County of Los Angeles

Options
SUMMARY PLAN DESCRIPTION

Effective January 1, 2024

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INTRODUCTION

The *Options* Flexible Benefits Plan ("*Options*") is a cafeteria plan that gives you and your eligible dependents access to the following benefits:

- Medical
- Dental
- Basic Term Life Insurance
- Optional Group Term Life Insurance
- Dependent Term Life Insurance
- Accidental Death and Dismemberment (AD&D) Insurance
- Medical Coverage Protection (LTD Health Insurance)
- Spending Accounts:
  - Health Care Spending Account
  - Dependent Care Spending Account

Note: For the purposes of this document a Plan Year is the same as a calendar year (January 1 through December 31). For New Hire employees the Plan Year starts in the month your benefits become effective through December 31.

If you have questions not answered in this Summary Plan Description (SPD), contact the insurance carrier directly (see **Contact Information** on page 52) or the County's Benefits Hotline at **213-388-9982** from 8:00 a.m. to 4:00 p.m., Monday through Friday.

GENERAL INFORMATION

Eligibility

Employee Eligibility

If you are a full-time, permanent employee of the County of Los Angeles and you are represented by a bargaining unit listed below, or you are in an eligible class of employees approved for *Options* by the Board of Supervisors, then you may enroll in *Options*.

Bargaining Units Eligible for *Options*

Bargaining Unit #	Bargaining Unit Name	Bargaining Unit #	Bargaining Unit Name
111	Clerical and Office Services	702	Supervising Deputy Probation Officers
112	Supervising Clerical & Office Services	711	Social Workers
121	Administrative, Technical & Staff Services	722	Medical Social Workers
122	Supervising Administrative, Technical & Staff Services	723	Child Welfare Workers
		729	Health Financial Support Services
201	Building Custodians & Services Employees	731	Social Services Investigators
211	Institutional Support Services Employees	732	Supervisory Social Services Investigators
221	Paramedical Technical Employees	777	Supervising Social Workers
222	Supervising Paramedical Health Employees	811	Librarians
311	Registered Nurses	850	LACERA Administrative, Technical, Clerical & Blue Collar
312	Supervising Registered Nurses		
341	Health Science Professionals	851	LACERA Supervising Unit
342	Supervisory Health Science Professionals	860	Superior Court Legal Process Unit
431	Artisan and Blue Collar Employees	861	Superior Court Reporters
432	Supervisory Artisan and Blue Collar Employees	867	Superior Court Supervisory Unit

Dependent Eligibility for County-Sponsored Plans

If you are eligible to participate in County-sponsored medical, dental, Optional Group Term Life, and Accidental Death and Dismemberment (AD&D) insurance plans, so are your eligible dependents. Your *eligible dependents*[1] generally include:

- Your spouse/domestic partner (see pages 3-5 for special rules concerning domestic partner eligibility)
- Your children through age 25 (through age 17 for legal guardianship)

Coverage for a Disabled Child

Coverage for a disabled child may continue past age 25. You must contact your health plan at least six months before your child reaches age 26 to apply for disabled status for your dependent. Your dependent will be eligible for coverage only if your health plan approves and determines that your child became disabled before the limiting age (check with your health plan to determine the limiting age). After your application has been approved by the health plan, proof of your child's disability may be required from time to time. Your disabled child's coverage ends when the plan no longer considers your child to be disabled, your child marries or no longer depends on you for support, you stop coverage for any reason, or at age 26 if you applied for disabled status late or your application has not been approved. If you apply for disabled status after your child's 26th birthday and the health plan later approves your application, you will not be able to add your child to your health plan until the next annual benefits enrollment.

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[1] The Dependent Term Life and Accidental Death and Dismemberment plans have different dependent eligibility requirements. See pages 25 and 26 for details. Different dependent requirements also apply to the spending accounts. See pages 30 and 34 for details.

For *New Hires and Newly Eligible:* If you are adding a disabled dependent during your initial enrollment, you must contact the health plan and receive certification for your disabled dependent within 90 days from the date of your initial enrollment, or your dependent will not be added to your coverage.

Children

For eligibility purposes, "children" includes children born to you, children legally adopted by you, children awaiting finalization of their adoption by you, stepchildren, children of whom you are the legal guardian (through age 17), children you support because of a valid court order, and children of your domestic partner.

Ineligible Dependents

Your ex-spouse/ex-domestic partner, ex-domestic partner's children, ex-stepchildren, parents, parents-in-law, other relatives, and non-disabled children age 26 or over are not eligible for coverage under your medical and dental plans.

You must drop coverage for your enrolled spouse/domestic partner or children/domestic partner's children when they lose eligibility under your medical and dental plans (e.g., divorce, death, end of a domestic partner relationship, or your non-disabled child reaching age 26).

Rules Governing Domestic Partners

If you are in a domestic partnership and you and your partner both meet **all** of the criteria listed below, you may enroll your domestic partner and their dependent children in your *Options* medical, dental, Optional Group Term Life insurance, Dependent Term Life insurance, and Accidental Death and Dismemberment Insurance plans.

Under the County's program, a domestic partnership is defined as a relationship between two people who are in an exclusive relationship and who both:

- Are at least age 18, unmarried, and not blood relatives close enough to bar marriage in the State of California, and
- Are jointly responsible for each other's welfare and financial obligations, and
- Live in the same principal residence and intend to do so indefinitely, and
- Are in a domestic partnership as attested by both parties through either a signed *County of Los Angeles Declaration of Domestic Partnership form*, or under a **registered** State of California *Declaration of Domestic Partnership form* or California Certificate of Registered Domestic Partnership (or valid proof of a similar legal union from another state) that has been submitted to and approved by the County of Los Angeles Benefits Plan Administrator (Benefits Plan Administrator).

Cost of Medical/Dental Benefits

If you have coverage for yourself only, or yourself and one family member, and you add a domestic partner, or the children of such partner to your medical and/or dental coverage, your monthly premium (cost of coverage) will increase. You will receive an increase in your monthly benefits allowance to help you pay for this coverage; the amount of the increase depends on the number of people enrolled.

Taxation of Medical/Dental Coverage for Domestic Partners

If you purchase medical and/or dental coverage for your domestic partner or their children who do not qualify as your federal tax dependents, the cost of that coverage is treated as taxable and is reported on your monthly paycheck as "imputed income."

However, if you currently pay medical and/or dental premiums for coverage for "you and two or more family members" and you add a domestic partner and/or their children, your monthly premium and benefits allowance will not increase, but you must pay taxes on the fair market value of the additional coverage. The value is set at the "you only" premium rate for your medical and/or dental plan, no matter how many of your domestic partner's children you enroll. The fair market value will appear as "imputed income" on your monthly paychecks.

If you provide the Benefits Plan Administrator with a copy of your **registered** State of California *Declaration of Domestic Partnership form* or California Certificate of Registered Domestic Partnership (or valid proof of a similar

legal union from another state), your cost for such coverage will be deducted before California state taxes are taken out of your pay. Note, your County of Los Angeles registration alone does not qualify you for this tax break.

If you want to take advantage of the state tax exemption applicable to domestic partners, you must submit a copy of your **registered** State of California *Declaration of Domestic Partnership form* or California Certificate of Registered Domestic Partnership (or valid proof of a similar legal union from another state) to the Benefits Plan Administrator (see the **Required Proof of Dependent Eligibility** section on page 6 and **Submitting Proof of Dependent Status** on page 7).

To register your domestic partnership with the State, obtain a State of California *Declaration of Domestic Partnership* form from the Secretary of State. You may write to the Secretary of State, Domestic Partners Registry, P.O. Box 942870, Sacramento, CA 94277-2870, or call 916-653-3984. You can also visit their website at **sos.ca.gov/registries/domestic-partners-registry for more information and eligibility rules.**

NOTE: Other insurance coverage provided to or on behalf of a domestic partner or their children may also be determined to be taxable. Thus, to the extent required by law, the County may require you to purchase these benefits with after-tax dollars or report imputed taxable income with respect to those benefits.

Enrolling a Domestic Partner

When enrolling a domestic partner for the first time, you must send a completed County of Los Angeles *Declaration of Domestic Partnership* form, and proof of same principal residence, or submit a copy of your **registered** State of California *Declaration of Domestic Partnership form* or California Certificate of Registered Domestic Partnership (or valid proof of a similar legal union from another state) to the Benefits Plan Administrator (see the **Required Proof of Dependent Eligibility** section on page 6 and **Submitting Proof of Dependent Status** on page 7). Coverage for your domestic partner and your domestic partner's eligible dependents will not be effective until the Benefits Plan Administrator receives your completed and signed form and approves your enrollment.

You can download and print the County of Los Angeles *Declaration of Domestic Partnership* form from the web enrollment system at **mylacountybenefits.com**.

Note: If you are a new hire or newly eligible for *Options* and meet with an enroller to enroll, you will receive a copy of the form and instructions during your enrollment meeting.

Adding Domestic Partners During the Year

You may add a domestic partner and your domestic partner's children to your medical and/or dental coverage during the year under the rules described in the section **Enrollment Changes During the Plan Year: Changes in Status** (see pages 14-17).

When Coverage for a Domestic Partner Begins

If you are enrolling your domestic partner during annual benefits enrollment, coverage will become effective January 1 of the following year, provided the Benefits Plan Administrator approves your form. If you are enrolling a domestic partner during your initial new hire enrollment, coverage will become effective as shown in the **Benefit Effective Date Schedule** on page 11. If you are enrolling a domestic partner during the year under the plan's changes in status rules, see section **When Changes Become Effective** on pages 17-18.

STOPPING COVERAGE FOR A DOMESTIC PARTNER DURING THE YEAR

You can stop coverage for your domestic partner and their children on the web enrollment system due to a qualified life event. See the rules described in the section **Enrollment Changes During the Plan Year: Changes in Status** (see pages 14-17).

If you terminate your domestic partnership, go to the web enrollment system and indicate that you have a termination of domestic partnership. If you enrolled a domestic partner using the *County of Los Angeles Declaration of Domestic Partnership form*, to terminate the domestic partnership, you must submit your completed *County of Los Angeles Termination of Domestic Partnership* form to the Benefits Plan Administrator and must wait **12 months** to enroll a domestic partner to coverage. If you enrolled a domestic partner using the registered State of California document, you must submit the State of California *Notice of Termination of Domestic Partnership form* (or proof of similar **valid** documents from another state) to the Benefits Plan Administrator and must wait **six months** (from the filing date) to enroll a domestic partner to coverage. See the **Submitting Proof of Dependent Status** on page 7 for more information.

Once you terminate a domestic partnership, your former domestic partner and their children will be removed from any and all insurance plans (e.g., medical, dental, life, etc.), and a COBRA notice will be mailed to them at your mailing address (see **COBRA Continuation of Health Coverage** on page 46).

Log on to **mylacountybenefits.com**, click “Life Event” at the top of the homepage, and indicate that you have a termination of domestic partnership. Download and print the *County of Los Angeles Termination of Domestic Partnership* form.

*Required Proof of Dependent Eligibility**

> **Note:** There are different rules for adding dependents due to a qualified change in status. See pages 14-17.

If you are a current participant and you choose to add a dependent during annual benefits enrollment, you must provide proof of dependent status and your dependent's Social Security number within **10 calendar days from the date of your enrollment.** If you are a new hire or newly eligible employee, you must provide proof of dependent status and the Social Security number for each dependent you are adding to coverage no later than the 25th of the month before your medical or dental benefits begin. Documents that serve as proof of dependent eligibility at the time of enrollment are:

Dependent	Required Documents	Note
Spouse	Photocopy of your church, county, state, or foreign (which also requires **notarized** translation) marriage certificate.	Marriage certificates must include: ▪ Names of parties, ▪ Signature of solemnizing official, and ▪ Marriage date **Marriage licenses will NOT be accepted.**
Child	Photocopy of the hospital, state, county, or foreign (which also requires **notarized** translation) birth certificate, court-appointed guardianship documents, legal adoption documents, or adoptive placement agreements. Children are eligible to be covered through age 25. Or, through age 17 for legal guardianships.	Birth certificates must indicate: ▪ Name of parent(s) ▪ Child's name and date of birth Hospital verification letter must indicate: ▪ Name of parent(s) ▪ Child's name and date of birth ▪ Hospital name ▪ Signature of hospital personnel
Disabled child age 26 or older	Proof of disability requirements may differ by plan and may include certification of the disability from a licensed doctor or the Social Security Administration.	See pages 2 and 3 for eligibility information and contact your health plan for proof documents. See pages 25 and 26 for life insurance eligibility information.
Domestic Partner	County of Los Angeles *Declaration of Domestic Partnership* form and proof of same principal residence document. **OR** A copy of your **registered** State of California *Declaration of Domestic Partnership* form or California Certificate of Registered Domestic Partnership (or valid proof of a similar legal union from another state).	Proof of a recent same principal residence document, which includes your domestic partner's name with your address (e.g., CA Driver's License, CA Identification Card, utility bill, or financial document such as a bank statement, etc.).
Domestic Partner's Child(ren)	Same documents required to add a Domestic Partner AND photocopy of the child's hospital, state, county, or foreign (which also requires **notarized** translation) birth certificate, court-appointed guardianship documents, legal adoption documents, or adoptive placement agreements.	Birth certificates must indicate: ▪ Domestic partner's name ▪ Child's name and date of birth Hospital verification letter must indicate: ▪ Domestic Partner's name ▪ Child's name and date of birth ▪ Hospital name ▪ Signature of hospital personnel

Other Important Information About Required Documentation	
Translated documents	If the document is in a foreign language (not in English), a notarized translation is acceptable and must be included with a copy of the foreign document.
Name changes	Provide court-ordered name change documents, passports, or naturalization documents which show both former and current name. **All names must match with names on system records. If names differ between supporting documents and name on record, a change of name document must be provided.**

Submitting Proof of Dependent Status
Submit all required documentation to the Benefits Plan Administrator. Write your name, employee number, and your dependent's Social Security number on each document or certificate. You may submit your documents by: ▪ **Document upload:** Click the "Doc Upload" button in the "Easily Submit Documents" tile on the homepage on **mylacountybenefits.com** ▪ **Email:** Attach scanned documents to an email and send to documents@mylacountybenefits.com ▪ **Fax:** 310-788-8775 ▪ **Mail:** County of Los Angeles Benefits Plan Administrator, P.O. Box 9005, Norfolk, VA 23501-9005

***The County reserves its right to audit ongoing dependent eligibility from time to time and may request information or proof of eligibility in addition to those required at the time of initial enrollment.**

Special Note for New Hires and Newly Eligible
For dependent coverage to be activated at the same time as your coverage, the Benefits Plan Administrator must receive the necessary documents providing proof of dependent status by the 25th of the month before your medical and/or dental benefits begin. Coverage for your dependents will not begin until the documents are received. If the Benefits Plan Administrator receives your documents by the 25th of the month, your dependent's coverage is effective the first day of the following month. If the documents are received after the 25th of the month, dependent coverage does not take effect for another month.

You have a total of 90 days from the date of your enrollment to submit the required documents. If the Benefits Plan Administrator does not receive the documents within 90 days of your enrollment date, your dependent's benefits (e.g., medical and/or dental) coverage will not go into effect, and you must wait until the next annual benefits enrollment to enroll your eligible dependents to coverage.

Enrolling in *Options*

Enrollment for Current Participants

The County conducts an annual benefits enrollment for current participants. Annual benefits enrollment is typically held in October, with coverage changes effective on January 1 of the following Plan Year. During annual benefits enrollment, you will have an opportunity to:

- Enroll or re-enroll in the Health Care and Dependent Care Spending Accounts.
- Enroll in or change medical and dental plans.
- Waive medical and/or dental coverage if you meet the criteria that you have other coverage (see **Waiving Medical and Waiving Dental Coverage** on page 9 for details).
- Decline medical coverage if you are enrolled in an individual plan or marketplace plan (see **Declining Medical Coverage** on page 9 for details).
- Select, change, or cancel Optional Group Term Life insurance, Accidental Death and Dismemberment (AD&D) insurance, or Medical Coverage Protection (LTD Health Insurance, see pages 27-28).
- Add or drop coverage for dependents. If you add dependents, you must provide the required documents, before coverage for your newly added dependent begins (see the **Required Proof of Dependent Eligibility** section on page 6 and **Submitting Proof of Dependent Status** on page 7).
- Do nothing and your current coverage will continue, with the following exceptions:
  - *Health Care and Dependent Care Spending Accounts* – you must re-enroll every year to continue participating.
  - *Waiving Medical Coverage* – If you are currently waiving medical coverage and want to continue waiving coverage in the next Plan Year, you must provide your waiver information each year (see **Waiving Medical Coverage** on page 9 for details).
  - *Declining Medical* – If you are currently declining medical coverage and want to continue declining coverage for the next Plan Year, you must complete an online certification form each year (see **Declining Medical Coverage** on page 9 for details).

