy of the form can be downloaded from:

- LADWP-sponsored coverage:
  https://eBenefits.ladwp.com
- IBEW Local 18-sponsored coverage ; on Resources Page, under Forms:
  www.mybenefitchoices.com/local18
  Cancellation and changes can also be made online at
  www.mybenefitchoices.com/local18

Or you may contact the LADWP Health Plans Administration Office or the IBEW Local 18 Benefit Service Center, as appropriate, to receive a plan termination form. Changes outside of the Open Enrollment period will be effective the first of the month after your form is received.

Note: If you have IBEW Local 18-sponsored coverage and you are on an emergency appointment, you may remain enrolled in Local 18-sponsored coverage for up to one year.

When You Are Ready to Retire

When you retire, your health and dental coverage does not continue automatically. You must contact the LADWP Health Plans Administration Office or the IBEW Local 18 Benefit Service Center at least one month before your retirement date to continue coverage for you and your covered eligible dependents. If you are changing plans for any reason, you must submit a completed enrollment/change form for LADWP, or for IBEW Local 18-sponsored plans, go online to make your changes at **www.mybenefitchoices.com/local18**.

Important: You can only choose an IBEW Local 18-sponsored health and/or dental plan for retirement if you were actively enrolled in the plan before your retirement.

Making Changes During the Year

You can log on and download change/enrollment forms:

- LADWP-sponsored coverage: **https://eBenefits.ladwp.com**
- IBEW Local 18-sponsored coverage, make online at: **www.mybenefitchoices.com/local18**

31 Days

Be sure to submit your completed enrollment/ change form and supporting documentation within **31 days** from your qualifying event.

Qualifying Events for Changing Coverage After Open Enrollment

If You...	You Should
Are a new employee	Enroll yourself and any eligible dependents in benefits within 31 days from your hire date.
Add a dependent as a result of marriage, domestic partnership, birth, adoption or placement for adoption	> Request enrollment within 31 days from the date of marriage, birth, adoption or placement for adoption. > Add a domestic partner within 31 days after 12 months of living together.
Transfer from another City of Los Angeles Department	> Enroll in a health and/or dental plan within 31 days from your date of hire with LADWP. > Contact the City Employee Benefits Office at (213) 978-1655 for information on your last day of coverage under your City health and/or dental plan.
Change from daily rated status (Payrolls 72, 02, 06) to monthly salaried status	Enroll in a health and dental plan (but not change from one plan to another) within 31 days from the change in status.
Change from part-time/half-time to full-time status (IBEW Local 18-represented employees only)	> Notify the appropriate plan administrative office (LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center) immediately. Enroll or change your health or dental plan within 31 days from the status change. > The full subsidies are effective the first of the month following the effective date of the change.
Change from full-time to part-time/ half-time status	Notify the appropriate plan administrative office (LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center) immediately. The earliest you can change or cancel coverage is the month you change to part-time status. You will no longer be eligible for the full LADWP subsidy amount as of the first of the month following your status change.
Return from a protected leave of absence	Enroll in benefits within 31 days from your first day back from leave.
Lose other health and dental coverage for one of the following reasons: > COBRA continuation coverage was exhausted > Coverage was terminated because of loss of eligibility as a result of legal separation, divorce, spouse's death or termination of spouse's employment > Spouse's employer contribution toward coverage was terminated	Enroll in coverage through the appropriate plan administrative office (LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center) within 31 days from the date you lost coverage.
Are reassigned for six months or more to an LADWP working location not in your plan's service area.	Re-enroll in a plan with coverage in that area within 31 days from reassignment.

10 Your Coverage Options

Health Plans

The plan you elect for yourself must also apply to your eligible covered dependents.

LADWP and IBEW Local 18 sponsor both health maintenance organization (HMO) plans and preferred provider organization (PPO) plans. Each plan offers you access to its own network of health care providers — hospitals, clinics and physicians — and administers the claims that you and other members submit for the care you receive.

Which plan is right for you? If you prefer to have your care coordinated through a single doctor, an HMO plan might be right for you. If you want greater flexibility or if you see a lot of specialists, a PPO plan might be a better option.

You can compare coverage of the various plans in the comparison charts on pages 20-28 of this guide.

LADWP-Sponsored Plans

- Kaiser HMO Plan
- UnitedHealthcare HMO Plan
- UnitedHealthcare PPO Plan
- UnitedHealthcare PPO Plan (Owens Valley employees only*)
- Health Plan of Nevada Plan HMO

IBEW Local 18-Sponsored Plans

- Anthem Blue Cross HMO
- Anthem Blue Cross PPO Plan
- Anthem Blue Cross Prudent Buyer PPO Plan (Owens Valley employees only*)

Note: For certain LADWP-sponsored plans, if your child lives outside your medical plan's service area, he or she will be covered for emergency care only. In the event that he or she receives emergency care, you should contact your medical plan immediately. IBEW Local 18-sponsored plans may have additional coverage.

*If you move out of the Owens Valley, you must re-enroll in a non-Owens Valley LADWP or IBEW Local 18-sponsored plan within 31 days from the change. You cannot remain enrolled in an Owens Valley plan if you move out of the area and/or your work location changes.

Understanding HMO Plans

HMOs cover only the care you receive from their provider networks, except for emergency care. If you want to use a specific provider for your care, be sure to verify that provider is in the HMO's network.

If you do not live in an HMO's network area, you should not enroll in that HMO's plan. If your covered eligible dependents live outside of the HMO's network area, they will have limited coverage, typically for emergencies only. IBEW Local 18-sponsored plans may have additional coverage if your eligible dependent is set up under Guest Membership.

You pay a **co-pay** amount when you receive care. Providers file claims for you, which helps eliminate paperwork.

Understanding PPO Plans

PPOs cover care you receive from their provider networks (in-network care), but they also cover care you receive from other providers (non-network care). However, your benefits are paid at the highest level when you use a provider in your PPO network.

The PPOs have an **annual deductible** for most health care expenses. You are responsible for paying your eligible health care expenses until you reach your annual deductible.

After you meet the deductible, you pay a percentage of the covered expenses; this is called a **coinsurance** amount. The PPO pays the remainder of your covered expenses.

If your coinsurance amounts reach your **annual maximum**, the PPO pays 100% of your covered expenses for the rest of the calendar year.

You may be responsible for paying a fixed **co-pay** for certain provider visits. Co-pays do not count toward your deductible or out-of-pocket maximum.

Note: Preauthorization may be required for certain types of care. If you use an out-of-network provider, you will be responsible for amounts exceeding eligible medical expenses, and you may be required to file claims for expenses incurred.

Prescription Drug Coverage

Benefits for prescription drugs are included with your health plan choice. All plans offer you the convenience of filling your prescription at a retail pharmacy (or Kaiser-based pharmacy on the Kaiser HMO Plan) and ordering a longer-term supply through mail order, which can be useful if you take a maintenance medication.

Dental Plans

All plans offer 100% coverage for diagnostic and preventive services. Highlights of each plan's coverage appear in the comparison charts on **pages 29-31**.

Understanding DHMO Plans

Dental Health Maintenance Organizations, or DHMOs, cover only the care you receive from their provider networks, unless you need emergency care outside the plan's service area. If you do not live in a DHMO's network area, you should not enroll in that DHMO's plan.

Understanding PPO Plans

A dental preferred provider organization, or PPO, gives you the choice of using in-network or out-of-network dentists. You will generally pay more if you use out-of-network dentists.

LADWP-Sponsored Plans

- Delta Dental PPO
- United Concordia Plus Dental Plan (DHMO)

IBEW Local 18-Sponsored Plans

- Guardian PPO
- Guardian DHMO

If you are a Security Officer (Class Code 3181), you are only eligible to enroll in the LADWP Delta Dental Plan, or you may elect the United Concordia Dental Plan through Local Union 721 Zenith American Solutions by calling **(877) 802-9740**.

12 Covering Your Eligible Dependents

If you elect coverage for yourself, you may also elect coverage for your family members who are "eligible dependents."

Covering Your Spouse or Domestic Partner

To elect coverage for your spouse or domestic partner, you must submit this documentation to establish eligibility to the appropriate plan administrator (LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center):

Dependent Type	Documents Required for Verifying Eligibility
Spouse	> Social Security number > A copy of certified marriage certificate
Registered domestic partner[1]	> Social Security number > Your Declaration of Domestic Partnership issued by the California Secretary of State, or > An equivalent document issued by: — A local California agency, — Another state, or — A local agency within another state
Nonregistered domestic partner[1]	> Social Security number > Copies of your and your domestic partner's California driver's licenses or identification cards that show you share the same address and that it matches your address of record with LADWP, or other acceptable written verification showing that you and your domestic partner have been living at the same address for the last 12 months, and > The Affidavit of Domestic Partnership – Health and Dental Enrollment form[2] that provides proof that you and your domestic partner meet LADWP's required criteria, including: — Neither of you was married, in another domestic partnership or covered a spouse or domestic partner during the previous 12 months — You have lived together for the previous 12 months — You are both at least 18 years old — You and your domestic partner are not related by blood closer than would bar marriage in the state of California

[1]For domestic partner coverage for Health Plan of Nevada, you must complete a Domestic Partner Rider form.
[2]The Affidavit of Domestic Partnership – Health and Dental Enrollment form authorizes your domestic partner to receive your **health care benefits only**.

Covering Your Children

Eligible employees may also elect coverage for their eligible dependent children. To elect coverage for your child, you must submit this documentation to establish eligibility to the appropriate plan administrator (LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center):

Dependent Type	Age Limit	Eligibility Definition	Documents Required for Verifying Eligibility
Biological child	Up to age 26[1]	Minor or adult child of employee who is under age 26	> Social Security number > A copy of the child's birth certificate
Stepchild	Up to age 26[1]	Minor or adult child of employee's spouse who is under age 26	> Social Security number > A copy of the child's birth certificate
Child legally adopted/ ward, including grandchildren of whom you have legal custody	Up to age 26[1]	Minor or adult child who is under age 26 and legally adopted/ward of employee	> Social Security number > Court documentation > A copy of the child's birth certificate
Child of domestic partner	Up to age 26[1]	Minor or adult child of employee's covered domestic partner who is under age 26	> Social Security number > A copy of the child's birth certificate
Disabled child	Over age 26	Child 26 years of age or older and wholly unable to engage in any gainful occupation due to a mental or physical disability that was established and certified as a disability before age 26 through the health care provider. A copy of the certification must be provided to the appropriate plan administrator (LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center)	> Social Security number > A copy of the child's birth certificate and proof of the child's disability must be established before the child turns 26 > In addition, you may be required to submit documentation directly to your health care plan carriers: — Kaiser: Complete a Special Disabled Dependent Application — Anthem Blue Cross and Guardian: Contact the IBEW Local 18 Benefit Service Center for any required documentation — All other carriers: Contact the carrier's member services for any required documentation
Grandchildren	Up to age 26[2]	Your grandchildren can be added to the plan if they are children of your covered children	> Social Security number > A copy of the child's birth certificate

[1]Eligibility continues through the end of the month your eligible dependent turns age 26.
[2]When dependent's parent turns age 26, eligibility will continue through the end of the month.

