Los Angeles Department of Water & Power

2016 RETIREE BENEFIT GUIDE

https://ebenefits.ladwp.com

IMPORTANT!

The right health insurance helps protect you and your finances. Make an appointment with yourself and your family to review this material carefully before making your health and dental plan choices.

MEDICARE CREDITABLE COVERAGE NOTICE

If you have Medicare or will become eligible for Medicare in the next 12 months, see "Important Notice for Medicare-eligible Retirees from LADWP About Your Prescription Drug Coverage and Medicare" on **page 26** for more information. You are responsible for providing a copy of this disclosure to your Medicare-eligible family members.

QUICK LOOK AT WHAT'S INSIDE

Contents

IMPORTANT!

When you enroll, you will be asked to provide each dependent's Social Security number for verification purposes.

This Guide represents a summary of the benefits available to you as an eligible retiree of the Los Angeles Department of Water & Power (LADWP). Every effort has been made to provide an accurate summary of the terms of the plans. To the extent there is a conflict between the information in this Guide and the official plan documents, the plan documents will govern in all cases. This Guide is for informational purposes only and information contained herein may include programs that are not applicable to all retirees. Receipt of this Guide does not constitute a waiver of any applicable eligibility requirements nor does it constitute any employment promise or contract.The rate information contained in this Benefit Guide is subject to the approval of the Board of Water and Power Commissioners.

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Welcome to Your Retiree Benefits

We ask you to take charge of your benefits by carefully reading this guide to help you better understand your plan options. When you understand your options, you can select the plan that will work best for you and your family.

This guide provides the "typical" benefit information such as what your co-pay may be for a doctor's office visit. In addition, it provides information about how the plans are designed, so you can understand if a Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO) option better fits your needs.

As an LADWP retiree, we recognize and appreciate your service. During your career, you demonstrated your attitude of empowerment serving Los Angeles every day. And now, we're empowering you to know more about your benefits so you can use them wisely and cost effectively.

New for 2016

Beginning January 2016, the Contraceptive Coverage Equity Act (SB 1053) requires health insurance coverage to include all FDA-approved and prescribed over-the-counter methods of birth control without restrictions or co-pays for patients, except those enrolled in a Kaiser or UnitedHealthcare HMO, which are "Grandfathered Status" health plans.

Therefore, birth control methods prescribed to retirees or their dependents enrolled in one of the above "Grandfathered Status" LADWP-sponsored health plans may have co-pays or other cost sharing requirements. Please consult your health care provider for additional information.

IBEW LOCAL-18 SPONSORED PLANS

Anthem Blue Cross changes

If as a retiree, you cancelled your IBEW Local 18-sponsored medical plan, you are now able to re-enroll into a Local 18 plan.

Retirees enrolled in an IBEW Local 18 Anthem Blue Cross plan now have access to LiveHealth Online. LiveHealth Online is 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 covered at the same level as an in-network doctor visit.

Guardian DHMO and PPO plans

If, as a retiree,you cancelled your IBEW Local 18-sponsored dental plan, you are now able to re-enroll into a Local 18 plan.

Important Reminders

RETIREMENT TIERS

Employees who were hired prior to January 1, 2014 are considered "Tier 1" retirees. If you were hired by LADWP prior to January 1, 2014, all of the information in this guide, including subsidies, applies to you.

Employees who were hired on or after January 1, 2014 are considered "Tier 2" retirees. If you were hired by LADWP on or after January 1, 2014, the plan design information in this guide applies to you. However, your subsidies are different. If you are a Tier 2 retiree, the maximum subsidy you are eligible to receive for retiree health care benefits is at the self-only rate. Please contact the LADWP Health Plans Administration Office at **(213) 367-2023** or **(800) 831-4778**.

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 receiving the Summaries of Benefits and Coverage (SBC) documents or allowing adult children up to age 26 to enroll in LADWP-sponsored or IBEW Local 18-sponsored plans.

The Individual Mandate

The biggest impact to U.S. residents is a provision called the **individual mandate.** This rule requires all U.S. residents, with few exceptions, to enroll in a qualified health plan or pay a penalty. 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-sponsored or IBEW Local 18-sponsored health plan, you satisfy the individual mandate and you **won't** have to pay a penalty. If you don't enroll in an LADWP-sponsored or IBEW Local 18-sponsored health plan or another qualified health plan, you may be responsible for paying a penalty. Another qualified health plan could include a spouse's plan. If you don't enroll in a qualified health plan for 2016, you'll pay the higher of these two amounts:

- **2.5% of your yearly household income.** (Only the amount of income above the tax filing threshold, about $10,000 for an individual, is used to calculate the penalty.) The maximum penalty is the national average premium for a bronze plan
- **$695 per person for the year ($347.50 per child under 18)**. The maximum penalty per family using this method is $2,085

The penalty increases each year until 2017 when it will be the greater of $695 or 2.5% of taxable income. In 2018 and beyond, smaller increases are expected.

The Health Insurance Marketplace

You've probably heard about the Health Insurance Marketplace or "exchange." In California, it's called **Covered California™**. Some states, like California, run their own Marketplace and some rely on the one run by the federal government. Each state is different and you can link to your state's Marketplace by going to **www.HealthCare.gov**. If you are under age 65, you may choose a Marketplace plan instead of enrolling in an LADWP-sponsored or IBEW Local 18-sponsored plan.

NOTE*:* If you choose to enroll in a Marketplace plan, and then drop that coverage, you will NOT be allowed to re-enroll in an LADWP-sponsored health plan until the next Open Enrollment period or if you have a qualifying event.

Do I have to purchase insurance through the Marketplace?

You're not required to buy insurance through the Marketplace, but it does offer many options.

If you're a pre-65 retiree, you may qualify for tax credits and subsidies to help you pay the premiums of your Marketplace plan. However, because LADWP and IBEW Local 18-sponsored health plans meet ACA requirements, you probably won't be eligible for the credits and subsidies even if you fall within the income requirements.

IMPORTANT: If you do choose a Marketplace plan, LADWP will not pay any part of your premium. Post-65 retirees cannot enroll through the Marketplace.

If you decide to enroll in a health plan through the Marketplace, please be aware that:

1. LADWP will not pay any part of your premiums,
2. You will pay for this coverage directly, and
3. LADWP will not reimburse you for any payments made to the Marketplace for health insurance.

NOTICE OF GRANDFATHERED STATUS

The Los Angeles Department of Water & Power believes all LADWP-sponsored medical plans, except the UnitedHealthcare PPO Plans, Health Plan of Nevada, and IBEW Local 18-sponsored plans for LADWP retirees, are "grandfathered health plans" under the 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, this means that beginning July 1, 2011, LADWP-sponsored medical 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:

LADWP Health Plans Administration Office
111 North 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.

Checklist for a Successful Benefit Enrollment

☐ **We need it in writing.** Enrolling in and changing your benefits can't be done verbally — all transactions must be made through a paper enrollment form. IBEW Local 18-sponsored plans, you can enroll online or by completing a form. (Retirees must be enrolled in Anthem Blue Cross or Guardian Dental prior to retirement to participate in the plan.) **See page 6 for details.**

☐ **Add new dependents.** You must add your new dependents (such as a new spouse, domestic partner, or a new child) within 31 days from a qualifying event, or you won't be able to add them until the next Open Enrollment period. **See page 6 for details.**

☐ **You can cover children up to age 26.** Your children, even if married, no longer in school or living with you, can be covered under your LADWP-sponsored or IBEW Local 18-sponsored medical and dental plans until they reach 26 years of age. **See page 11 for details.**

☐ **You must remove your ex-spouse/ex-domestic partner from coverage if you divorce/terminate your domestic partnership.** If you and your spouse divorce, or you and your domestic partner terminate your domestic partnership, you must notify the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center, as appropriate, by completing an enrollment/change form and, upon request, providing proof of the divorce/termination of domestic partnership within 31 days after the divorce/termination of domestic partnership is finalized. If you don't:

- You will be billed for any services incurred by your ex-spouse/ex-domestic partner after the divorce/termination of domestic partnership is finalized, and
- You will continue to be taxed for your domestic partner.
- Your ex-spouse's COBRA rights will be forfeited. **See page 58** for more information on COBRA Continuation Coverage.

Your ex-spouse's/ex-domestic partner's coverage will end on the first day of the month after the forms are received. **See page 16 for details.**

☐ **If you marry your domestic partner, you must let us know.** If you marry your domestic partner and you want to continue his or her coverage under your health care plans, you must submit the following to the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center within 31 days, as appropriate:

- Enrollment/change form
- A copy of your certified marriage certificate, and
- A termination of domestic partnership form. **See page 13 for details.**

IF YOU ARE 65 OR OLDER

☐ **Enroll in Medicare Part B by age 65.** All retired employees must enroll in Medicare Part B before their 65th birthday, and provide the LADWP Health Plans Administration Office with proof of enrollment. If you don't enroll in Medicare Part B, your health care coverage will be cancelled. In addition, you may be required to pay any additional costs incurred by the LADWP for your failure to enroll in or maintain medicare coverage for you or your spouse. For IBEW Local 18-sponsored plans, you must have both Medicare Parts A and B. If your Medicare status changes after age 65, you must provide the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center with written confirmation of the change immediately. **See page 22 for details.**

- **Retirees may be eligible for Medicare Part B premium reimbursement.** When you enroll in Medicare Part B at age 65, you may be eligible for reimbursement of the premium that's taken out of your Social Security check if you have enough LADWP subsidy left over after your health premium has been deducted. Contact the LADWP Health Plans Administration Office to find out if you're eligible and obtain the forms to request the reimbursement. **See pages 24-25 for details.**
- **Medicare Part B Reimbursement** – Annual Enrollment. You are required to request enrollment in Medicare B Reimbursement on an annual basis. Failure to do so will result in benefit termination. **See page 25 for details.**
- **LADWP can directly pay your Medicare Part B premiums.** You can make arrangements for your Medicare Part B premiums to be paid directly to the Centers for Medicare and Medicaid Services (CMS). To start this process, contact the LADWP Health Plans Administration Office **(213) 367-2023** when you receive the Notice of Premium Payments Due statement from CMS to request the necessary form to enroll in group payment. It is also recommended that you call the LADWP Health Plans Administration Office a couple of days after you mail the documents to confirm receipt. **See page 24 for details.**
- **Fax Medicare Part B premium documentation received from Social Security to LADWP.** Any communications you receive from Social Security regarding your and/or your spouse's Medicare Part B premium should be faxed immediately to the LADWP Health Plans Administration office at **(213) 367-2078**.
- **Medicare-eligible participants have Medicare Part D prescription drug coverage.** If you or your dependent is eligible for Medicare and enroll in an LADWP-sponsored medical plan, your prescription drug coverage is an enhanced Medicare Part D Prescription Drug Plan that is offered through LADWP. If you receive a bill for a premium surcharge for Medicare Part D, **YOU MUST PAY THE PREMIUM SURCHARGE. IT IS YOUR RESPONSIBILITY TO PAY THIS. FAILURE TO PAY WILL RESULT IN LOSS OF COVERAGE**.

  You should not enroll in an Individual Medicare Prescription Drug Plan on your own. If you do, you will lose your LADWP-sponsored prescription drug and medical coverage, and you will lose your LADWP subsidy. **See page 26-27 for details.**

Enrolling in the Plans and Enrollment Deadlines

Follow these instructions by the deadlines to ensure you and your dependents are correctly enrolled in a plan and are covered. Open Enrollment is from April 25 - May 6, 2016. In addition, there will be a special retiree in-person enrollment session from 8 a.m. to noon on April 30, 2016. Benefit elections are effective July 1, 2016.

OPEN ENROLLMENT APRIL 25 - MAY 6, 2016

Once a year, generally in the spring, you are given an opportunity to change your benefits. During the annual Open Enrollment period, you will have the opportunity to review your benefits and make any needed changes. You do not have to take action if you wish to maintain your current benefits and coverage levels (for example, the number of people you cover on your plan).

OTHER OPPORTUNITIES TO MAKE ENROLLMENT CHANGES

You can change your health and/or dental plans outside of the annual Open Enrollment period if you experience an eligible change in family status. You must act quickly if you need to add or delete a dependent based on one of the qualifying events outlined below.

Contact the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center (for Anthem Blue Cross and Guardian plans) as soon as possible to report the following events and then submit a completed enrollment/change form. Proof of a qualifying event is required.

31
DAYS

Be sure to submit your completed enrollment/change form within *31 days* from your qualifying life event!

SPECIAL ENROLLMENT PERIODS (QUALIFYING EVENTS)

IF YOU...	YOU SHOULD...
Get married	Add your new spouse to your plan(s) within 31 days from your wedding date, and submit a copy of your marriage certificate with your change form.
Have a baby	Add a newborn child to your plan(s) within 31 days from the date of birth. Coverage will be effective on the first of the month following the date you submit an enrollment/change form to the LADWP Health Plans Administration Office and/or the IBEW Local 18 Benefit Service Center. If you do not enroll the newborn within 31 days, you must wait until the next Open Enrollment period to add the newborn. If court-ordered paternity has recently been determined, you may add the child within 31 days from court award with proof of paternity. If your covered dependent child has a baby, you can add that grandchild to your health and dental plans within 31 days from the date of birth. Please note that any medical expenses incurred by the newborn prior to the effective enrollment date are the responsibility of the retiree.

SPECIAL ENROLLMENT PERIODS (QUALIFYING EVENTS) CONTINUED

IF YOU...	YOU SHOULD...
Adopt a child	Add an adopted child to your plan within 31 days from placement. Submit copies of the adoption papers with your enrollment/change form.
You or your spouse becomes the legal guardian of a child	Add the child to your plan within 31 days from the date of the court order placing the child in your guardianship. Submit copies of the court order with the enrollment/change form.
Want to add a spouse and/or other dependent who has lost other health and dental coverage	Add the spouse and/or dependent who loses coverage for one of the following reasons within 31 days from the date coverage was terminated: Loss of eligibility (such as termination of employment, death, divorce, or reduction in the number of hours of employment), or loss of employer's contribution toward coverage. Submit a certificate or letter from the employer giving the last day of coverage and the reason for the loss of coverage with the enrollment/change form.
Want to add a dependent up to age 26 who has lost coverage	Provide a copy of the child's birth certificate when you first enroll the dependent in an LADWP-sponsored plan or when you first enroll the dependent in an IBEW Local 18-sponsored Plan with the enrollment/change form.
Want to add your domestic partner and your domestic partner's child(ren) once you have lived together for 12 months	Add your domestic partner and your domestic partner's child(ren) within 31 days from the end of the 12-month period. A domestic partner's child can only be covered if the domestic partner is also covered. For more information on domestic partner eligibility, see the Dependent Eligibility At-A-Glance chart starting on **page 11**.
Were covered by other health and dental insurance, for example, by a spouse's employer, then lost coverage. Loss of other coverage is limited to 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 LADWP when the other coverage ends, provided that you request enrollment within 31 days after your coverage ends.
Are a retiree enrolled in a Kaiser, Anthem Blue Cross, UnitedHealthcare, Health Plan of Nevada, Guardian DHMO Dental or United Concordia Plus Dental plan who moves out of these plans' service areas (UnitedHealthcare PPO Plan is nationwide)	Re-enroll in another plan that is within the new service area you will be moving to within 60 days from the date you establish residency at the new address.
Are an early retiree, under age 65 and enrolled in Anthem Blue Cross HMO, who moves out of state	Contact IBEW Local 18 Benefit Service Center at **(800) 842-6635** for information on the Anthem Blue Cross out-of-state plans.