Enrollment for New Hires and Newly Eligible

Represented Employees
Special enrollment meetings are held for represented new hires or represented employees newly eligible for the *Options* program. At your meeting, you will review the different coverage options available to you, see how your benefit elections can affect your take-home pay, and enroll in the benefits of your choice. There is no enrollment form to complete. The benefit enroller will enter your elections directly into the computer during your meeting. At the end of the meeting, you will receive a confirmation statement of your coverage. **Important: If you miss your enrollment meeting, inform your Departmental Personnel Office immediately, then contact BenefitVision directly at 800-499-9190 to reschedule your meeting.**

Non-represented Employees
If you are a new hire or newly eligible for *Options* and are a non-represented employee, you must enroll via the web enrollment system at **mylacountybenefits.com**.

When You Need to Enroll
As a new hire, or an employee who is newly eligible to participate in *Options*, the benefits you elect during your enrollment meeting are effective through December 31 of the year you become eligible.

Under the Affordable Care Act, starting January 1, 2014, the County must provide new hires with an opportunity to have medical benefits begin by their 91st day of employment. To ensure that your benefits begin within 90 days, you must meet with a benefits enroller within the first 30 days of employment. If you are not scheduled to meet with an enroller within that time frame, contact your Departmental Personnel Office immediately. Your final enrollment deadline is 60 days from your date of hire. If you do not enroll in 60 days, you will not have coverage and you will not be eligible to receive a monthly benefits allowance from the County. This means you will not receive benefits and your next opportunity to enroll for benefit coverage in *Options* will be the next scheduled annual benefits enrollment.

If you are newly eligible for *Options* and are currently enrolled in benefits under *Choices*, *MegaFlex,* or *Flex* and you do not enroll in *Options* within the 60-day period, you are automatically enrolled in comparable benefits under *Options* on the first day of the second month after the 60-day period ends.

Monthly Benefits Allowance and Taxable Cash Cap

As an *Options* participant, you get a monthly benefits allowance based on the number of dependents you enroll for medical coverage. You use this monthly allowance to spend on the benefits you need. If you have any allowance left over, the unused amount will be added to your paycheck as taxable cash (FLEX EARN), up to the monthly taxable cash cap of $244. You will not receive any unused amount above the cap.

For example, Joe plans to enroll his spouse and child in his medical and dental plans. He will receive a monthly benefits allowance of $2,382.84, spend $1,809.91 on benefits, and have an unused benefits allowance amount of $572.93. Because the unused amount is more than the $244 taxable cash cap, only $244 will be added to his paycheck, as taxable cash, and he will not receive the remaining balance of $328.93.

If your benefits cost more than your benefits allowance, you are responsible for paying the difference. Your portion of the cost is deducted from your paycheck before taxes are applied.

Waiving Medical Coverage

You may waive medical coverage only if you meet **all** of the following criteria:

1) You have medical coverage through your spouse's/domestic partner's plan, another employer-sponsored plan, Veteran's benefits, or Medicare (Parts A and Part B).
2) You are enrolled in the other plan when you waive coverage under *Options*, and you stay enrolled in that other plan for the duration of the Plan Year.

If you waive medical coverage, the monthly medical waiver allowance of $228, minus the cost of other benefits you elect, is added to your paycheck as taxable cash.

Waiving Dental Coverage

You must enroll in a County-sponsored dental plan. Or, you may elect to waive dental if you have other dental coverage.

Declining Medical Coverage

You may decline medical coverage if you are enrolled in an individual plan or marketplace plan after January 1, 2015. If you decline medical coverage, you will not receive the monthly medical waiver allowance. The cost of other benefits you elect under *Options* will be deducted from your paycheck before taxes are applied.

Pensionability Notice:
If you were hired before January 1, 1996 (on a permanent full-time status) and became a member of the Los Angeles County Employees Retirement Association (LACERA) by that date, you were automatically enrolled in pensionable *Options.* As a pensionable participant, $244 of your monthly *Options* benefits allowance is included in the compensation that is taken into account when calculating your pension upon retirement (referred to as your "Pensionable Amount"). If you decline medical coverage, you will not receive the pensionable amount of $244 when your retirement is calculated.

Waiver or Decline Certification

During Annual Benefits Enrollment

When you elect to waive medical and/or dental coverage or decline medical coverage, you must submit an online certification form. If you do not elect to waive or decline medical coverage by the deadline, or it is not approved, you will be automatically enrolled in the lowest-cost medical plan that you are eligible for effective January 1 of the following Plan Year.

For New Hires and Newly Eligible

If you want to waive or decline coverage, you must elect "waive coverage" or "decline coverage" during your special enrollment meeting. You should bring your medical ID card for your other coverage to your meeting. After your medical and/or dental waiver is approved, you may not enroll in an *Options* medical and/or dental plan for the remainder of the year unless you have a qualified change in status (see pages 14-17). If you are not required to attend a special enrollment meeting and enroll using the web enrollment system, you can enter your information online.

Effective Date of Coverage

During Annual Benefits Enrollment

If you enroll or make changes during annual benefits enrollment, your benefits become effective January 1 of the following Plan Year.

For New Hires and Newly Eligible

You become an *Options* participant on the first day of the month after you complete your enrollment. Your *Options* benefits start on the date shown in the **Benefit Effective Dates Schedule** on page 11 and continue through December 31.

The following benefits start the same month you become an *Options* participant:

- Health Care Spending Account
- Dependent Care Spending Account

This means that if you enroll in a spending account, you generally may begin incurring expenses eligible for reimbursement in the month you become a participant. However, your first payroll deduction and/or County contribution to your Dependent Care Spending Account will not begin until your benefits effective month (see the **Benefit Effective Dates Schedule** on page 11). **Note: If you enroll in November, your spending account coverage will not begin until January 1, when your payroll deductions begin.**

The following benefits begin on the first day of the month following the month you become an *Options* participant:

- Medical plan
- Dental plan
- Basic Term Life Insurance
- Optional Group Term Life Insurance
- Dependent Term Life Insurance
- Accidental Death and Dismemberment (AD&D) Insurance
- Medical Coverage Protection (LTD Health Insurance)

If you qualify for, and enroll in, the SEIU Local 721-sponsored Optional Universal Life insurance during your enrollment meeting, your coverage is effective immediately. Payroll deductions for this voluntary benefit begin within 60 days of your enrollment meeting. You will receive more information about this benefit in your enrollment packet. If you have questions about this insurance, call BenefitVision at 800-499-9190. Note, this is a Union-sponsored life insurance. This coverage is not offered by the County and does not replace the County-sponsored Optional Group Term Life insurance. For more information about **Optional Group Term Life insurance**, see pages 23-25.

Benefit Effective Dates Schedule			
Month in Which You Enroll	**Participation Begins[2] (Participation Date)**	**Benefit Effective Date**	**Date Paycheck Deductions & Benefits Allowance Begin[3]**
January	February	March 1	March 15
February	March	April 1	April 15
March	April	May 1	May 15
April	May	June 1	June 15
May	June	July 1	July 15
June	July	August 1	August 15
July	August	September 1	September 15
August	September	October 1	October 15
September	October	November 1	November 15
October	November	December 1	December 15
November	January	January 1	January 15
December	January	February 1	February 15

[2] *Generally, you may begin incurring expenses for spending account reimbursement during the month you become a participant. If you enroll in November, your spending account coverage will not begin until January 1 of the following Plan Year, when your payroll deductions begin.*

[3] *You will not receive the monthly benefits allowance and have paycheck deductions, if you work less than eight hours per month or receive less than eight hours of leave benefits*.

After You Enroll

Verifying Payroll Deductions for the Benefits You Elected

To make sure you are enrolled in the benefits you elected, check your mid-month paycheck during the month in which your payroll deductions are scheduled to begin. Compare the information at the bottom of your paycheck stub to the information on your confirmation statement.

Your paycheck stub will show the amount of your monthly benefits allowance (RF011 OPTIONS CONTRIB) and the cost of the specific benefits you elected. Payroll deduction codes for all benefits are listed below. Additionally, below is a sample paycheck stub. Note: If you elected to “Decline Medical Coverage,” your paycheck stub will not show the monthly benefits allowance. The cost of the other benefits you selected will show under “Salary Reduction.”

Cafeteria Benefits Information

Cafeteria Category	Cafeteria %	County Contribution	Salary Reduction	Contributed Benefits	Taxable Cash	Taxable Cash Limit
RF011 OPTIONS CONTRIB	0.00%	1,037.10	0.00	988.92	48.18	244.00

Benefit Category	Benefit Type	Benefit Plan	Benefit Plan Description	Deduction %	Current Base	County Contributed	County Contributed YTD	Salary Reduction	Salary Reduction YTD	Benefits Applied	Benefits Applied YTD	Available Balance YTD
EF140	EF140	C1	UHC HMO 1PTY		0.00	908.41	6,358.87	0.00	0.00	908.41	6,358.87	0.00
EF300	EF300	C1	DLTADNTL-O 1PTY		0.00	29.27	175.62	0.00	0.00	29.27	175.62	0.00
EF410	EF410	250E	AD&D 250K-EE		0.00	3.10	21.70	0.00	0.00	3.10	21.70	0.00
EL202	EL202	5XNE	LIFE 5XSAL	2.80%	48.00	1.35	9.45	0.00	0.00	1.35	9.45	0.00
EF045	EF045	EF045	LTD-H OP		0.00	3.00	21.00	0.00	0.00	3.00	21.00	0.00
EF500	EF500	EF500	HLTH CARE REIM		0.00	40.00	280.00	0.00	0.00	40.00	280.00	0.00
EF012	EF012	OP2WF	OPTIONS ADM FEE		0.00	3.79	26.53	0.00	0.00	3.79	26.53	0.00
Total Cafeteria Benefits						$988.92	$6,893.17	$0.00	$0.00	$988.92	$6,893.17	$0.00

Administrative Fee

You will be assessed a pre-tax administrative fee of $3.79 per month to help defray *Options* administration costs.

Payroll Deduction Codes

Review your paycheck stub to verify that you are enrolled in the benefits you elected. The payroll deduction codes shown below will appear on your paycheck stub next to the *Options* benefits you elected.

Medical Insurance

EF136-138 Kaiser Permanente HMO
EF140-142 UnitedHealthcare HMO
EF144-146 UnitedHealthcare Select Plus PPO
EF213-215 UnitedHealthcare Harmony HMO

Dental Insurance

EF300-302 Delta Dental PPO
EF312-314 DeltaCare HMO
EF320-322 MetLife (SafeGuard) HMO

AD&D

EF410, EF411, & EF413 AD&D
(employee only or employee plus family)

Spending Accounts

EF500 Health Care Spending Account
EF502 Dependent Care Spending Account (employee contribution)
RS505 Dependent Care Spending Account (County subsidy)

Miscellaneous

EF045 100% LTD Health Insurance
EF012 *Options* administrative fee

Life Insurance

EL202 Employee only (1x - 8x salary pre-tax)
EL203 Employee only (1x - 8x salary after-tax)
EL301 Dependent Term Life ($5,000-$20,000)

When Coverage Ends

For Yourself

<u>Your</u> coverage under *Options* ends as shown in the table below:

If this event occurs…	Then your coverage ends…
Your employment ends	At the end of the month following the month in which your employment ends, as long as you are in a paid status for at least 8 hours during the month your employment ends
Your employment status changes to temporary or part-time	At the end of the month following the month in which your permanent status ends, as long as you receive at least 8 hours of pay under permanent status during the month your status changes
You are billed for insurance premiums under the County's self-pay program (see pages 18-19) and you do not pay by the deadline	On the first day of the billed coverage month
You are offered and you elect to pay for coverage under COBRA	When you stop paying your monthly premiums or at the end of the continuation coverage period (see page 51)
You become eligible for a new benefit plan, such as *MegaFlex* or *Choices*	On the date your benefits under the new plan begin

For Your Dependents

<u>Your dependent's</u> coverage under *Options* ends as follows:

If this event occurs…	Then coverage for your child ends…
Your child reaches age 26	At the end of the month in which your child reaches age 26* (or age 18 in the case of a child for whom you are the legal guardian)
A dependent otherwise ceases to be an eligible dependent under the terms of the applicable benefit plan	On the last day of the month your dependent no longer qualifies as an eligible dependent. For Spending Accounts, coverage ends on the day your dependent no longer qualifies as an eligible dependent (e.g., divorce or termination of domestic partnership)
Your child is 26 or older and your health plan requests proof of disability, but you do not comply or do not meet the criteria for disability	On the last day of the month your child no longer qualifies as an eligible dependent. For Spending Accounts, coverage ends on the day your child no longer qualifies as an eligible dependent

You and your dependents may continue coverage under certain circumstances when coverage otherwise would end, as described in General Plan Administration: COBRA Continuation of Health Coverage on page 46. Your former spouse and stepchildren or domestic partner and domestic partner's children are no longer eligible for benefits upon divorce or termination of domestic partnership, and you must remove them from your medical and/or dental coverage in accordance with the Change in Status rules on pages 14-17.

**For the Health Care Spending Account, coverage ends on the first of the year your child reaches 27 years of age.*

IMPORTANT NOTE REGARDING CONSEQUENCES OF MISREPRESENTING ELIGIBILITY: When you enroll for coverage under the Plan, you certify that you and anyone you cover under *Options* meet all applicable eligibility requirements for the entire period of enrollment. You must notify the Benefits Plan Administrator by completing a "Change of Status" event (or "Life Event") via the web enrollment system and provide documentation when you or any dependent loses eligibility within 90 days of such event. In addition, the County reserves the right to request information or proof of eligibility that may be different than the proof requested upon initial enrollment for you and your dependents at any time. If you enroll someone who is ineligible or fail to remove an ineligible dependent from coverage within the time provided, your actions may be considered an intentional misrepresentation and/or fraud.

If you make fraudulent claims or misrepresentations regarding eligibility, participation, or entitlement to benefits under *Options*, you may be subject to disciplinary action, up to and including termination from participation in the plan, termination of employment, and criminal prosecution. In addition, to the extent permitted by law, your coverage may be terminated retroactively, and you may be required to reimburse the County or a plan for any premiums or benefits paid due to your fraud or misrepresentations. Medical coverage may not be retroactively terminated unless you have committed fraud or made an intentional misrepresentation of material fact as prohibited under *Options* and you have received at least 30 days advance written notice.

Enrollment Changes During the Plan Year: Changes in Status (Life Events)

If you do not enroll in *Options* when you are first eligible, or you do not make changes during annual benefits enrollment, you will not be allowed to enroll or make changes later UNLESS:

- You qualify for certain special health plan enrollment periods under HIPAA.[4]
- You have a qualified change in status.
- There are certain cost or coverage changes.
- You experience other special circumstances (see page 16 for details).

Special Enrollment Periods for Medical Plans

Special Medical Plan Enrollment Rights for New Dependents

If you have a new dependent due to a life event such as marriage, birth, adoption, or placement for adoption, then you, your new dependent, and your spouse or domestic partner (even if they are not the new dependent) may enroll under any *Options* medical plan option. (See **Consistency Rules** on page 15 for more details).

HIPAA special enrollment rules allow you to switch medical plans. However, you must enroll your new dependent into your medical plan. If you switch medical plans, be mindful that services (e.g., doctor visits, pharmacy, and prescriptions) sought under your current plan may not be covered under your new plan. Be sure to check with the new plan before the date of your special enrollment to ensure it will pay any costs incurred because you will be subject to the new plan's continuity/transition-of-care rules. If you have questions, contact the Benefits Hotline at 213-388-9982.

When you request a change in medical plan coverage due to birth, adoption, or placement for adoption, coverage will be effective on the date that the birth, adoption, or placement for adoption took place.

Loss of Health Coverage

If you previously waived medical coverage under *Options* because you had alternative health coverage and you lose that alternative coverage, you may enroll yourself and any dependents in any *Options* medical plan. In addition, if your dependent loses health coverage under another plan, you may enroll that dependent and yourself under any *Options* medical plan (whether or not you are already enrolled in an *Options* medical plan). For these purposes, **a person is generally not considered to have lost coverage if he or she failed to pay premiums or lost overage for cause** (e.g., fraud); COBRA coverage is considered lost only when the available COBRA period runs out.