Verifying Domestic Partner Coverage

After you submit the required documentation listed on **page 12**, you should follow up with the appropriate plan administrator to ensure it was accepted and to determine when the coverage will be effective.

If You Marry Your Domestic Partner

If you're in a domestic partnership and you marry your domestic partner, you need to submit a copy of your certified marriage certificate, an enrollment/change form and a Termination of Domestic Partnership form to the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center within 31 days from the date of marriage. If you don't submit the necessary documents, you will continue to pay income taxes on the subsidy for your domestic partner's coverage and any coverage for his or her children.

If You and Your Spouse or Domestic Partner Divorce/End Partnership

If you divorce or end your domestic partnership, **you must remove your ex-spouse/ex-domestic partner from coverage within 31 days**. You must:

- Notify the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center, as appropriate
- Complete an enrollment/change form
- Provide proof of the divorce/termination of domestic partnership

If you do not take these steps within 31 days after your divorce or termination of your domestic partnership:

- You will be billed for any services incurred by your ex-spouse or ex-domestic partner after the divorce/termination of your domestic partnership, and
- Your ex-spouse's COBRA rights *will be forfeited*. **See pages 38-41 for more information on COBRA Continuation Coverage.**
- **Your ex-spouse's/ex-domestic partner's coverage ends on the first day of the month after the enrollment/change form is received.**

If You and Your Spouse or Domestic Partner Work for LADWP

If you and your spouse or domestic partner work at LADWP and are eligible for health care coverage, you must **each** elect coverage; LADWP employees cannot be enrolled as the dependent of another LADWP employee. In addition, children can be covered by one eligible employee only. But if you have two children, the first can be enrolled by one parent and the second can be enrolled by the other parent, or one parent can enroll both children, while the other parent does not enroll any.

Tax Implications

If you cover your domestic partner and his or her children under your coverage, you will pay income tax on the amount of the health and/or dental plan subsidy that LADWP pays for their coverage. However, if you and your domestic partner are in a California-recognized domestic partnership, you won't have to pay California state income tax on this subsidy.

Verifying Child Coverage

To cover your dependent child, you must submit the required documentation, listed on **page 13**, to the appropriate plan administrator (LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center). The effective date is the first of the following month after submission for changes made outside of the Open Enrollment period.

IMPORTANT: It is your responsibility to remove dependent(s) from your plan if they no longer qualify for coverage. See **page 47**, Improper Use of Benefits.

Dependent Eligibility Verification Program

A Dependent Eligibility Verification Program (DEV) will be conducted during the 2018-2019 Plan Year (July 1, 2018 – June 30, 2019) for dependents enrolled in health plans. The purpose of the DEV is to ensure that only qualified eligible dependents are enrolled in health and dental coverage. Information about the DEV process will be mailed to all employees who cover dependents during the 2018-2019 Plan Year.

Surviving Eligible Dependents

Upon your death, your surviving spouse or domestic partner and/or surviving children may continue coverage if they:

- Are eligible to receive a monthly allowance under the Water and Power Employees' Retirement Plan, and
- Were covered as dependents on your health and/or dental plans at the time of your death

In order to continue coverage, your eligible surviving dependents must enroll in an LADWP-sponsored or IBEW Local 18-sponsored health and/or dental plan within 60 days after your death. **If they do not enroll within this time frame, they will lose eligibility for surviving dependent coverage, and will not be eligible to enroll at a later date.**

Important points to consider about surviving dependent coverage:

- The retiree premium rates are used to determine the health premiums for surviving dependents.
- While surviving dependents can enroll in dental coverage, they will pay the full cost of coverage.

When Coverage Ends for Your Eligible Dependents

This chart shows when coverage ends for your eligible dependents. It also outlines the documentation that you must provide to either the appropriate plan administrator (LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center).

If You Cover Your...	Reasons to End Dependent Coverage	How To End Dependent Coverage	What Happens if You Fail to Notify Health Plan Providers
Spouse	Your divorce is final	Complete an enrollment/ change form and provide proof of the divorce before the first of the month after divorce is final.	You will be billed for any services incurred by your former spouse; COBRA rights for your former spouse will be forfeited.
Registered and or nonregistered domestic partner	You end your domestic partnership	Provide a completed Termination of Domestic Partnership form and enrollment/change form before the first of the month after dissolution of the partnership.	You will be billed for any services incurred by your former domestic partner and continue to pay income tax on the health and dental plans.
Children	At the end of the month the child reaches age 26	Coverage is automatically terminated.	
Dependent grandchildren	The grandchild's parent is no longer eligible	Coverage is automatically terminated.	
Surviving children under family death benefit	The child reaches 18	Coverage is automatically terminated.	

Important: When coverage for your spouse, children, grandchildren or surviving children ends, they will be eligible to elect continuation coverage under COBRA, unless they have forfeited their COBRA rights. For more details about COBRA, see **pages 38-41**.

Paying for Coverage

Health and Dental Plan Subsidy

LADWP subsidizes the cost of health and dental coverage for most eligible employees. If the subsidy you receive is not enough to cover your entire premium, you make up the difference with your contribution, usually paid through automatic deduction from your pay. Be sure to review your paycheck stub to verify all information and deductions are correct. If you notice any incorrect information on your paycheck stubs, contact the LADWP Health Plans Administration Office immediately.

If you are disabled, your contributions are withheld from your disability check. But if you are receiving monthly Workers' Compensation benefits, your contributions cannot be withheld; you will be billed for your contributions.

If you are not eligible for a subsidy, you will be billed monthly by the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center. If you do not pay your health and dental plan premiums on time, you will lose your health and/or dental coverage and have to wait until the next annual Open Enrollment period to re-enroll in a health and/or dental plan.

Health Plan Subsidy

You are eligible to receive a monthly subsidy from LADWP if you meet certain requirements. The subsidy can only be used for LADWP-sponsored or IBEW Local 18-sponsored health and dental plans; the subsidy cannot be used for private insurance plans or plans of outside organizations unless specified in the applicable Memorandum of Understanding (MOU).

If you are eligible, you will receive LADWP's subsidy toward the cost of your health and dental plans beginning on the first of the month following membership in the Water and Power Employees' Retirement Plan.

You are eligible for a health plan subsidy if you are:

- A full-time or part-time employee receiving a salary and a member of the Water and Power Employees' Retirement Plan.
  - **Note:** As a part-time employee you are eligible for **half** the health plan subsidy
- Receiving a disability check from LADWP's disability plan or a Workers' Compensation check, or are on leave under Family Care Leave (details on Family Care Leave are on **page 37**)

*You **are not** eligible for a health plan subsidy if you are...*

- On disability, not receiving a disability benefit check and not on Family Care Leave
- An exempt employee on Payrolls 02, 03, 06, 72, 94 or 95

Note: For Payrolls 02, 06 or 72 — Construction exempt employees are eligible to enroll in the health and dental plans offered; however, they are not eligible for the LADWP subsidy.

Dental Plan Subsidy

You are eligible for a full subsidy of the cost of dental coverage for the LADWP-sponsored or IBEW Local 18-sponsored dental plan if you are an eligible full-time employee.

For part-time employees, in the LADWP-sponsored or IBEW Local 18-sponsored dental plans, LADWP subsidizes half the cost of the Delta Dental family rate.

Change in Employment Status

If your employment status changes, your subsidy will also change.

Part-time > Full-time

- You will be eligible for the full health and dental plans subsidy.
- The full subsidies are effective the first of the month following the effective date of your status change.

Full-time > Part-time

- Your health and/or dental plan subsidy will decrease to 50% of your full-time subsidy.
- The reduction in your subsidy will be effective from the first of the month following the effective date of your status change.

Rate and Subsidy Charts

The maximum LADWP subsidy is $1,850.63. Rates are effective July 1, 2018 through June 30, 2019.

LADWP and IBEW Local 18-Sponsored Health Plan Rates

Everyone except Owens Valley, Los Angeles Water and Power Dispatchers Association, Management Employees Association and Association of Confidential Employees[1]

Coverage Level	Kaiser HMO	UHC HMO	UHC PPO	Health Plan of Nevada[2]	Anthem Blue Cross HMO (Local 18)	Anthem Blue Cross PPO (Local 18)
Employee only						
With subsidy	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Without subsidy	$653.93	$897.52	$899.63	$1,218.94	$1,518.83	$1,716.26
Employee + 1 eligible dependent						
With subsidy	$0.00	$0.00	$0.00	$0.00	$0.00	$328.80
Without subsidy	$1,307.86	$1,793.70	$1,797.90	$2,442.56	$1,797.80	$2,179.43
Employee + 2 or more eligible dependents						
With subsidy	$0.00	$409.43	$414.73	$0.00	$0.00	$848.75
Without subsidy	$1,850.63	$2,260.06	$2,265.36	$3,412.96	$1,850.63	$2,699.38

[1]Los Angeles Water and Power Dispatchers Association, Management Employees Association and Association of Confidential Employees will continue contributing toward their health insurance premiums.
[2]Only for employees assigned to a Southern Nevada work location.

For LADWP and IBEW Local 18 Owens Valley Health Plans[1]

Coverage Level	UnitedHealthcare Non-Differential PPO	Anthem Blue Cross PPO (Local 18) Prudent Buyer/Owens Valley
Employee only		
With subsidy	$0.00	$0.00
Without subsidy	$1,270.95	$1,844.50
Employee + 1 eligible dependent		
With subsidy	$0.00	$0.00
Without subsidy	$2,540.00	$3,841.73
Employee + 2 or more eligible dependents		
With subsidy	$0.00	$0.00
Without subsidy	$3,200.36	$4,765.66

[1]Available to employees who are assigned to work locations not covered by LADWP-sponsored or IBEW Local 18-sponsored HMO health plans, who live and work in the Owens Valley.

Only for Los Angeles Water and Power Dispatchers Association, Management Employees Association and Association of Confidential Employees[1]

Coverage Level	Kaiser HMO	UHC HMO	UHC PPO
Employee only			
With subsidy (includes 5% contribution)	$32.70	$44.88	$44.98
Without subsidy	$653.93	$897.52	$899.63
5% contribution level[1]	$32.70	$44.88	$44.98
Employee + 1 eligible dependent			
With subsidy (includes 5% contribution)	$65.39	$89.69	$89.90
Without subsidy	$1,307.86	$1,793.70	$1,797.90
5% contribution level[1]	$65.39	$89.69	$89.90
Employee + 2 or more eligible dependents			
With subsidy (includes 5% contribution)	$92.53	$509.43	$514.73
Without subsidy	$1,850.63	$2,260.06	$2,265.36
5% contribution level[1]	$92.53	$100.00	$100.00

[1]Up to a maximum of $100

LADWP and IBEW Local 18-Sponsored Dental Plan Rates

Rates are effective July 1, 2018 through June 30, 2019.