IMPORTANT THINGS TO REMEMBER

- **Age 65 Requirements:**
  - **LADWP-sponsored plan - You must enroll in Medicare Part B**
  - **IBEW Local 18-sponsored plan - You must enroll in Medicare Parts A and B**
- **If you are 65 or will be turning 65 within 3 months, you must enroll in Medicare and provide proof of coverage. See page 22 for details**
- **Get it in writing — always keep copies of your enrollment/change form to show proof of enrollment and any changes you make, including fax receipts**
- **Check your retirement pay stub each month to make sure your benefit choices are correct. If not, please contact either the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center**
- **You can only elect IBEW Local 18-sponsored health and dental retirement plans if you were enrolled in IBEW Local 18-sponsored health and dental plans prior to retirement**

WHEN COVERAGE IS EFFECTIVE

Once you have retired and you've enrolled in a retiree group plan, your coverage begins on the first of the month following your retirement date (e.g., if you retire on June 1, 2016, your active coverage terminates on June 30, 2016 and your retiree coverage begins on July 1, 2016).

HOW TO ENROLL

It is important to know you may NOT enroll in benefits over the telephone.

LADWP-sponsored Plans

You must obtain an enrollment/change form from the LADWP Health Plans Administration Office. Once you complete your form, submit it and the required paperwork to:

LADWP Health Plans Administration Office
111 North Hope Street, Room 564
Los Angeles, CA 90012

Make sure all enrollment forms are complete, signed by you and your spouse, if necessary, and submitted on time. Be sure to include the Social Security numbers of your dependents. Always keep copies of your enrollment/change form to show proof of enrollment and any changes you make, including fax receipts.

IBEW Local 18-sponsored Plans

You can enroll online or by completing an enrollment form. (*Retirees must be enrolled in Anthem Blue Cross or Guardian Dental prior to retirement to participate in the plan*.) To enroll online, log on to **www.mybenefitchoices.com/local18**. Call IBEW Local 18 Benefit Service Center at **(800) 842-6635** to request an enrollment kit. Once you receive your kit and complete your enrollment forms, submit your completed forms to:

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

Make sure all enrollment forms are complete, and submitted on time. Always keep copies of your forms to show proof of enrollment and any changes you make, including fax receipts.

Once you enroll in either LADWP-sponsored or IBEW Local 18-sponsored plans, review your pay stub each month as another point of confirmation that LADWP reflects your benefit choices accurately. Contact the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center immediately if you find any errors or omissions on your retirement pay stub.

LADWP-SPONSORED PLANS	IBEW LOCAL 18-SPONSORED PLANS
Before age 65, you and your dependent(s) must enroll in Medicare Part B and provide proof of enrollment to avoid termination of your LADWP-sponsored health plan.	• For IBEW Local 18 Anthem Blue Cross HMO and PPO, at age 65 you must be enrolled in Medicare Parts A and B, and show proof of enrollment to avoid termination of your IBEW Local 18-sponsored health plan • For IBEW Local 18-sponsored Anthem Blue Cross Owens Valley: This plan is not available when you reach age 65

If you are 65 or older and you or your spouse fail to enroll in or maintain your Medicare coverage, you may incur additional fees.

CHANGE OF ADDRESS

If you move, make sure that the LADWP Retirement Office, LADWP Health Plans Administration Office, and IBEW Local 18 Benefit Service Center has your current mailing address.

LADWP Retirement Office	**(213) 367-1715** or **(800) 367-7164**
LADWP Health Plans Administration Office	**(213) 367-2023** or **(800) 831-4778**
IBEW Local 18 Benefit Service Center	**(818) 678-0040** or **(800) 842-6635**

Health and dental plan information and correspondence are sent to the address on record in the LADWP Retirement Office or IBEW Local 18 Benefit Service Center.

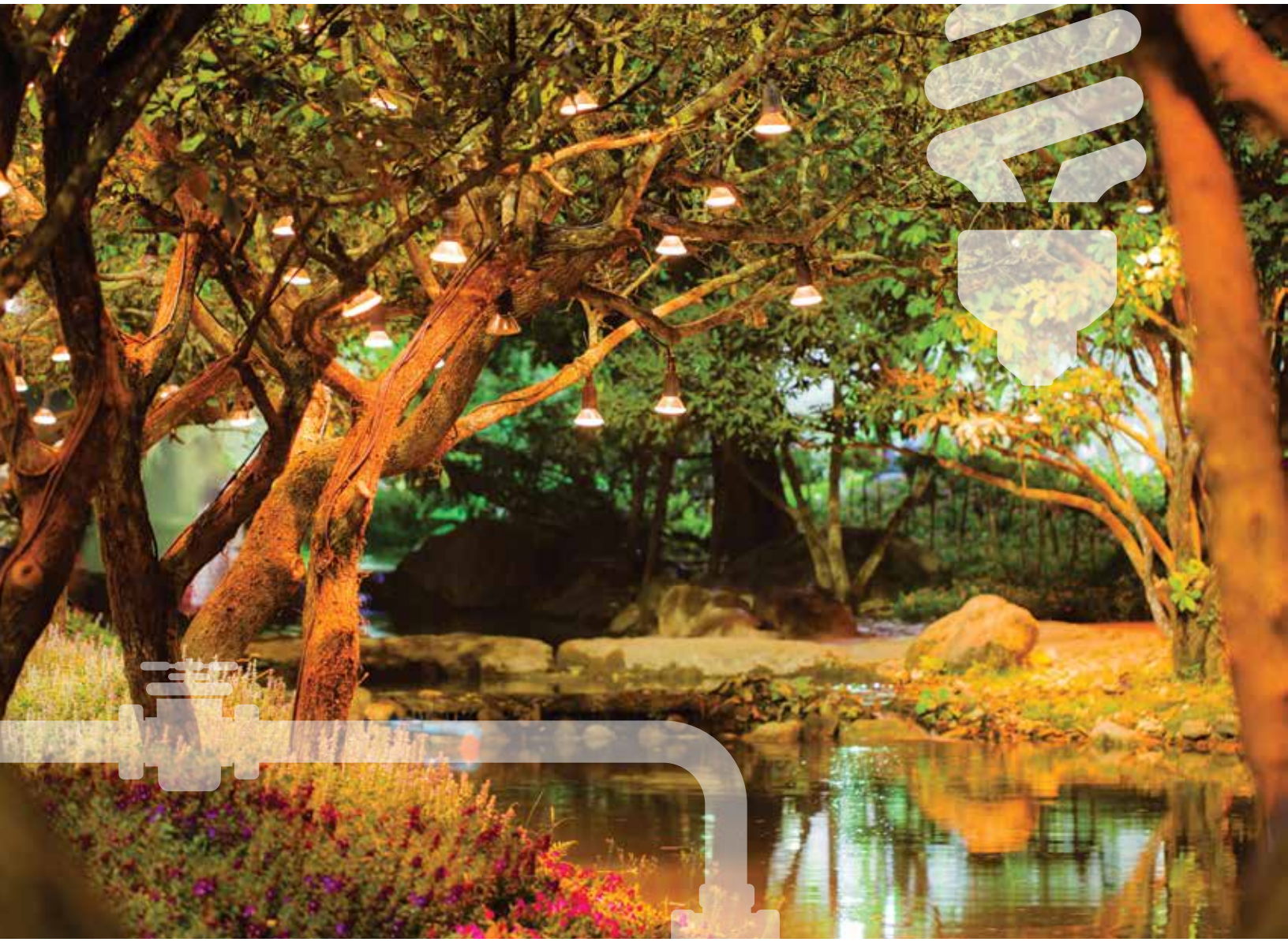
CANCELLING COVERAGE

If you are currently enrolled in an LADWP-sponsored plan, you must call the LADWP Health Plans Administration Office at **(213) 367-2023** or **(800) 831-4778** to obtain the form to cancel your coverage. To cancel coverage in a IBEW Local 18-sponsored plan, you must contact IBEW Local 18 Benefit Service Center at **(800) 842-6635** for a form, **or** go online to **www.mybenefitchoices.com/local18** to decline coverage.

IMPORTANT THINGS TO REMEMBER

- **If you have Delta Dental coverage when you retire and you do not choose another dental plan, you will not have any dental coverage. You will not be able to enroll in a dental plan until the next Open Enrollment period**
- **Health and dental subsidies can only be used for LADWP-sponsored or IBEW Local 18-sponsored health and dental plans; the contribution cannot be used for private insurance plans, the Marketplace or for plans of outside organizations unless specified in the applicable MOU**
- **If you do not pay your monthly premiums to continue health and/or dental coverage, the coverage will be cancelled the first month that payment is not received. You will have to wait until the next annual Open Enrollment period to re-enroll in LADWP or IBEW Local 18-sponsored health and/or dental coverage**
- **You will be advised in writing of the opportunity to pay health and/or dental premiums if deductions were missed**
- **You can only elect IBEW Local 18-sponsored health and dental retirement plans if you were enrolled in IBEW Local 18-sponsored health and dental plans prior to retirement**

Eligibility



RETIREES

IF YOU ARE...	THEN YOU ARE ELIGIBLE FOR...
An LADWP retiree and you are eligible to receive a minimum pension from the Water and Power Employees' Retirement Plan	LADWP-sponsored and/or IBEW Local 18-sponsored retiree plans; however, you must already be enrolled in a IBEW Local 18 plan prior to retirement in order to keep your IBEW Local 18-sponsored coverage
If you were an employee of LADWP immediately prior to your retirement and you're receiving a monthly retirement allowance under the LADWP retirement plan	

DEPENDENTS

If you elect coverage for yourself, you may also elect coverage for your family members if they are considered eligible dependents. When you elect coverage for an eligible dependent, you will be asked to provide each dependent's Social Security number and documentation to verify eligibility. Failure to provide your dependent's Social Security number or supporting documents may result in loss of benefits.

DEPENDENT ELIGIBILITY AT-A-GLANCE

DEPENDENT TYPE	AGE LIMIT	ELIGIBILITY DEFINITION	DOCUMENTS REQUIRED FOR VERIFYING ELIGIBILITY
Spouse	N/A	Person of the opposite or same sex to whom you are legally married	• Social Security number • A copy of certified marriage certificate
Registered domestic partner	N/A	Meet LADWP's eligibility requirements as listed on **page 13** of this guide	• 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
Non-registered domestic partner	N/A	Meet LADWP's eligibility requirements as listed on **page 13** of this guide	• 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 • A confidential affidavit that shows you and your domestic partner meet LADWP's required criteria, including: - Neither of you were 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
Biological child	Up to age 26[1]	Minor or adult child(ren) of retiree who is under age 26	• Social Security number • A copy of the child's birth certificate when you first enroll the dependent in an LADWP-sponsored plan or when you first enroll the dependent in an IBEW Local 18-sponsored plan
Stepchild	Up to age 26[1]	Minor or adult child of retiree's spouse who is under age 26	• Social Security number • A copy of the child's birth certificate

[1] *Eligibility continues through the end of the month your dependent turns age 26.*

DEPENDENT ELIGIBILITY AT-A-GLANCE CONTINUED

DEPENDENT TYPE	AGE LIMIT	ELIGIBILITY DEFINITION	DOCUMENTS REQUIRED FOR VERIFYING ELIGIBILITY
Child legally adopted/ward, including grandchildren for whom you have legal custody	Up to age 26[1]	Minor or adult child legally adopted/ward by retiree who is under age 26[2]	• Social Security number • Court documentation • A copy of child's birth certificate
Child of domestic partner	Up to age 26[1]	Minor or adult child of retiree's covered domestic partner who is under age 26	• Social Security number • A copy of child's birth certificate • Proof of domestic partnership
Disabled child	Up to age 26[1]	Child as defined in the child categories above	• Social Security number • A copy of child's birth certificate
Disabled child	Over age 26	Disabled child over the age of 26 who is dependent on you for support and was disabled before age 26. To be eligible, your child must remain unmarried, dependent on you for financial support and disabled as determined by your health plan	• 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 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 child's birth certificate

[1] Eligibility continues through the end of the month your dependent turns age 26.

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

Your Spouse or Domestic Partner

You can elect coverage for:

- Your lawful spouse
- Your registered domestic partner, or
- Your non-registered domestic partner

To elect coverage for your spouse or domestic partner, you must submit the documentation listed in the charts on **pages 11 and 12** to establish eligibility.

When you submit the required documentation to establish eligibility, you should follow up with the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center, as appropriate, to confirm that the documentation was received and when your dependent's coverage will be effective.

Tax Implications for Domestic Partner Coverage

If you cover your domestic partner and/or his or her children under your health and/or dental plan, you will pay income tax on the amount of the health 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.

If You Marry Your Domestic Partner

If you are 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. Note that the change becomes effective the first of the month following the date that the forms are received.

LADWP will use Social Security numbers to verify eligibility of your dependents.

PLEASE NOTE:

For domestic partner coverage for Health Plan of Nevada, you must complete a Domestic Partner Rider.

IMPORTANT

The confidential Domestic Partner Affidavit authorizes your domestic partner to receive only your health care benefits. If you would like your domestic partner to receive retirement benefits, you must file a separate domestic partner affidavit with the Retirement Office.

ARE YOU ALSO ELIGIBLE AS A DEPENDENT SPOUSE OR DOMESTIC PARTNER?

If you're eligible for coverage as an LADWP retiree, you are not allowed to be covered as a dependent spouse or domestic partner under another LADWP employee's or retiree's plan unless:

- **The subsidies for your coverage are lower than the subsidies for your spouse or domestic partner, or**
- **You are not eligible for the Department's subsidy.**

If you meet either of these criteria, you may choose to participate in the health and dental plans as either a retiree subscriber or a dependent. However, once you make the choice, you may not change this decision.

Children

Eligible retirees may also enroll their children in coverage. In this *2016 Retiree Benefit Guide*, eligible children are defined as:

- Your biological children
- Your stepchildren
- Your legally adopted children
- Children for whom you and/or your spouse are the legal guardian
- Children of your domestic partner (if you also cover your domestic partner), and
- Your grandchildren, if they are the children of your covered children

To be eligible for coverage, your children must be:

- Under 26 years of age, or
- 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 before age 26 (for LADWP-sponsored plans only)

To cover your children, you must provide the required documentation to establish eligibility. When you submit the documentation to establish eligibility, you should follow up with the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center, as appropriate, to confirm that the documentation was received and to determine when your dependent's coverage will be effective.

Grandchildren

You can cover your grandchildren under your health care plans only if the grandchild is the child of your covered eligible dependent and meets eligibility requirements listed in the chart on **page 12**.

Surviving 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 Water and Power Employees' Retirement Plan, and
- Were covered as dependents on your health care plans at the time of your death.

If eligible, in order to continue coverage, your surviving dependents must re-enroll in an LADWP-sponsored or IBEW Local 18-sponsored health plan within 60 days from 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. There are a few important points to consider about surviving dependent coverage:

- The retiree premium rates are used to determine the health premium for surviving dependent(s)
- While surviving dependent(s) can enroll in dental coverage, the dependent will pay the full cost of coverage — there is no subsidy

IMPORTANT THINGS TO REMEMBER

Don't wait until your dependents need medical and dental care to enroll them in coverage. Plan ahead and ensure that your family has health and dental coverage when they need care. Enroll them within 31 days from the qualifying event or you will have to wait for the next annual Open Enrollment period.

When Coverage Ends for Your Dependents

The chart below shows when coverage ends for your eligible dependent(s). It also outlines the documentation that you must provide to either the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center.