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[4] *Health Insurance Portability and Accountability Act of 1996.*

Changes in Status (Life Events)

You may request a change to your *Options* coverage during the year (e.g., adding or dropping coverage) provided the election change is on account of and consistent with a qualified change in status that affects eligibility for coverage for you or your dependents.

Financial hardship is not considered a qualified life event or change in status by the federal government. You may not use financial hardship as a reason to make changes during the year.

Qualified changes in status include:

- You get married or establish a domestic partnership.
- You get divorced or legally separated, your marriage is annulled, or you terminate your domestic partnership.
- A child is born to you, placed with you for adoption, or you obtain legal guardianship (through age 17).
- Your spouse/domestic partner or dependent dies.
- Your spouse/domestic partner or dependent begins or ends employment.
- You, your spouse/domestic partner, or your dependent has a change in employment status that affects employment hours, and you lose or gain eligibility (this includes changes in hours due to strikes and lockouts).
- Your eligible dependent child loses eligibility status due to age.
- Your dependent gains eligibility for other employer-sponsored coverage.
- You or your spouse/domestic partner begins or ends an unpaid leave of absence.
- You, your spouse/domestic partner, or your dependent changes where that individual lives or works and this change affects eligibility for benefits under *Options*.

Consistency Rules

If you have a qualified change in status during the year and you request a change in your benefit election, your election change must satisfy the following consistency rules:

- **For Medical and/or Dental Coverage:** If a qualified change in status causes you, your spouse/domestic partner, or a dependent to lose or gain eligibility for coverage under *Options*, or under a plan sponsored by your spouse's/domestic partner's or dependent's employer, you may make a change in your medical and/or dental coverage as long as the change is because of, and is consistent with, that change in status. For example: If a dependent dies or is no longer eligible for coverage, you may elect to cancel coverage for that dependent; however, you cannot cancel coverage for any other individual. Another example would be, if you gain a new dependent child due to the birth life event, you may elect to enroll that dependent into your medical plan and may change medical plans provided you enroll the new dependent into your medical plan.
- **For Life Insurance and/or AD&D Coverage:** If you have a qualified change in status, you may increase or decrease your life insurance and/or AD&D coverage. Life insurance increases are limited to one level or "increment." For example: If you have coverage equal to one times your annual salary, you may increase coverage to two times your annual salary. If you have coverage equal to two times your annual salary, you may increase coverage to three times your annual salary, etc.
- **For the Dependent Care Spending Account:** If you have a qualified change in status, you may make a change in your spending account election as long as that change is consistent with your status change. For example: If you have another baby, you may elect to increase your Dependent Care Spending Account contribution to cover the additional day care costs.

Cost or Coverage Changes

Options benefits and benefit costs have been agreed to by the County, SEIU Local 721, and the insurance carriers; approved by the Board of Supervisors; and are not expected to change during the year. If the Benefits Plan Administrator determines that the cost of the benefit plan you elected has increased significantly, the Benefits Plan Administrator may allow you to make a corresponding change in your payroll deductions *or* allow you to revoke your existing election and enroll in another benefit plan with similar coverage. If the cost of another *Options* Plan has significantly decreased, the Benefits Plan Administrator may allow you to change your existing election and enroll in the *Options* Plan that has lower costs. Similarly, if the Benefits Plan Administrator determines that your existing coverage under a benefit plan was reduced significantly, the Benefits Plan Administrator may allow you to revoke your existing election and enroll in another plan that offers more coverage. Finally, if during the year a new benefit

plan is offered or an existing benefit plan is eliminated, the Benefits Plan Administrator may allow you to enroll in the new benefit plan, or the replacement plan, depending on the circumstances.

Spending Account Cost or Coverage Changes

You cannot make changes to your Health Care Spending Account elections because of changes in benefit costs or coverage.

Elections on how much you put in your Dependent Care Spending Account can be adjusted in the middle of the year if your day care expenses change. Dependent Care Spending Account changes are only allowed if the dependent care provider is not your relative. For these purposes, a relative includes any of the following: (1) your spouse; (2) your child (including an adopted child, stepchild, or foster child) or grandchild; (3) your sibling, half-sibling, or stepsibling; (4) your parent (or ancestor thereof) or stepparent; (5) your uncle, aunt, niece, and nephew; (6) your in-laws; or (7) an individual who lives with you as a member of your household. Also, a dependent care election may be changed during the year to reflect a change in your dependent care provider or a change in the number of hours or days you utilize the provider.

Other Special Circumstances

You may make changes to your *Options* coverage under the following special circumstances:

Judgment, Decree, or Court Order

If you receive a judgment, decree, or court order requiring you to cover a child, then you may elect to cover the child during the year under the *Options* medical, dental, or AD&D plan. If your spouse/domestic partner receives a judgment, decree, or court order requiring him/her to provide medical, dental, or AD&D coverage for a child, then you may elect to cancel that child's same coverage under *Options*.

Medicare or Medicaid Entitlement

If you become covered under Medicare (Parts A and Part B) or Medicaid, you may cancel or reduce coverage under the *Options* medical, dental, and AD&D plans. Also, if your spouse/domestic partner or dependent becomes covered under Medicare or Medicaid, you may cancel or reduce coverage for that person under the *Options* medical, dental, and AD&D plans. If you, your spouse/domestic partner, or your dependent loses eligibility under Medicare or Medicaid, you may elect to begin (or increase) medical, dental, or AD&D coverage under *Options* for the affected person.

Change in Coverage Under Another Employer-Sponsored Plan

You may make a corresponding change to your *Options* election if you are doing so because of a change that was made during an open enrollment under another employer-sponsored plan (e.g., your spouse's/domestic partner's employer's plan).

You may also make a corresponding change to your *Options* election if you are doing so because of a change that was made under another employer-sponsored benefit plan, if the change was permitted by the other plan, and is as a result of one of the federal tax rules discussed in this section.

For purposes of both of the above circumstances, "another employer-sponsored benefit plan" includes: 1) a plan offered as an option under *MegaFlex*, *Flex*, *Choices*, or *Options*, and 2) a plan sponsored by your spouse's/domestic partner's or dependent's employer.

Example: Assume that you enroll your family for health coverage under *Options*. Also, assume that your spouse's/ domestic partner's employer previously offered employee-only health coverage, but in the middle of the year adds family coverage as an option. The addition of family coverage constitutes the addition of a new coverage option under the cost or coverage change rules described earlier. Therefore, you may be permitted to revoke your election under *Options* if your spouse/domestic partner elected family coverage under their employer's plan.

If you have any questions related to this section, call the County's Benefits Hotline at 213-388-9982.

Taxation of Medical/Dental Coverage for Domestic Partners
Remember, if you purchase medical and/or dental coverage for your domestic partner, the cost of that coverage is treated as taxable and is reported on your monthly paycheck as “imputed income.” However, if you provide the Benefits Plan Administrator with a copy of your **registered** State of California *Declaration of Domestic Partnership* form or California Certificate of Registered Domestic Partnership (or valid proof of a similar legal union from another state), your cost for such coverage will be deducted before California state taxes are taken out of your pay. Note, your County of Los Angeles registration alone does not qualify you for this tax break.

Other insurance coverage provided to or on behalf of a domestic partner or their children may also be determined to be taxable under federal law. Thus, to the extent required by law, the County may require you to purchase these benefits with after-tax dollars or report imputed taxable income with respect to those benefits.

How to Submit a Request for an Election Change Due to a Change in Status or Life Event

Within 90 days of the qualified change in status, you must:

1) **Go** to the web enrollment system at **mylacountybenefits.com** and click "Life Events” at the top of the homepage. Follow the instructions. If you are adding new dependents to your health coverage, you must provide Social Security numbers. (Social Security numbers for newborns must be provided within 90 days from the date of birth).
2) **Confirm** your elections and submit your request on the system.
3) **Photocopy** any appropriate “proof” documents, such as a marriage certificate, birth certificate, or divorce decree (see the list on pages 6-7). In the case of an election change that involves obtaining coverage under another employer’s plan, you will be asked to certify that such coverage was or will be obtained.
4) **Write** your employee number on each certificate and document.
5) **Submit** your proof documents within 90 days of the date of your life event. See the **Required Proof of Dependent Eligibility** section on page 6 and **Submitting Proof of Dependent Status** section on page 7. Any request for a qualified change in status is not finalized until the Benefits Plan Administrator receives and approves all necessary proof documents and processes your request. **Proof documents received after 90 days will not be processed!**

Important Life Event Notes

- The 90-day time period for an election change due to a life event is intended to give the participant a reasonable time to make one election that is consistent with their change in status. It does not give the participant the right to make multiple election changes.
- If you have a life event between October 1 and December 31, you must complete one life event enrollment for the current Plan Year, and another for the next Plan Year. If you add dependents in November and December through the marriage or birth/adoption life event, but do not complete the second life event enrollment, only the medical and dental coverage you elect for your new dependent automatically carries over to the following Plan Year.

Getting Changes Approved

When all supporting documents are received and approved, the Benefits Plan Administrator mails a *Confirmation Statement* to you. This statement shows the effective date of any approved changes. If the Benefits Plan Administrator does not approve your request, you will also be notified.

When Changes Become Effective

If the Benefits Plan Administrator receives your change request and the required supporting documentation on or before the 25th day of any month, the changes you requested will be effective on the first day of the following month. However, when you request to enroll a spouse or child to your current medical coverage due to marriage, birth, adoption, or placement for adoption, coverage will be effective on the date that the respective marriage, birth, adoption, or placement for adoption took place. When you request a change in medical plan coverage due to birth, adoption, or placement for adoption, coverage will be effective on the date that the birth, adoption, or placement for adoption took place.

Coverage While Not Receiving Pay

If for any reason, you receive no pay for any month, you will not receive the *Options* monthly benefits allowance the following month.[5] For example, if you are on an unpaid leave for the entire month of January, you will not receive pay or the benefits allowance in February. When you do not receive an *Options* monthly benefits allowance, your insurance premiums cannot be withheld from your paycheck. Thus, to continue your insurance coverage while you are in a "no-pay" status, you must pay the entire monthly insurance premiums for your coverage.
Note: Different rules may apply in regard to your coverage if you are on leave covered by the Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). See pages 44-45 for details.

If you are enrolled in one or more of the following *Options* Plan benefits, you will be billed monthly for your insurance premiums under the County's **self-pay program**:

- Kaiser, UnitedHealthcare HMO, UnitedHealthcare Harmony HMO, or UnitedHealthcare Select Plus PPO medical
- DeltaCare, Delta Dental, or MetLife (SafeGuard) dental
- Optional Group Term Life Insurance (for a maximum of three years)
- Dependent Term Life Insurance (for a maximum of three years)
- Accidental Death and Dismemberment Insurance (for a maximum of three years)
- Medical Coverage Protection (LTD Health Insurance)
- Health Care Spending Account (only during the Plan Year)

IMPORTANT: If you are in the process of filing a claim for long-term disability (LTD) benefits or waiting for approval, you must continue to pay for your medical premiums until your claim is approved. If you stop paying the medical premiums, your medical coverage is not continuous, and you will not be eligible for LTD Health Insurance when your LTD benefits begin. See **Medical Coverage Protection (LTD Health Insurance)** on pages 27-28 for more details.

Your insurance coverage continues as long as you are employed with the County and you pay your monthly insurance premiums by the given deadlines. You will continue to receive a billing notice each month while you are in a "no-pay" status.

If you are enrolled in Optional Group Term and Dependent Term Life insurance, you may qualify for a premium waiver while on a leave of absence. Contact New York Life Group Benefit Solutions at 800-842-6635 for an application.

Nonpayment of Premiums Under the County's Self-Pay Program

If you do not pay the monthly bill for your insurance plans under the County's self-pay program:

- You will no longer receive a billing notice and your coverage will end.
- You may be eligible for continuation of coverage under a federal law known as COBRA.
- You will not be an active participant in the Health Care Spending Account and will be ineligible for claim reimbursement for expenses incurred during the month you did not pay. See pages 31-32 for **Important Rules on a Health Care Spending Account**.

If you leave County service, you will be offered the opportunity to elect and pay for continued health coverage for up to 18 months (29 months if you are disabled) under a federal law known as COBRA. When federal COBRA coverage ends, you may be entitled to extend coverage further under California law. In addition, under federal COBRA, your dependents may be entitled to elect and pay for continued coverage for up to a total of 36 months if certain "qualifying events" occur during the 18-month period. When you first become covered under a County-sponsored health plan, you should receive a notice that explains your rights and obligations under COBRA as well as a notice

[5] *This is also true if you work less than eight hours in a month or receive pay for less than eight hours of leave benefits such as sick or vacation.*

explaining your rights and obligations under California law. Contact the County's Benefits Hotline at 213-388-9982 if you did not receive your notices or need new copies.

If you elect to continue your health coverage under COBRA or California law, you are responsible for paying the monthly insurance premiums, plus an administrative fee, by the given deadlines. Your COBRA or California continuation coverage ends when you stop paying your monthly premiums or at the end of the continuation coverage period. If you become entitled to COBRA or California continuation coverage, you will receive more detailed information regarding your rights from your health plan. Also, see pages 46 through 50 for more information about COBRA and Cal-COBRA.

Return to Work

If you return to work from a leave of absence, your coverage resumes on the first day of the following month. Your monthly benefits allowance resumes and your insurance premiums are deducted from your mid-month paycheck.

YOUR MEDICAL PLAN OPTIONS

As a member of *Options*, you have the option of enrolling in one of several medical plans. A brief description of each is provided below.

Plans	How They Work
Kaiser Permanente HMO *A group model Health Maintenance Organization (HMO) with its own hospitals, outpatient facilities, doctors, nurses, and other health care professionals*	You receive all care from a Kaiser facility or physician. No benefits are paid for services received from other providers — except for emergencies outside the Kaiser Permanente service area. You choose a Kaiser Permanente Primary Care Provider (PCP) after coverage begins. (Contact Kaiser directly for details).
UnitedHealthcare HMO *A Health Maintenance Organization (HMO) that contracts with private hospitals, medical groups and individual private practice physicians for services at negotiated rates*	Each family member may choose their own PCP from UnitedHealthcare's network of private practice physicians. You pay only a small copayment for most services. There's no deductible and no claim forms. Services received from other providers are not covered — except for emergencies outside the UnitedHealthcare network provider area.
UnitedHealthcare Harmony HMO *A narrow network Health Maintenance Organization (HMO)*	Each family member may choose a provider group in Los Angeles County, Orange County, San Bernardino County, Riverside County, or San Diego County. Once a provider is selected, all of your and your family's care must be received within your chosen provider group. Each family member may choose their own PCP within their chosen provider group. You pay only a small co-payment for most services. There's no deductible and no claim forms. Services received from other providers are not covered — except for emergencies outside the UnitedHealthcare Harmony HMO provider area.
UnitedHealthcare Select Plus PPO *A Preferred Provider Organization (PPO) medical plan that allows you to choose an in-network PPO provider or an out-of-network provider each time you need care*	You have the freedom to see any physician you choose at any time; however, when you use a UnitedHealthcare network provider (doctor or hospital) you pay less.

Special Notices Regarding Your Rights Under the Health Plans

Statement of Newborns' and Mothers' Rights

Under federal or state law, as applicable, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Additionally, plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your health plan administrator.

Important Notice About the Women's Health and Cancer Rights Act

Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes)

The Plan will determine the manner of coverage in consultation with you and your attending doctor. Coverage for breast reconstruction and related services is subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the Plan.

Precertification Requirements

The medical plan administrators have the sole and exclusive power to exercise discretion as to claims for coverage for any other items not specifically listed in the *Medical and Dental Plans Comparison* Chart (included in your enrollment packet). You should contact the providers before obtaining a service or treatment if you have a question about whether the Plan covers the service or treatment. See page 52 for a complete list of the insurance carriers and their contact information.

Refer to the *Medical and Dental Plans Comparison* chart included in your enrollment packet for details about services covered that require precertification (e.g., out-of-network hospital care). Failure to pre-certify before obtaining services that require precertification can mean a reduction in benefits or a penalty.

Exclusions and Limitations for HMO and PPO Medical Plans

The medical plan options limit or exclude some medical treatments, services, and supplies. Contact your insurance carrier for information about items that are not eligible for reimbursement. See page 52 for **Contact Information**.