Coverage Level	Delta Dental Plan (PPO)	United Concordia Plus Dental Plan (DHMO)	Guardian Dental Plans (PPO and DHMO) (Local 18)
Employee only			
With subsidy	$0.00	$0.00	$0.00
Without subsidy	$33.35	$20.18	$117.90
Employee + 1 eligible dependent			
With subsidy	$0.00	$0.00	$0.00
Without subsidy	$68.60	$28.82	$117.90
Employee + 2 or more eligible dependents			
With subsidy	$0.00	$0.00	$0.00
Without subsidy	$121.55	$40.98	$117.90

If you are a Security Officer (Class Code 3181), you are eligible to enroll in the LADWP Delta Dental Plan, or you may elect a United Concordia Dental Plan through Local Union 721 Zenith American Solutions by calling **(877) 802-9740**.

Health Plan Comparison Charts

Note: Preauthorization may be required for certain types of care. If you use an out-of-network provider, you will be responsible for amounts exceeding eligible health expenses, and you may be required to file claims for your expenses.

LADWP-Sponsored Health Plan Options

Benefit Comparison	UnitedHealthcare PPO Plan		United Healthcare HMO Plan	Kaiser HMO Plan	Health Plan of Nevada HMO (for Southern Nevada Residents Only)
	In-Network	Out-of-Network			
Calendar-year deductible	$500/individual; $1,500/family	$1,000/individual; $3,000/family	N/A	N/A	N/A
Annual out-of-pocket maximum[1]	$2,000/ individual; $6,000/family	$6,000/ individual; $18,000/family	$800/individual $2,400/family, up to three individuals only at $800 each	$1,500/ individual; $1,500/ individual in a family $3,000/family	N/A
Lifetime maximum	N/A	N/A	N/A	N/A	N/A
Physician and hospital	Unrestricted	Unrestricted	> Physicians who are members of the plan's network > Any licensed acute care general hospital designated by a plan physician	Kaiser Permanente physicians and hospitals	> HPN physicians > Any licensed acute care general hospital designated by an HPN physician
Physician services	In-hospital: covered at 80% Office visit: > $25 co-pay per visit/ primary care physician > $35 co-pay per visit/ specialist	Covered at 60%	In-hospital: covered at 100% Office visit: > $3 co-pay per visit/primary care physician > $3 co-pay per visit/specialist	In-hospital: covered at 100% Office visit: covered at 100%	In-hospital: covered at 100% Office visit: > $3 co-pay per office visit/ primary care physician $3 co-pay per visit/specialist

[1]An annual out-of-pocket maximum is the most you pay in a calendar year for health care expenses for any one individual before the plan pays covered expenses at 100% for the rest of that year. Once the family maximum has been reached, all covered family members' benefits are paid at 100%. No person can apply more than the individual maximum toward the family maximum.

LADWP-Sponsored Health Plan Options, continued

Benefit Comparison	UnitedHealthcare PPO Plan		United Healthcare HMO Plan	Kaiser HMO Plan	Health Plan of Nevada HMO (for Southern Nevada Residents Only)
	In-Network	Out-of-Network			
Hospital services - inpatient	Covered at 80%	Covered at 60%	Semi-private room and board, miscellaneous expenses and prescription drugs: covered at 100% Ambulance: covered at 100% when medically necessary	Semi-private room and board, miscellaneous expenses and prescription drugs: covered at 100% Ambulance: covered at 100% if authorized	Semi-private room and board, miscellaneous expenses and prescription drugs: covered at 100% Ambulance: $50 co-pay per trip when medically necessary
Preventive care	Covered at 100%	Not Covered	Covered at 100%	Covered at 100%	Covered at 100%
Surgery – Outpatient	Covered at 80%	Covered at 60%	Covered at 100%	Covered at 100%	Covered at 100%
Home health care	Home visits: covered at 80% up to 100 visits	Home visits: covered at 60% up to 100 visits	Home visits: covered at 100% up to 100 visits	Home visits: covered at 100% up to 100 visits	> Covered at 100% if home confined; includes private-duty nursing and home care service > $20 co-pay for physician house calls
Physical therapy	$35 co-pay per visit, up to 20 visits	Covered at 60% per visit, up to 20 visits	Outpatient: $3 co-pay per visit	Covered at 100% if prescribed; limited to short-term therapy	Outpatient: $3 co-pay per visit; maximum of 60 days/visits per calendar year
Chiropractic care	$35 co-pay per visit; up to 20 visits	Covered at 60% per visit; up to 20 visits	Not covered	Not covered	$3 co-pay per visit
X-ray and lab (no additional charge for network providers when performed as part of physician office visit)	Covered at 100%	Covered at 60%	Covered at 100%	Covered at 100%	Covered at 100%
Extended care/skilled nursing facility (custodial care is not covered)	Covered at 80% for up to 100 days per benefit period	Covered at 60% for up to 100 days per benefit period	Covered at 100% for up to 100 days per benefit period	Covered at 100% for up to 100 days per benefit period	Covered at 100% for up to 100 days per calendar year when prescribed by a physician

LADWP-Sponsored Health Plan Options, continued

Benefit Comparison	UnitedHealthcare PPO Plan		United Healthcare HMO Plan	Kaiser HMO Plan	Health Plan of Nevada HMO (for Southern Nevada Residents Only)
	In-Network	Out-of-Network			
Prescription Drugs					
Pharmacy	Per-prescription co-pay (up to a 31-day supply): Tier 1: $10 Tier 2: $20 Tier 3: $20		$5 per 30-day supply of drugs in UnitedHealthcare formulary at participating pharmacies	$5 co-pay for up to 100-day supply for most generic and brand name or up to a 30-day supply for specialty medications (or three cycles for oral contraceptives) $5 co-pay for drugs for treatment of sexual dysfunction (up to a maximum of 8 doses in any 30-day period or up to 27 doses in any 100-day period)	> Generic: $7 co-pay for drugs in preferred drug list > Brand-name in preferred drug list when no generic available: $15 co-pay > Brand-name in preferred drug list when generic available: $15 co-pay plus difference between generic and brand-name > Preferred brand-name when no generic available: $40 co-pay > Brand-name when generic available: $40 co-pay plus difference between generic and brand-name
Mail order	Per-prescription co-pay (up to a 90-day supply): Tier 1: $20 Tier 2: $40 Tier 3: $40	Not Covered	$5 co-pay for up to a 90-day supply of maintenance medication	$5 co-pay for up to 100-day supply of maintenance medication; may be obtained through mail order or at a Kaiser pharmacy Items on the specialty tier: Availability for mail order varies by item. Talk to your local pharmacy.	Generic: $14 co-pay Brand-name: $30 co-pay
Maternity	Covered at 100%	Covered at 60%	Inpatient, prenatal and postnatal care; covered at 100%	Covered at 100%	Semi-private room and board, miscellaneous expenses and prescription drugs: covered at 100%
Acupuncture	$10 co-pay per visit; up to 20 treatments per year	Covered at 60%; up to 20 treatments per year	Not covered	Covered at 100% with physician referral	Not covered

LADWP-Sponsored Health Plan Options, continued

Benefit Comparison	UnitedHealthcare PPO Plan		United Healthcare HMO Plan	Kaiser HMO Plan	Health Plan of Nevada HMO (for Southern Nevada Residents Only)
	In-Network	Out-of-Network			
Alcohol/Substance Abuse					
Outpatient	$35 co-pay per visit	Covered at 60%	Covered at 100%	Covered at 100% for individual or group visits	$3 co-pay per visit includes rehabilitation counseling group/ family and individual therapy and detox
Inpatient	Covered at 80%	Covered at 60%	Covered at 100%	Covered at 100%	Covered at 100%
Vision care	$30 co-pay; one exam every two years	Not Covered	Eye exam: $3 co-pay	Eye exam: covered at 100%	Preventive vision exam benefit through LensCrafters $10 co-pay/exam
Emergency care	$100 co-pay per visit		$35 co-pay per visit (waived if admitted)	Covered at 100%	> $25 co-pay for physician services > $75 co-pay per ER visit (waived if admitted) > No charge for inpatient hospital services
Urgent care	$50 co-pay per visit	Covered at 60%	> $3 co-pay per visit in service area > $35 co-pay per visit outside service area	Covered at 100%	$15 co-pay per visit

IBEW Local 18-Sponsored Plan Options

Anthem Blue Cross HMO and PPO

Benefit	Anthem Blue Cross HMO	Anthem Blue Cross PPO	
		In-Network	Out-of-Network[1]
Calendar-year deductible	N/A	$250/individual; maximum of three separate deductibles/family	$1,000/individual; maximum of three separate deductibles/family
Annual out-of-pocket maximum[2]	$500/individual $1,000/ two-party $1,500/family	$2,000/individual $4,000/family	$6,000/individual $12,000/family
Lifetime maximum	N/A	N/A	
Choice of physician	Physicians who are members of the plan's network	Any licensed physician	
Choice of hospital	Any licensed acute care general hospital selected and designated by a plan physician	Any licensed acute care general hospital	
Physician Services			
In-hospital	No co-pay	Covered at 80%	Covered at 60%[3]
Physician office visits	No co-pay Includes LiveHealth Online visits	No co-pay; deductible waived	Covered at 60%
Specialist office visits	No co-pay	$35 co-pay/visit; deductible waived	Covered at 60%
Hospital Services			
Inpatient and outpatient care	No co-pay	Covered at 80%	Covered at 60%[3]
Ambulance	No co-pay	Covered at 70%	Covered at 70%
Preventive care	No co-pay	No co-pay; deductible waived	Covered at 60%
Surgery	No co-pay	Covered at 80%	Covered at 60%

[1]When using out-of-network PPO providers, members are responsible for any difference between the covered expense and actual charges as well as any deductible and percentage co-pay.
[2]The annual out-of-pocket maximum is the most you pay in a calendar year for covered medical expenses and prescription co-pays. For the PPO out-of-network, you are responsible for costs in excess of the maximum allowed amount.
[3]For PPO out-of-network, $500/admission deductible applies for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained; waived for emergency admission.

Please note: This is a summary only. For more detailed information about the benefits, please refer to the Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations in your plan.