IF YOU COVER YOUR...	COVERAGE WILL END FOR YOUR DEPENDENT WHEN...	COVERAGE WILL TERMINATE WHEN YOU...	IF YOU FAIL TO NOTIFY...
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 non-registered domestic partner	You terminate 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.	

PLEASE NOTE

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 page 58.

Contributions for Coverage

A NOTE ABOUT THE MONTH OF JULY

It is important to remember that any changes to *premiums* take effect on June 30 for the month of July, while *cost-of-living adjustments* to your retirement check are not reflected on your retirement check until July 31.

HEALTH PLAN SUBSIDY

If you are a retiree receiving a "Formula Pension" from the Water and Power Employees' Retirement Plan, you are eligible for a health plan subsidy. LADWP's health plan contribution is based on a formula accounting for years of service as a member of the retirement plan and age at retirement. The information is determined by the Retirement Plan Office.

The maximum health subsidy for the 2016-17 Plan Year is:

Tier 1 - $1,485.68 or

Tier 2 - $742.84

If you are the eligible spouse of a deceased retiree, you are eligible to receive the subsidy that would have been given to the deceased retiree if he or she were still living, if the eligible spouse was enrolled in the deceased retiree's health or dental plan at the time of the member's death, and is eligible to receive a monthly allowance.

DENTAL PLAN SUBSIDY

If you are a retiree receiving a "Formula Pension" from the Water and Power Employees' Retirement Plan, you are eligible for a dental plan subsidy. Spouses or surviving dependents are not eligible for the LADWP dental plan subsidy.

HEALTH AND DENTAL PLAN PREMIUMS

When you enroll in a health and/or dental plan, your portion of the cost will be deducted from your retirement check. Health and dental plan premiums for retirees are deducted from the retiree's retirement check according to the following schedule:

RETIREE PAY PERIODS

DEDUCTION TAKEN FOR PERIOD ENDING	PAY HEALTH/DENTAL PREMIUM FOR
January 31	February
February 28	March
March 31	April
April 30	May
May 31	June
June 30	July
July 31	August
August 31	September
September 30	October
October 31	November
November 30	December
December 31	January

RETIREE HEALTH PLAN RATE CHART FOR 2016 - 2017

Rates are effective July 1, 2016 through June 30, 2017.[1]

		UNITED HEALTHCARE OPTION A	UNITED HEALTHCARE OPTION B	UNITED HEALTHCARE OPTION C	KAISER/ SENIOR ADVANTAGE	UNITED HEALTHCARE MEDICARE ADVANTAGE HMO[2]	HPN/SR DIMENSIONS	ANTHEM BLUE CROSS HMO[3] (LOCAL 18)	ANTHEM BLUE CROSS PPO[3] (LOCAL 18)	ANTHEM BLUE CROSS OWENS VALLEY[3] (LOCAL 18)
1	Retiree Under Age 65									
A	**Self only**	$1,387.58	$1,204.28	$937.29	$742.84	$1,307.16	$1,016.86	$1,485.60	$1,678.73	$1,803.48
B	**Self + 1 dependent under 65**	$2,775.23	$2,408.61	$1,874.61	$1,485.68	$2,697.54	$2,037.62	$1,758.81	$2,133.89	$3,757.46
C	**Self + 2 or more dependents under 65**	$3,634.58	$3,154.43	$2,455.09	$2,102.23	$2,959.40	$2,847.15	$1,816.52	$2,643.04	$4,661.79
D	**Self + 1 dependent enrolled in Medicare Parts A & B**	$1,968.44	$1,633.41	$1,195.58	$1,073.66	$1,770.07	$1,288.51	$1,758.81	$2,133.89	$3,757.46
E	**Self + 1 dependent enrolled in Medicare Part B**	$2,422.34	$1,977.17	$1,437.39	$1,385.66	$2,424.36	$2,037.62	$1,758.81	$2,133.89	$3,757.46
2	Retiree Over Age 65 and Enrolled in Medicare Parts A & B									
A	**Self only**	$580.86	$429.13	$258.29	$330.82	$462.91	$267.75	$939.98	$1,511.84	N/A
B	**Self + 1 dependent under 65**	$1,968.44	$1,633.41	$1,195.58	$1,073.66	$1,770.07	$1,288.51	$1,544.52	$1,960.56	N/A
C	**Self + 2 or more dependents under 65**	$2,827.86	$2,379.28	$1,776.09	$1,690.21	$2,115.15	$2,098.04	$2,112.79	$2,493.97	N/A
D	**Self + 1 dependent enrolled in Medicare Parts A & B**	$1,161.72	$858.26	$516.58	$661.64	$925.82	$535.50	$1,523.03	$1,960.56	N/A
E	**Self + 1 dependent enrolled in Medicare Part B**	$1,615.62	$1,202.02	$758.39	$973.64	$1,580.11	$1,288.51	N/A	N/A	N/A
3	Retiree Over Age 65 and Enrolled in Medicare Part B Only									
A	**Self only**	$1,034.76	$772.89	$500.10	$642.82	$1,117.20	$1,016.86	N/A	N/A	N/A
B	**Self + 1 dependent under 65**	$2,422.34	$1,977.17	$1,437.39	$1,385.66	$2,424.34	$2,037.62	N/A	N/A	N/A
C	**Self + 2 or more dependents under 65**	$3,281.76	$2,723.04	$2,017.90	$2,002.21	$2,769.45	$2,847.15	N/A	N/A	N/A
D	**Self + 1 dependent enrolled in Medicare Parts A & B**	$1,615.62	$1,202.02	$758.39	$973.64	$1,580.11	$1,288.51	N/A	N/A	N/A
E	**Self + 1 dependent enrolled in Medicare Part B**	$2,069.52	$1,545.78	$1,000.20	$1,285.64	$2,234.40	$2,037.62	N/A	N/A	N/A

[1] The rates are subject to the approval of the Board of Water and Power Commissioners.

[2] The Medicare rates through UnitedHealthcare Medicare Advantage renew on a calendar-year basis, not a plan-year basis. As a result, those retirees enrolled in a Medicare tier will receive a rate adjustment on January 1, 2017.

[3] Retirees must be enrolled in Anthem Blue Cross or Guardian Dental prior to retirement to participate in the plan.

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RETIREE HEALTH PLAN SUBSIDY CHART

Rates are effective July 1, 2016 through June 30, 2017.[1]

Tier 2 retirees (employees who were hired on or after January 1, 2014) should call the LADWP Health Plans Administration Office at **(213) 367-2023** or **(800) 831-4778** for Tier 2 health and dental rates and subsidy information.

YEARS OF SERVICE	AGE AT RETIREMENT														
	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69
9 years or less	Minimum subsidy is $30.32														
10	$297.14	$302.48	$307.98	$313.33	$318.68	$324.18	$329.52	$335.02	$340.37	$345.72	$351.21	$356.56	$361.91	$367.41	$372.76
11	$356.56	$363.10	$369.49	$376.03	$382.41	$388.95	$395.49	$402.03	$408.41	$414.95	$421.34	$427.88	$434.41	$440.80	$447.34
12	$415.99	$423.57	$431.14	$438.72	$446.30	$453.88	$461.30	$468.88	$476.46	$484.03	$491.61	$499.19	$506.77	$514.34	$521.92
13	$475.42	$484.03	$492.65	$501.27	$510.03	$518.65	$527.27	$535.88	$544.65	$553.27	$561.88	$570.50	$579.12	$587.74	$596.35
14	$534.84	$544.65	$554.31	$563.96	$573.77	$583.43	$593.23	$602.89	$612.69	$622.35	$632.01	$641.81	$651.62	$661.28	$670.93
15	$594.27	$605.12	$615.96	$626.66	$637.51	$648.35	$659.05	$669.89	$680.74	$691.44	$702.28	$713.13	$723.97	$734.82	$745.51
16	$653.70	$665.58	$677.47	$689.36	$701.24	$713.13	$725.01	$736.90	$748.78	$760.67	$772.55	$784.44	$796.32	$808.21	$820.10
17	$713.13	$726.05	$739.13	$752.05	$764.98	$777.90	$790.98	$803.90	$816.83	$829.75	$842.83	$855.75	$868.68	$881.75	$894.68
18	$772.55	$786.67	$800.63	$814.60	$828.71	$842.83	$856.79	$870.91	$885.02	$898.98	$912.95	$927.06	$941.18	$955.14	$969.11
19	$831.98	$847.13	$862.29	$877.29	$892.45	$907.60	$922.76	$937.91	$953.06	$968.07	$983.22	$998.38	$1,013.53	$1,028.68	$1,043.69
20	$891.41	$907.60	$923.80	$939.99	$956.18	$972.38	$988.72	$1,004.91	$1,021.11	$1,037.30	$1,053.50	$1,069.69	$1,085.88	$1,102.08	$1,118.27
21	$950.84	$968.07	$985.45	$1,002.69	$1,019.92	$1,037.30	$1,054.54	$1,071.92	$1,089.15	$1,106.39	$1,123.77	$1,141.00	$1,158.24	$1,175.62	$1,192.85
22	$1,010.26	$1,028.68	$1,047.11	$1,065.38	$1,083.65	$1,102.08	$1,120.50	$1,138.92	$1,157.20	$1,175.47	$1,193.89	$1,212.31	$1,230.74	$1,249.16	$1,267.43
23	$1,069.69	$1,089.15	$1,108.61	$1,127.93	$1,147.39	$1,166.85	$1,186.46	$1,205.93	$1,225.39	$1,244.70	$1,264.17	$1,283.63	$1,303.09	$1,322.55	$1,341.87
24	$1,129.12	$1,149.62	$1,170.27	$1,190.62	$1,211.27	$1,231.78	$1,252.28	$1,272.78	$1,293.43	$1,313.79	$1,334.44	$1,354.94	$1,375.44	$1,396.09	$1,416.45
25	$1,188.54	$1,210.23	$1,231.78	$1,253.32	$1,275.01	$1,296.55	$1,318.24	$1,339.79	$1,361.48	$1,383.02	$1,404.56	$1,426.25	$1,447.94	$1,469.49	$1,485.68
26	$1,247.97	$1,270.70	$1,293.43	$1,316.02	$1,338.75	$1,361.48	$1,384.06	$1,406.79	$1,429.52	$1,452.10	$1,474.83	$1,485.68	$1,485.68	$1,485.68	
27	$1,307.40	$1,331.17	$1,354.94	$1,378.71	$1,402.48	$1,426.25	$1,450.02	$1,473.79	$1,485.68	$1,485.68	$1,485.68				
28	$1,366.83	$1,391.64	$1,416.60	$1,441.26	$1,466.22	$1,485.68	$1,485.68	$1,485.68							
29	$1,426.25	$1,452.25	$1,478.10	$1,485.68	$1,485.68										
30	$1,485.68	$1,485.68	$1,485.68												

There are additional rates that are not listed on this chart; contact the LADWP Health Plans Administration Office for those rates, if needed. The maximum subsidy is **$1,485.68**.

[1] *The rates are subject to the approval of the Board of Water and Power Commissioners.*

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RETIREE HEALTH PLAN SUBSIDY CHART FOR RETIRED EMPLOYEES UNDER AGE 55

Rates are effective July 1, 2016 through June 30, 2017.

YEARS OF SERVICE	AGE AT RETIREMENT						
	48	49	50	51	52	53	54
14 years or less	Minimum subsidy is $30.32						
15							
16							
17							$30.75
18			$30.84	$31.46	$32.08	$32.69	$33.31
19	$31.89	$32.56	$33.21	$33.88	$34.55	$35.21	$35.87
20	$34.17	$34.88	$35.59	$36.30	$37.01	$37.73	$38.44
21	$36.44	$37.21	$37.96	$38.72	$39.48	$40.24	$41.00
22	$38.72	$39.53	$40.33	$41.14	$41.95	$42.75	$43.56
23	$41.00	$41.85	$42.71	$43.56	$44.42	$45.27	$46.12
24	$43.28	$44.18	$45.08	$45.98	$46.89	$47.78	$48.69
25	$45.56	$46.51	$47.45	$48.40	$49.36	$50.30	$51.25
26	$47.83	$48.83	$49.83	$50.82	$51.82	$52.82	$53.81
27	$50.11	$51.16	$52.20	$53.24	$54.29	$55.33	$56.37
28	$52.39	$53.48	$54.57	$55.66	$56.76	$57.84	$58.94
29	$54.67	$55.81	$56.94	$58.08	$59.22	$60.36	$61.50
30	$56.94	$58.13	$59.31	$60.50	$61.69	$62.87	$64.06
31	$59.22	$60.46	$61.68	$62.92	$64.16	$65.39	$66.62
32	$61.50	$62.78	$64.06	$65.34	$66.62	$67.91	$69.19
33	$63.78	$65.11	$66.43	$67.76	$69.09	$70.42	
34	$66.06	$67.44	$68.80	$70.18			
35	$68.33	$69.76					
36	$70.61						

If years of service equal 37 or more, the maximum contribution is **$71.18**.

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RETIREE DENTAL PLAN RATE CHARTS FOR 2016 - 2017

Rates are effective July 1, 2016 through June 30, 2017.[1]

COVERAGE SELECTED	UNITED CONCORDIA PREFERRED DENTAL PLAN (PPO)			UNITED CONCORDIA PLUS DENTAL PLAN (DHMO)		
Retirees	Total Premium	LADWP Subsidy	Monthly Deduction	Total Premium	LADWP Subsidy	Monthly Deduction
Retiree only	$36.61	$36.61	$0.00	$18.35	$18.35	$0.00
Retiree + 1 eligible dependent	$69.35	$36.61	$32.74	$27.53	$18.35	$9.18
Retiree + 2 or more eligible dependents	$117.91	$36.61	$81.30	$37.19	$18.35	$18.84

COVERAGE SELECTED	GUARDIAN DENTAL PLAN (PPO) (LOCAL 18)[2]			GUARDIAN DENTAL PLAN (DHMO) (LOCAL 18)[2]		
Retirees	Total Premium	LADWP Subsidy	Monthly Deduction	Total Premium	LADWP Subsidy	Monthly Deduction
Retiree only	$126.77	$126.77	$0.00	$126.77	$126.77	$0.00
Retiree + 1 eligible dependent	$126.77	$126.77	$0.00	$126.77	$126.77	$0.00
Retiree + 2 or more eligible dependents	$126.77	$126.77	$0.00	$126.77	$126.77	$0.00

[1] The rates are subject to the approval of the Board of Water and Power Commissioners.

[2] Retirees must be enrolled in a IBEW Local 18-sponsored dental plan prior to retirement to participate in a Local 18-sponsored dental plan in retirement.

Please Note: Eligible spouses and surviving dependents are not eligible for LADWP Dental Plan Subsidy for either an LADWP or IBEW Local 18-sponsored plan.

Medicare

This section explains the different Medicare plans and how they relate to your LADWP-sponsored or IBEW Local 18-sponsored health plans.