Other Benefits and Programs

Each medical plan carrier has special programs and benefits for members. They may include healthy lifestyle, smoking cessation, and stress management programs, discounts, etc. Visit each plan's website, or contact the member services department, for details. See page 52 for a complete list of the insurance carriers and their contact information.

YOUR DENTAL PLAN OPTIONS

As a member of *Options*, you have the option of enrolling in the following dental plan options:

Plans	How They Work
MetLife (SafeGuard) and DeltaCare *HMO dental plans*	You receive all of your dental care within a network of participating dental offices. When you enroll, you choose a dental office that becomes your "primary care office," and you must obtain all of your care from this office.
Delta Dental *A PPO dental plan*	You have the freedom to visit any in-network or out-of-network dentist of your choice. You pay less out-of-pocket when you visit in-network dentists.

How to Obtain Dental Benefits

HMO Dental Plans

When you enroll in a Health Maintenance Organization (HMO) dental plan, you must choose a primary care office to coordinate all of your dental care. When you need care, call your designated dental office and schedule an appointment. Depending on the services you obtain, you may have to pay a co-payment. You do not need to file any claim forms for services.

PPO Dental Plans

Under a PPO dental plan, you have the freedom to visit any licensed dentist of your choice. The Delta Dental plan has a special network feature with two different networks of participating dentists and dental care providers:

- The Delta Preferred Provider Organization (PPO) network: This network offers the highest benefit. Most preventive services are covered at 100 percent; many other services are covered at 85 percent. You pay no deductible.
- The Delta Participating Dentist network: Under this network, Delta pays benefits based on a pre-arranged fee agreed to by the network's dentists. Most routine services are covered at 85 percent.

You may go to any dentist from either network, or you may go to an out-of-network dentist. When you go to any licensed out-of-network dentist, the plan pays the same percentage of cost that it pays a Delta Participating Dentist. However, the payment is based on the charge that is considered Reasonable and Customary (R&C) for the geographical area. This means that your share of the expenses may be higher if your out-of-network dentist charges more than the R&C amount.

If You Lose Coverage During Treatment

If you or a covered dependent terminates or loses dental coverage during a course of treatment, the plan may continue coverage for certain specified dental conditions. Upon loss or termination of coverage, call your plan's customer service department to see if your course of treatment qualifies.

Exclusions and Limitations for HMO and PPO Dental Plans

The dental plan options limit or exclude some dental treatments, services, and supplies. Contact your insurance carrier for information about items that are not eligible for reimbursement. See page 52 for **Contact Information**.

Need More Information?

If you have questions about the medical and dental plan options, or need more information about what's covered, contact the insurance carrier directly. See page 52 for a complete list of the insurance carriers and their contact information.

LIFE INSURANCE BENEFITS

Life insurance offers you and your family financial protection if you or a covered family member dies.

Basic Term Life Insurance

The County gives you Basic Term Life insurance at no cost to you.

- General Members of Retirement Plan A, B, C, D, or G: You are insured for $5,000.
- Members of Retirement Plan E: You are insured for $13,000.

Optional Group Term Life Insurance

When you are newly eligible for *Options*, you may purchase Optional Group Term Life insurance at low monthly group rates, in amounts equal to 1, 2, 3, 4, 5, 6, 7, or 8 times your annual salary. If you buy Optional Group Term Life insurance for yourself, you may also buy a limited amount of life insurance for your spouse/domestic partner and dependent children. The monthly premium rates go up as your salary increases or as you reach the age brackets shown in the **Optional Group Term Life Monthly Rates** table on page 24.

Pre-Tax/After-Tax Premiums for You

Internal Revenue Service (IRS) rules say you can receive or buy up to $50,000 worth of life insurance through *Options* with *pre-tax* dollars. So, if you need more than $50,000 worth of life insurance, you will pay for the excess coverage with *after-tax* dollars (see the example on page 24).

Example: Paying for Optional Group Term Life insurance with pre-tax dollars

	Amount of Basic Life Insurance County Provides	IRS Maximum	Amount of Optional Life Insurance You May Buy with Pre-Tax Dollars
Members of Retirement Plan E	$13,000	$50,000	$37,000
Members of all other Retirement Plans	$5,000	$50,000	$45,000
The cost of any life insurance over $50,000 must be paid with after-tax dollars.			

IMPORTANT NOTICE
The IRS places a $50,000 limit on the total combined life insurance you can receive from the County and purchase for yourself on a tax-free basis. The cost of life insurance coverage over the $50,000 limit is deducted from your paycheck after taxes. In addition, the difference between the approved IRS value of life insurance more than $50,000, and your actual cost of insurance is treated as taxable income to you and reported on your Form W-2 as "imputed income."

Calculating Your Monthly Premium

To calculate your monthly premium, take the cost information that applies to your age as of your participation date from the **Optional Group Term Life Monthly Rates** table below and follow the steps shown in the sample calculation. Keep in mind, the County pays 15 percent of the monthly premium. You pay the difference. The rates below are rounded to two decimal points for simplicity. Actual rates are three decimal points.

Optional Group Term Life Monthly Rates	
Employee Age	**Cost Per $1,000 of Insurance***
Under 30	$.033
30-34	$.056
35-39	$.063
40-44	$.071
45-49	$.105
50-54	$.162
55-59	$.304
60-64	$.466
65-69	$.664
70 and older	$1.278

***You only pay 85% of this cost because the County pays 15%.**

After your new coverage takes effect, the County automatically adjusts your monthly premium cost as your age or salary changes. Review the rates above carefully as your cost significantly increases based on your age bracket above.

Sample Calculation

Use the following example to calculate your monthly cost of coverage on a pre-tax and after-tax basis.

You are 42 years old, you earn $37,500 per year, and you choose coverage of two times your annual salary.

❶ Round your salary to the next highest $1,000 if it is not an even multiple of $1,000 ($38,000)
❷ $38,000 x 2 = $76,000
❸ $76,000 ÷ $1,000 = $76
❹ $76 x $.071 x .85 = $4.59 your share of the monthly premium**

You are a member of Retirement Plan D; therefore, the total amount of coverage you can pay for with pre-tax dollars is $45,000.

❺ $45,000 ÷ $1,000 = $45
❻ $45 x $.071 x.85 = $2.72 your *monthly pre-tax cost***

Your monthly after-tax cost is:

❼ $4.59 - $2.72 = $1.87 *monthly after-tax cost***

***The County pays 15% of the monthly premium and you pay 85% of the premium. In addition, the difference between the IRS value of your life insurance over $50,000 and your after-tax cost will be treated as additional or "imputed" taxable income.*

Be sure that the life insurance coverage you elect meets your current needs. Each year at annual benefits enrollment, you will have the opportunity to increase your coverage by one level, to a maximum of eight times your annual salary.

Example: If you elected coverage equal to one times your annual salary, at the next annual benefits enrollment you would only be able to increase coverage to two times your annual salary. If you elected coverage equal to two times your annual salary, you would be able to increase it to three times your annual salary, etc.

Important Note: The Optional Group Term Life insurance is a group term policy, not an individual term policy. A group term policy is intended to be available to active County employees maintaining premiums throughout their employment regardless of their age. It is not an individual policy, but a policy owned by the County. See the Coverage While Not Receiving Pay on pages 18-19, if for any reason you receive no pay for any month and your premiums are not paid. Contact New York Life Group Benefit Solutions (New York Life) at 800-842-6635, for information on converting the group term policy to an individual term policy when you retire or leave County service.

Beneficiary Designation
When you designate a specific beneficiary (such as a child) and your personal circumstances change (such as marriage), your beneficiary remains the same as you originally designated unless you request a change. To designate a beneficiary, mail a completed *Beneficiary Designation Form* to New York Life. The form is included in new hire packets, and you may request one from New York Life at 800-842-6635. If you do not have a named beneficiary on file, the plan will pay out your life insurance benefit in the following order:

1) Your surviving spouse
2) Your surviving children
3) Your surviving parents
4) Your surviving siblings
5) Your estate

Disability and Terminal Illness Provisions
If you become totally disabled before age 65 and provide proof of disability to New York Life, your Optional Group Term Life insurance coverage is extended for the period of disability without further premium payment. In addition, if you become terminally ill and have a life expectancy of 12 months or less, you can receive 25 percent to 75 percent of the face value of your policy and use it for whatever you choose. Read the plan brochure or policy material for details.

Dependent Term Life Insurance

When you purchase Optional Group Term Life insurance for yourself, you may also purchase coverage for your spouse/domestic partner and dependent children. You may purchase one of the following coverage amounts for your dependents:

Amount of Optional Dependent Term Life Coverage*	Monthly Cost for Family Coverage
$5,000	$0.83
$10,000	$1.66
$15,000	$2.50
$20,000	$3.33

**Coverage for newborns from birth to six months is limited to $500.*

The monthly cost is for coverage for *all* of your eligible family members, regardless of the number of family members covered. For example, a person covering a spouse/domestic partner and one dependent child will pay the same amount as a person covering four dependent children. **The cost is added to your monthly life insurance premium, and you pay it with after-tax dollars.**

Each covered family member over age six months is insured for the same coverage amount. **Unmarried dependent children are covered for the full amount from age six months through age 20 (through age 25 for full-time students) and primarily supported by you, your legal spouse or domestic partner. Age 26 or older if your child is disabled, primarily supported by you, your legal spouse or domestic partner and incapable of self-sustaining employment.** Dependent children from birth to six months are covered at $500.

Dependent Term Life Insurance Coverage for Domestic Partners
To purchase Dependent Term Life insurance for your domestic partner, you must have a County of Los Angeles *Declaration of Domestic Partnership* form or registered State of California *Declaration of Domestic Partnership* form or California Certificate of Registered Domestic Partnership (or valid proof of a similar legal union from another state) on file with the Benefits Plan Administrator.

Note: When you end a domestic partner relationship and complete the termination of domestic partnership life event, your former domestic partner is no longer eligible for the Dependent Term Life insurance coverage. See Stopping Coverage for a Domestic Partner on page 5.

Accidental Death and Dismemberment Insurance

You can buy Accidental Death and Dismemberment (AD&D) insurance at low monthly group rates. If you die in an accident, become paralyzed, or lose a limb, eyesight, speech, or hearing because of an accident, your AD&D insurance pays benefits. AD&D coverage amounts are shown in the table below. During annual benefits enrollment, refer to the *Personalized Enrollment Worksheet* in your enrollment package. It will show the pre-tax monthly premium rates for AD&D insurance. If you are enrolling for the first time, you will receive a rate sheet with your enrollment package.

Beneficiary Designation

When you designate a specific beneficiary (such as a child) and your personal circumstances change (such as marriage), your beneficiary remains the same as you originally designated unless you request a change. To designate a beneficiary, mail a completed *Beneficiary Designation Form* to New York Life Group Benefit Solutions (New York Life). The form is included in new hire packets, and you may request one from New York Life at 800-842-6635. If you do not have a named beneficiary on file, the plan will pay out your life insurance benefit in the following order:

1) Your surviving spouse
2) Your surviving children
3) Your surviving parents
4) Your surviving siblings
5) Your estate

AD&D Coverage for Dependents

When you enroll yourself for AD&D coverage under *Options*, you may also buy coverage for your **spouse/domestic partner under age 70 and unmarried dependent children through age 20 (or through age 25 if full-time students) and primarily supported by you. Coverage for a child may continue past age 26 if your disabled child is primarily supported by you and incapable of self-sustaining employment.** Contact New York Life at 800-842-6635 for more information. The amount of coverage you have for yourself determines the amount of coverage your family members may have. The amounts are shown in the following table.

Accidental Death Benefits				
Employee	**Spouse/Domestic Partner only**	**Spouse/Domestic Partner with Children**		**Children Only**
Coverage	Spouse/Domestic Partner	Spouse/Domestic Partner	Each Child	Each Child[2]
$ 10,000	$ 6,000	$ 5,000	$ 1,000	$ 2,000
$ 25,000	$ 15,000	$ 12,500	$ 2,500	$ 5,000
$ 50,000	$ 30,000	$ 25,000	$ 5,000	$ 10,000
$ 100,000	$ 60,000	$ 50,000	$ 10,000	$ 20,000
$ 150,000	$ 90,000	$ 75,000	$ 15,000	$ 25,000[2]
$ 200,000	$ 120,000	$ 100,000	$ 20,000	$ 25,000[2]
$ 250,000[1]	$ 150,000	$ 125,000	$ 25,000	$ 25,000[2]

[1] *The maximum employee AD&D benefit is limited to the lesser of 10 times salary or $250,000.*

[2] *The maximum death benefit for each child is limited to $25,000.*

AD&D Coverage for Domestic Partners

To purchase AD&D insurance for your domestic partner, you must have a County of Los Angeles *Declaration of Domestic Partnership* form or registered State of California *Declaration of Domestic Partnership* form or California Certificate of Registered Domestic Partnership (or valid proof of a similar legal union from another state) on file with the Benefits Plan Administrator. **Remember, if you end a domestic partner relationship and complete the termination of a domestic partnership life event, your former domestic partner is no longer eligible for the AD&D coverage.** **See Stopping Coverage for a Domestic Partner on page 5.**

Note: If you are enrolled in AD&D under *Options*, you cannot also be insured as a spouse/domestic partner or dependent on another employee's AD&D coverage. In addition, dependent children may only be insured under one County employee's AD&D coverage.

MEDICAL COVERAGE PROTECTION (LTD HEALTH INSURANCE)

The LTD Health Insurance plan is designed to help you continue your medical insurance coverage if you are eligible for long-term disability and become totally and permanently disabled. If you meet the eligibility requirements listed below and become totally disabled, the LTD Health Insurance plan continues your County medical insurance coverage while you are receiving County LTD benefits.

You are eligible to participate in the LTD Health Insurance plan if you meet both of the following requirements:

- You are a General (not safety) Member of Retirement Plan A, B, C, D, E, or G of the Los Angeles County Employees Retirement Association (LACERA).
- You are enrolled in a County-sponsored medical plan.

If you meet the eligibility requirements, and you experience a disability on or after the later of January 1, 2008, or the date your medical coverage begins, the LTD Health Insurance plan pays 75 percent of your monthly medical premium while you are disabled and receiving LTD benefits. You must pay the other 25 percent of the monthly medical premium. For disabilities occurring after January 1, 2008, this coverage is provided automatically at no cost to you.

For disabilities occurring on or after January 1, 2008, eligible employees can elect the 100 percent LTD Health Insurance “buy up” at a cost of $4.75 per month. Under this optional coverage, the LTD Health Insurance plan will pay 100 percent of the monthly medical plan premium while you receive LTD benefits. **If you do not elect to purchase the optional 100 percent coverage for a Plan Year, you cannot elect this coverage for the next Plan Year. You must wait two Plan Years before you again have the option to elect this coverage.**

When Coverage Begins

If you meet the LTD Health Insurance eligibility requirements described above, your Medical Coverage Protection under the LTD Health Insurance plan begins after you satisfy the long-term disability plan’s eligibility waiting period (five years of continuous County service **OR** total disability as a result of a work-related or active military service-related injury or illness). **When you are in the process of filing a claim, or have filed a claim for Long-Term disability benefits, you must continue to pay for your medical premiums (maintain continuous coverage) until you are approved for LTD Health Insurance. LTD Health Insurance benefits begin when you start receiving LTD benefits. Failure to maintain continuous coverage will end your eligibility for LTD Health Insurance.**

Increasing Your Coverage During Annual Benefits Enrollment

If you are already currently disabled and in the qualifying period, or receiving Long-Term Disability benefits, and you were not covered by the 75 or 100 percent LTD Health Insurance plan when you became disabled, your enrollment in the 75 percent LTD Health Insurance plan, or your election to the 100 percent LTD Health Insurance “buy up” will not become effective until you return to work. The enrollment or election will not be effective with regard to a recurrence of the same disability unless you have returned to work for at least six months.

When Benefits Begin and End

If you enroll in the LTD Health Insurance plan while you are still actively at work, and you satisfy the eligibility requirements, your LTD Health Insurance plan benefits begin when you start receiving long-term disability benefits (after six months of total disability). Your LTD health benefits will continue for so long as you are disabled and receiving LTD benefits, except that, if you become eligible to receive retiree health benefits from the Los Angeles County Employees Retirement Association (LACERA), your LTD health benefits will stop whether or not you elect to receive the retiree health benefits provided by LACERA. You must continue your County-sponsored medical coverage by paying premiums under the County’s self-pay program or with payroll deductions until you begin long-term disability benefits to qualify for continuation coverage under the plan.