IBEW Local 18-Sponsored Health Plan Options, continued

Benefit	Anthem Blue Cross HMO	Anthem Blue Cross PPO	
		In-Network	Out-of-Network[1]
Nurse **• Home health care**	No co-pay	Covered at 80%	Covered at 60%
	Limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less		
Physical and occupational therapy (includes physical medicine, occupational therapy)	No co-pay; limited to a 60-day period of care	Covered at 80%	Covered at 60%
Chiropractic care	$10 co-pay/office visit; 30 visits/calendar year; visits combined with acupuncture	No co-pay; deductible waived	Covered at 60%
		Limited to 30 visits/calendar year	
Acupuncture (services for the treatment of disease, illness or injury)	$10 co-pay/office visit; 30 visits/calendar year; visits combined with chiropractic care	No co-pay; deductible waived	Covered at 60%
		Limited to 20 visits/calendar year	
X-ray and lab	No co-pay	Covered at 80%	Covered at 60%
Extended care/skilled nursing facility	No co-pay	Covered at 80%	Covered at 60%
	Limited to 100 days/calendar year (does not apply for Mental Health and Substance Abuse)		
Prescription Drugs			
In-hospital	No co-pay	Covered under Hospital Services (ancillary)	
Retail (30-day supply)	Generic: $5 co-pay Brand-name: $10 co-pay	Generic: $5 co-pay Brand-name: $10 co-pay	Generic: $5 co-pay Brand-name: $10 co-pay plus 50% of the remaining drug maximum allowed amount, plus all costs in excess of the allowed amount
Mail order (90-day supply)	Generic: $10 co-pay Brand-name: $20 co-pay	Generic: $10 co-pay Brand-name: $20 co-pay	N/A

[1]When using out-of-network providers, members are responsible for any difference between the covered expense and actual charges, as well as any deductible and percentage co-pay.

Please note: This is a summary only. For more detailed information about the benefits, please refer to the Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations in your plan.

IBEW Local 18-Sponsored Health Plan Options, continued

Benefit	Anthem Blue Cross HMO	Anthem Blue Cross PPO	
		In-Network	Out-of-Network[1]
Maternity			
Physician office visits	No co-pay	No co-pay; deductible waived	Covered at 60%
Specialist office visits	No co-pay	$35 co-pay; deductible waived	Covered at 60%
Hospital services	No co-pay	Covered at 80%	Covered at 60%
Mental or Nervous Disorders and Substance Abuse			
Inpatient Outpatient	No co-pay No co-pay	Covered at 80% No co-pay; deductible waived	Covered at 60% Covered at 60%
Emergency care	No co-pay	Covered at 80% $100 deductible; waived if admitted	Covered at 80%
Urgent care	No co-pay	$25 co-pay/visit; deductible waived	Covered at 60%
Body scan	One body scan, which includes a cervical spine scan, for employee and spouse/domestic partner, every plan year, at any licensed body scan provider; $1,000 maximum payable per scan		

IBEW Local 18-Sponsored Vision Plan (included with Local 18 Anthem Blue Cross plans)

Vision Care[2]	Vision Service Plan (VSP)	
	In-Network	Out-of-Network (VSP covers)
Exam	No co-pay; every 12 months	Up to $50
Lenses	No co-pay; every 12 months	Single: up to $50 Bifocal: up to $75 Trifocal: up to $100
Frames	No co-pay; every 12 months $130 plan allowance	Up to $70
Contact lenses (in lieu of glasses)	$120 allowance	Up to $120

[1]When using out-of-network providers, members are responsible for any difference between the covered expense and actual charges, as well as any deductible and percentage co-pay.
[2]Services provided through Vision Service Plan (VSP). See plan limitations and exclusions for full disclosure.

Please note: This is a summary only. For more detailed information about the benefits, please refer to the Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations in your plan.

LADWP and IBEW Local 18-Sponsored Owens Valley Medical Plan Options

Benefit Comparison	UnitedHealthcare PPO Plan (Owens Valley)[1]	Anthem Blue Cross PPO Prudent Buyer/Owens Valley (IBEW Local 18)	
		Prudent Buyer Providers	Non-Prudent Buyer Providers
Calendar-year deductible	No deductible	No deductible	No deductible
Annual out-of-pocket maximum	$500/individual $1,500/family	$1,000/individual $2,000/family	$2,000/individual $4,000/family
Lifetime maximum	N/A	N/A	N/A
Hospital room and board	Covered at 100%	Covered at 100%	Covered at 100%
Ambulance	Covered at 100%	Covered at 100%	Covered at 100%
Surgeon and assistant surgeon	Covered at 100%	Covered at 100%	Covered at 100%
Doctor's hospital visits **Doctor's office visits**	Covered at 100%	Covered at 100%	Covered at 100%
Physical exams	Covered at 100%	Covered at 100%	Covered at 100%
X-ray and lab charges	100% (some services may require preauthorization)	Covered at 100%	Covered at 100%
Emergency care	Covered at 100% after $25 co-pay per visit (waived if admitted)	Covered at 100% after $25 co-pay per visit (waived if admitted)	Covered at 100% after $25 co-pay per visit (waived if admitted)
Skilled nursing facility	Covered at 100%; up to 60 days/calendar year	Covered at 100%; up to 100 days/calendar year Limitation removed for mental health and substance abuse	Covered at 100%; up to 100 days/calendar year
Home health care	Covered at 100%; up to 100 days/calendar year	Covered at 100%; up to 100 days/calendar year Limitation removed for mental health and substance abuse	Covered at 100%; up to 100 days/calendar year
Prescription drugs			
Pharmacy (up to a 30-day supply)	Tier 1: $5 co-pay Tier 2 and Tier 3: $10 co-pay	Participating Pharmacy Generic: $5 co-pay Brand-name: $10 co-pay	Pharmacy Generic: $5 co-pay Brand-name: $10 co-pay plus 50% of the maximum amount allowed and costs in excess of the maximum amount
Mail order (up to a 90-day supply)	Tier 1: $10 co-pay Tier 2 and Tier 3: $20 co-pay	Generic: $10 co-pay Brand-name: $20 co-pay	You must use the Prudent Buyer mail order provider
Psychiatric care and substance abuse Inpatient Outpatient	 Covered at 100% Covered at 100%	 Covered at 100% Covered at 100%	 Covered at 100% Covered at 100%

[1]Payments are based on UnitedHealthcare's allowable amounts. Out-of-network charges covered; co-pay and any amount in excess of the allowable amount are the member's responsibility for out-of-network providers.

Please note: For Anthem Blue Cross PPO, this is a summary only. For more detailed information about the benefits, please refer to the Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations in your plan.

LADWP and IBEW Local 18-Sponsored Owens Valley Medical Plan Options, continued

Benefit Comparison	UnitedHealthcare PPO Plan (Owens Valley)[1]	Anthem Blue Cross PPO Prudent Buyer/Owens Valley (IBEW Local 18)	
		In-Network	Out-of-Network
Durable medical equipment	Covered at 100%	Covered at 100%	Covered at 100%
Acupuncture services (20 treatments per year)	Covered at 100%	Covered at 100%	Covered at 100%
Chiropractic care (manipulative treatments)	Covered at 100%; maximum 24 visits/year	Covered at 100%; maximum 30 visits/year	Covered at 100%; maximum 30 visits/year
Vision benefits	Covered at 100%; exam, lenses and frames covered every 12 months[2]	Covered at 100% ; exam, lenses and frames covered every 12 months[3]	Covered up to plan maximums for non-VSP providers[3]
Body scan	Not covered	One body scan, which includes a cervical spine scan, for both employee and spouse/domestic partner, every calendar year, at any licensed body scan provider; $1,000 maximum payable per scan	

[1]Payments are based on UnitedHealthcare's allowable amounts. Out-of-network charges covered; co-pay and any amount in excess of the allowable amount are the member's responsibility for out-of-network providers.
[2]Services provided through Spectra Vision. See plan limitations and exclusions for full disclosure.
[3]Services provided through Vision Service Plan (VSP). VSP can be reached at **(800) 877-7195**.

Please note: For Anthem Blue Cross PPO, this is a summary only. For more detailed information about the benefits, please refer to the Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations in your plan.

Dental Plan Comparison Charts

LADWP-Sponsored Dental Plan Options

Benefit Comparison	Delta Dental Fee-for-Service/Preferred Provider Organization (PPO)		United Concordia Plus Dental Health Maintenance Organization (DHMO)
	In-Network	Out-of-Network	
Choice of dentist	Delta (PPO) dentists only	Any licensed dentist or specialist	United Concordia Plus DHMO panel dentists only
Annual deductible	$10/individual $30/family	$25/individual $75/family	None
Annual benefit maximum	$1,000/individual	$1,000/individual	Unlimited
Covered Services			
Diagnostic and preventive (no deductible; includes exams, X-rays, routine cleaning, fluoride treatments, sealants)	Covered at 100%	Covered at 100%	Covered at 100%
Basic services (basic restorative, oral surgery, endodontics, sealants, periodontics, simple extractions)	Covered at 80%	Covered at 80%	Co-pay according to fee schedule
Major services (crowns, inlays, onlays, prosthetics)	Covered at 60% (includes implants)	Covered at 60% (includes implants)	Co-pay according to fee schedule (implants not covered)
Orthodontics (no deductible; diagnostic, active treatment, retention)	Children to age 26 only covered at 50%; lifetime maximum of $1,200		Children: $1,500 co-pay Adults: $2,000 co-pay Covers banding and retention only
Limitations			
Oral exams	Two per calendar year		No limit
Teeth cleaning	Two per calendar year		One per six consecutive months

Benefit	Delta Dental Fee-for-Service/Preferred Provider Organization (PPO)		United Concordia Plus Dental Health Maintenance Organization (DHMO)
	In-Network	Out-of-Network	
Bitewing X-rays	One per calendar year if 18 years and older; twice per calendar year if under 18 years of age		One per six consecutive months to age 19
Fluoride treatments	Two per calendar year		One per six consecutive months to age 19
Full-mouth X-rays	One set every five years		One set every three years
Inlays/crowns/bridges/dentures	Once every five years (includes implants)		No limit (implants not covered)
Emergency services	Standard plan coverage, to annual maximum		Subject to members copayment schedule at member's dentist; $100 maximum benefit for more than 50 miles away from primary office

IBEW Local 18-Sponsored Guardian Dental Plan Options

Benefit Comparison	IBEW Local 18-Sponsored Guardian Dental Plans		
	Preferred Provider Organization (PPO) Plan		DHMO A Prepaid/Managed Dental Care Plan
	In-Network	Out-of-Network	
Choice of dentist	Any PPO provider in the DentalGuard Preferred network	Any licensed dentist	Any Guardian DHMO dentist
Annual deductible	None	$25/individual; $75/family (waived for diagnostic and preventive services)	None
Annual benefit maximum	$2,000/individual; excluding orthodontia (in-network and out-of-network combined)	$2,000/individual; excluding orthodontia (in-network and out-of-network combined)	Unlimited
Covered Services			
Diagnostic and preventive (oral examinations, X-rays, biopsy/tissue, routine cleaning, fluoride treatments)	100% of PPO fee	100% of customary and reasonable charges; deductible does not apply	100% after co-pay

Please note: This is a summary only. For more detailed information about the benefits, please refer to the Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations in your plan.