MAINTAINING LADWP-SPONSORED OR IBEW LOCAL 18-SPONSORED HEALTH COVERAGE

If you are retired and age 65 or over, and you (and your spouse age 65 or older) would like to continue your LADWP-sponsored or IBEW Local 18-sponsored health plan, you must follow these steps:

IF YOU'RE ENROLLED IN...	WHAT IT IS	WHAT TO DO TO KEEP YOUR LADWP-SPONSORED OR IBEW LOCAL 18-SPONSORED HEALTH COVERAGE	IMPORTANT THINGS TO REMEMBER
Medicare Part B	Medical Insurance	• Present proof of enrollment in Medicare Part B to the LADWP Health Plans Administration Office • Complete the Medicare application for the following plans: - Kaiser Senior Advantage - UnitedHealthcare Medicare Advantage - Health Plan of Nevada Senior Dimensions	It is necessary to file this proof of Medicare Part B coverage and provide proof prior to reaching age 65 to avoid cancellation of your LADWP-sponsored health plan
Medicare Parts A and B	Hospital and Medical Insurance	**LADWP-sponsored plans:** Submit a copy of your Medicare card and complete the Medicare application for the following plans: • Kaiser Senior Advantage • UnitedHealthcare Medicare Advantage • Health Plan of Nevada Senior Dimensions **IBEW Local 18-sponsored plans:** • Must submit a copy of your Medicare card to maintain coverage in IBEW Local 18-sponsored Anthem Blue Cross HMO and PPO plans	• LADWP requires that you enroll in Medicare Part B only • LADWP does not recommend that you enroll in Medicare Part A, unless it is premium free • Provide proof of Medicare to LADWP Health Plans Administration Office • IBEW Local 18-sponsored HMO and PPO Plans require Medicare Parts A and B
Medicare Part D	Prescription Drug Coverage	If you're enrolled in an LADWP-sponsored medical plan, your prescription drug coverage is an enhanced Medicare Part D Prescription Drug Plan. The plan benefits offered through LADWP or IBEW Local 18 are better than most Part D plans available to Medicare-eligible individuals. You should not enroll in an Individual Medicare Prescription Drug Plan on your own. **RETIREES WHO RECEIVE A BILL FOR A PREMIUM SURCHARGE FOR MEDICARE PART D ARE RESPONSIBLE TO PAY THE PREMIUM SURCHARGE; FAILURE TO PAY WILL RESULT IN A LOSS OF COVERAGE**	If you enroll in a Medicare Part D plan on your own, you will lose your LADWP-sponsored or IBEW Local 18-sponsored prescription drug and medical coverage as well as your LADWP subsidy

PROVIDING PROOF OF MEDICARE COVERAGE

Proof of Medicare coverage must be provided in the form of:

- Copy of Medicare Card
- Copy of Awards Letter

It is your responsibility to inform the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center of any change of Medicare status by submitting proof from the Centers for Medicare and Medicaid Services (CMS).

MEDICARE PART A (HOSPITAL INSURANCE)

Medicare Part A (hospital insurance) covers some inpatient hospital care and limited care in a skilled nursing facility. To be eligible for Medicare Part A with no premium rate, you must:

- Have satisfied the federal requirements for work covered by Social Security (accrued at least 40 quarters of credits with Social Security),
- Be a citizen or permanent resident of the United States, and
- Have a current domestic address (no P.O. Box).

You can receive Part A at age 65 if you are already receiving retirement benefits from Social Security or the Railroad Retirement Board. Persons who qualify for a monthly Social Security check are automatically enrolled in Medicare Part A.

PLEASE NOTE:

LADWP does not pay for Medicare Part A.

PLEASE NOTE

With LADWP's UnitedHealthcare Medicare Advantage HMO plan (with Medicare Part B only), the Health Plan of Nevada (with Medicare Part B only) and the UnitedHealthcare PPO Plan, Medicare is primary and your LADWP sponsored health plan is secondary. For Kaiser, UnitedHealthcare, and Health Plan of Nevada, once you provide the LADWP Health Plans Administration Office with your Medicare information, you cannot use Medicare on its own. Using Medicare on its own will cause your LADWP-sponsored health plan to be terminated.

If you or your spouse have Medicare Part A only or Part B only, then you must file your medical claim (for facility services or physician services, respectively) with Medicare first. Once you or your provider (facility or physician) have received the Medicare Explanation of Benefits (EOB), the claim and the EOB must be submitted to UnitedHealthcare or Health Plan of Nevada for secondary payment. The Medicare EOB is required in order for UnitedHealthcare or Health Plan of Nevada to process the claim as secondary. This does not apply if you enrolled in an HMO plan with both Medicare Parts A and B.

For more information on the health plans available to retirees, see page 28.

MEDICARE PART B (MEDICAL INSURANCE)

All retirees and dependent spouse(s) age 65 and over, or otherwise eligible for Medicare Part B, must be enrolled in Medicare Part B to remain in an LADWP-sponsored health plan.

Medicare Part B (medical insurance) covers medical and surgical services provided by a physician, diagnostic X-ray and laboratory tests, outpatient hospital services, ambulance transportation, prosthetic devices, medical equipment, and other services. Medicare Part B pays 80% of the allowable charges after the annual deductible (currently $166) has been met. See your Medicare handbook or contact your local Social Security office for information regarding Medicare coverage.

You are eligible for Medicare Part B if:

- You are a United States resident, a U.S. citizen, or an alien admitted for permanent residence with at least five years' residency
- You also must have a current domestic address (no P.O. Box)

You must contact your local Social Security office to enroll in Medicare Part B. The standard monthly premium for Medicare Part B is currently $121.80.

Paying for Your Medicare Part B Premiums

	HOW MEDICARE PART B PREMIUMS ARE PAID	HOW TO GET REIMBURSED FOR YOUR MEDICARE PART B PREMIUMS
If you receive a Social Security check	Medicare Part B premiums are automatically deducted from your Social Security check	If you are eligible to be reimbursed by LADWP for your Medicare Part B premium: • It is your responsibility to request reimbursement at the time of eligibility by completing a deduction authorization form and submitting the required documents (copy of Medicare Card and Awards letter) • Reimbursement will begin the first of the following month after LADWP Health Plans Administration Office receives your request and supporting documents. **LADWP will not reimburse retroactively**
If you *do not* receive a Social Security check	You may make arrangements in writing to have LADWP pay Medicare Part B premiums directly to the Center for Medicare and Medicaid Services (CMS) for you or your spouse by completing a deduction authorization form and submitting the original Notice of Premium Payment Due	To make group payment arrangements you must: • Provide LADWP with the original Notice of Premium Payment Due from Medicare as soon as you receive it, and mail it to: LADWP Health Plans Administration Office, Room 564 P.O. Box 51111 Los Angeles, CA 90051-0100 • You must request to be enrolled in group payment by completing a deduction authorization form and submitting the Notice of Premium Payment Due The Notice of Premium Payment Due must be submitted before the due date. Failure to do so will result in termination of your Medicare and health plan coverage. LADWP will not pay retroactively

PLEASE NOTE

It is important that you verify eligibility with the LADWP Health Plans Administration Office and confirm that your request has been received.

REIMBURSEMENT OF MEDICARE PART B PREMIUMS

Reimbursement of Medicare Part B is not automatic; you must request it in writing by completing a deduction authorization form to the LADWP Health Plans Administration Office and submitting the required supporting document/s.

You and your spouse may be eligible for the LADWP's quarterly Medicare Part B reimbursement if you are:

- A retired employee (surviving and eligible spouses are not eligible for Medicare Part B reimbursements),
- Enrolled in Medicare Part B, and
- Receiving a monthly Social Security check, and
- Receiving an LADWP subsidy toward the cost of your health care plan that is equal to or greater than the cost of your health plan premium plus the cost of your Medicare Part B.

If you fail to request a Medicare Part B premium reimbursement, LADWP will not reimburse you retroactively. It is your responsibility to request reimbursement in writing at the time you become eligible by completing a deduction authorization form and submitting the required supporting document/s.

Reimbursement will begin the first of the following month after LADWP Health Plans Administration Office receives your request and supporting documents.

If you are currently enrolled in the Medicare B Reimbursement program, **benefit renewal is not automatic**. Therefore, you are required to provide LADWP Health Plans Administration with a copy of your Annual Award Letter from the Social Security Administration postmarked on or before 12/31 of each year to ensure your benefits continue. If not, your Medicare B Reimbursement benefit will be terminated. Documents received after 12/31 will be processed the following month after LADWP Health Plans Administration Office receives your documentation. **LADWP will not retroactively reimburse.**

MEDICARE PART B REIMBURSEMENT CHECKS

Medicare Part B reimbursement checks are mailed quarterly to eligible retirees. Dates are subject to change and checks are not guaranteed to be mailed by any certain date.

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). It requires our health plan to 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 submit them to Medicare.

If this information is not already on file with the LADWP Health Plans Administration Office, 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.

MEDICARE B REIMBURSEMENT REMINDERS

1. It is your responsibility to enroll in or request the LADWP to renew your Medicare B reimbursement. Annual Award Letters should be received in LADWP Health Plans Administration Office on or before 12/31 of each year to ensure continued benefits.
2. Income Related Monthly Adjustment Amount (IRMAA) — It is imperative that you and your spouse provide the annual IRMAA notification to LADWP Health Plans Administration Office by 12/31 of each year. Failure to do so will result in benefit termination.
3. LADWP will not make retroactive payments or reimbursements.

Medicare B Reimbursement eligibility is not guaranteed. Please check with LADWP Health Plans Administration Office to determine eligibility.

Any communications you receive from Social Security regarding you and/or your spouse's Medicare Part B premium should be faxed immediately to the LADWP Health Plans Administration office at **(213) 367-2078**. It is suggested that you confirm LADWP received all documents transmitted via fax.

GROUP PAYMENT

If you do not receive a Social Security check, you may request LADWP to pay your Medicare Part B premiums on behalf of you and your spouse. Please contact the LADWP Health Plans Administration Office to request the necessary form.

While LADWP continues its efforts to verify eligibility of your dependent(s), we must use your SSN for the process as required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We understand and handle retiree information according to those requirements, which is included as part of LADWP HIPAA Policies and Procedures, Group Health Plan Amendments.

IMPORTANT NOTICE FOR MEDICARE-ELIGIBLE RETIREES FROM LADWP ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it for your records. 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 a IBEW Local 18-sponsored medical plan, your current prescription drug coverage is not an enhanced Medicare Part D Prescription Drug Plan, however, it is "creditable coverage."

There are two important things you need to know about your current prescription drug coverage through LADWP-sponsored or IBEW Local 18-sponsored plans 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 LADWP-sponsored 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"
- When you have a choice in generic or brand-name prescription drugs, generic drugs are the more cost-effective option
- Remember, once you reach the "catastrophic coverage" level, your costs will go up
- The catastrophic coverage level is reached once a Medicare beneficiary spends $4,850 out of pocket for 2016. The member will pay $2.95 for generic, $7.40 for brand name, or 5%, whichever is greater

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. RETIREES ARE RESPONSIBLE FOR PAYING THE PREMIUM SURCHARGE FOR MEDICARE PART D. FAILURE TO PAY WILL RESULT IN LOSS OF COVERAGE.

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?

If you drop or lose your current prescription drug coverage with LADWP or IBEW Local 18 and don't join an individual Medicare drug plan within 63 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 percent 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 percent 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 ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact the office listed below for further information.

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 MORE INFORMATION 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 the 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 **(800) 772-1213; TTY, (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 2016

Name of Entity/Sender: Los Angeles Department of Water & Power

Contact–Position/Office: LADWP Health Plans Administration Office

Address: 111 N. Hope Street, Room 564
Los Angeles, CA 90012

Phone Number: (800) 831-4778 or **(213) 367-2023**

Health Plans

LADWP offers a variety of health plans to light the path for you to reach your health goals. Everyone has unique health care needs, which is why you have many options to consider. We encourage you to explore each plan, so you can make an illuminated choice when selecting the plan that best meets your needs.

LADWP-sponsored Plans

- UnitedHealthcare PPO Plan A
- UnitedHealthcare PPO Plan B
- UnitedHealthcare PPO Plan C
- Kaiser/Senior Advantage HMO
- UnitedHealthcare Medicare Advantage HMO (formerly Secure Horizons)
- Health Plan of Nevada/HPN Senior Dimensions HMO

If you are an eligible retiree living overseas on a full-time basis and maintain a U.S. address, you will be enrolled in UnitedHealthcare Option A Pre-65 Plan.

IBEW Local 18-sponsored Plans

- Anthem Blue Cross HMO Plan
- Anthem Blue Cross PPO Plan
- Anthem Blue Cross Prudent Buyer Plan (Owens Valley retirees only, under 65)

MORE ABOUT HMO PLANS

An HMO, or health maintenance organization, provides health care through a network of doctors, hospitals and other health care providers.

- If you enroll in an HMO, you must use providers within the HMO's network (except in an emergency)
  - You can locate an in-network provider in your area on your HMO's website
  - If your covered 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 a dependent is set up under Guest Membership
- You pay a co-pay amount for your services
  - Be sure to verify with your health care provider if he/she is in your specific HMO network
  - Providers file claims for you

MORE ABOUT PPO PLANS

A preferred provider organization (PPO) is a network of doctors, hospitals and other health care providers that have agreed to offer quality medical care and services at discounted rates.

- If you enroll in a PPO, you may use any provider to receive care, however, benefits are paid at the highest level when you use a provider in your PPO network
- You are responsible for all eligible health expenses until you reach your annual deductible
- After you meet the deductible, you pay a percentage of the covered expense; this is called a coinsurance amount and it counts toward your annual out-of-pocket maximum
- You may be responsible for paying a fixed co-pay for certain provider visits; co-pays do not count toward your deductible

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.

You can compare coverage of the various plans in the comparison charts on pages 34-57 of this guide.

YOU CAN HELP CONTROL YOUR HEALTH PLAN EXPENSES:

- **Use in-network providers if you enroll in a PPO.** This allows both you and LADWP to share in the benefit of lower contracted rates for services
- **Choose the most appropriate level of care for services.** For example, only use the emergency room for true emergencies. Using urgent care for non-emergencies helps keep the increase of health care costs to a minimum
- **Purchase generic drugs.** When you have a choice in generic or brand-name prescription drugs, generic drugs are the more cost-effective option
- **Lead a healthy lifestyle.** When you exercise, eat right and avoid unhealthy behaviors like tobacco use, your need for medical care and the expense of such care is much less
- **Use Wellness Resources.** See pages 30-31 for a variety of Wellness Resources offered through the health and dental carriers.

Wellness Resources

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

As a retiree, when you actively engage in healthy behaviors you can live a longer, higher-quality life. LADWP is committed to providing resources that will help you and your covered family members find the healthy opportunities around us. 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 PLANS

UnitedHealthcare HMO Medicare Advantage

www.myuhc.com and
www.uhcretiree.com

SilverSneakers® Fitness Program

This program is especially designed to help our retirees stay physically fit and active. The program is available at no cost to you when you enroll in a UnitedHealthcare HMO Medicare Advantage plan with Medicare A and B. Some of the features include:

- A basic fitness membership at more than 11,000 participating locations
- Access to all amenities, programs and services of a basic membership
- Nationwide access to any participating fitness location (find them at www.silversneakers.com)
- Many women-only locations, including Curves®

If the nearest facility is 15 miles or more from your home, you can register for the SilverSneakers Steps program. You'll receive personalized fitness tools, including resistance bands, exercise DVDs and "how to" materials to help you measure, track and increase your daily activities.