Survivor Coverage

If you die while receiving benefits under this plan, coverage is extended to your survivor. A “survivor” for this purpose means your spouse, or state registered domestic partner (as defined in the **Eligibility** section of this SPD), or children through age 25, provided that the survivor was an eligible dependent covered under your Kaiser or UnitedHealthcare medical plan at the onset of your disability (or, if you died before making your disability claim, the date of your death). Survivor benefits continue until the survivor’s death or until the individual ceases to be an eligible survivor, except that, if the survivor becomes eligible to receive retiree health benefits from LACERA, the LTD health benefits will stop whether or not the survivor elects to receive the retiree health benefits provided by LACERA. However, if you have between five and ten years of service, and your disability or death does not arise out of and in the course of the performance of your duties, benefits won't stop because of eligibility for benefits from LACERA unless and until your survivor has received LTD health benefits for a period of two years.

For more information on long-term disability benefits, visit **employee.hr.lacounty.gov/benefits-2** and click on “Return to Work” on the left side menu.

HEALTH CARE AND DEPENDENT CARE SPENDING ACCOUNTS

Health care and dependent care can get expensive. But you can save money by paying certain health and dependent care expenses with pre-tax dollars. How? Through a Health Care Spending Account or a Dependent Care Spending Account maintained for eligible employees of the County of Los Angeles. These accounts are available to employees under *Options*. This section summarizes the important terms that apply to the spending account plans available to eligible County of Los Angeles employees. These plans are intended to comply with applicable federal tax law and will be interpreted and administered by the County consistent with the law. If there is any discrepancy between the statements in this SPD and the terms of the relevant plans, as stated in the County Code, the terms of the plans will rule.

The Spending Account Tax Advantage

When you elect to participate in a spending account, you set aside part of your salary on a pre-tax basis to pay certain eligible expenses. In addition, the County will make contributions to a Dependent Care Spending Account on your behalf if you elect to participate. (See page 35 for information on the County contribution). You would normally pay these expenses out of your own pocket with after-tax dollars. But when you make contributions to a spending account, you pay no taxes on the money you contribute. This means you lower your taxable income and pay less in taxes.

How Spending Accounts Work

- First, you need to estimate your eligible out-of-pocket health care and dependent care expenses for the coming Plan Year. These are the expenses not covered by your health plans, such as deductibles, co-payments, prescribed and over-the-counter medication expenses, day care costs, etc. Use the handy worksheets on pages 33 and 40 of this SPD to help you estimate expenses.
- When you have an eligible health care or dependent care expense, pay the bill as usual and then submit your claim for reimbursement. You may also submit unpaid bills for eligible expenses. See pages 41-42 of this SPD for information on submitting a claim for eligible spending account expenses.
- You are reimbursed from your spending account with tax-free dollars:
  — Anytime during the year, you may file a health care claim and be reimbursed for the maximum annual amount that you elected to be deposited into your Health Care Spending Account, even if the total amount has not yet been deposited into your account.
  — Dependent care expenses are reimbursed up to the amount in your account at the time the claim is filed.
- Remember, these are separate accounts. You may not use money from your Health Care Spending Account to pay Dependent Care Spending Account expenses, and you may not use money from your Dependent Care Spending account to pay health care expenses.

Careful planning is the key to saving taxes through spending accounts. You should contribute money only for eligible expenses you expect to have during the Plan Year. Due to certain forfeiture requirements imposed by the Internal Revenue Service (IRS), you may not want to deposit money for unanticipated expenses. You will forfeit any money in your Dependent Care Spending Account that is not used to reimburse you for eligible day-care costs incurred during the Plan Year. You also will forfeit any unused amount in your Health Care Spending Account in excess of the applicable "carryover" amount (See the **Important Rules on a Health Care Spending Account** on pages 31-32). Be sure to estimate your expenses carefully AND submit your claims on time. You have until June 30 of the following year to file a claim for reimbursement of eligible expenses that you incurred as a spending account participant in the Plan Year in which the money was deposited in your account.

Eligibility

To have a spending account, you must be eligible to participate in *Options*.

Enrolling in a Spending Account

Annual Benefits Enrollment: If you are an "existing" employee (e.g., not a new hire or a newly eligible employee), and you would like to participate in a spending account, you may elect to participate in one or both accounts during annual benefits enrollment. You must re-enroll each year you wish to participate in the Dependent Care Spending Account or contribute to a Health Care Spending Account. You will have an opportunity to elect a spending account when you use the web enrollment system. If you enroll during annual benefits enrollment, you will begin participating in your spending accounts — and contributing to your spending accounts — in January.

New Hires and Newly Eligible Employees: If you are a new hire or a newly eligible employee, you will have an opportunity to enroll in one or both of the spending accounts during your initial enrollment. If you do not enroll in a spending account when you are first eligible, you will have to wait until the next annual benefits enrollment to enroll unless you have a qualified change in status (see pages 14-17). The schedule below provides key dates that apply to new hires and newly eligible employees who enroll in a spending account from January through December. Employees who are hired and enroll in November and December, or employees who are newly eligible for and enroll in the spending account plans in November and December, will begin participation in January of the following year and will begin making contributions in January (November enrollees) or February (December enrollees).

Spending Account Eligibility/Enrollment/Participation/Contribution Schedule for New Hires and Newly Eligible Employees

You Become Eligible and Enroll During...	Your Participation Begins...	Your Contributions Begin...
January	February	March
February	March	April
March	April	May
April	May	June
May	June	July
June	July	August
July	August	September
August	September	October
September	October	November
October	November	December
November	January	January
December	January	February

Health Care Spending Account

The Health Care Spending Account (HCSA) helps you save tax dollars on eligible out-of-pocket medical, dental, vision, and hearing expenses. You may submit claims for yourself, your spouse, your eligible federal tax dependents, and any of your natural, adopted, step or foster children who will not reach age 27 during the Plan Year (even if they are not tax dependents).

Federal Tax Dependents — An eligible tax dependent for the Health Care Spending Account includes qualifying children and qualifying relatives:

- For whom you provide more than half of his or her financial support for the taxable year, and
- Who lived with you for the entire year as a member of your household or is related to you by blood or marriage or adoption, and
- In each case, the individual must be a U.S. citizen or resident, or a resident of Canada or Mexico for some part of the tax year.

Under applicable federal tax rules, a domestic partner and his or her dependents who do not qualify as your federal tax dependents may not participate in your Health Care Spending Account.[6] More details on who qualifies as a dependent eligible to receive tax-favored benefits under a Health Care Spending Account are found in IRS Code Sections 105 and 152 and Notice 2010-38.

Eligible expenses *include the following items if they are not covered by your insurance. See the worksheet on page 33 for additional eligible expenses:*

- Medical and dental deductibles and co-payments
- Menstrual care products — including pads, liners, and similar products
- CDC-approved masks
- Orthodontia treatment not covered by your dental insurance
- Vision care — including prescription eyeglasses, contact lenses and solution, laser eye surgery, and nonprescription reading glasses
- Nicotine patches and nicotine gum (with a doctor's prescription)
- Smoking cessation programs
- Hearing aids and tests
- Special equipment prescribed by a doctor for family members with mental or physical disabilities
- Over-the-counter medications and drugs, such as pain relievers, antacids, allergy and cold medicines
- Insulin

*Examples of expenses that **cannot** be reimbursed from your Health Care Spending Account include:*

- Cosmetic surgery and procedures, if not medically necessary, including teeth whitening.
- Insurance premiums, including long-term care insurance premiums, and Medicare premiums
- Expenses reimbursed by any other health care plan, including Medicare or Medicaid
- Diaper service (unless medically required)
- Funeral expenses
- Long-term care services
- Herbal remedies
- Weight loss medications or weight control programs not prescribed to treat a specific condition or disease
- Cotton balls, bandages, rubbing alcohol, Vaseline, toothpaste, and cosmetics
- Health club dues (unless prescribed by a doctor for a medical condition)
- Nonprescription dietary supplements or vitamins
- Dependent care expenses
- Health foods
- Electrolysis

Refer to Internal Revenue Service (IRS) Publication 502 for the types of expenses that qualify for a tax deduction under Internal Revenue Code Section 213. Call your local IRS office to obtain a copy of Publication 502 or access the list through the IRS website at **irs.gov/forms-pubs/about-publication-502**.

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[6] The IRS takes the position that a registered domestic partner in California must report one-half of the community income on his or her federal tax return. For that reason, it will be difficult for a registered domestic partner to satisfy the "support" test to qualify as a tax dependent.

An Example of How You Can Save Money Using Your Health Care Spending Account
Suppose you paid $350 for new prescription sunglasses, which are not considered a covered expense under your medical plan. You wrote a check for $350 and gave it to your optometrist. If you paid 25 percent in federal income taxes when you earned this $350, **your actual cost for the** prescription **sunglasses was $437.50** ($350.00 + $87.50 federal income taxes = $437.50).

Now suppose you bought the same prescription sunglasses for $350, but you paid for them with money you put into your Health Care Spending Account. Because you did not pay federal income taxes on this money, **your actual cost for the prescription sunglasses was only $350.** You saved $87.50 in taxes by paying for your prescription sunglasses with money in your Health Care Spending Account.

Contributing to Your Health Care Spending Account

You may put from $10 to $254 each month (up to $3,048[7] each Plan Year) into your Health Care Spending Account. To calculate your monthly contribution amount, estimate your eligible out-of-pocket health care expenses for the Plan Year (or the remainder of that year if you are enrolling mid-year) and divide that number by the number of months in the year that you have left to contribute. Your contributions must be stated in whole dollars.

Example: Let's assume you estimate that your annual eligible out-of-pocket health care expenses will come to $800. As a new hire, you enroll in a Health Care Spending Account in January and begin contributing in March (see schedule on page 29). To determine your monthly contribution amount, divide $800 by 10 (the number of months left in the Plan Year). In this example, you would be contributing $80 a month to your Health Care Spending Account.

You might also have "carryover" amounts. As explained below and on the next page, unused amounts up to $610 may be carried over for those employees who are participants (including COBRA participants) at the end of the Plan Year. Any carryover amount is in addition to the up to $3,048 that you may elect to contribute. See the **"Use-It-or-Lose-It" Rule and the $610 Carryover Rule below and on the next page.**

Remember, the money in your spending account is yours to use for eligible health care expenses you incur while you are an active participant *and* in the same Plan Year in which you contributed money to your account.
TIP: To help you estimate your health care expenses, use the worksheet on page 33. You should also review the following important rules.

Important Rules on a Health Care Spending Account

- **Plan carefully** — the IRS says that your election to put a specific amount of money each month into a Health Care Spending Account is an "irrevocable" decision. This means that once you make your election for the year, you may not change your mind unless you experience a qualified change in status and your change is consistent with the change in status. The change-in-status rules are explained in this SPD. Note, the beginning or end of an unpaid leave of absence is not treated as a qualified change in status for purposes of your Health Care Spending Account. If you take an unpaid leave of absence, you will be billed directly for your monthly contribution to your Health Care Spending Account while you are on leave and, upon your return, your contribution amounts will resume at the level in effect before your leave. Unless you have a qualified change in status, you may not change your election even if you do not incur an estimated expense or an expense turns out to be ineligible for reimbursement. See page 44 for special rules when you take FMLA leave.
- **Deadline for reimbursement claims** — HCSA claims for reimbursement may be made at any time during the current Plan Year but must be received by June 30 of the following year (the end of the "run-out period").
  - **"Use-It-or-Lose-It" Rule** — do not put more money into your account than you think you'll need. Why? Any amount over the allowed "carryover amount" (see **$610 Carryover Rule** below and on the next page) that remains in your account at the end of the run-out period will be forfeited (lost) to the County.
  - **$610 Carryover Rule —** if you are a participant (including a COBRA participant) on the last day of the Plan Year, any unused amount in your account up to $610 is carried over to the next Plan Year (the "carryover amount"). This carryover amount is in addition to any elective contributions (up to $3,048) that you make for

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[7] *Based on 2023 IRS limits.*

the current Plan Year. The HCSA pays all claims for expenses incurred during the current Plan Year first from coverage elected for the current Plan Year before using the carryover amount.

Example: During annual benefits enrollment in October 2023, Jane elects a Health Care Spending Account salary reduction amount of $3,048 for 2024. By December 31, 2023, Jane's unused amount from the 2023 Plan Year is $800. On February 1, 2024 **—** during the run-out period for 2023 **—** Jane submits claims and is reimbursed $350 of expenses incurred during the 2023 Plan Year. That leaves a carryover on June 30, 2024 (the end of the run-out period) of $450 of unused Health Care Spending Account funds from 2023. The unused amount of $450 is not forfeited. Instead, it is carried over to 2024 and available to pay claims incurred in that year so that $3,498 (that is, $3,048 + $450) is available to pay claims incurred in 2024. Jane incurs and submits claims for expenses of $2,700 during the month of July 2024 and does not submit any other claims during 2024. Jane is reimbursed with respect to the $2,700 claim, leaving $798 as a potential unused amount from 2024. After the run-out period, Jane will only be able to carry over $610 to 2024 and will forfeit $188.

- **Expenses are "incurred" at the point-of-service** — an expense is "incurred" when a service is provided or a product is received, not when a bill is sent or paid. A Health Care Spending Account typically cannot make advance reimbursements of future or projected expenses.
- **Expenses must not be reimbursed or reimbursable from other sources** — any eligible expenses for which you are not otherwise reimbursed may be paid from your account.
- **You must be an active participant (or have a carryover amount) to have eligible claims** — with respect to your current year's elected coverage, you may submit claims for expenses incurred only for those months in the Plan Year in which you are an "active participant" in the HCSA. You are considered an active participant during any month that you contribute to the account and, if you are a new hire or are newly eligible, the month before your first contribution. Except for employees who are newly eligible for and enroll in a HCSA in November. These employees' participation and contribution begin in January of the following year. In addition, you are and active participant to the extent of any "carryover amount" from a prior Plan Year that is not yet exhausted, even if you did not elect to make contributions for a Plan Year. You may not submit claims for reimbursement of expenses that are incurred before the date you become a participant in an account, after December 31 (except with regard to any "carryover amount"), or after the month in which you terminate employment (or otherwise become an ineligible employee) unless you elect COBRA.
- **COBRA participation is available** — If you take a leave of absence or leave County service while you are a participant, you may continue participation in a Health Care Spending Account for the rest of the year by making your monthly payments through COBRA. Also, see the rules on page 44 regarding the special rules that apply while you are on FMLA leave.
- **Accounts must be kept separate** — dollars you put into your Health Care Spending Account may not be transferred to a Dependent Care Spending Account, or vice versa. These accounts must be kept separate. In addition, dependent care expenses may not be reimbursed from your Health Care Spending Account.
- **No double tax shelter** — you may not take a tax deduction on your income tax return for expenses paid through your Health Care Spending Account. Also, you cannot deduct any unclaimed account money from your federal income taxes.
- **You must enroll every year in order to contribute to a HCSA** — you must re-enroll in the Health Care Spending Account every year if you wish to make elective contributions to it. However, if you have a carryover amount from the prior year, an account will automatically be established on your behalf to hold that carryover amount. If you wish to make elective contributions in addition to any carryover amount, you must make an election during annual benefits enrollment.
- **Termination of participation during a Plan Year** — your active participation in the Health Care Spending Account terminates during a Plan Year when you terminate employment, otherwise cease to be an eligible employee, or go on a leave of absence and do not elect COBRA and make any necessary premium payments, or do not otherwise continue to make any required elective contributions to your account (e.g., while on FMLA leave). Expenses incurred while you are not an active participant are not eligible for reimbursement. If you return to County service in the same year in which your employment terminated and within 30 days of your termination, you must make the same election that was in effect at the time of your termination unless you experience a qualified change in status during your unemployment. If you return to County service 30 or more days after your termination, you can make a new election for coverage under the account. See pages 44 for rules governing certain leaves of absence.

Health Care Spending Account Worksheet

Your Health Care Spending Account may reimburse only those expenses that are medical expenses, as defined in Code Section 213(d). Note, some expenses (such as insurance premiums) that are deductible for purposes of Code Section 213 are not eligible for reimbursement from your Health Care Spending Account. In addition, while expenses are reimbursable from your Health Care Spending Account based on the year in which they are *incurred* — that is, when the services or products are provided — expenses are deductible in the year paid. The following is a partial list of expenses eligible for reimbursement.