Benefit Comparison	IBEW Local 18-Sponsored Guardian Dental Plans		
	Preferred Provider Organization (PPO) Plan		DHMO A Prepaid/Managed Dental Care Plan
	In-Network	Out-of-Network	
Basic services (oral surgery, including extractions, fillings, root canals, periodontics (gum) treatment, sealants)	90% of PPO fee	80% of customary and reasonable charges	100% after co-pay; one sealant per tooth in any three-year period to age 16 on permanent teeth Periodontics: Scaling and root planning limited to one course of therapy per quadrant during any 12-month period
Major services (crowns, jackets, cast restorations, prosthetics)	60% of PPO fee	60% of customary and reasonable charges	100% after co-pay
Orthodontics	For adults and children 80% of PPO rate; subject to $2,000 lifetime maximum/individual (in-network and out-of-network combined)	For adults and children; 80% of customary and reasonable; subject to $2,000 lifetime maximum/individual (in-network and out-of-network combined)	Children: $1,500 co-pay Adults: $2,800 co-pay
Limitations			
Oral exams	Two per calendar year		Two per calendar year
Teeth cleaning	Two per calendar year		Two per calendar year
Bitewing X-rays	Two sets every 12 months		No limit
Fluoride treatments	Two per calendar year; to age 19		Two every 12 months
Full-mouth X-rays	One set every three years		One every three years
Inlays/crowns/bridges/ dentures	Once in a five-year period		Once in a five-year period
Emergency services	Standard plan coverage, to annual maximum		No charge for member's dentist; limited to $50 benefit for providers other than member's dentist

Please note: This is a summary only. For more detailed information about the benefits, please refer to the Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations in your plan.

Wellness and Program Resources

Maintaining good health is the best way to save on the cost of health care. Getting and keeping you healthy is important to LADWP. Check out all that is available to you and your family:

REGENERATE
Your Health | Your Life
Los Angeles Department of Water & Power

- **Department-sponsored educational programs,** including lunch 'n learn classes on a wide range of topics such as healthy eating, stress management, financial wellness, aging and EAP topics
- **Wellness fairs,** including interactive games about better health and health screenings to capture important health information like your body mass index (BMI), blood pressure and glucose levels
- **Online coaching,** including prescription drug counseling, health risk assessments, preventive exams, and women's health and fitness programs through our health plan providers
- **Flu shots,** administered by our Occupational Health Services (OHS) section
- **Healthy competitions,** administered by our health plan providers, including a chance to win a variety of prizes
- **New Employee Orientation,** where you can learn about the importance of wellness for your work and home life

See What's Online

You can find links to all of the LADWP health and dental carriers' newsletters and other wellness resources on the wellness link of the LADWP intranet: **https://insidedwp.ladwp.com**.

Find what you need to stay engaged in healthy behaviors, including:

- Healthy recipes
- Gym locations
- Lunch 'n learn schedules
- Apps and tools to track your physical activities
- Weight loss success stories
- Information on diabetes management

Wellness Resources from Our Health Plan Providers

You and your family members enrolled in LADWP or IBEW Local 18-sponsored health plans can participate in the following wellness activities offered through our health plan providers:

LADWP-Sponsored Health Plans

Kaiser Permanente

For more information on Kaiser resources, visit ***www.kp.org***

NEW! Telephone Visits

You can now get care from a doctor by phone for some minor heath conditions that do not require an in-person medical exam. You must be 18 years of age or over and have had at least one prior face-to-face visit with a Kaiser doctor. Contact Kaiser for more information.

My Health Manager

Schedule doctor appointments, refill prescriptions or other health-related items online.

Healthy lifestyle programs

Online resources to help you stay active, quit smoking, lose weight or eat better.

Good health on the go

An app to help you create a daily walking routine.

Wellness coaches

To give you extra support when you make healthy changes.

Farmers market

Purchase fresh fruits and veggies at Kaiser facilities, or schedule delivery to your home.

Complimentary health

Discounts on services such as massages.

UnitedHealthcare (UHC)

For more information on UHC resources, visit ***www.myUHC.comMyUHC.com (for UHC PPO and HMO)***

Connecting all your benefit, health and wellness information on one site

- Experience innovative health and wellness tools
- Search for a doctor, clinic, hospital or lab
- See the current status of your claims, as well as claim history
- Get tips on living healthy and using health plan benefits to your advantage
- Get reminders when it's time for checkups, prescription refills or treatments
- Get suggestions on when to get immunizations, well-visits, routine tests or lab work
- Chat with a nurse

Virtual Visits (for UHC PPO and HMO)

Talk with a doctor from your laptop or mobile device, a convenient and affordable way to access care. Covered under your UHC PPO and HMO health plan benefits. Learn more on **www.myUHC.com** or UHC's Health4Me® app.

Real Appeal Weight Loss Program
(for UHC PPO and HMO)

This program includes a personalized transformation coach for one year, 24/7 online support and mobile app, a "success kit" and more.

Introducing Rally (for UHC PPO and HMO)

An app offered by UnitedHealthcare that makes it easier for you to improve and maintain your health. Based on your responses to a quick Health Survey, you'll get your Rally Age, a measure of your overall health. Once you learn your Rally Age, you'll get personalized recommendations, known as Missions, designed to help you start improving your diet, fitness, and mood. Register today at ***myuhc.com***.

New! UnitedHealthcare Healthy Pregnancy Mobile Application (for UHC PPO and HMO)

Offers a one-click connection to a nurse to help provide answers to your questions and personal support throughout your pregnancy. You can also use the helpful online tools to track milestones based on your due date, access your health plan resources and receive timely care reminders that help you stay focused on the wonder and excitement while you are expecting.

UHC NurseLine Services (for UHC PPO and HMO)

Coping with health concerns can be time-consuming and complex. With so many choices, it can be hard to know where to look for information and support. NurseLine was designed specifically to help make your health decisions simple and convenient by providing:

- Immediate answers to your health questions anytime, anywhere – 24 hours a day, 7 days a week.
- Access to registered nurses with clinical experience.
- Information to guide your health care decisions.

To talk with a NurseLine nurse, call the number on your health plan ID card.

UnitedHealth Allies Health Discount Program
(for PPO and HMO)

We want to help you and your family live healthier lives. Our health discount program is designed to save you money – typically 10 percent to 50 percent – on health and wellness products and services beyond what's included in your benefit plan. Visit a participating provider and save on:

- Laser eye surgery.
- Acupuncture, chiropractic care and massage therapy.
- Assisted living and respite programs.
- Infertility support services.
- Weight management programs.
- Nutrition counseling.
- Fitness clubs including Anytime Fitness, Curves, Gold's Gym, Jazzercise, MyGym and Snap Fitness
- Smoking cessation.

Go to ***myhc.com*** and click on either the Health & Wellness tab and Discounts or the Health Resource tab and UnitedHealth Allies.

Health Plan of Nevada (HPN)

Virtual Visits through NowClinic

Talk with a doctor from your computer or mobile device, a convenient and affordable way to access care. Covered under your HPN HMO health plan benefits. No appointment necessary, and copays are usually $10 or less. Learn more at ***NowClinic.com*** or NowClinic® app.

Real Appeal Weight Loss Program

This program includes a personalized transformation coach for one year, 24/7 online support and mobile app, a "success kit" and more

United Concordia

For more information on United Concordia resources, visit ***www.unitedconcordia.com***

Chomper Chums

Free app teaches kids about brushing their teeth and making healthy choices. This award-winning app makes brushing fun for kids.

Dental Health Center

With a host of resources aimed at promoting oral and overall health, the online Dental Health Center provides helpful insights on everything from the basics of brushing and flossing to dental emergency information, resources on nutrition, and how a healthy mouth influences a healthy body.

My Dental Benefits

This is United Concordia's online member portal. Members can create a private account to access information on their plan, print additional ID cards, and find answers to common questions. Below is a link to a short video for My Dental Benefits on How to Create an Account:

http://embed.vidyard.com/share/zRvJtMAtR4P7EFRm29zR9r

My Dental Assessment

This free online tool helps identify oral health risks and shows how your lifestyle factors and medical conditions impact the health of the mouth. When finished, a printable report card is generated for you to easily take to your dentist to review at your next appointment.

Delta Dental

For more information on Delta Dental resources, visit ***www.deltadentalins.com/oral_health*** *or* ***www.mysmilekids.com***

SmileWay Wellness Program

Teaches you and your children how to have a healthy smile. You can enjoy:

- **Videos** – To understand proper nutrition for good dental care, and how to avoid gum disease.
- **Quizze**s – To review your dental health habits.
- **Resources** – To help you improve your oral hygiene habits.
- **Resources for kids** – To make oral health a fun habit that will last a lifetime.

IBEW Local 18-Sponsored Health Plans

Wellness Resources for IBEW Local 18-Sponsored Health Plans

Anthem Blue Cross

For more information on Anthem resources, visit ***www.anthem.com/ca/ibewlocal18***

NEW! Polarized Lenses Through VSP

All IBEW Local 18-sponsored health plans through Anthem Blue Cross will cover polarized lenses through VSP. Polarized lenses will be covered in full with a $0 copay from VSP in-network providers.

Mobile Health Consumer

The Anthem Mobile Health App is included in all IBEW Local 18 Anthem Blue Cross medical plans, and available to all Anthem Blue Cross enrolled members and their dependents over age 18. Some features of the app include:

- Mobile access to plan information
- Mobile access to ID cards
- Integration with LiveHealth Online
- Links to find a provider

Body Scan Cervical Spine

The Body Scan benefit available through IBEW Local 18 and Anthem Blue Cross also includes a comprehensive cervical spine scan.

Diabetes Prevention Program

A 12-month program to help at-risk members reach health and wellness goals. Elements of the program include: a personal health coach, weekly lessons, and access to a network of weight management programs.

Online health resources

Includes resources and videos to target specific health groups such as children, women, men and seniors.

24/7 NurseLine

Find quick answers to health questions anytime day or night.

Online access to plan information

Understand your plan benefits, the status of a claim, etc.

LiveHealth Online

A convenient way for members to interact with a U.S. board-certified doctor via live, two-way video on your computer or mobile device. LiveHealth Online visits are secure, safe and available at $0 co-pay, which is the same level as an in-network doctor visit. Anthem LiveHealth Online also includes visits to certified psychologists and therapists. LiveHealth Online Psychology visits are covered at $0 co-pay, which is the same level as traditional LiveHealth Online visits. Please note that users must be at least 18 years old to use LiveHealth Online Psychology.