Other UHC wellness programs include:

- **Online health tracker tools** – To help you monitor physical activities
- **Online coaching programs** – To help you monitor ongoing conditions
- **Online health library** – To find health and wellness information
- **www.UHCTV.com** – To find videos on healthy recipes, coaching to help manage ongoing conditions like diabetes or high cholesterol, exercise tips and more

Kaiser

www.kp.org

- **My Health Manager** – Use it from your desktop, smartphone or tablet to manage your care at Kaiser facilities, including lab test results, prescription refills or scheduling appointments
- **Healthy lifestyle programs** – Online resources to help you get or stay active or take personal action to get in good health. Resources include a total health assessment, tools to quit smoking, stress management, weight loss and more
- **Good Health on the Go** – An app for your smartphone or tablet that helps you manage your Kaiser care and includes fun programs like "Every Body Walk!" to create a

daily walking routine. You can also find wellness-related videos and podcasts

- **Wellness coaches** – You can get extra support to help you make healthy changes. At no cost, your coach works with you one-on-one to set goals and find the tools and resources you need to support you. Coaching is available in English and Spanish. Call **(866) 862-4295** to get started, Monday through Friday, 6 a.m. to 7 p.m.
- **Farmers market** – Makes eating well easier with fresh foods. You can pick up fresh fruits and veggies at Kaiser facilities or schedule them to be delivered to your home. You can also find healthy recipes and cooking tips
- **Complimentary health** – Receive discounts on services such as massage therapy and acupuncture to take care of your body, mind and spirit

United Concordia

www.unitedconcordia.com

- **Online nutrition resources** – Including the right foods to build strong teeth
- **Tips to care for your teeth, gums and lips** – Including the right brushing and flossing techniques
- **My Dental Assessment** – This online tool helps identify oral health risks and shows how your lifestyle factors and medical conditions impact the health of the mouth
- **Chomper Chum**s – Free app to make brushing fun for kids. Download it today

IBEW LOCAL 18-SPONSORED PLANS

Anthem Blue Cross

www.Anthem.com/ca/ibewlocal18

- **Online health resources** – Including resources and videos to target specific health groups such as children, women, men and seniors

30

Minutes

Did you know walking 30 minutes a day, five days a week can bring down blood pressure, strengthen your heart and reduce stress?

— American Heart Association

- **24/7 NurseLine** – To help you find quick answers to health questions anytime day or night
- **Online access to plan information** – To help you understand your plan benefits, the status of a claim, etc.
- **Health and fitness discounts**
- **Health Rewards**
- **360° Health Programs**
- **MyHealth@Anthem**
- **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.

Guardian Dental

www.GuardianAnytime.com

- **Online resources** – To understand your dental benefits, look up the status of a claim, find forms and plan materials, and estimate your dental costs
- **Provider app** – To download to your smartphone or tablet to find a provider anytime you need to

Prescription Drugs

When the waters get rough, you need a safe harbor and peace of mind. LADWP-sponsored and IBEW Local 18-sponsored plans offer prescription drug coverage as a part of the health plan to help you get the prescription drug therapy you need to treat an infection or manage a chronic condition.

HOW YOUR PRESCRIPTION COVERAGE WORKS

Your prescription drug coverage varies based on the health plan in which you enroll. 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.

Once you select a plan, you can learn more about your options for filling your prescriptions from the provider's website. **Highlights of the prescription drug plans are listed starting on page 34 of this guide in the health plan comparison charts.**

You should not enroll in an Individual Medicare Part D Prescription Drug Plan if you are enrolled in an LADWP or IBEW Local 18-sponsored health plan. The prescription drug coverage in LADWP and IBEW Local 18-sponsored health plans is better than most Medicare Part D plans available to Medicare-eligible individuals.

If you enroll in a Medicare Part D plan on your own, you will lose your LADWP-sponsored or IBEW Local 18-sponsored prescription drug and medical coverage as well as your LADWP subsidy.

Retirees who receive a Notice of Premium Due billing notice for a premium surcharge for Medicare Part D are responsible for paying the premium surcharge. Failure to pay the surcharge amount on the billing notice will result in a loss of coverage. LADWP does not pay the Medicare Part D premium surcharge.

Dental Plans

Make your smile carefree when you enroll in an LADWP-sponsored or IBEW Local 18-sponsored dental plan. Both offer a choice of dental plans to keep your teeth healthy and strong.

LADWP-sponsored Plans

- The United Concordia Plus Dental Plan (DHMO)
- The United Concordia Preferred Dental Plan (PPO)

IBEW Local 18-sponsored Plans

- Guardian PPO
- Guardian DHMO

Like the health plans, you have PPO and DHMO options.

DHMO	PPO
A DHMO, or dental health maintenance organization, requires that you use the plan's dentists, unless emergency care is required outside the plan's service area.	A dental 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.

All plans offer 100 percent coverage for diagnostic and preventive services.
You can find a comparison of the dental plans on page 56 of this guide.

IMPORTANT THINGS TO REMEMBER

If you have Delta Dental coverage when you retire, you must choose a new plan in order to continue your dental coverage. If you do not change plans, you will not be able to enroll in a new dental plan until the next Open Enrollment period.

You can only elect IBEW Local 18-sponsored health and dental retirement plans if you were enrolled in IBEW Local 18-sponsored health and dental plans prior to retirement.

LADWP Health Plan Comparison Charts

UNITEDHEALTHCARE PPO PLAN A

For retirees under age 65 or with Medicare Part B only.

NOTE: Benefits are coordinated with Medicare for retirees. Medicare benefits will be considered primary for any eligible retiree (and/or covered spouse or domestic partner) who is age 65 or over.

BENEFIT COMPARISON	RESIDE WITHIN PPO[1] AREA[2]	
	PPO	Non-PPO
Choice of physician and hospital • Physician	PPO Only	Any[3]
• Hospital	Member hospital only	Any[3]
General information • Annual deductible	None	$200/individual; $400/family
• Annual out-of-pocket maximum	$1,000/individual; $2,000/family	$3,000/individual; $6,000/family
Prescription drugs (30-day supply; no deductible) • Tier 1	$5; prescribed drugs must be purchased at participating pharmacies	$5
• Tier 2	$10; prescribed drugs must be purchased at participating pharmacies	$10
• Tier 3	$10; prescribed drugs must be purchased at participating pharmacies	$10
• Mail order (for maintenance prescriptions)	$10 per prescription for 90-day supply of Tier 1 drugs; $20 per prescription for 90-day supply of Tier 2 or 3 drugs	
Hospital services • Semi-private room and board	Covered at 90%[4]	Covered at 60%
• Miscellaneous charges	Covered at 90%[4]	Covered at 60%
• Ambulance services	Covered at 90%	Covered at 90%
Physician services • Surgery	Covered at 90%	Covered at 60%
• Physician visits (office)	$10 co-pay; co-pay waived for members in Medicare	Covered at 60%
• Physical therapy	$10 co-pay	Covered at 60%
X-ray & lab services (some services may require preauthorization by UnitedHealthcare)	Covered at 90%	Covered at 60%
Accident/emergency care (life-threatening)	$25 co-pay; co-pay waived if admitted directly to the hospital	$25 co-pay; co-pay waived if admitted directly to the hospital

[1] PPO—Preferred Provider Organization.

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

[3] Any—The licensed personal physician or hospital of your choice.

[4] Hospital-based physicians (e.g., anesthesiologists, radiologists, pathologists, etc.) at a PPO hospital may not be in the PPO network. In order to assure PPO benefits for eligible physician charges, confirm that the physicians attending you while you are in the hospital are part of the PPO network.

UNITEDHEALTHCARE PPO PLAN A COMPARISON CHART CONTINUED

BENEFIT COMPARISON	RESIDE WITHIN PPO[1] AREA[2]	
	PPO	Non-PPO
Preventive health services • Preventive examination (no deductible)	Covered at 100%	Not covered
• Vision/hearing exam	$10 co-pay; one exam every two years	Not covered
• Well-baby care	Covered at 100%	Not covered
Mental health care[5] • Outpatient office visits (30 visits per calendar year for non-severe mental health combined with substance abuse)	$10 co-pay	Covered at 60%
• Inpatient (non-emergency inpatient mental health requires preauthorization or else subject to the plan paying only 50% of the benefit or not at all)	Covered at 90%	Covered at 60%
Alcohol and substance abuse[5] • Outpatient	$10 co-pay	Covered at 60%
• Inpatient	Covered at 90%	Covered at 60%
Home medical equipment • Durable medical equipment (maximum $2,500 per calendar year)	Covered at 90%	Covered at 60%
• Prosthetics/orthotics (no maximum; equipment/ devices only)	Covered at 90%	Covered at 60%
Skilled nursing	Covered at 90%; up to 60 days/ calendar year. **Custodial care is not covered**	Covered at 60%; up to 60 days/ calendar year. **Custodial care is not covered**
Home health care/ home infusion care	Covered at 90%, but only if approved by UnitedHealthcare; maximum of 100 visits/year	Covered at 60%; maximum of 100 visits/year
Hospice care	Covered at 90%; preauthorization by UnitedHealthcare required	Covered at 60%
Acupuncture services (20 treatments per year)	$10 co-pay	Covered at 60% after deductible has been met
Manipulative treatments (chiropractor; 24 visits)	$10 co-pay	Covered at 60% after deductible has been met

[5] *Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the United Behavioral Health (UBH) Participating Providers and Non-Participating Providers. Inpatient services for medical acute detoxification are accessed through UnitedHealthcare.*

UNITEDHEALTHCARE PPO PLAN B

For retirees under age 65 or with Medicare Part B only.

NOTE: Benefits are coordinated with Medicare for retirees. Medicare benefits will be considered primary for any eligible retiree (and/or covered spouse or domestic partner) who is age 65 or over.

BENEFIT COMPARISON	RESIDE WITHIN PPO[1] AREA[5]	
	PPO	Non-PPO
Choice of physician and hospital • Physician	PPO Only	Any[2]
• Hospital	Member hospital only	Any[2]
General information • Annual deductible	$250/individual; $500/family	$500/individual; $1,000/family
• Annual out-of-pocket maximum	$2,000/individual; $4,000/family	$5,000/individual; $10,000/family
Prescription drugs (30-day supply; no deductible) • Tier 1	$10	$10
• Tier 2	$20	$20
• Tier 3	$20	$20
• Mail order (for maintenance prescriptions)	$20 per prescription for 90-day supply of Tier 1 drugs; $40 per prescription for 90-day supply of Tier 2 or 3 drugs	
Hospital services • Semi-private room and board	Covered at 90%; no deductible[3]	Covered at 60%
• Miscellaneous charges	Covered at 90%[3]	Covered at 60%
• Ambulance services	Covered at 90%	Covered at 90%
Physician services • Surgery	Covered at 90%	Covered at 60%
• Physician visits (office)	$10 co-pay	Covered at 60%
• Physical therapy	$10 co-pay	Covered at 60%
X-ray and lab services (some services may require preauthorization by UnitedHealthcare)	Covered at 90%	Covered at 60%
Accident/emergency care[4] (life-threatening)	$25 co-pay; co-pay waived if admitted directly to the hospital	$25 co-pay; co-pay waived if admitted directly to the hospital
Preventive health services • Preventive examination	Covered at 100%	Not covered
• Vision	$10 co-pay; one exam every two years	Not covered
• Well-baby care	Covered at 100%	Not covered

[1] PPO—Preferred Provider Organization.

[2] Any—The licensed personal physician or hospital of your choice.

[3] Hospital-based physicians (e.g., anesthesiologists, radiologists, pathologists, etc.) at a PPO hospital may not be in the PPO network. In order to assure PPO benefits for eligible physician charges, confirm that the physicians attending you while you are in the hospital are part of the PPO network.

[4] If ER services are later determined to have been a non-emergency, plan pays 90% for PPO services and 60% for non-PPO services after you've met the deductible and, for PPO services, paid the $25 co-payment.

UNITEDHEALTHCARE PPO PLAN B COMPARISON CHART CONTINUED

BENEFIT COMPARISON	RESIDE WITHIN PPO[1] AREA[5]	
	PPO	Non-PPO
Mental health care[6] • Outpatient office visits	$10 co-pay	Covered at 60%
• Inpatient (Non-emergency inpatient mental health requires preauthorization or else subject to the plan paying only 50% of the benefit or not at all)	Covered at 90%	Covered at 60%
Alcohol and substance abuse[6] • Outpatient	$10 co-pay	Covered at 60%
• Inpatient	Covered at 90%	Covered at 60%
Home medical equipment • Durable medical equipment (maximum $2,500 per calendar year)	Covered at 90%	Covered at 60%
• Prosthetics/orthotics (no maximum; equipment/ devices only)	Covered at 90%	Covered at 60%
Skilled nursing	Covered at 90%; up to 60 days per calendar year. **Custodial care is not covered**	Covered at 60%; up to 60 days per calendar year. **Custodial care is not covered**
Home health care/ home infusion care	Covered at 90%, but only if approved by UnitedHealthcare; maximum of 100 visits/year	Covered at 60%; maximum of 100 visits/year
Hospice care	Covered at 90%; preauthorization by UnitedHealthcare required	Covered at 60%
Acupuncture services (20 treatments per year)	$10 co-pay	Covered at 60% after deductible has been met
Manipulative treatments (chiropractor; 20 visits)	$10 co-pay	Covered at 60% after deductible has been met

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

[6] *Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the United Behavioral Health (UBH) participating providers and non-participating providers. Inpatient services for medical acute detoxification are accessed through UnitedHealthcare.*

UNITEDHEALTHCARE PPO PLAN C

For retirees under age 65 or with Medicare Part B only.

NOTE: Benefits are coordinated with Medicare for retirees. Medicare benefits will be considered primary for any eligible retiree (and/or covered spouse or domestic partner) who is age 65 or over.

BENEFIT COMPARISON	RESIDE WITHIN PPO[1] AREA[5]	
	PPO	Non-PPO
Choice of physician and hospital • Physician	PPO only	Any[2]
• Hospital	Member hospital only	Any[2]
General information • Annual deductible	$2,000/individual; $4,000/family	
• Annual out-of-pocket maximum	$2,000/individual; $4,000/family	$10,000/individual; $20,000/family
Prescription drugs (Calendar-year brand-name drug deductible)	N/A	
• Retail (30-day supply) - Tier 1 - Tier 2 - Tier 3	 $15 $30 $45	 $15 $30 $45
• Mail order (up to 90-day supply) - Tier 1 - Tier 2 - Tier 3	 $30 $60 $90	 Not covered Not covered Not covered
Hospital services • Semi-private room and board	Covered at 80% after a $250 co-pay per admission	Covered at 60%
• Ambulance services	Covered at 80%	Covered at 80%
Physician services • Surgery	Covered at 80%	Covered at 60%
• Physician visits (office)	$10 co-pay	Covered at 60%
• Physical therapy	$10 co-pay	Covered at 60%
X-ray & lab services (some services may require preauthorization by UnitedHealthcare)	Covered at 80%	Covered at 60%
Accident/emergency care[4] (life-threatening)	$250 co-pay	$250 co-pay
Preventive health services • Preventive examination	Covered at 100%	Not covered
• Vision	$10 co-pay; one exam every two years	Not covered
• Well-baby care	Covered at 100%	Not covered

[1] *PPO—Preferred Provider Organization.*

[2] *Any—The licensed personal physician or hospital of your choice.*

[3] *Hospital-based physicians (e.g., anesthesiologists, radiologists, pathologists, etc.) at a PPO hospital may not be in the PPO network. In order to assure PPO benefits for eligible physician charges, confirm that the physicians attending you while you are in the hospital are part of the PPO network.*

[4] *If ER services do not result in direct admission, the calendar-year deductible does not apply.*

UNITEDHEALTHCARE PPO PLAN C COMPARISON CHART CONTINUED

BENEFIT COMPARISON	RESIDE WITHIN PPO[1] AREA[5]	
	PPO	Non-PPO
Mental health care[6] • Outpatient office visits	$10 co-pay	Covered at 60%
• Inpatient (non-emergency inpatient mental health requires preauthorization or else subject to the plan paying only 50% of the benefit or not at all)	Covered at 80% after a $250 co-pay per admission	Covered at 60%
Alcohol and substance abuse • Outpatient	$10 co-pay	Covered at 60%
• Inpatient	Covered at 80% after a $250 co-pay per admission	Covered at 60%
Home medical equipment • Durable medical equipment (maximum $2,500 per calendar year)	Covered at 80%	Covered at 60%; preservice notification required for equipment over $1,000
• Prosthetics/orthotics (no maximum; equipment/ devices only)	Covered at 80%	Covered at 60%
Skilled nursing (up to 100 preauthorized days per calendar year) • Freestanding facility	Covered at 80%	Covered at 80% with preauthorization
• Hospital facility	Covered at 80%	Covered at 60%
Home health care/ home infusion care	Covered at 80%; maximum of 100 visits/year	Covered at 60%; maximum of 100 visits/year
Hospice care	Covered at 80%	Covered at 60%
Acupuncture services (20 treatments per year)	$10 co-pay	Covered at 60% after deductible has been met
Manipulative treatments (chiropractor; 20 visits)	$10 co-pay	Covered at 60% after deductible has been met

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

[6] Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the United Behavioral Health (UBH) participating providers and non-participating providers. Inpatient services for medical acute detoxification are accessed through UnitedHealthcare.