Type of Expense	Expense Amount
Acupuncture	______
Ambulances	______
Artificial limbs	______
Birth control pills	______
Braille books	______
Breast pump	______
Charges in excess of reasonable & customary	______
Chiropractic care	______
Crutches	______
Deaf adapters for telephone & television	______
Deductibles and copayments	______
Dental fees	______
Dentures	______
Doctor's fees	______
Eyeglasses or contact lenses	______
Insulin	______
Lab fees	______
Lactation supplies	______
Laser eye surgery	______
Learning disability counseling	______
Nursing fees	______
Orthodontia	______
Orthopedic shoes	______
Over-the-counter medicines	______
Oxygen	______
Podiatry	______
Prescription drugs	______
Psychiatric care	______
Psychoanalysis	______
Radial keratotomy	______
Routine physicals	______
Seeing-eye dogs	______

Type of Expense	Expense Amount
Smoking cessation programs; and, nicotine patches, and nicotine gum (with doctor's prescription)	______
Special equipment and treatment for an eligible mentally or physically disabled dependent	______
Sterilization	______
Substance abuse and alcohol treatment programs	______
Surgery	______
Therapy	______
Transplants	______
Weight loss programs as prescribed by a physician to treat a specific medical condition	______
Wheelchairs	______
X-ray fees	______

A. Total annual eligible health care expenses: A. $______

B. Decide how much of the total annual amount in Line A you want to put into your individual account for the year: B. $______

C. Divide the annual amount in Line B above by the number of months during the year that you can put money into your Health Care Spending Account. This will give you your monthly contribution amount (must be between $10 and $254): C. $______

Dependent Care Spending Account

A Dependent Care Spending Account allows you to use non-taxable County contributions and pre-tax contributions deducted from your own salary to pay certain eligible dependent care expenses so you (and your spouse) can work or attend school full-time. You may use the account to pay eligible dependent care expenses for the following qualifying individuals:

- A dependent child under age 13 for whom you may claim an exemption on your federal income tax return. Generally, in the case of divorce or separation, the parent who has custody of a child for the greater portion of the calendar year may treat the child as a dependent for purposes of the spending account.
- Your spouse and any member of your household who is your dependent for federal tax purposes and who is physically or mentally incapable of caring for himself/herself. This person must live with you at least eight hours per day if his or her care is provided outside the home.

A qualifying child, spouse, or other dependent must live with you for more than half of the year. Under applicable federal tax rules, a domestic partner and his or her dependents who do not qualify as your federal tax dependents are not eligible for coverage under your Dependent Care Spending Account.

Eligible expenses include, but are not limited to:

- Day care provided in your home
- Nursery schools and preschools, if the cost of schooling cannot be separated from the cost of care
- Properly licensed day care centers that care for six or more children (including summer day camps)
- Care provided outside of your home
- The cost of transportation of a qualifying individual by the care provider to or from the place care is provided

*Expenses that **cannot** be reimbursed from your Dependent Care Spending Account include:*

- Overnight camps
- Babysitting so you can attend a social event
- Tutoring or summer school
- Payments you make to: 1) someone you or your spouse may claim as a dependent, 2) your child who is under age 19 at the end of the year, 3) your spouse, or 4) the other parent of your qualifying dependent child
- Kindergarten
- Education for a child in the first grade or a higher grade
- Dependents' health care expenses
- Food, education, or entertainment expenses unless they are incidental to, and cannot be separated from, the cost of dependent care

Refer to IRS Publication 503 for a list of eligible and ineligible expenses. Call your local IRS office to obtain a copy or access the list through the IRS website at **irs.gov/forms-pubs/about-publication-503**. If you are married and would like to use a Dependent Care Spending Account, your spouse must also be currently employed, seeking employment, enrolled as a full-time student for at least five months of the year, or disabled and incapable of self-care.

Contributing to Your Dependent Care Spending Account

Your Dependent Care Spending Account (DCSA) may be funded on a tax-free basis with County contributions. **To receive the County contribution, you must contribute at least $10 each month.** Your contribution and the County's contribution cannot exceed $400 per month. If you elect to participate in the DCSA, the County will make a non-taxable monthly contribution of up to the following amount (subject to an annual cap[1]) to your DCSA account based on your annual base pay:

Your Annual Base Pay	**County's Monthly Contribution** (subject to the annual cap on contribution[1])
Less than $34,999	$375
$35,000 - $39,999	$300
$40,000 - $44,999	$275
$45,000 - $49,999	$200
$50,000 - $54,999	$125
$55,000 or more	$100

[1] **NOTE: The County and SEIU Local 721 negotiated the level of County contribution and agreed to a cap on total annual County contributions. If the cap for the Plan Year is reached, the monthly contribution described above will be reduced pro rata for the month in which the cap is reached and then will be stopped completely for the remainder of the Plan Year. Because of the cap, there is no guarantee that you will receive the full monthly contribution listed above during the whole Plan Year. You will be notified if the County contribution is reduced or stopped during the Plan Year.**

If the County contribution is reduced and/or stopped because of the cap, you may have the opportunity to increase the contribution amount deducted from your pay in order to keep the same total contribution level for the remainder of the Plan Year. In addition, you may be allowed to make other changes that are consistent with a qualified change in status, cost or coverage (for example, revoking your election if your dependent care provider quits or terminates its contract with you). (See pages 14-17 for a discussion of the changes in status and cost and coverage rules).

The County will contribute to your DCSA if you are paid for a minimum of eight hours of earnings per month or received a minimum of eight hours of leave benefits. If you become ineligible to participate in *Options* (e.g., because you terminate employment), your County contribution will end (See **When Coverage Ends** on page 13). If you change flexible benefits program eligibility in the middle of a Plan Year (e.g., from *Options* to *Choices*) due to a change in employment status, you can make changes that are on account of and consistent with your eligibility change. However, if you do not complete your enrollment on time, you will be defaulted into a Dependent Care Spending Account under the new flexible benefits program as of the first day of the second month after the enrollment period ends. You then will be subject to the County contribution cap that applies under the new plan.

Limits on Total Contributions to Your Dependent Care Spending Account

The amount that you deduct from your pay and contribute to a Dependent Care Spending Account may not be less than $10 per month and, when added to the County contributions made to your account, may not exceed the limits discussed below.

Single or Married Filing a Joint Federal Tax Return?

If you are single or married filing a joint return, the amount you deduct from your pay and contribute to the Dependent Care Spending Account cannot cause total contributions to the Dependent Care Spending Account to exceed $400 per month ($4,800 per calendar year) (or the lesser of your or your spouse's earned income). NOTE: If you are married filing jointly (or single), the maximum amount that you and your spouse collectively may contribute to one or more Dependent Care Spending Accounts on a tax-free basis is $5,000 per year (or, if less, the lesser of your or your spouse's earned income). In other words, if both you and your spouse are employed by the County and you both participate in a County-sponsored Dependent Care Spending Account, any amount you and your spouse receive under the Dependent Care Spending Accounts in excess of the applicable limit for a calendar year will be taxable income, even if not reported as taxable income in your individual W-2.

Married Filing Separate Federal Tax Returns?

If you are married filing separate returns, the amount you elect to deduct from your pay and contribute to the Dependent Care Spending Account may not cause total contributions to the Dependent Care Spending Account to exceed $2,500 per calendar year. NOTE: If you are married filing separately, the maximum amount that you and your spouse each may contribute to Dependent Care Spending Accounts on a tax-free basis is $2,500 per calendar year (or, if less, the lesser of your or your spouse's earned income).

For any month that your spouse is a full-time student or incapable of self-care, your spouse is deemed to be gainfully employed with an earned income of $250 (or $500 if you have more than one qualifying individual as described on page 34).

Calculating Your Monthly Contribution Amount

To calculate your monthly contribution amount, estimate your annual eligible, out-of-pocket dependent care expenses and divide that number by 12 months (or, if you are a new hire, the number of months in the Plan Year that you have left to contribute, see page 29). This number is the total monthly contribution that should be made to your account. If this number exceeds your monthly County contribution, subtract the monthly County contribution from this total amount to determine the amount you should deduct from your own pay. Your contribution must be stated in whole dollars.

Example: Assume that you make $47,000 per year and your estimated out-of-pocket dependent care expenses for the Plan Year come to $3,600. To determine how much, you should contribute to the Dependent Care Spending Account, divide $3,600 by 12, or $300. Because this amount exceeds the County contribution ($200 for someone making $47,000), subtract the monthly County contribution to determine the monthly amount you should have deducted from your pay ($300 - $200 = $100). This means you would elect to contribute $100 per month, which will be deducted from your pay and deposited into your Dependent Care Spending Account. The County will contribute $200 each month, for a total of $300 per month.

Note: Use the worksheet on page 40 to determine your monthly contribution amount.

How Does a Dependent Care Spending Account Save You Money?
Taking the facts from the example at the bottom of page 36, assume that you pay 25 percent in federal income taxes. This means that, without the Dependent Care Spending Account, your real cost for dependent care would be $4,500 ($3,600 + $900 in federal taxes). However, if you elect to participate in a County Dependent Care Spending Account, your dependent care will only cost you $1,200 for the year ($100 x 12 = $1,200) because you receive a County subsidy and you do not pay federal income taxes on amounts contributed to and distributed from your account.

Remember, the money in your spending account is yours to use for eligible dependent care expenses that you incur while you are a participant *and* in the same Plan Year in which you contributed money to your account. Any money that is not used to reimburse expenses during the Plan Year is forfeited.

TIP: To help you determine the amount you should contribute to a Dependent Care Spending Account to cover your estimated dependent care expenses, use the worksheet on page 40. You should also review the important rules in the next section.

Important Rules on a Dependent Care Spending Account

- **Plan carefully** — the IRS says that your election to put a specific amount of money each month into a Dependent Care Spending Account is an "irrevocable" decision. This means that once you make your election for the year, you cannot change or cancel your monthly contribution amount unless you experience a qualified change in status or certain cost or coverage changes. And you cannot change your monthly contribution amount just because your expenses turn out to be ineligible for reimbursement. The changes in status, cost, and coverage rules that are applicable to you are explained on pages 14-17. Note, to change your contributions to your Dependent Care Spending Account, your change must be consistent with a qualified change in status. Generally, you may be permitted to change your monthly contribution amount if, for example, you:
  - Experience an increase or decrease in day care fees charged by a dependent care provider who is not your relative.
  - Change day care providers and this change causes your day care fees to change.
  - Have a change in your work schedule (e.g., from full-time to part-time or vice versa), which causes a change in the number of hours or days worked by a provider.
  - Your dependent child ceases to be eligible because he or she reaches age 13 (and is not mentally or physically incapable of self-care).

  In addition, if you are subject to a cap on annual County contributions and because of that cap your monthly County contribution stops, you may have an opportunity to increase the contributions deducted from your pay in order to keep the same total contribution level for the remainder of the Plan Year.
- **Dependent care must enable you to work** — your dependent care expenses must be incurred to enable you to work. If you are married, your spouse also must be currently working, seeking employment, enrolled as a full-time student for at least five months of the year, or disabled and incapable of self-care.
- **Forfeiture of unused amounts** — don't put more money into your account than you think you'll need. Why? Because the IRS says you must forfeit (lose) any money that you don't spend on unreimbursed, eligible dependent care expenses that are incurred while you were a participant. Be sure to submit all of your claims for eligible expenses that are incurred while you were a participant by June 30 of the following year! You cannot deduct any unclaimed account money from your federal income taxes.
- **Expenses must be incurred during the Plan Year and while you are a participant** — you may not submit claims for reimbursement of expenses that are incurred before the date you become a participant in the account or after December 31. You generally may not submit claims for expenses while you are absent from work, and expenses incurred for a period during only part of which you are actively at work must be allocated on a daily basis. You are not required to "carve out" expenses incurred during short, temporary absences from work (such as for vacation or minor illness) if your dependent care arrangement requires you to pay for care during the absence. An absence of two consecutive calendar weeks or less is deemed to be a short, temporary absence.
- **Expenses are "incurred" at the point-of-service** — an expense is "incurred" when a service is provided, not when a bill is sent or paid. Your Dependent Care Spending Account cannot be used to make advance reimbursements of future or projected expenses.
- **Be an active participant** — you may submit claims for expenses incurred only for those months during the Plan Year in which you are an "active participant" in a Dependent Care Spending Account. You are considered an active participant during any month that contributions are made to your account and, if you are a new hire or a newly eligible employee, the month before contributions begin. (Except for employees who are newly eligible for and enroll in a Dependent Care Spending Account in November. These employees' participation and contributions begin in January of the following year).
- **No COBRA rights** — Dependent Care Spending Accounts may not be continued after your County service ends.
- **Accounts must be kept separate** — dollars you put into your Dependent Care Spending Account cannot be transferred to a Health Care Spending Account, or vice versa. These accounts must be kept separate. In addition, eligible health care expenses cannot be reimbursed from your Dependent Care Spending Account.
- **There is no double tax shelter** — you cannot take a tax deduction on your income tax return for expenses paid through your Dependent Care Spending Account**.**

- **Expenses must not be reimbursed from other sources** — only eligible expenses for which you are not otherwise reimbursed may be paid from your account.
- **You must enroll every year** — participation in a Dependent Care Spending Account does not continue automatically from one year to the next. If you want to participate in the Dependent Care Spending Account, you must enroll every year.
- **Termination of participation** — your participation in the Dependent Care Spending Account terminates on the first day of the second month after you are no longer eligible to participate in a County flexible benefits program, for example, because you terminate from County service. Expenses incurred when you are not a participant are not eligible for reimbursement. If you return to County service in the same year in which your employment terminated and within 30 days of your termination, you must make the same election that was in effect at the time of your termination, unless you experience a qualified change in status during your unemployment. If you return to County service 30 or more days after your termination, you can make a new election for coverage under the account.

Dependent Care Spending Account vs. Child and Dependent Care Expense Tax Credit

- Your eligible dependent care expenses are the same expenses that can qualify for a tax credit for child and dependent care expenses on your federal income tax return. Therefore, before signing up for a Dependent Care Spending Account, you should consider whether the tax credit for child dependent care expenses taken on your tax return would provide you with a greater tax benefit. This determination depends on your specific income and tax situation. Some things to consider:
- Generally, if you receive your full County contribution for the whole Plan Year, that County contribution should be more valuable than the maximum tax credit you could receive unless you make $50,000 or more per year. If you make $50,000 or more per year and make pre-tax contributions from your own pay, the Dependent Care Spending Account still might be a better choice because you may receive an added tax advantage from the Dependent Care Spending Account that, together with the County contribution, may outweigh the value of the tax credit.
- You cannot take a tax credit on your income tax return for expenses reimbursed by your Dependent Care Spending Account. Any expenses you do not claim through your Dependent Care Spending Account are eligible to be claimed as part of your tax credit at the end of the year. However, the maximum tax credit is reduced for any benefits received from your Dependent Care Spending Account.
- You can participate in a Dependent Care Spending Account even if you and your spouse file separate tax returns. However, to claim an income tax credit, married couples generally have to file a joint return.

The County cannot give tax advice, consult a tax advisor to determine which option is best for your individual situation.

Dependent Care Spending Account Worksheet

The following worksheet illustrates possible tax savings if you elect to participate in a Dependent Care Spending Account — be sure to complete the worksheet before deciding that you want to participate. Calculate your Dependent Care Spending Account contribution for the Plan Year using the worksheet below. If appropriate, compare this amount to your possible savings from the child and dependent care tax credit. Refer to IRS Publication 503 or Form 2441 for information on how to calculate this amount. You might want to refer to your latest tax return for information as you complete this worksheet.

Determine Your Depending Care Spending Account Contribution	
A. Estimate what you plan to spend on eligible dependent care:	A. $______________
B. If you are married and filing a joint return, enter your estimated earned income or your spouse's estimated earned income for the year, or $4,800, whichever is less:	B. $______________
C. If you are married and filing separately, enter your estimated earned income for the year or $2,500, whichever is less:	C. $______________
D. If you are a single/head of household, enter your estimated earned income for the year or $4,800, whichever is less:	D. $______________
E. Enter the lesser of A or either B, C, or D, whichever applies:	E. $______________
F. Divide the amount in E by the number of months during the Plan Year that you can put money into a Dependent Care Spending Account; this will give you your monthly contribution amount (this amount must be at least $10 and no more than $400 a month and must be stated in whole dollars); this is the **total** monthly contribution that should be made to your account to cover your estimated dependent care expenses:	F. $______________
G. Subtract the monthly County contribution from the amount in F; this is the monthly amount that you should elect to have deducted from your pay to cover your estimated dependent care expenses:	G. $______________

Estimating Your Dependent Care Spending Account Tax Savings

Visit **mylacountybenefits.com**, click on “How Spending Accounts Work,” located under the “My Financial Security” menu to access the Spending Account Calculators. Use the FSA tax savings calculator to help you determine your estimated tax savings.