Other Anthem resources

- Health and fitness discounts
- Health Rewards
- 360° Health Programs
- MyHealth@Anthem

Guardian Dental

For more information on Guardian Dental resources, visit ***www.guardianananytime.com***

NEW! Composite Fillings

Composite, white or tooth-colored, fillings will be covered for posterior teeth on the Guardian PPO dental plan. This new benefit will be covered as a basic service (90% of PPO fee in-network, 80% of customary and reasonable charges out-of-network)

Online resources

Understand your dental benefits, look up the status of a claim, find forms and plan materials, and estimate your dental costs.

Provider app

Download on your smartphone or mobile device to find a provider anytime you need to.

When You Have a Leave of Absence

If you take a temporary leave of absence from LADWP, you may be able to continue your health and/or dental coverage and, under certain circumstances, continue to receive LADWP's subsidy. In other cases, you will be responsible for paying your full premiums while on leave so that you do not lose health and/or dental coverage.

IMPORTANT: You are responsible for confirming that health and/or dental premiums are paid when you are on any kind of leave of absence. If you do not pay the required premium amount when you do not qualify for the subsidy, your health and dental coverage may be terminated.

There are various leave types:

- Leave Without Pay
- Disability Leave
- Workers' Compensation Leave
- Family Care Leave
- Additional four weeks of Bonding Leave[2]
- Military Leave

<table>
<tr><th>Type of Leave</th><th>Continue Receiving LADWP Subsidy?</th><th>What Happens</th><th>What You Must Do</th></tr>
<tr><td>Leave without pay</td><td>Depends on your status</td><td rowspan="3">If you're not eligible for the subsidy, the appropriate administration office (LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center) will bill you for the entire premium</td><td rowspan="3">Pay the full amount of your health care premiums</td></tr>
<tr><td>Disability Leave[1]</td><td>No, if you are not receiving a paycheck</td></tr>
<tr><td>Workers' Compensation Leave[1]</td><td>Depends on your Workers' Comp status</td></tr>
<tr><td>Family Care Leave</td><td>Yes, for the first 12 weeks</td><td colspan="2">LADWP continues to pay your subsidy, and any portion you pay will continue to be deducted from your paycheck</td></tr>
<tr><td>Additional four weeks of Bonding Leave[2]</td><td>No, not for the additional four-week period, unless you received compensation during the calendar month</td><td colspan="2">You pay the full amount of your health and dental premiums</td></tr>
<tr><td>Military Leave</td><td>Yes</td><td>LADWP continues to pay your subsidy</td><td>Be on approved Military Leave</td></tr>
</table>

[1]You are eligible for a subsidy as long as you continue to receive a disability or Workers' Compensation check.
[2]Applies only under some LADWP MOUs (only for the birth or placement of a child). Refer to the MOU for details.

Family Care Leave of Absence

Federal and state laws allow employees to take up to 12 weeks of Family Care Leave to care for a family member with a serious health condition, a newborn or newly placed child. Your LADWP subsidy continues during the 12-week period.

Additional Four Weeks of Family Care Leave

You may take an additional four weeks of leave under certain LADWP MOUs, but during that time you are not eligible for a subsidy if you are not being compensated during the calendar month.

If you take the extended four-week Bonding leave and do not qualify for the subsidy, and your spouse or domestic partner is an eligible LADWP employee, you may apply to be covered by your spouse or domestic partner's health and/or dental plan. Your spouse or domestic partner must complete an enrollment/change form to add you as a dependent within 31 days from the date your extended four-week period begins. At the same time, you must complete a health or dental plan termination form.

Coverage as a dependent of a LADWP spouse/domestic partner must remain in effect until the next annual Open Enrollment period. At that time, the dependent spouse/domestic partner must re-enroll as a subscriber in a health or dental plan. This is the only instance where an active employee can be covered on another active employee's health or dental plan. For more information on making changes to your health and dental coverage, see **page 9**.

When You Must Repay Your Subsidies

If you are not covered by a Family Care Leave of Absence and are not being compensated during the calendar month, you do not qualify for a subsidy. The appropriate administration office (LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center) will bill for the entire premium. The billing notice will be for the unsubsidized period (prior month).

If you do not return to work after your Family Care Leave of Absence, you must repay the subsidies advanced by LADWP, unless your failure to return is caused by the unexpected continuation of a serious health condition (as defined by federal legislation), or other circumstances beyond your control.

For information on how a Family Care Leave of Absence affects your health and/or dental plan, please refer to Administrative Manual Volume 2, 60-11, pages 10 and 11.

For More Information on Family Care Leaves

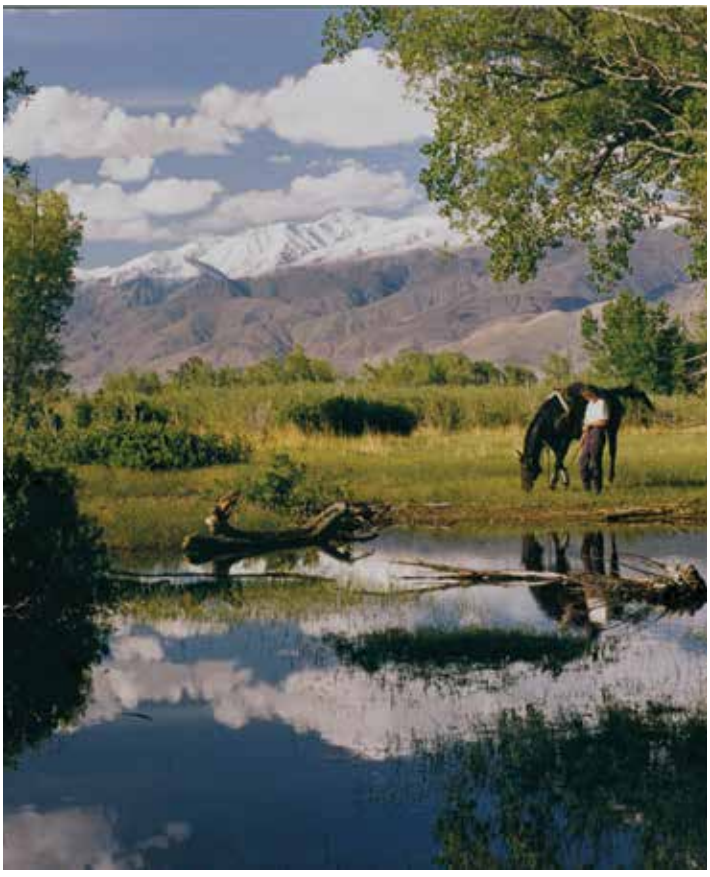
For additional information regarding Family Care Leaves of Absence, contact your Division coordinator or Family Care at **(213) 367-8770**.

You are responsible to make sure that health and/or dental premiums are paid when you are on any kind of leave of absence. Payments not received could result in termination of health or dental coverage.

Special Situations

If you are terminated from LADWP as a result of a discharge, and a reverse decision is made on your termination, you must notify the appropriate plan administrator (LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center) to reinstate your insurance coverage.

If your employment transfers to the City, please contact the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center to find out when your coverage will end. If you transfer to another City of Los Angeles Department, you need to contact the City's Benefits Office at **(213) 978-1655** to enroll in a City health or dental plan.



38 Continuing Coverage with COBRA

The following notice applies to all participants covered under a group health plan maintained by LADWP or IBEW Local 18. This notice generally explains group health insurance continuation coverage, when it may become available and what you need to do to protect your right to receive it. It is important that all covered individuals take the time to read this notice carefully and be familiar with its contents. Please note that the Employee Assistance Program (EAP) will remain available to COBRA program participant(s) if elected and paid for.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Health and/or dental coverage ends on the last day of the month in which your employment with LADWP ends. You may be able to extend your health and/or dental coverage with COBRA as outlined below.

As initially enacted in 1985 under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), employers are required to provide employees and their covered dependents the opportunity to elect continued group health coverage upon the occurrence of certain "qualifying events." Under this federal law, LADWP is required to offer this opportunity for a temporary extension of health coverage, called "continuation coverage," at group rates. This coverage, however, is only available when coverage is lost due to certain qualifying events. Should an actual qualifying event occur in the future, the plan administrator will send you additional information and the appropriate election notice at that time.

Qualifying Events for Covered Employees

- Termination of employment (for reasons other than gross misconduct on the employee's part)
- Reduction in hours of employment

Qualifying Events for Covered Spouses

- A termination of your spouse's employment for any reason other than gross misconduct or reduction in your spouse's hours of employment
- Death of a covered employee
- Divorce from a covered employee or, if applicable, legal separation from the covered employee
- Your spouse becomes enrolled in Medicare benefits (Part A, Part B or both)

Qualifying Events for Covered Children

- A termination of the parent-employee's employment for any reason other than gross misconduct or reduction in the parent-employee's hours of employment
- The death of the parent-employee
- Parent's divorce or, if applicable, legal separation
- The parent-employee becomes enrolled in Medicare benefits (Part A, Part B or both)
- Covered dependent ceases to be an eligible child under the terms of the LADWP group health plan

Qualifying Events Defined Under COBRA

A COBRA qualifying event occurs when an event listed in the COBRA statute occurs, and the event causes a covered employee, a covered spouse or a covered dependent to lose health insurance under an employer's group health plan. To lose health insurance means the individual ceases to be covered under the same terms and conditions they were covered under before the event happened.

If a Death Occurs During COBRA

If a death of a subscriber occurs under the COBRA continuation and there are dependents being covered under the plans, the appropriate plan administrator

(LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center), must be notified immediately of the death by the surviving dependents. The surviving dependents will be advised on how to continue the plan(s).

Important Notification Requirements Under COBRA

Under COBRA, a covered employee, a covered spouse or other covered family member has the responsibility to notify the appropriate plan administrator (LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center) of any qualifying event, including death, divorce, legal separation, or when a dependent ceases to be a dependent under the LADWP or IBEW Local 18-sponsored plans. This notification must be made within 60 days from the date of such event.

If this notification is not completed within the 60-day notification period, the right to continuation coverage is forfeited.

Eligibility Under COBRA

You, your spouse and your children are eligible for COBRA continuation if you and your dependents were covered under the plan on the day before the qualifying event. Once the election to continue coverage has been made, additional dependents may be added following the same guidelines specified under "Special Enrollment Events" on **page 45** of this guide. You, your spouse and your dependents have independent election rights and must make an election for continuation coverage to become effective. If you have a covered dependent whose legal residence is different from yours, you must provide written notification to the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center so that a notice can be sent to them as well. Should you add more children in the future, notice to the covered employee and spouse at that time will be deemed notification to the newly covered dependent.