KAISER

For retirees under age 65.

NOTE: Retirees with Medicare Parts A and B, see Senior Advantage benefits, **page 52**.

BENEFIT	COVERAGE
Physician and hospital	• Kaiser Permanente physicians and hospitals • Enrollees must reside within a Kaiser Permanente service area
Hospital	• Room and board covered at 100% • Miscellaneous expenses covered at 100% • Ambulance, if authorized, covered at 100%
Surgical	Covered at 100%, including the services of an assistant surgeon and anesthesiologist
Doctor visits	• In-hospital: Covered at 100% • Out-of-hospital: In the medical office, provided at $5 per visit. Home visits covered at 100% when part of a prescribed home care program
Nurse	• Special-duty: Covered at 100% when prescribed under hospital care • Home visits: Covered at 100% for prescribed visits (see plan brochure for details)
Physical therapy	Provided at a $5 co-payment, if prescribed. Covered at 100% for inpatient. Limited to short-term therapy
X-ray and lab	Covered at 100%
Prescription drugs (only FDA-approved drugs are covered)	• In-hospital: Included under hospital services; covered at 100% • Out-of-hospital: Closed formulary plan. Only prescribed drugs listed in the formulary will be covered, unless requested by physician. $5 per prescription for up to 100-day supply. Sexual dysfunction drugs covered at 50% coinsurance with a maximum dosage limit of 27 doses for 100-day supply
Extended care or skilled nursing facility	Covered at 100%; care prescribed by Kaiser Permanente doctors at designated facilities primarily engaged in providing care to inpatients who require skilled nursing care and related services, including room and board; general nursing care and related services, and physicians' services (up to 100 days per benefit period). **Custodial care is not covered**
Durable medical equipment	Covered at 100% if doctor prescribes medically necessary
Mental health care • Outpatient	$5 per visit
• Inpatient	No charge; includes charge for partial intense therapy
Eye examinations	No charge
Emergency care • Outside service area	$5 co-pay (waived if admitted); pays for necessary emergency medical care or hospitalization resulting from unforeseen illness or injury. Member must notify Kaiser within 24 hours of emergency
• Inside service area	$5 co-pay at Kaiser Permanente facilities; $5 co-pay at non-plan facilities is limited to cases of life-threatening emergency or where choice of facility is beyond your control or the control of your immediate family. See plan brochure for full description and limitations of emergency coverage. Co-pay is waived if admitted
Home health care	Covered at 100%, but only if you are confined to your home. Services include nurses, home health aides; medical social services; physical, occupational or speech therapy; and medical supplies as prescribed by a physician (see plan brochure for details)
Hospice care	Covered at 100%, but only if you are diagnosed as having a terminal illness with a life expectancy of six months or less. Benefits include nursing care; medical social services; physical, respiratory or occupational therapy; medical supplies; physician services; short-term inpatient care, including respite care and care for pain control; counseling; and bereavement services

UNITEDHEALTHCARE HMO

For retirees under age 65 or with Medicare Part B only.

NOTE: Retirees with Medicare Parts A and B, see UnitedHealthcare Medicare Advantage benefits, **page 54**.

BENEFIT	COVERAGE
Choice of physician	Physicians who are members of the plan's network
Choice of hospital	• Any licensed acute care general hospital selected and designated by a plan physician • Semi-private room and board covered at 100% • ICU, labor and delivery room covered at 100% • Ambulance services (land or air), as medically necessary, covered at 100%
Surgical	Covered at 100%, including services of assistant surgeon and anesthesiologist
Doctor visits	• In-hospital: Covered at 100% • Out-of-hospital: $3 co-pay per visit
Nurse	• Home health care visits by a licensed professional: $3 co-pay per visit • In-hospital skilled nursing care covered at 100%
Physical therapy • Inpatient	Covered at 100%
• Outpatient	$3 per office visit
X-ray and lab	Covered at 100%
Prescription drugs	• In-hospital: Drugs, anesthesia, medication and biologicals are covered at 100% • Out-of-hospital: $5 co-pay per 30-day supply from UnitedHealthcare formulary at participating pharmacies • Mail order: $5 co-pay for up to 90-day supply of maintenance medications may be obtained through mail order. For more information, call Member Services at **(800) 624-8822**
Extended care or skilled nursing facility	Skilled nursing care or convalescent care covered at 100% for up to 100 consecutive days from the first treatment per disability**. Custodial care is not covered**
Maternity	• Prenatal and postnatal care office visits: covered at 100%. • Hospital services, physician services, and delivery and newborn care: covered at 100%
Mental health care	• Covered at the medical plan co-payment • For more information, please refer to your UnitedHealthcare Behavioral Health Schedule of Benefits or call **(800) 999-9585**
Eye examinations	Eye exams at $3 co-pay per visit
Emergency care	$35 co-pay per emergency room visit; waived if admitted as an inpatient
Durable medical equipment	Provided at no charge and must be in accordance with DME formulary guidelines
Home health care	Covered at 100% if under a plan of treatment reviewed and approved by a contracting medical group physician. Services include nursing care; home health aide; physical, speech and occupational therapy; medical social services; and medical supplies and equipment
Hospice care • Inpatient	Paid in full; prognosis of life expectancy of one year or less
• Outpatient	Paid in full; prognosis of life expectancy of one year or less

HEALTH PLAN OF NEVADA (HPN)

For retirees under age 65 or with Medicare Part B only.

NOTE: Retirees with Medicare Parts A and B, see HPN Senior Dimensions benefits, **page 55**.

BENEFIT	COVERAGE
Choice of physician	HPN physicians; hospital services in any licensed acute care general hospital designated by an HPN physician. Enrollees must reside within the HPN service area
Hospital	• Semi-private room and board: Covered at 100% • Miscellaneous expenses: Covered at 100% • Ambulance: $50 per trip when medically necessary
Surgical	• Covered at 100% including the services of assistant surgeon • Anesthesia: $100 co-pay per surgery
Doctor visits	• In hospital: Covered at 100% • Out-of-hospital: $3 charge per office visit, $20 charge per house call when medically necessary
Nurse	• Special-duty: Covered at 100% when medically necessary and recommended by an HPN physician • Home visits: No charge for prescribed calls
Physical therapy • Inpatient	Covered at 100%
• Outpatient	$3 co-pay per visit
X-ray and lab	Routine X-ray and lab: Covered at 100%
Prescription drugs	• In-hospital: Included under miscellaneous hospital expenses • Out-of-hospital: - Retail: $7 co-pay for generic drugs in formulary; $15 co-pay for brand-name drugs in formulary when no generic available; $15 co-pay plus difference between generic and brand-name for brand-name in formulary when generic is available; $40 co-pay for brand-name not on formulary when no generic available; $40 co-pay plus difference between generic and brand-name for brand-name not in formulary when generic is available - Mail order (up to 90-day supply): $14 co-pay generic; $30 co-pay brand-name
Extended care or skilled nursing facility	Covered at 100% for up to 100 days when prescribed by an HPN physician. **Custodial care is not covered**
Maternity	Covered as any other disability
Mental health care • Outpatient care	• Individual therapy: $3 co-pay/per visit • Group therapy: $3 co-pay/per visit
• Inpatient care	Covered at 100%
Eye examinations	Provided only as part of an examination to diagnose an illness or injury to the eye
Emergency care outside of service area	• Outside Service Area: $25 co-pay, Physicians Services, $75 co-pay per emergency room visit (waived if admitted as inpatient). No charge for inpatient hospital service outside of the service area. $25 co-pay per office visit • Inside Service Area: $25 co-pay, Physicians Services, $75 co-pay per emergency room visit (waived if admitted as inpatient). No charge for inpatient hospital. $25 co-pay per office visit for non-plan physician
Urgent care	$15 per visit
Home health care	• Covered at 100%, but only if you are confined to your home • $20 co-pay for physician house calls. No charge for private-duty nursing and home care service
Hospice care	• Inpatient respite services limited to $1,500 per member/calendar year at no charge • Outpatient respite services limited to $1,000 per member/calendar year at no charge • Bereavement services limited to five group therapy sessions or maximum of $500, whichever is less. A $20 per visit co-pay is required
Preventive care	Covered at 100%

ANTHEM BLUE CROSS HMO AND PPO (FOR CURRENT IBEW LOCAL 18 RETIREES ONLY[1])

For retirees under age 65 and for retirees over age 65 with Medicare Parts A and B.

BENEFIT COMPARISON	ANTHEM BLUE CROSS HMO	ANTHEM BLUE CROSS PPO	
		In-Network	Out-of-Network[2]
Calendar year deductible	N/A	$250/individual; maximum of 3 separate deductibles/family	$1,000/individual; maximum of 3 separate deductibles/family
Annual out-of-pocket maximum[3]	$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%[4] $500/admission deductible applies if utilization review not obtained; waived for emergency admission
• Physician office visits	No co-pay	No co-pay; deductible waived	Covered at 60%
	Includes LiveHealth Online visits		
• Specialist office visits	No co-pay	$35 co-pay/visit; deductible waived	Covered at 60%
Hospital services	No co-pay	Covered at 80%	Covered at 60%
• Outpatient care	No co-pay	Covered at 80%	Covered at 60%
• 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%
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		

[1] If, as a retiree, you canceled your IBEW Local 18-sponsored medical plan, you are now able to re-enroll into a Local 18 plan.

[2] 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.

[3] 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.

[4] For PPO out-of-network, $500/admission deductible applies for non-Anthem Blue Cross PPO hospital or residential treatment center or ambulatory surgical center if utilization review not obtained; waived for emergency admission.

Retirees must be enrolled in Anthem Blue Cross or Guardian Dental prior to retirement to participate in the plan.

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

ANTHEM BLUE CROSS HMO AND PPO COMPARISON CHART CONTINUED

BENEFIT COMPARISON	ANTHEM BLUE CROSS HMO	ANTHEM BLUE CROSS PPO	
		In-Network	Out-of-Network[2]
Physical 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 per calendar year; visits combined with acupuncture	Covered at 100%	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 per calendar year; visits combined with chiropractic care	Covered at 100%	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	Limited to 100 days calendar/year	
	Limitation removed for Mental Health and Substance Abuse		
Prescription drugs • In-hospital	No co-pay	Covered under Hospital Services (ancillary)	
• Out-of-hospital - Retail (30-day supply)	$5 co-pay for generic; $10 for brand name	$5 co-pay for generic; $10 for brand name	$5 co-pay for generic $10 co-pay for brand-name plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount
- Mail order (90-day supply)	$10 co-pay for generic; $20 co-pay for brand name	$10 co-pay for generic; $20 co-pay for brand name	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.

[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 or ambulatory surgical center if utilization review not obtained; waived for emergency admission.

Retirees must be enrolled in Anthem Blue Cross or Guardian Dental prior to retirement to participate in the plan.

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

ANTHEM BLUE CROSS HMO AND PPO COMPARISON CHART CONTINUED

BENEFIT COMPARISON	ANTHEM BLUE CROSS HMO	ANTHEM BLUE CROSS PPO	
		In-Network	Out-of-Network[2]
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 • Outpatient	No co-pay	No co-pay; deductible waived	Covered at 60%
• Inpatient	No co-pay	Covered at 80%	Covered at 60%
Emergency care	No co-pay	Covered at 80%	Covered at 80%
		$100 deductible; waived if admitted	
Urgent care	No co-pay	$25 co-pay/visit; deductible waived	Covered at 60%
Body scan	One body scan for retiree and spouse/DP, every plan year, at any licensed body scan provider; $750 maximum payable per scan[4]		
Vision care	**PROVIDED BY VISION SERVICE PLAN (VSP)[5]**		
	In-Network		Out-of-Network (VSP covers)
• Exam	No co-pay; every 12 months	No co-pay; every 12 months	Up to $50
• Lenses	No co-pay; every 12 months	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; up to $130 plan allowance	No co-pay; every 12 months; up to $130 plan allowance	Up to $70
• Contact lenses (in lieu of glasses)	$120 allowance	$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] 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 or ambulatory surgical center if utilization review not obtained; waived for emergency admission.

[4] Body scan available to retirees and spouse/DP under age 65.

[5] Services provided through Vision Service Plan (VSP). See plan limitations and exclusions for full disclosure.

Retirees must be enrolled in Anthem Blue Cross or Guardian Dental prior to retirement to participate in the plan.

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

UNITEDHEALTHCARE PPO PLAN A

For retirees with Medicare Parts A and B.

NOTE: Benefits are coordinated with Medicare for retirees. Medicare benefits will be considered primary for any eligible retiree (and/or covered spouse or domestic partner) who is age 65 or over.