The County of Los Angeles cannot give tax advice, consult your tax advisor to help you determine whether the tax credit or the Dependent Care Spending Account is best for you.

Submitting Your Spending Account Expense Claims

1. When you have a claim under either your **Health Care Spending Account** or **Dependent Care Spending Account,** you have to complete and submit a claim form and include an itemized bill or receipts for each expense. Below is information regarding submitting claims based on your spending account:
    - **Health Care Spending Account Claims.** Complete a *claim form* and submit an itemized bill or receipt. The Spending Account Plan Administrator will not process your claim unless you include itemized bills or receipts from the provider of the services (you may be asked to provide an Explanation of Benefits statement), for each claim you submit. Canceled checks will not be accepted. Your itemized bill or receipt must include all of the following items:
        - Name of person who incurred service or expense
        - Name and address of provider or merchant
        - Date service or expense was incurred
        - Detailed description of service or expense
        - Amount charged for service or expense
    - **Dependent Care Spending Account Claims**. Complete the *Dependent Care Spending Account Claim Form* and submit an itemized bill or receipt. The Spending Account Plan Administrator will not process your claim unless you include itemized bills or receipts as proof of each expense. Canceled checks will not be accepted. If you do not include bills or receipts, you must provide the following information on your claim form:
        - Name of person who incurred service or expense
        - Name and address of provider or merchant
        - Date(s) service was provided
        - Amount charged for service or expense

2. You can submit your claim by:
    - **Online:** use your smartphone, tablet, or computer to submit your claims anytime 24/7.
        - Log on to **mylacountybenefits.com**
        - Click on the “Spending Account” tile to be navigated to the BenefitWallet website
        - Click on “File a Claim”
        - Follow the online instructions to submit your claims. Begin by selecting the type of account you want the claim to be paid from, and who should receive the reimbursement. On the subsequent screens, you will have the opportunity to enter details regarding your claims and upload any supporting documentation.
    - **BenefitWallet+ App:** use your smartphone to download BenefitWallet+ app from the Apple App Store or Google Play. The app registration process will require you to establish a User ID and password. You can also use the BenefitWallet+ app to check your balance, file claims, take photos of your receipts, and upload documents. With the BenefitWallet+ app, your DCSA provider can also sign the electronic receipt on your phone or tablet, so you don’t need to submit a claim form.
    - **Fax:** fax your completed Health Care or Dependent Care Claim Form and documentation (e.g., itemized bill or receipt, or Explanation of Benefits) toll-free to 877-841-1152.
    - **Mail:** mail copies (not the originals) of your completed Health Care or Dependent Care Claim Form and documentation (e.g., itemized bill or receipt, or Explanation of Benefits) to:

      BenefitWallet
P.O. Box 18009, Suite A
Norfolk, VA 23501

3. Claims are processed within 3-5 business days from the date they are received. You will either receive a check in the mail or (if you prefer) your reimbursement will be deposited directly into your bank account. To initiate direct deposit of your reimbursements:
   - Log on to **mylacountybenefits.com**
   - Click on the "Spending Account" tile to be navigated to the BenefitWallet website
   - Click on "Direct Deposit Information"
   - Follow the online instructions and enter, verify, and save the requested account information to set up your direct deposit

Every three months, you will receive a statement to help you monitor your account balance. Review these statements carefully.

You must submit your claims for all eligible expenses incurred while you are an active participant during the Plan Year by June 30 of the following year. If you submit a Dependent Care Spending Account claim that is postmarked after this date, the claim will not be paid, and you will forfeit any money left in your spending accounts. If your Health Care Spending Account claim is postmarked after this date, the claim will not be paid and any amount over the allowed "carryover amount" will be forfeited.

If you leave County service during the Plan Year, you may continue to submit claims for eligible expenses incurred during the Plan Year until June 30 of the following year. However, these claims must be for eligible expenses incurred during the Plan Year while you were actively participating in the applicable spending account.

If you have any questions about claims administration of the spending accounts, call the Spending Account Plan Administrator, BenefitWallet, at **866-225-0067.** Or, you can check your claims and your balance in your account at any time by going to **mylacountybenefits.com**, and clicking on the "Spending Account" tile.

What Happens to My Spending Accounts if I Leave County Service or Retire?

You still have until June 30 of the next year to submit claims, but only for the months in which you contributed to the account as an active participant. If you leave the County or retire, your contributions stop and participation in the account ends. You cannot submit claims for eligible expenses incurred during the months you did not contribute to the account. See pages 31-32 and 38-39 for **Important Rules** regarding active participation.

If you were participating in a HCSA, you may continue your participation in the account after leaving County service by electing COBRA coverage and paying the monthly contributions after-tax through the remainder of the Plan Year. If you spend more from your HCSA than you contribute before you leave the County, you should elect COBRA coverage to continue your HCSA for the remainder of the Plan Year.

Health Care Spending Account Visa Card

When you elect to enroll in a Health Care Spending Account, you will automatically be mailed a Health Care Spending Account (HCSA) Visa card. Once you activate your card, you can use your HCSA Visa card instead of cash or credit to instantly pay most health care providers and pharmacies for eligible expenses (when you swipe your card at checkout choose credit). When you use your HCSA Visa card you save time by not having to file a claim for most common expenses (e.g., standard copays for doctor's office visits and prescriptions). You can request additional HCSA Visa cards for yourself or your eligible dependents through BenefitWallet's website available at **mylacountybenefits.com**.

BenefitWallet may ask you for receipts, Explanation of Benefits (EOB), or other documentation for verification, so keep your receipts. Failure to provide the requested information may result in your HCSA Visa card being suspended. If you have lost or cannot produce an EOB or receipt, contact BenefitWallet at 866-225-0067 to find out what your options are. If you lose your HCSA Visa card, or it is stolen, report it to BenefitWallet immediately.

Miscellaneous
The spending account plans may be amended from time to time or terminated at any time by the County (subject to any applicable collective bargaining obligations). Subject to the approval of the Board of Supervisors, the CEO (or their delegate) is authorized to interpret the terms of the spending account plans, and any action is binding on all participants and their beneficiaries.

AFFORDABLE CARE ACT (ACA) COMPLIANCE

In January, the County and your medical plan will mail tax forms, 1095-B and 1095-C.

Form 1095-B
Your medical plan will mail Form 1095-B to your address because it documents the months you and your dependents had ACA-compliant medical coverage during the Plan Year.

Form 1095-C
The County is required to mail this form to your address. Form 1095-C documents whether you were treated as a "full-time" employee for ACA purposes and whether you (and your dependents) received an offer of ACA-compliant medical insurance each month during the Plan Year.[8] Full-time employees who were offered coverage, but who waived or declined it for the Plan Year, will still receive the Form 1095-C.

Keep these forms; you may need to file them with your tax returns.

GENERAL PLAN ADMINISTRATION

This section contains information on the administration of the *Options* benefit program, as well as your rights as a participant. You probably do not need this information on a day-to-day basis; however, it is important for you to understand your rights and the procedures you need to follow in certain situations.

If you have any questions about this information, contact the County's Benefits Hotline at **213-388-9982**, 8:00 a.m. to 4:00 p.m., Monday through Friday, or your Departmental Personnel Office.

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[8] *For purposes of ACA and reporting on Form 1095-C, an employee is considered to be full-time if he or she is credited with an average of 30 hours of service a week (or 130 hours of service per month). An hour of service is an hour for which you are paid or entitled to pay for performing services or for time away from work due to vacation, sickness/disability, military duty, jury duty or other leave of absence. If you are initially hired into a position that is expected to be full-time, your full-time status is determined on a month-to-month basis until you have been employed for an entire "measuring period." A measuring period runs from October 1 through September 30. Once you have been employed for a full measuring period, your status is determined by looking back at your employment history for the measuring period ending immediately prior to the Plan Year. If you have any questions about your status for the purposes of ACA and reporting on Form 1095-C, contact the County's Benefits Hotline at 213-388-9982. Be aware that your treatment as "full-time" for the purposes of ACA and reporting on Form 1095-C has no bearing on your employment status for any other purpose.*

CONTINUING COVERAGE UNDER CERTAIN CIRCUMSTANCES

Family and Medical Leave Act (FMLA) Leave, California Family Rights Act (CFRA) Leave, and Pregnancy Disability Leave (PDL)

During Family and Medical Leave Act (FMLA) leave, California Family Rights Act (CFRA) leave, and Pregnancy Disability Leave (PDL) your group medical and dental coverage and Health Care Spending Account coverage will be continued on the same basis and under the same conditions as were applicable prior to the commencement of the leave. This means:

- If you are in pay status for at least eight hours in any month, the County will pay your full *Options* contribution.
- If you are not in pay status during the month FMLA/CFRA leave or PDL is taken, the County will continue to pay the portion of the County contribution allocated to the County-sponsored or County approved Union-sponsored medical plan, the County-sponsored dental plan, and the Health Care Spending Account.
- If you paid any portion of the premium for your medical, dental, and Health Care Spending Account coverage prior to the FMLA/CFRA leave or PDL, you will be billed for the same amount while on leave.
- If you choose not to continue your coverage by paying your premium, or otherwise fail to timely pay your share of the premium, your coverage will be suspended as of the first day of the month following the last month for which the premium was paid. You will not be entitled to payment or reimbursement of expenses incurred during any period your coverage is suspended.
- Under FMLA and CFRA, the County is entitled to recover any premium payments made on your behalf if you fail to return to work from FMLA/CFRA leave after the leave entitlement has been exhausted or the leave expires, unless:
  - You are unable to return to work because of the continuation, recurrence, or onset of a serious health condition which would entitle you to continue FMLA/CFRA leave,
  - You are unable to return to work due to unexpected circumstance(s) beyond your control.
- Likewise, under the PDL law, the County is entitled to recover any premium payments made on your behalf if you fail to return to work from PDL after the leave entitlement has been exhausted or the leave expires, unless:
  - You are unable to return to work because you are taking CFRA leave,
  - You are unable to return to work because of the continuation, recurrence, or onset of a health condition which would entitle you to continue PDL,
  - You are unable to return to work due to non-pregnancy related medical conditions requiring further leave,
  - You are unable to return to work due to unexpected circumstance(s) beyond your control.

You also may continue your Life insurance, Accidental Death & Dismemberment (AD&D), and Long-Term Disability (LTD) Health Insurance, at your own cost. You will be billed monthly for the cost of these benefits, under the County's "self-pay" program. If you do not pay for the cost of one or more of these benefits, the benefit(s) will be canceled. See pages 18-19 for more information regarding the self-pay program.

Reinstatement of Benefits Upon a Return From Leave of Absence

Benefits that are terminated during a leave of absence will be reinstated on the first of the month following the month you return to work. When you are reinstated in your Health Care Spending Account and your Dependent Care Spending Account, you will resume premium payments at the level in effect before the leave with a corresponding reduction in the total level of coverage for the remainder of the Plan Year. Alternatively, with regard to the reinstatement of your Health Care Spending Account only, you may elect to resume coverage for the remainder of the Plan Year at the level in effect before your leave with a corresponding increase in your premium payments. Any other change in your pre-tax premiums may only be made in accordance with the Change in Status rules described on pages 14-17.

Example: Employee Colin elects $1,200 worth of coverage under a Plan Year Health Care Spending Account provided under *Options*, with an annual contribution of $1,200. Colin is paying the $1,200 through pre-tax salary reduction amounts of $100 per month throughout the 12-month period of coverage. Colin incurs no medical expenses prior to April 1. On April 1, Colin takes FMLA leave after making three months of contributions totaling $300 (3 months x $100 = $300). Colin chooses not to pay his premiums during his FMLA leave and, thus, coverage ceases during his leave – that is, for the months of April, May, and June. Consequently, Colin is not entitled to submit claims or receive reimbursements for expenses incurred during this period. Colin returns from leave and is reinstated in the Health Care Spending Account on July 1.

Colin will resume Health Care Spending Account coverage at a level that is reduced on a pro rata basis for the period during the leave for which no contributions were made (that is, reduced for 3 months or ¼ of the Plan Year) less prior reimbursements ($0) with contributions due in the same monthly amount payable before the leave ($100 per month). Thus, Colin's coverage for the remainder of the Plan Year would equal $900 and Colin would resume making contributions of $100 per month for the remainder of the Plan Year. Alternatively, Colin could elect to resume coverage at the level in effect before the leave ($1,200) and making up the unpaid contributions ($300). If Colin chooses to resume coverage at the level in effect before the leave, Colin's coverage for the remainder of the Plan Year would equal $1,200 and Colin's monthly contributions would be increased to $150 per month for the remainder of the Plan Year, to make up the $300 in premiums missed [$100 per month plus $50 per month ($300 divided by the remaining 6 months)].

Continuation of Coverage During Active Military Service

If you are ordered to active military duty, you are entitled to receive benefits for a period not to exceed 720 days. On August 15, 2017, the Board of Supervisors approved the suspension of the 720-day limit on County-provided paid military benefits. The County will comply with any obligation to continue benefits in accordance with the federal law known as USERRA.

While on active military duty, you may continue participation in *Options* benefits and may participate in annual benefits enrollment. Any benefit changes you make during annual benefits enrollment will be effective on January 1 of the following year. If you make no changes, your benefits will continue except for Health Care and Dependent Care Spending Accounts, which will be canceled. **If you are away from home during the annual benefits enrollment period, you may designate someone to enroll for you.** If you use a designee, ensure that person completes your enrollment by the annual enrollment deadline.

County Monthly Benefits Allowance — Full-time permanent County employees receive a monthly benefits *allowanc*e as part of *Options*. While on military leave, you may continue to receive County pay. In your 15th of the month paycheck, you will receive your monthly benefits allowance and have payroll deductions taken for insurance premiums. If you do not receive enough County pay (because your County pay is offset by your military pay, causing you to have a smaller paycheck) and your monthly benefits allowance is not enough to cover your portion of the insurance premiums, you will be billed monthly for your portion of the premiums. If you fail to timely pay your share of the premiums, your coverage will be suspended as of the first day of the month following the last month for which the premiums were paid.

Medical & Dental Insurance — Provided you timely pay your share of the premiums, you and any enrolled family members generally will continue to be covered under your County-sponsored, or Union-approved, medical and dental insurance plans. Your medical coverage with the military will be "primary" – that is, pay first – for all military service-related injuries or illnesses.

Life Insurance — Coverage under Optional Group Term Life insurance for you and any family members will continue while you are on active duty if the required premiums are paid.

Accidental Death & Dismemberment (AD&D) — AD&D coverage will continue for 36 months if the required premiums are paid. The policy excludes loss resulting from declared or undeclared war or act of war, or from travel or flight of aircraft being used for any military authority.

Health Care and Dependent Care Spending Accounts — Provided you continue to make contributions to your spending accounts; you may continue to participate in these accounts while on active duty. Remember, claims for reimbursement for services used during the year in which you are a participant must be claimed by June 30 of the following year. See **Submitting Your Spending Account Expense Claims** on pages 41-42.

Benefit Changes — You may make certain changes to your benefits as a result of your military activation. You have 90 days from the date you begin active duty to change your benefits using the web enrollment system. If you do not have life insurance coverage, you may purchase coverage in an amount equal to one times your annual salary. If you have life insurance coverage, you may increase your coverage by one level. **You may make changes to your medical and dental coverage only to the extent your military leave affects eligibility for coverage under an *Options* or military plan.** *For example: You may waive your County medical insurance because you will be covered under military medical; however, you generally cannot change your County medical plan from one plan to another or add dependents to a County plan solely due to your military service.* Other benefit changes may be allowed as is approved by the Board of Supervisors.

COBRA Continuation of Health Coverage

A federal law known as COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) requires that the County offer employees and their families the opportunity for a temporary extension of health plan coverage (called "continuation coverage"), at group rates, in certain instances where group health coverage would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of that law. ***Both you and your spouse/domestic partner should take time to read this notice carefully.*** For additional information about your rights and obligations under the plan and under federal law, you should review the plan's enrollment materials or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse/domestic partner and your dependent children could become qualified beneficiaries if coverage under the group health plan is lost because of a qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for continuation coverage.

Qualifying Events

If you are a County ***employee***, you will become a "qualified beneficiary" if you lose your group medical and/or dental coverage under the plan because *either* of the following qualifying events happens:

1) your hours of employment are reduced; or
2) your employment ends for any reason other than gross misconduct on your part.