Domestic Partners Are Not Eligible for COBRA

While LADWP-sponsored and IBEW Local 18-sponsored group health plans allow domestic partners to be covered, if a domestic partner loses group health insurance as a result of one of the listed qualifying events under the COBRA statute, the domestic partner will not be offered the opportunity to continue the group health insurance. This is because COBRA is regulated under federal law. Under federal rules, the term "spouse" does not include domestic partners.

Election Period and Coverage

Once the appropriate plan administrator (LADWP Health Plan Administration Office or IBEW Local 18 Benefit Service Center) has been notified of a qualifying event, the formerly covered individual(s), also known as "qualified beneficiaries," are notified of their rights to elect continuation coverage. Each qualified beneficiary has independent election rights and will have 60 days to elect continuation coverage. The 60-day election window is measured from the date of notification. This is the maximum period allowed to elect continuation coverage, as the plan does not provide an extension of the election period beyond what is required by law.

If a qualified beneficiary does not elect continuation coverage within the 60-day election period, then rights to continue health insurance will end, forfeiting any rights and protections that were afforded to the participant under the COBRA law. Once a qualified beneficiary elects continuation coverage, he or she has up to 45 days to pay the first premium. You may not have a lapse in coverage. Premiums will be due back to your original termination date.

The length of continuation coverage is:

- 18 months for formerly covered employees
- 36 months for formerly covered spouses and/or children for events other than the employee's termination of employment or reduction in hours

California COBRA AB 1401

California COBRA AB 1401 (effective September 1, 2003) stipulates that an employer shall offer an insured who has exhausted continuation coverage under COBRA the opportunity to continue coverage for up to 36 months from the date the insured's continuation coverage begins if the insured is entitled to less than 36 months of continuation coverage under COBRA.

Continuation Coverage from 18 Months to 29 Months

Two situations will extend continuation coverage beyond the coverage date if applicable. The 18 months of continuation coverage will be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries provided that the:

- Social Security Administration determines a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act as of the date of the qualifying event or at any time during the first 60 days of continuation coverage. It is the qualified beneficiary's responsibility to obtain the disability determination from the Social Security Administration and provide a copy of the Social Security Disability determination to the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center (for Anthem Blue Cross plans) within 60 days of the date of determination and before the original 18 months of continuation coverage expires; or
- Secondary event takes place (divorce, legal separation, death, Medicare entitlement or a dependent ceasing to be a dependent). If a secondary event occurs, then the original 18 or 29 months of continuation coverage will be extended to 36 months from the date of the original qualifying event date for dependent qualified beneficiaries. If a secondary event occurs, it is the qualified beneficiary's responsibility to notify the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center in writing within 60 days from the secondary event, and within the original 18-month continuation coverage timeline. In no event, however, will continuation coverage last beyond three years from the date of the event that originally made the qualified beneficiary eligible for continuation coverage.

Monthly Premiums Under COBRA

Group health coverage for COBRA participants is usually more expensive than health coverage for employees, since a COBRA participant is required to pay the entire cost for health insurance plus a 2% administration fee for regular federal COBRA, but that goes up to 10% for California COBRA. Premiums may be increased if the costs to the plan increase but generally must be fixed in advance of each 12-month premium cycle. The initial premium payment must be paid within 45 days of the election. You may not have a lapse in coverage. Premiums will be due back to your original termination date.

Premiums for successive periods of coverage are due on the first of each month, but a qualified beneficiary has a 30-day grace period to pay the monthly premium, and the envelope must be postmarked within or by the end of the grace period. The 30-day grace period is measured after the due date (first of the month). If the monthly premium is not paid by the due date or within the 30-day grace period, the continuation coverage elected is cancelled. Monthly premiums could be adjusted during the continuation period if the applicable premium amounts change.

Medicare Entitlement Under COBRA

If an individual is on continuation coverage and becomes entitled to Medicare after the date of COBRA election, the COBRA coverage can be terminated. However, as clarified under the final COBRA regulations, if an individual has been entitled to Medicare and becomes eligible for COBRA continuation, the individual is allowed to have both. For more information on HIPAA Special Enrollment Rights, see **page 45**.

Cancellation of Continuation Coverage Under COBRA

Continuation coverage will terminate prior to the expiration of the continuation period (18 or 36 months) for any of the following reasons:

- LADWP ceases to provide any group health plan to any of its employees;
- Any required monthly premium for continuation coverage is not paid in a timely manner. Monthly premiums are due on the first day of each month. In addition, qualified beneficiaries have a maximum 30-day grace period after the due date in which to pay these monthly premiums;
- A qualified beneficiary notifies the LADWP Health Plans Administration Office to cancel continuation coverage and request a cancellation form;
- A qualified beneficiary, after the date of election, becomes entitled to Medicare;
- A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability, and a final determination has been made that the qualified beneficiary is no longer disabled;
- For cause, on the same basis that the plan terminates the coverage of similarly situated non-COBRA participants;
- A qualified beneficiary enrolls in another group health plan.

Conversion After COBRA

Some health and dental plan providers offer the opportunity to convert to an individual plan (versus group coverage through LADWP) following cancellation of COBRA coverage.

Plan providers that offer conversion to individual coverage:

- Kaiser HMO
- UnitedHealthcare HMO
- Health Plan of Nevada HMO
- IBEW Local 18-sponsored Anthem Blue Cross health plans

Plan providers that do not offer conversion to individual coverage:

- Delta Dental
- United Concordia
- IBEW Local 18-sponsored Guardian Dental plans

However, members can contact Delta Dental, United Concordia or IBEW Local 18-sponsored Guardian Dental plans after COBRA is exhausted and request an individual plan. For more information, please contact member services for your health or dental provider.

This section is a summary of the COBRA federal and state regulations. For detailed exceptions, conditions and exclusions, please contact the appropriate administration office:

LADWP Health Plans Administration Office
111 N. Hope Street, Room 564
Los Angeles, CA 90012
(213) 367-2023
(800) 831-4778

IBEW Local 18 Benefit Service Center
9500 Topanga Canyon Blvd.
Chatsworth, CA 91311
(800) 842-6635

Medicare Information for Employees

Medicare Information for Employees

If you are an employee (or a spouse of an employee) age 65 or over and have elected to have an LADWP-sponsored or IBEW Local 18-sponsored health plan as your primary coverage over Medicare, you (or your spouse) are not required to enroll in Medicare Part B until you retire. If you plan to retire, contact your local Social Security Administration office to enroll in Medicare Part B three months before your retirement date.

If you are an employee and have elected Medicare as your primary coverage, you cannot be enrolled in an LADWP-sponsored or IBEW Local 18-sponsored health plan. You may change your selection of Medicare as your primary coverage to an LADWP-sponsored or IBEW Local 18-sponsored health plan during the Open Enrollment period.

For information regarding Medicare, including the impact of enrolling in Medicare Part B and how to make plan changes, call the LADWP Health Plans Administration Office at **(800) 831-4778**. For IBEW Local 18-sponsored Anthem Blue Cross plans, please call the IBEW Local 18 Benefit Service Center weekdays at **(818) 678-0040** or **(800) 842-6635** between the hours of 8:30 a.m. and 12:00 p.m. and 12:45 p.m. and 5:00 p.m.

Disabled Employees and Disabled Spouses of Employees Under Age 65

If you are a disabled employee (or a disabled spouse of an employee) under age 65, you must elect either Medicare or an LADWP-sponsored health plan as your primary coverage. You cannot be enrolled in both. You may change your selection of either Medicare or an LADWP-sponsored or IBEW Local 18-sponsored health plan as your primary coverage during the annual Open Enrollment period.

Verification Process

As you may be aware, the Secretary of the Department of Health and Human Services has directed that all organizations comply with the mandatory insurer law (Public Law 110-173; Section 111) regarding the requirement that our health plan must report information that the Secretary requires for purposes of coordination of benefits between your health plan and Medicare. In order for Medicare to properly coordinate Medicare payments with other insurance and/or workers' compensation benefits, Medicare relies on our health plan to collect the Medicare Health Insurance Claim Number (HICN) or Social Security number (SSN) from you and your family members and provide them to Medicare.

As such, if this information is not already on file with the LADWP Health Plans Administration Office and IBEW Local 18 Benefit Service Center, if applicable, Medicare HICNs and SSNs will likely be requested in order to meet the requirements of this law. Unfortunately, if you or your family member is a Medicare beneficiary and you do not provide the requested information, the affected member may be violating obligations to assist Medicare in coordinating benefits. Please assist us by providing this information, if requested.

Please keep in mind that while LADWP continues its efforts to verify eligibility of your dependent(s), we do need to utilize your SSN for the process. As required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we understand and handle employee information according to those requirements, which is included as part of the LADWP HIPAA Policies and Procedures, Group Health Plan Amendments.

Medicare Creditable Coverage Notice

Important Notice for Medicare-Eligible Employees from LADWP About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice contains important information about your current prescription drug coverage through your LADWP-sponsored or IBEW Local 18-sponsored health plan and about your options for enrolling in an individual Medicare prescription drug plan. If you are enrolled in an LADWP-sponsored health plan, your current prescription drug coverage is an enhanced Medicare Part D Prescription Drug Plan. If you are enrolled in an IBEW Local 18-sponsored health plan, your current prescription drug coverage is not an enhanced Medicare Part D Prescription Drug Plan, but it is "creditable coverage."

There are two important things you need to know about your current prescription drug coverage through LADWP or IBEW Local 18 and the individual Medicare prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join an individual 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.

- If you're enrolled in an LADWP-sponsored health plan, your prescription drug coverage is an enhanced Medicare Part D Prescription Drug Plan. LADWP has determined that the prescription drug coverage offered by the LADWP and IBEW Local 18-sponsored health plans, on average for all plan participants, is expected to pay out as much as individual Medicare prescription drug coverage pays and is, therefore, considered "creditable coverage."

You are required to enroll in a Medicare Part D Prescription Drug Plan when you first become eligible for Medicare (or face higher premiums if and when you eventually enroll in an individual Medicare Part D plan) unless you are already enrolled in a plan that provides you with creditable coverage. Because your existing coverage through an LADWP-sponsored or IBEW Local 18-sponsored health plan is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to drop this coverage and join an individual Medicare drug plan.

When Can You Join an Individual Medicare Drug Plan?
You can join an individual Medicare drug plan when you first become eligible for Medicare, and each year from October 15 through 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-month Special Enrollment Period (SEP) to join an individual Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join an Individual Medicare Drug Plan?
If you decide to enroll in an individual prescription drug plan through Medicare, you will lose your LADWP-sponsored or IBEW Local 18-sponsored prescription drug and health coverage, as well as your LADWP subsidy.