BENEFIT COMPARISON	RESIDE WITHIN PPO[1] AREA[2]	
	PPO	Non-PPO
Choice of physician and hospital • Physician	PPO Only	Any[3]
• Hospital	Member hospital only	Any[3]
General information • Annual deductible	None	$200/individual; $400/family
• Annual out-of-pocket maximum	$1,000/individual; $2,000/family	$3,000/individual; $6,000/family
Prescription drugs (30-day supply; no deductible) • Tier 1	$5; prescribed drugs must be purchased at participating pharmacies	$5
• Tier 2	$10; prescribed drugs must be purchased at participating pharmacies	$10
• Tier 3	$10; prescribed drugs must be purchased at participating pharmacies	$10
• Mail order (for maintenance prescriptions)	$10 per prescription for 90-day supply of Tier 1 drugs; $20 per prescription for 90-day supply of Tier 2 or 3 drugs	
Hospital services • Semi-private room and board	Covered at 90%[4]	Covered at 60%
• Miscellaneous charges	Covered at 90%[4]	Covered at 60%
• Ambulance services	Covered at 90%	Covered at 90%
Physician services • Surgery	Covered at 90%	Covered at 60%
• Physician visits (office)	Covered at 100%	Covered at 60%
• Physical therapy	$10 co-pay	Covered at 60%
X-ray and lab services (some services may require preauthorization by UnitedHealthcare)	Covered at 90%	Covered at 60%
Accident/emergency care[4] (life-threatening)	$25 co-pay; co-pay waived if admitted directly to the hospital	$25 co-pay; co-pay waived if admitted directly to the hospital

[1] *PPO—Preferred Provider Organization.*

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

[3] *Any—The licensed personal physician or hospital of your choice.*

[4] *Hospital-based physicians (e.g., anesthesiologists, radiologists, pathologists, etc.) at a PPO hospital may not be in the PPO network. In order to assure PPO benefits for eligible physician charges, confirm that the physicians attending you while you are in the hospital are part of the PPO network.*

UNITEDHEALTHCARE PPO PLAN A COMPARISON CHART CONTINUED

BENEFIT COMPARISON	RESIDE WITHIN PPO[1] AREA	
	PPO	Non-PPO
Preventive health services • Preventive examination (no deductible)	Covered at 100%	Not covered
• Vision/hearing exam	$10 co-pay; one exam every two years	Not covered
• Well-baby care	Covered at 100%	Not covered
Mental health care[5] • Outpatient office visits	$10 co-pay	Covered at 60%
• Inpatient (non-emergency inpatient mental health requires preauthorization or else subject to the plan paying only 50% of the benefit or not at all)	Covered at 90%	Covered at 60%
Alcohol and substance abuse[5] • Outpatient	$10 co-pay	Covered at 60%
• Inpatient	Covered at 90%	Covered at 60%
Home medical equipment • Durable medical equipment (maximum $2,500/calendar year)	Covered at 90%	Covered at 60%
• Prosthetics/orthotics (no maximum; equipment/ devices only)	Covered at 90%	Covered at 60%
Skilled nursing	Covered at 90%; up to 60 days/ calendar year. **Custodial care is not covered**	Covered at 60%; up to 60 days/ calendar year. **Custodial care is not covered**
Home health care/ home infusion care	Covered at 90%, but only if approved by UnitedHealthcare; maximum of 100 visits/year	Covered at 60%; maximum of 100 visits/year
Hospice care	Covered at 90%; preauthorization by UnitedHealthcare required	Covered at 60%
Acupuncture services (20 treatments per year)	$10 co-pay	Covered at 60% after deductible has been met
Manipulative treatments (chiropractor; 24 visits)	$10 co-pay	Covered at 60% after deductible has been met

[5] *Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the United Behavioral Health (UBH) participating providers and non-participating providers. Inpatient services for medical acute detoxification are accessed through UnitedHealthcare.*

UNITEDHEALTHCARE PPO PLAN B

For retirees with Medicare Parts A and B.

NOTE: Benefits are coordinated with Medicare for retirees. Medicare benefits will be considered primary for any eligible retiree (and/or covered spouse or domestic partner) who is age 65 or over.

BENEFIT COMPARISON	RESIDE WITHIN PPO[1] AREA[5]	
	PPO	Non-PPO
Choice of physician and hospital • Physician	PPO Only	Any[2]
• Hospital	Member hospital only	Any[2]
General information • Annual deductible	$250/individual; $500/family	$500/individual; $1,000/family
• Annual out-of-pocket maximum	$2,000/individual; $4,000/family	$5,000/individual; $10,000/family
Prescription drugs (30-day supply; no deductible) • Tier 1	$10; prescribed drugs must be purchased at participating pharmacies	$10
• Tier 2	$20; prescribed drugs must be purchased at participating pharmacies	$20
• Tier 3	$20	$20
• Mail order (for maintenance prescriptions)	$20 per prescription for 90-day supply of Tier 1 drugs; $40 per prescription for 90-day supply of Tier 2 or 3 drugs	
Hospital services • Semi-private room and board	90%; no deductible[3]	Covered at 60%
• Miscellaneous charges	Covered at 90%[3]	Covered at 60%
• Ambulance services	Covered at 80%	Covered at 80%
Physician services • Surgery	Covered at 90%	Covered at 60%
• Physician visits (office)	Covered at 100%	Covered at 60%
• Physical therapy	$10 co-pay	Covered at 60%
X-ray and lab services (some services may require preauthorization by UnitedHealthcare)	Covered at 90%	Covered at 60%
Accident/emergency care[4] (life-threatening)	$25 co-pay; co-pay waived if admitted directly to the hospital	$25 co-pay; co-pay waived if admitted directly to the hospital
Preventive health services • Preventive examination	Covered at 100%	Not covered
• Vision	$10 co-pay; one exam every two years	Not covered
• Well-baby care	Covered at 100%	Not covered

[1] *PPO—Preferred Provider Organization.*

[2] *Any—The licensed personal physician or hospital of your choice.*

[3] *Hospital-based physicians (e.g., anesthesiologists, radiologists, pathologists, etc.) at a PPO hospital may not be in the PPO network. In order to assure PPO benefits for eligible physician charges, confirm that the physicians attending you while you are in the hospital are part of the PPO network.*

[4] *If ER services are later determined to have been a non-emergency, plan pays 90% for PPO services and 60% for non-PPO services after you've met the deductible and, for PPO services, paid the $25 co-payment.*

UNITEDHEALTHCARE PPO PLAN B COMPARISON CHART CONTINUED

BENEFIT COMPARISON	RESIDE WITHIN PPO[1] AREA[5]	
	PPO	Non-PPO
Mental health care[6] • Outpatient office visits	$10 co-pay	Covered at 60%
• Inpatient (non-emergency inpatient mental health requires preauthorization or else subject to the plan paying only 50% of the benefit or not at all)	Covered at 90%	Covered at 60%
Alcohol and substance abuse[6] • Outpatient	$10 co-pay	Covered at 60%
• Inpatient	Covered at 90%	Covered at 60%
Home medical equipment • Durable medical equipment (maximum $2,500 per calendar year)	Covered at 90%	Covered at 60%
• Prosthetics/orthotics (no maximum; equipment/ devices only)	Covered at 90%	Covered at 60%
Skilled nursing	Covered at 90%; up to 60 days/ calendar year	Covered at 60%; up to 60 days/ calendar year
Home health care/ home infusion care	Covered at 90%, but only if approved by UnitedHealthcare; maximum of 100 visits/year	Covered at 60%; maximum of 100 visits/year
Hospice care	Covered at 90%; preauthorization by UnitedHealthcare required	Covered at 60%
Acupuncture services (20 treatments per year)	$10 co-pay	Covered at 60% after deductible has been met
Manipulative treatments (chiropractor; 20 visits)	$10 co-pay	Covered at 60% after deductible has been met

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

[6] Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the UnitedBehavioral Health (UBH) participating providers and non-participating providers. Inpatient services for medical acute detoxification are accessed through UnitedHealthcare.

UNITEDHEALTHCARE PPO PLAN C

For retirees with Medicare Parts A and B.

NOTE: Benefits are coordinated with Medicare for retirees. Medicare benefits will be considered primary for any eligible retiree (and/or covered spouse or domestic partner) who is age 65 or over.

BENEFIT COMPARISON	RESIDE WITHIN PPO[1] AREA[5]	
	PPO	Non-PPO
Choice of physician and hospital • Physician	PPO only	Any[2]
• Hospital	Member hospital only	Any[2]
General information • Annual deductible	$2,000/individual; $4,000/family	
• Annual out-of-pocket maximum	$2,000/individual; $4,000/family	$10,000/individual; $20,000/family
Prescription drugs • Retail (30-day supply) - Tier 1 - Tier 2 - Tier 3	 $10 $30 Covered at 50%	 Not covered Not covered Not covered
• Mail order (up to 90-day supply) - Tier 1 - Tier 2 - Tier 3	 $20 $60 Covered at 50%	 Not covered Not covered Not covered
Hospital services • Semi-private room and board	Covered at 80% after a $250 co-pay per admission	Covered at 60%
• Ambulance services	Covered at 80%	Covered at 80%
Physician services • Surgery	Covered at 80%	Covered at 60%
• Physician visits (office)	Covered at 100%	Covered at 60%
• Physical therapy	$10 co-pay	Covered at 60%
X-ray and lab services (some services may require preauthorization by UnitedHealthcare)	Covered at 80%	Covered at 60%
Accident/emergency care[4] (life-threatening)	$250 co-pay	$250 co-pay
Preventive health services • Preventive examination	Covered at 100%	Not covered
• Vision	$10 co-pay; one exam every two years	Not covered
• Well-baby care	Covered at 100%	Not covered

[1] *PPO—Preferred Provider Organization.*

[2] *Any—The licensed personal physician or hospital of your choice.*

[3] *Hospital-based physicians (e.g., anesthesiologists, radiologists, pathologists, etc.) at a PPO hospital may not be in the PPO network. In order to assure PPO benefits for eligible physician charges, confirm that the physicians attending you while you are in the hospital are part of the PPO network.*

[4] *If ER services do not result in direct admission, the calendar-year deductible does not apply.*

UNITEDHEALTHCARE PPO PLAN C COMPARISON CHART CONTINUED

BENEFIT COMPARISON	RESIDE WITHIN PPO[1] AREA[5]	
	PPO	Non-PPO
Mental health care[6] • Outpatient office visits	$10 co-pay	Covered at 60%
• Inpatient (non-emergency inpatient mental health requires preauthorization or else subject to the plan paying only 50% of the benefit or not at all)	Covered at 80% after a $250 co-pay per admission	Covered at 60%
Alcohol and substance abuse[6] • Outpatient	$10 co-pay	Covered at 60%
• Inpatient	Covered at 80% after a $250 co-pay per admission	Covered at 60%
Home medical equipment • Durable medical equipment (maximum $2,500 per calendar year)	Covered at 80%	Covered at 60%; preservice notification required for equipment over $1,000
• Prosthetics/orthotics (no maximum; equipment/ devices only)	Covered at 80%	Covered at 60%
Skilled nursing (up to 100 preauthorized days/ calendar year) • Freestanding facility	Covered at 80%	Covered at 80% with preauthorization
• Hospital facility	Covered at 80%	Covered at 60%
Home health care/ home infusion care	Covered at 80%; maximum of 100 visits/year	Covered at 60%; maximum of 100 visits/year
Hospice care	Covered at 80%	Covered at 60%
Acupuncture services (20 treatments per year)	$10 co-pay	Covered at 60% after deductible has been met
Manipulative treatments (chiropractor; 20 visits)	$10 co-pay	Covered at 60% after deductible has been met

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

[6] Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the United Behavioral Health (UBH) participating providers and non-participating providers. Inpatient services for medical acute detoxification are accessed through UnitedHealthcare.

KAISER SENIOR ADVANTAGE

For retirees with Medicare Parts A and B or Medicare Part B only.

NOTE: If you elect Kaiser Senior Advantage you must reside in a Senior Advantage service area.

BENEFIT	COVERAGE
Physician and hospital	• Kaiser Permanente physicians and hospitals • Enrollees must reside within a Kaiser Permanente service area
Hospital	• Room and board: Covered at 100% • Miscellaneous expenses: Covered at 100% • Ambulance, if authorized: Covered at 100%
Surgical	• Covered at 100%; including the services of an assistant surgeon and anesthesiologist
Doctor visits	• In-hospital: Covered at 100% • Out-of-hospital: In the medical office, provided at $5 per visit. Home visits covered at 100% when part of a prescribed home care program • At home: Covered at 100% when home visits are part of a prescribed home care program
Nurse	• Special-duty: Covered at 100% when prescribed under hospital care • Home visits: Covered at 100% for prescribed visits (see plan brochure for details)
Physical therapy • Outpatient	$5 co-pay per visit
• Inpatient	$5 co-payment for medically necessary therapy
X-ray and lab	Covered at 100%
Prescription drugs • Outpatient	Covered at 100% during hospitalization
• Inpatient	Closed formulary plan: Only prescribed drugs listed in formulary will be covered unless requested by physician. $5 co-pay per prescription for up to 100-day supply. Sexual dysfunction drugs covered at 25% coinsurance, with a maximum dosage limit of 27 doses, up to 100-day supply
Extended care or skilled nursing facility	Covered at 100%; care prescribed by Kaiser Permanente doctors at designated facilities primarily engaged in providing care to inpatients who require skilled nursing care and related services, including room and board, general nursing care and related services, and physicians' services up to 100 days per benefit period. **Custodial care is not covered**
Durable medical equipment, orthotics, prosthetics	• Durable medical equipment: No charge (in accordance with the durable medical equipment formulary) • Orthotics, prosthetics: No charge • Replacement of orthotics or prosthetics, unless due to loss or misuse: No charge • Repair unless due to loss or misuse: No charge
Mental health care • Outpatient	$5 co-pay per visit, as covered by Medicare; unlimited visits
• Inpatient	Covered at 100%
Eye exams/ vision care	• Eye examinations are provided at a $5 charge per visit • $150 eyewear allowance (frames, lenses, contacts), purchased from a Kaiser Permanente optical office every 24 months

KAISER SENIOR ADVANTAGE COMPARISON CHART CONTINUED

BENEFIT	COVERAGE
Dental care	Not covered
Hearing evaluation/ hearing aid	Hearing exams provided at $5 per visit; up to $500 allowance per aid every 36 months
Emergency care • Outside service area	Necessary emergency medical care or hospitalization resulting from unforeseen illness or injury. $5 per visit (waived if admitted to hospital). Notify Kaiser Permanente within 24 hours of emergency
• Inside service area	Provided at $5 per visit at Kaiser Permanente facilities (waived if admitted to hospital within 24 hours for the same condition). Coverage at non-plan facilities limited to cases of life-threatening emergency or where choice of facility is beyond your control or the control of your immediate family. You pay any co-payments that normally apply. See plan brochure for full description and limitations of emergency coverage
Home health care	Covered at 100%, but only if you are confined to your home. Services include nurses; home health aides; medical social services; physical, occupational or speech therapy; and medical supplies, as covered by Medicare (see plan brochure for details)
Hospice care	Covered at 100%, but only if you are diagnosed as having a terminal illness with a life expectancy of 12 months or less. Benefits include nursing care; medical social services; physical, respiratory or occupational therapy; medical supplies; physician services; short-term inpatient care, including respite care and care for pain control; counseling; and bereavement services

Please note: Senior Advantage enrollees must receive all their health care from Kaiser. Neither Kaiser nor Medicare will pay for any medical services received from any other health care providers, except for emergency services, urgently needed out-of-area care and authorized referrals.

UNITEDHEALTHCARE MEDICARE ADVANTAGE

For retirees with Medicare Parts A and B.

NOTE: If you elect UnitedHealthcare Medicare Advantage you must reside in a United Healthcare Medicare Advantage service area.

BENEFIT	COVERAGE
Choice of physician	Must select a primary care physician who is contracted with UnitedHealthcare Medicare Advantage
Hospital	• Covered at 100% for unlimited number of days; must be authorized by primary care physician • Semi-private room and board covered at 100% • Covered at 100% for unlimited days • Ambulance covered at 100%
Surgical	Covered at 100% for inpatient or outpatient services. Must be authorized by primary care physician
Doctor visits	• Office visit: Covered at 100% per visit • Covered at 100% per visit for consultation; diagnosis and treatment by a specialist
Physical therapy	Covered at 100% for both inpatient and outpatient services
X-ray and lab	Covered at 100%
Prescription drugs • Outpatient	Drugs, anesthesia and medications covered at 100% while in hospital
• Inpatient	$5 co-pay per prescription for a 30-day supply for drugs in the UnitedHealthcare Medicare Advantage formulary, prescribed by a UnitedHealthcare Medicare Advantage plan physician, and purchased at any participating pharmacy. $5 co-payment for a 90-day supply for mail order prescriptions for drugs in the UnitedHealthcare Medicare Advantage formulary. Unlimited annual maximum. For more information, please call Member Service at **(800) 228-2144**
Skilled nursing facility	Covered at 100% for 100 days per benefit period
Maternity	Covered as any other disability
Mental health care • Outpatient care	Covered; no co-pay per visit (unlimited)
• Inpatient care	Covered in full in a Medicare-approved psychiatric hospital
Eye exams/ vision care	• Covered at 100% for annual routine eye examination; no co-pay for eyeglasses • Eyeglasses covered every 24 months at contracting providers
Hearing aids	Covered in full up to $500 per year
Chiropractic	Chiropractic Medicare-covered services: No co-pay
Emergency care	No co-pay per emergency room visit. Ambulance services covered in full worldwide
Durable medical equipment	Provided at no charge
Home health care	Covered at 100%, but only if you are homebound and under a plan of treatment reviewed and approved by a contracting medical group physician. Services include nursing care; home health aide; physical, speech and occupational therapy; medical social services; and medical supplies and equipment
Hospice care	Not a UnitedHealthcare Medicare Advantage benefit. If member chooses hospice care, Medicare coverage for billing purposes is reinstated. Medicare structures its hospice by periods and includes two periods of 90 days, a subsequent 30-day period, and a final unlimited period, which most immediately follows the 30-day period to be covered. Benefits include nursing, social services, physician, counseling, short-term inpatient and supplies

HEALTH PLAN OF NEVADA (HPN)

For retirees with Medicare Parts A and B.