When Will You Pay a Higher Premium (Penalty) to Join an Individual Medicare Drug Plan?
You should also know that if you drop or lose your current prescription drug coverage under the LADWP-sponsored or IBEW Local 18-sponsored plans and don't join an individual Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join an individual 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 individual Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have individual Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information

For further details about this notice or your current prescription drug coverage, contact the LADWP Health Plans Administration Office.
Note: You will get this notice each year. You will also get it before the next period you can join an individual Medicare drug plan, and if coverage through LADWP changes. You also may request a copy of this notice at any time.

For details about your options under individual Medicare Prescription Drug Coverage:
More detailed information about individual Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You will 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 individual Medicare prescription drug coverage:

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

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

Remember: Keep This Creditable Coverage Notice

If you decide to join one of the individual 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're required to pay a higher premium (a penalty).

Date: April 2018
Name of Entity/Sender: Los Angeles Department of Water & Power; Contact/Office: LADWP Health Plans Administration; Address: 111 N. Hope Street, Room 564, Los Angeles, CA 90012; Phone Number: **(213) 367-2023** or **(800) 831-4778**

44 Health Care Notices

Federal laws require that LADWP provide you with certain notices that inform you about your rights regarding eligibility, enrollment and coverage of health care plans. The following sections explain these rules; please read them carefully and keep them where you can find them.

Health Care Reform

The Affordable Care Act (ACA), also known as the health care reform law, was signed into law in 2010. While the law was created to expand access to health care coverage, control health care costs and improve health care quality and coordination, it also impacts employer-sponsored health plans. In the past, you've seen certain changes to your benefits. Examples include coverage for breastfeeding support and allowing adult children up to age 26 to enroll in LADWP-sponsored and IBEW Local 18-sponsored health plans.

The Individual Mandate

The biggest impact to U.S. residents is a provision called the individual mandate. The individual mandate requires all U.S. residents, with few exceptions, to enroll in a qualified health plan. You need to know that LADWP-sponsored and IBEW Local 18-sponsored health plans are "qualified" under the ACA. This means if you enroll in an LADWP or IBEW Local 18-sponsored health plan, you satisfy the individual mandate.

The Health Insurance Marketplace

You've probably heard about the Health Insurance Marketplace or "exchange." In California, it's called Covered California™. You may choose a Marketplace plan instead of enrolling in an LADWP or IBEW Local 18-sponsored health plan. In addition, because you would be paying for this coverage directly, you would not be able to pay for it on a pre-tax basis.

Note: If you choose to enroll in a Marketplace plan, and then drop that coverage, you will NOT be allowed to enroll in an LADWP or IBEW Local 18-sponsored health plan until the next Open Enrollment period, unless you experience a qualifying event — for example, having a baby or getting married.

Caution:
If you do choose a Marketplace plan, LADWP will not pay any part of your premiums — and, because LADWP-sponsored and IBEW Local 18-sponsored health plans meet the ACA coverage and affordability requirements, you likely will not qualify for tax credits or subsidies to help you pay for Marketplace plan premiums, even if you fall within the income levels to receive government support.

Notice of Grandfathered Status

The Los Angeles Department of Water and Power (LADWP) believes all LADWP-sponsored health plans, except the UnitedHealthcare PPO Plans and IBEW Local 18-sponsored health plans for LADWP employees, are "grandfathered health plans" under the Affordable Care Act (ACA). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. As health plans that are grandfathered, LADWP-sponsored health plans may not include certain consumer protections of the ACA that apply to non-grandfathered plans — for example, certain provisions affecting benefits for emergency services. However, grandfathered health plans must comply with certain other consumer protections in the ACA — for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections don't apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, can be directed to the plan administrator.

Contact/Office: LADWP Health Plans Administration
Address: 111 N. Hope Street, Room 564, Los Angeles, CA 90012

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **(866) 444-3272** or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and don't apply to grandfathered health plans.

HIPAA Special Enrollment Rights

If you decline 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 an LADWP or IBEW Local 18-sponsored health plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your — or your dependents' — other coverage). You must request enrollment within 31 days after your — or your dependents' — other coverage ends (or after the employer stops contributing toward the other coverage). The plan will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.
- For these enrollment opportunities, you will have 60 days — instead of 30 — from the date of the Medicaid/CHIP eligibility change to request enrollment in the plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.
- Also, 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 an LADWP or IBEW Local 18-sponsored plan. You must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or to learn more, contact the appropriate plan administration office (LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center).

Contact/Office: LADWP Health Plans Administration
Address: 111 N. Hope Street, Room 564, Los Angeles, CA 90012
Phone Number: (213) 367-2023 or **(800) 831-4778**

IBEW Local 18 Benefit Service Center, 9500 Topanga Canyon Blvd., Chatsworth, CA 91311; **(800) 842-6635**

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other health and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers 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. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Special Enrollment Events

Special enrollment events allow you and your eligible dependents to enroll for health coverage outside the Open Enrollment period under certain circumstances if you lose eligibility for other coverage, become eligible for state premium assistance under Medicaid or the Children's Health Insurance Program (CHIP), or acquire newly eligible dependents. This is required under the Health Insurance Portability and Accountability Act (HIPAA).

If you decline enrollment in an LADWP-sponsored or IBEW Local 18-sponsored health plan for you or your dependents (including your spouse/domestic partner) because of other health insurance coverage, you or your dependents may be able to enroll in an LADWP-sponsored or IBEW Local 18-sponsored health plan without waiting for the next Open Enrollment period if you:

Lose other coverage. You must request enrollment within 31 days after the loss of other coverage;

Gain a new dependent as a result of marriage, birth, adoption or placement for adoption. You must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption; or

Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request enrollment within 60 days after the loss of such coverage.

In addition, you may enroll in an LADWP-sponsored or IBEW Local 18-sponsored health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for coverage.

IMPORTANT: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health option.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can 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, you can contact your state Medicaid or CHIP office at **(877) KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan — as long as you and your dependents are eligible but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in California, you may be eligible for assistance to pay your employer health plan premiums. You should contact the state for further information on eligibility.

If you live in a state other than California, you may be eligible for assistance to pay your employer health plan premiums. Contact the Department of Labor at **www.dol.gov/ebsa/pdf/chipmodelnotice.pdf** to view the complete state eligibility information.

CALIFORNIA

Medicaid Website
www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Medicaid Phone: 1-800-541-5555

CHIP Website
https://www.insurekidsnow.gov/state/ca/index.html
CHIP Phone: (800) 880-5305

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
(877) 267-2323, Ext. 61565

Improper Use of Benefits

Employees who receive benefits for themselves or their ineligible dependents from an LADWP-sponsored or IBEW Local 18-sponsored health or dental plan based on a false, deceptive or otherwise improper act may have their health or dental plan cancelled and may be considered ineligible for enrollment in LADWP-sponsored or IBEW Local 18-sponsored health and dental plans. Employees may also be subject to disciplinary action. In addition, employees will be billed for any LADWP subsidy paid for ineligible dependents.

Where to File Complaints — Department of Managed Health Care

The LADWP-sponsored and IBEW Local 18-sponsored health and dental plans are licensed under a California law known as the Keene Care Service Plan Act of 1975, which is administered by the Department of Managed Health Care (DMHC). If you wish to file a complaint against your health or dental plan with the DMHC, you may do so only after you have contacted your health or dental plan member service and used the plan's grievance process. However, you may immediately file a complaint with the DMHC if the health or dental plan has not satisfactorily resolved your grievance within 30 days from filing a formal complaint with the health or dental plan. The DMHC toll-free telephone number is **(800) 400-0815**; the DMHC website is **www.dmhc.ca.gov**.

Verify Coverage

Every employee should verify his or her LADWP-sponsored or IBEW Local 18-sponsored health and dental plan coverage each month by checking his or her "Statement of Earnings, Allowances and Deduction" (paycheck stub). Errors and omissions should be reported to the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center immediately.

Not notifying the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center immediately could cause you to have to wait for the next Open Enrollment period before you can make any changes to your benefit elections.

This Brochure Is Not a Contract

For detailed exceptions, conditions or exclusions, contact:
LADWP Health Plans Administration Office
111 North Hope Street, Room 564
Los Angeles, CA 90012
Phone: **(213) 367-2023**

Remember, it is your responsibility to complete all of the necessary forms for the health or dental care plan of your choice and return them to the LADWP Health Plans Administration Office. Changes in your health or dental plan require new forms to be filled out. If you have any questions regarding the Department of Water and Power health and dental plans, you may call **(213) 367-2023** or **(800) 831-4778**. For more information regarding IBEW-sponsored Local 18 health and dental plans, call the IBEW Local 18 Benefit Service Center at **(818) 678-0040** or **(800) 842-6635**.

Contact Information

Health and Dental Plan Contact Information

LADWP-Sponsored		
LADWP Health Plans **Administration Office** **111 N. Hope Street, Room 564** **Los Angeles, CA 90012**	**(213) 367-2023** **(800) 831-4778** **HealthPlans@ladwp.com**	**https://eBenefits.ladwp.com**
Carrier	**Phone**	**Website**
Delta Dental	(800) 765-6003	www.deltadentalins.com
Health Plan of Nevada	(800) 777-1840	www.myhpnonline.com
Kaiser Permanente	(800) 464-4000	www.kp.org
United Concordia Dental (DHMO)	(866) 851-7568	www.unitedconcordia.com
UnitedHealthcare HMO	(800) 624-8822	www.myUHC.com
UnitedHealthcare PPO/ Owens Valley	(866) 783-7481	www.myUHC.com

IBEW Local 18-Sponsored		
IBEW Local 18 **Benefit Service Center** **9500 Topanga Canyon Boulevard** **Chatsworth, CA 91311**	**(800) 842-6635** **(818) 678-0040** **Local18@mybenefitchoices.com**	**www.mybenefitchoices.com/local18**
Carrier	**Phone**	**Website**
Anthem Blue Cross HMO and PPO	(800) 227-3771	www.anthem.com/ca/ibewlocal18
Anthem Blue Cross Owens Valley PPO	(800) 759-3030	www.anthem.com/ca/ibewlocal18
Guardian Dental	PPO: (800) 541-7846 DHMO: (800) 273-3330	www.guardiananytime.com

Additional Contact Information

Department	Details
California Medicaid	(916) 636-1980
Local 721 Dental Zenith American Solutions	(877) 802-9740
L.A. City Employee Benefits	(213) 978-1655 (800) 778-2133
U.S Department of Health and Human Services Centers for Medicare & Medicaid Services	(877) 267-2323. Ext. 61565 www.cms.hhs.gov
U.S. Department of Labor Employee Benefits Security Administration	(866) 444-EBSA (3272) www.dol.gov/ebsa