NOTE: If you elect HPN Senior Dimensions you must reside in an HPN Senior Dimensions service area.

BENEFIT	COVERAGE
Choice of physician	HPN physicians; hospital services in any licensed acute care general hospital designated by an HPN physician. Enrollees must reside within the HPN service area
Hospital	• Semi-private room and board: Covered at 100% • Miscellaneous expenses: Covered at 100% • Ambulance: Covered at 100%
Surgical	Covered at 100%; including services of assistant surgeon
Doctor visits	• In-hospital: Covered at 100% • Out-of-hospital: $3 co-pay per office visit • Specialists: $10 co-pay per office visit
Physical therapy • Outpatient	Outpatient therapy: $10 co-pay per visit
• Inpatient	Inpatient therapy: Covered at 100%
X-ray and lab	• Routine services: Covered at 100%
Prescription drugs	• In-hospital: Included under miscellaneous hospital expenses • Out-of-hospital: $5 generic/$15 brand-name/$30 non-preferred per prescription, including mail-order option
Extended care or skilled nursing facility	Provided at no cost for up to 100 days per benefit period, when prescribed by a physician. **Custodial care covered under home health care**
Maternity	Covered as any other disability
Mental health care • Outpatient care	Outpatient individual and group therapy: $10 co-pay per visit
• Inpatient care	Covered at 100%
Vision care	Vision exam once every calendar year. $3 co-pay per exam. 20% discount off remaining charges for eyewear services. Eyeglass lenses every 24 months at no charge. Frames up to $60 value every 24 months covered at 100%
Hearing evaluation/ hearing aids	Hearing exam and aids: Up to 40% discount at participating provider
Emergency care	• Physician's services: $25 co-pay • Emergency room: Covered at 100% • Urgent care facility: $15 per visit in plan; $25 per visit out of plan
Durable medical equipment	No charge
Home health care	Provided at no charge, but only if you are confined to your home. Services include physician house calls, private-duty nursing and home care services
Hospice care	When you enroll in a Medicare-certified hospice, Medicare provides coverage for hospice services

DENTAL PLAN OPTIONS FOR RETIREES

BENEFIT COMPARISON	UNITED CONCORDIA PREFERRED ALLIANCE NETWORK A FEE-FOR-SERVICE/PREFERRED PROVIDER ORGANIZATION (PPO)		UNITED CONCORDIA CONCORDIA PLUS NETWORK A DENTAL HEALTH MAINTENANCE ORGANIZATION (DHMO)
	In-Network	Out-of-Network	
Choice of dentist	United Concordia Alliance (PPO) dentists only	Any licensed dentist or specialist	United Concordia Plus DHMO panel dentists only
Annual deductible	$25/person; $75/family	$25/person; $75/family	None
Annual maximum	$1,500 per calendar year	$1,500 per calendar year	Unlimited
Covered services • Diagnostic and Preventive (no deductible; examinations, X-rays, routine cleaning, fluoride treatments, sealants)	100% of PPO-approved fee; no deductible applies for diagnostic/preventive services	100% of the United Concordia allowable charge; no deductible applies for diagnostic/preventive services	100% after co-pay; no deductible applies for diagnostic/preventive services
• Basic services (basic restorative, oral surgery, endodontics, repairs, simple extractions)	80% of PPO-approved fee	80% of the United Concordia allowable charge	100% after co-pay
• General anesthesia	80% of PPO-approved fee	80% of the United Concordia allowable charge	100% after co-pay (impacted extractions only)
• Major services (crowns, inlays, onlays, prosthetics)	70% of PPO-approved fee	50% of the United Concordia allowable charge	100% after co-pay
Orthodontics (diagnostic, active retention treatment)	Not covered	Not covered	Children: $1,500 co-pay Adults: $2,000 co-pay Covers banding and retention only
Limitations • Oral exams	Two per 12 months	Two per 12 months	No limit
• Teeth cleaning	Two per 12 months	Two per 12 months	One per 6 consecutive months
• Bitewing X-rays	One set per 12 months for individuals age 14 and over; one set per 6 months for children under age 14		One set per six consecutive months
• Fluoride treatments	Two per 12 months to age 19	Two per 12 months to age 19	Two per six consecutive months to age 19
• Full mouth X-rays	One set every 5 years	One set every 5 years	One set every 3 years
• Inlays/crowns/ bridges/ dentures	Once in a 5-year period	Once in a 5-year period	No limit
Emergency services	Standard plan coverage, to annual maximum	Standard plan coverage, to annual maximum	No charge at member's dentist; $100 benefit per member per year if out of area

IBEW LOCAL 18-SPONSORED GUARDIAN DENTAL PLANS

FOR CURRENT IBEW LOCAL 18 RETIREES ONLY. (If, as a retiree, you cancelled your IBEW Local 18-sponsored dental plan, you are now able to re-enroll into a Local 18 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	
Choice of dentist	Any PPO provider in the DentalGuard Preferred network	Any licensed dentist	Any Guardian DHMO dentist
Annual deductible	None	$25 per person; $75 per family (waived for diagnostic and preventive services)	None
Annual 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; Periodontics: Scaling and root planing limited to one course of therapy per quadrant during any 12-month period
• Basic services (oral surgery, including extractions, fillings, root canals, periodontic (gum) treatment, sealants)	90% of PPO fee	80% of customary and reasonable charges	100%; co-pay required for sealants; one sealant per tooth in any 3-year period to age 16 on permanent teeth
• 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 per person (in-network and out-of-network combined)	For adults and children: 80% of customary and reasonable charges; subject to $2,000 lifetime maximum/ person (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	Two per calendar year
• Teeth cleaning	Two per calendar year	Two per calendar year	Two per calendar year
• Bitewing X-rays	Two sets every 12 months	Two sets every 12 months	No limit
• Fluoride treatments	Two per calendar year; to age 19	Two per calendar year; to age 19	Two sets every 12 months
• Full mouth X-rays	One set every 3 years	One set every 3 years	One set every 3 years
• Inlays/crowns/bridges/ dentures	Once in a 5-year period	Once in a 5-year period	Once in a 5-year period
Emergency services	Standard plan coverage, to annual maximum	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.

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 the 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.

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), COBRA mandates that employers provide retired 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 Spouses	• Death of covered retiree • Divorce from a covered retiree, or if applicable, legal separation from the covered employee or covered retiree • Your spouse becomes enrolled in Medicare benefits (Part A, Part B, or both)
Qualifying Events for Covered Children	• The death of the parent-retiree • Parent's divorce or, if applicable, legal separation • The parent-retiree 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 retiree, 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 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 plans.

IMPORTANT NOTIFICATION REQUIREMENTS UNDER COBRA

Under COBRA, a covered retiree, a covered spouse, or other covered family member has the responsibility to notify the 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 Health Plans Administration 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 has been made, additional dependents may be added following the same guidelines specified under "Special Enrollment Periods" on **page 6** 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 additional children in the future, notice to the covered retiree and spouse at this time will be deemed notification to the newly covered dependent.

DOMESTIC PARTNERS ARE NOT ELIGIBLE FOR COBRA

While LADWP 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 LADWP Health Plans 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.

- Length of Continuation Coverage – 18 months for formerly covered employees
- Length of Continuation Coverage – 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 AB1401

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 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 beneficiaries' responsibility to notify the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center in writing within 60 days of 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 retired employees since a COBRA participant is required to pay the entire cost for health insurance plus a 2 percent administration fee for regular federal cobra, but goes up to plus 10% for California COBRA. Premiums may be increased if the costs to the plan increases 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 day 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 day 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 canceled. Monthly premiums could be adjusted during the continuation period if the applicable premiums amount changes.

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.

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 retired 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 requests 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 medical plans

Plan providers that do not offer conversion to individual coverage:

- United Concordia
- IBEW Local 18-sponsored Guardian dental plans

However, members can contact 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 medical or dental provider.

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

LADWP Health Plans Administration Office

P.O. Box 51111, Room 564
Los Angeles, CA 90051-0100

(213) 367-2023
(800) 831-4778

IBEW Local 18 Benefit Service Center

9500 Topanga Canyon Blvd.
Chatsworth, CA 91311

(800) 842-6635

Additional 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.

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 30 days from 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 plan. You must request enrollment within 30 days from the marriage, birth, adoption or placement for adoption.

To request special enrollment or to learn more, contact the LADWP Health Plans Administration Office at **(213) 367-2023** or IBEW Local 18 Benefit Service Center at **(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 medical 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 medical 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 medical 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 from 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 from the loss of such coverage.

In addition, you may enroll in an LADWP-sponsored or IBEW Local 18-sponsored medical 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 or dial **(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 from being determined eligible for premium assistance.

CALIFORNIA

Medicaid Website:
www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx

Medicaid Phone: (866) 298-8443

CHIP Website:
http://healthyfamilies.ca.gov/About/

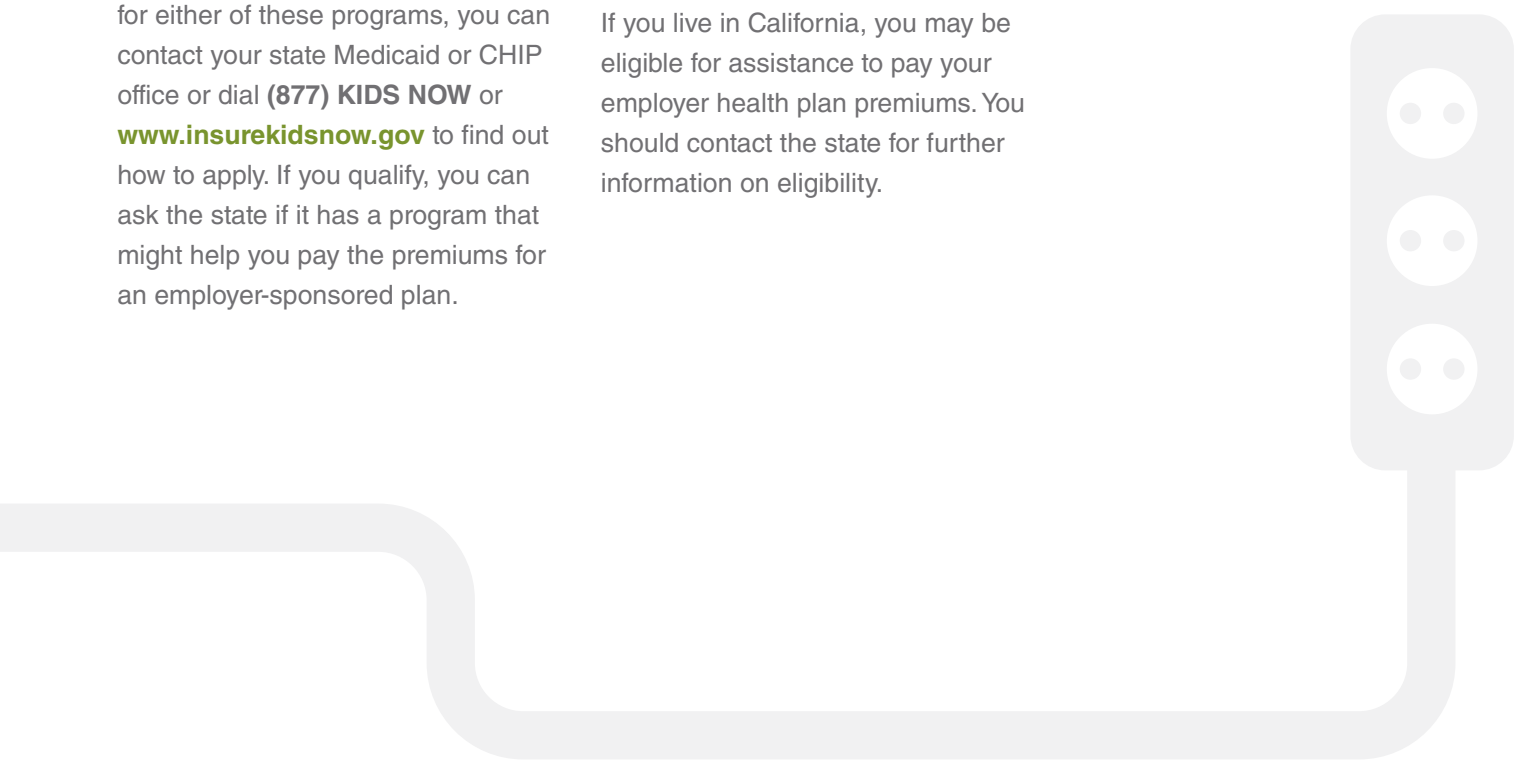
CHIP Phone: (800) 880-5305

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 **http://www.dol.gov/ebsa/pdf/chipmodelnotice.pdf** to view the complete state eligibility information.

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

IMPROPER USE OF BENEFITS

Retirees 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. In addition, retirees will be billed for any LADWP subsidy paid for ineligible dependents.

WHERE TO FILE COMPLAINTS – DEPARTMENT OF MANAGED HEALTH CARE

The LADWP and IBEW Local 18 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**.

Every retiree should verify his or her LADWP-sponsored or IBEW Local 18-sponsored health and dental plan coverage each month by checking his or her data mailer. 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.

Health and Dental Plan Contact Information

CARRIER	PHONE	WEBSITE
LADWP-sponsored:		
LADWP Health Plans Administration Office	(213) 367-2023 (800) 831-4778	https://ebenefits.ladwp.com
Health Plan of Nevada	Las Vegas: (800) 777-1840 Reno: (800) 753-0669	www.myHPNonline.com
Kaiser Permanente	(800) 464-4000	www.kp.org or www.my.kp.org/ca/ladwp
United Concordia Dental (DHMO AND PPO)	(866) 851-7568	www.unitedconcordia.com
UnitedHealthcare HMO	(800) 624-8822	www.uhcwest.com
UnitedHealthcare PPO	(866) 783-7481	www.myuhc.com
UnitedHealthcare HMO Medicare Advantage	(800) 457-8506	www.UHCRetiree.com
IBEW Local 18-sponsored:		
Benefit Service Center	(800) 842-6635	www.mybenefitchoices.com/local18
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

Other Important Telephone Numbers

DEPARTMENT	PHONE
LADWP Health Plans Administration Office	(213) 367-2023 (800) 831-4778
IBEW Local 18 Benefit Service Center	(818) 678-0040 (800) 842-6635
Local 721 Dental Zenith American Solutions	(877) 802-9740
L.A. City Employee Benefits	(800) 778-2133

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 medical and dental plans, call IBEW Local 18 Benefit Service Center at **(818) 678-0040** or **(800) 842-6635**.*