If you are the ***spouse/domestic partner*** of a County employee, you will become a "qualified beneficiary" if you lose your group medical and/or dental coverage under the plan because *any* of the following qualifying events happens:

1) your spouse/domestic partner dies;
2) your spouse's/domestic partner's hours of employment are reduced;
3) your spouse's/domestic partner's employment ends for any reason other than gross misconduct on his or her part; or
4) your annulment, divorce, legal separation from your spouse, or termination of domestic partnership.

Your ***dependent children*** who are covered by a County-sponsored group medical and/or dental care plan will become "qualified beneficiaries" if they lose group coverage under that plan because ***any*** of the following qualifying events happens:

1) the parent-employee dies;
2) the parent-employee's hours of employment with the County are reduced;
3) the parent-employee's employment with the County ends for any reason other than gross misconduct on his or her part;
4) the parents become divorced, legally separated, receive an annulment, or terminated domestic partnership; or,
5) a child ceases to be a "dependent child" under the terms of the plan.

If a County employee (or former employee) elects COBRA continuation coverage, a child who is born to or placed for adoption with that employee *during the continuation coverage period* also will become a "qualified beneficiary" and have a right to be added to that continuation coverage. Such a child will be added to the existing COBRA continuation coverage as of the date of birth or adoption if the Plan Administrator is notified of the addition within 30 days of the birth or adoption and will have the same rights as other qualified beneficiaries. The addition of a newborn or newly adopted child to the existing COBRA coverage may result in an increase in your monthly premium. Moreover, if you take leave under the Family and Medical Leave Act of 1993 ("FMLA") and do not return to County employment the at the end of the FMLA leave, you will be considered to have ended your employment with the County and you and your covered family members may have the right to elect COBRA continuation coverage.

When is COBRA Coverage Available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has happened. If the qualifying event is the employee's death, end of employment, or reduction of hours, the County must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (*annulment*, *divorce,* or *legal separation* of the employee and spouse, or a *dependent child losing eligibility for coverage* as a dependent child), **you (or the qualified beneficiary) must notify the Plan Administrator in writing within 60 days after the later of (1) the qualifying event, or (2) the date coverage will end as a result of the event.** ***The procedure for notifying the Plan Administrator of a qualifying event is explained on pages 48-49.***

How is COBRA Coverage Provided?

When the Plan Administrator is properly notified that a qualifying event has happened, the Plan Administrator will send a notice of COBRA eligibility and election form, offering COBRA continuation coverage to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses/domestic partners, and parents may elect COBRA continuation coverage on behalf of their children.

If you properly elect and pay for continuation coverage, your regular group health coverage will end, and your COBRA continuation coverage period will begin on the date of your qualifying event. If you have a right to elect continuation coverage because of the end of FMLA leave, your COBRA continuation coverage period will begin on the last day of FMLA leave.

If you elect continuation coverage, you are entitled to continue the coverage you were receiving immediately before the qualifying event that caused you to lose coverage. You may elect different coverage options only during an open enrollment.

How Long Will COBRA Coverage Be Provided?

The law requires that you be afforded the opportunity to maintain continuation coverage for a period of three years (36 months) from the date of the qualifying event that made you eligible to elect continuation coverage, unless the qualifying event was the end of County employment or a reduction in hours of employment. In that case, the required continuation coverage period is 18 months from the date of the qualifying event. If, however, the employee becomes

entitled to Medicare benefits less than 18 months before the employee's end of employment or reduction in hours, the employee's spouse/domestic partner and dependent children may continue coverage for up to 36 months from the date of the employee's Medicare entitlement. For example, if the employee became entitled to Medicare 8 months before the date his or her employment ends, COBRA continuation coverage for the employee's spouse/domestic partner and children may last up to 36 months after the date of Medicare entitlement, which equals 28 months after the qualifying event (36 months minus 8 months).

The maximum period of coverage for a child born to or placed for adoption with an employee who has elected COBRA continuation coverage is measured from the same date of the same qualifying event as for other qualified beneficiaries, and not from the date of birth or adoption.

Disability Extension of 18-month Continuation Coverage Period

If any qualified beneficiary is determined by the Social Security Administration (SSA) to have been disabled at any time before the 60th day of continuation coverage (or, for a newborn or adopted child, within 60 days of the birth or adoption), the 18-month continuation coverage period may be extended to 29 months for each qualified beneficiary, if the disability lasts at least until the end of the 18-month period of continuation coverage. **However, in order for the extended coverage to apply, you must notify the Plan Administrator about the disability determination before the end of the 18-month continuation coverage period and within 60 days after the latest of (1) the date of the SSA determination; (2) the date of the qualifying event; or (3) the date on which the qualified disabled beneficiary loses (or will lose) coverage as a result of the qualifying event.** The procedure for notifying the Plan Administrator of a disability determination is explained on pages 48-49.

If the SSA later determines that the qualified disabled beneficiary is no longer disabled, you must notify the Plan Administrator of that fact within 30 days of the SSA's determination following the procedure on pages 48-49. The plan may end the extended continuation coverage for all qualified beneficiaries as of the first month that begins more than 30 days after the SSA's final determination.

Second Qualifying Event Extension of 18-month Continuation Coverage Period

The 18-month period of COBRA continuation coverage may be extended for an employee's spouse/domestic partner and dependent children if, during the original continuation coverage period, another qualifying event occurs, and the Plan Administrator is notified of the second qualifying event. This extension may be available to the spouse/domestic partner and any dependent children receiving continuation coverage if one of the following qualifying events occurs: (1) the employee and spouse are divorced or legally separated, or receive an annulment; (2) the employee dies; or (3) a child ceases to be a dependent child under the plan. If one of these events has occurred during the original continuation coverage period, coverage for the employee's spouse/domestic partner and dependent children may be extended up to 18 months, for a maximum of 36 months. ***In order for the spouse/domestic partner and dependent children to be entitled to this extended coverage, the Plan Administrator must receive notice of the second qualifying event within 60 days of the date of the event.*** The procedure for notifying the Plan Administrator of a second qualifying event is explained in the following section.

How Do I Notify the Plan Administrator of a Disability Determination or a Qualifying Event?

If you wish to notify the Plan Administrator of a qualifying event, including a second qualifying event, or a disability determination, you must complete a ***Notice of Qualifying Event or Disability*** *form* and return it according to the instructions on the form. This form is available from the Plan Administrator. The *Notice of Qualifying Event or Disability* will not be considered complete unless the Plan Administrator is able to determine:

1) the covered employee and qualified beneficiary or beneficiaries,
2) the qualifying event, and
3) the date of the qualifying event.

If you are notifying the Plan Administrator of a disability determination, you must also include a copy of the SSA's determination with the completed form. If the SSA later determines that the disabled qualified beneficiary is no

longer disabled, you must notify the Plan Administrator using the *Notice of Qualifying Event or Disability* form and should include a copy of the SSA's final determination.

The *Notice of Qualifying Event or Disability* may be completed and submitted to the Plan Administrator on behalf of all related qualified beneficiaries with respect to a qualifying event by the covered employee, a qualified beneficiary, or any representative acting on behalf of the covered employee or qualified beneficiary. **If a completed *Notice of Qualifying Event or Disability* is not timely delivered to the Plan Administrator, the affected qualified beneficiary will lose any right to elect continuation coverage.** You may be required to provide additional information or documents to the Plan Administrator.

Can COBRA Coverage Be Cut Short?

The law provides that the continuation coverage described page 47 **may be cut short for *any* of the following reasons**:

1) the County ceases to provide group medical and/or dental coverage to any of its employees;
2) the monthly premium for your continuation coverage is not received within 30-days of the due date;
3) after electing COBRA coverage, the qualified beneficiary becomes covered under another group health plan that does not impose any exclusion or limitation with respect to any pre-existing condition of the person (Note: pre-existing condition exclusions became prohibited under the Affordable Care Act beginning in 2014);
4) after electing COBRA coverage, the qualified beneficiary becomes entitled to Medicare; or
5) for any reason the group medical and/or dental plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

If a qualified beneficiary becomes covered under another group health plan after electing COBRA coverage, the Plan Administrator may request that he or she provide a copy of the other plan or other information it may need to evaluate whether or not, and for what period of time, the other plan excludes or limits coverage with respect to a pre-existing condition.

Special Rules for the Health Care Spending Account

In certain circumstances, you may be entitled to continue coverage under your Health Care Spending Account. The Plan Administrator will provide you with additional information about any rights you have to continue this coverage if you experience a qualifying event. Generally, unlike your group medical and dental coverage, your Health Care Spending Account coverage may be continued only for the rest of the Plan Year.

Electing and Paying for COBRA Continuation Coverage

Under the law, each qualified beneficiary has at least 60 days from the later of (1) the date he or she would lose coverage because of a qualifying event or (2) the date of the notice of COBRA eligibility, to notify the Plan Administrator of his or her election of continuation coverage.

You do not have to show that you are insurable to elect continuation coverage. However, under the law, you will have to pay all of the premium for your continuation coverage, which may include an administrative charge of 2% (or 50% if you extend the 18-month continuation coverage period up to 29 months due to disability, unless the disabled individual is not included the group of qualified beneficiaries purchasing the extended coverage). If the cost of coverage under the plan is increased, you will be notified of the increased rates and will be subject to the new premiums. In addition, any changes to the plan that will affect you, including termination of the plan.

Generally, payment for continuation coverage is due monthly. Your initial payment of COBRA premiums, however, is due no later than 45 days from the date you elect continuation coverage. If you submit the continuation coverage request form after your regular coverage ends, this initial payment must include the full cost of your selected continuation coverage for the months after your regular coverage ended up through the month in which you make your initial payment.

Following your initial premium payment, your monthly premium payment is due on the first day of each month of coverage. Although periodic payments are due on the first day of the month of coverage, you will be given a grace

period of 30 days to make each monthly payment. Your continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than its due date but during its grace period, your coverage under the medical and/or dental plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the monthly payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you make a monthly payment on or before its due date, your coverage under the medical and/or dental plan will continue for that month without any break.

IF YOUR FIRST PAYMENT OR ANY SUBSEQUENT MONTHLY PAYMENT IS NOT RECEIVED ON TIME, YOUR COVERAGE WILL END AND CANNOT BE REINSTATED.

There may be other coverage options for you and your family. For example, you are able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA (but not enrolled) does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

After COBRA Continuation Coverage Ends

During the 180-day period immediately before the expiration of your 18-month, 29-month, or 36-month continuation coverage period, you have the option of enrolling in the conversion health plan otherwise generally available under the medical and/or dental plan under which you are covered. For detailed information on your conversion rights, contact the Plan Administrator listed below.

Keep the County Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

If you have questions about the Plan or COBRA continuation coverage, contact the Plan Administrator:

COUNTY OF LOS ANGELES
Department of Human Resources
Employee Benefits Division – COBRA Unit
510 S. Vermont Avenue, 12th Floor
Los Angeles, CA 90020
213-388-9982

Extended Medical Coverage Under California Law After Exhaustion of Federal COBRA

Eligibility Period and Extended Coverage

Under California law, if you elect 18 months (or 29 months in the case of disability) of federal COBRA continuation coverage, you may be entitled to extend your medical insurance coverage (but not separate dental or vision coverage) after your federal COBRA coverage is exhausted, for up to 36 months from the date federal COBRA coverage first began. If you are eligible for and elect Cal-COBRA coverage, the coverage will begin when federal COBRA coverage is exhausted. Cal-COBRA coverage will provide the same benefits as if your federal COBRA medical coverage had remained in force.

The extended medical coverage ends automatically on the earlier of:

1) 36 months after the COBRA continuation coverage began,
2) the date the covered individual is covered under any other group health plan that does not impose any exclusion or limitation for a pre-existing condition of the covered individual,
3) the date the covered individual is entitled to Medicare,
4) the date that the County ceases to provide any group health plan for its employees,
5) the date the covered individual moves out of the service area for the HMO or insurance contract or commits fraud or deception in the use of HMO or insurance contract services.

Extended medical coverage may also be terminated as provided in the applicable group contract and the insurer or HMO for failure to pay premiums on time.

Electing and Paying for Extended Coverage

If you are entitled to Cal-COBRA extended medical coverage and wish to elect it, you must do so by *notifying the applicable insurer or HMO directly in writing during your 60-day federal COBRA election period*, or at any later date stated by the applicable insurer or HMO. You also must pay the premium for your coverage on time.

You will be responsible for paying the premiums for your Cal-COBRA extended medical coverage. Your premiums generally will be 110% (or 150% in the case of a disabled individual) of the total premiums that otherwise would be charged for that coverage. The insurer or HMO can tell you the amount of your premium and when it is due.

NOTE: If you are eligible and want to elect Cal-COBRA extended coverage, you must contact the applicable insurer or HMO directly during the election period. The County does not handle these elections. Additional details regarding your rights under California law should be included in the evidence of coverage provided by the insurer or HMO.

Conversion Option After Extended Coverage Ends

If you elect extended coverage under California law, you may have the option of obtaining conversion coverage under California law from the applicable insurer or HMO after your extended coverage is exhausted.

Generally, you have up to 63 days from the date that your extended coverage ends under California law to notify the insurer or HMO that you want to convert your medical coverage and to pay the initial premium payment for such conversion coverage.

Examine your options carefully before declining the coverage described in this notice. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

KEEP THE COUNTY INFORMED OF ADDRESS CHANGES

To protect you and your family's rights, you should keep your Departmental Personnel Office informed of any changes in your mailing address. Or, if you have access to a County computer, you can update your address and phone number at **mylacounty.gov** – choose the Employee Self Service option**.**

Contact Information

Contact	Group Number	Phone Number	Website	App
County of Los Angeles Department of Human Resources				
Benefits Hotline	N/A	213-388-9982	**employee.hr.lacounty.gov**	N/A
Benefits System				
Web enrollment	N/A	N/A	**mylacountybenefits.com**	N/A
Fax	N/A	310-788-8775	N/A	N/A
Medical				
UnitedHealthcare HMO (Vision Benefits – Contact VSP at 800-877-7195, or vsp.com)	HMO 401056	800-367-2660	**healthyatcola.com**	Health4Me
UnitedHealthcare Harmony HMO (Vision Benefits – Contact VSP at 800-877-7195, or vsp.com)	HMO 252014	800-367-2660	**healthyatcola.com**	Health4Me
UnitedHealthcare Select Plus PPO (Vision Benefits – Contact VSP at 800-877-7195, or vsp.com)	716822-0005	800-367-2660	**healthyatcola.com**	Health4Me
Kaiser Permanente HMO (Vision Benefits – Contact Kaiser)	101000-0	800-464-4000	**kp.org/countyofla**	Kaiser Permanente
Dental				
MetLife (SafeGuard) HMO	3417	800-880-1800	**metlife.com/safeguard**	MetLife US App
DeltaCare HMO	70831-00001	800-422-4234	**deltadentalins.com**	Delta Dental Mobile App
Delta Dental PPO	4915-10001	888-335-8227	**deltadentalins.com**	Delta Dental Mobile App
Health Care and Dependent Care Spending Account Administrator				
BenefitWallet	N/A	866-225-0067	**mylacountybenefits.com** Click on "Spending Accounts"	BenefitWallet+
Fax	N/A	877-841-1152	N/A	N/A
Life and AD&D Insurance				
New York Life	Life: FLI52070 AD&D: OK819451	800-842-6635 818-477-1494 (Fax)	**bsc4lac.com**	N/A

This guide is the Summary Plan Description (SPD) for the *Options* Flexible Benefits Plan. The benefits described in this SPD are offered to certain employees of the County of Los Angeles.

This SPD is a summary of the Plan and does not constitute an implied or express contract or guarantee of employment. This SPD provides highlights of important information about your participation in *Options*. Complete details about the Plan are contained in the legal plan documents that govern plan operation and administration. If there is a discrepancy between the information provided in the SPD and the provisions of plan documents, the plan documents will govern.

The County of Los Angeles reserves the right in its sole discretion to terminate, suspend, withdraw, amend, or modify the Plan, or any benefit or cost-sharing arrangement under any plan, at any time and for any reason (subject to any relevant collective bargaining arrangements).

The County of Los Angeles also reserves the right to take appropriate action against any person who knowingly presents a false or fraudulent claim for payment under the Plan, or who otherwise attempts to defraud the Plan. If you make fraudulent claims or misrepresentations regarding eligibility, participation, or entitlement to benefits under the Plan, you may be subject to disciplinary action, up to and including termination from participation in the plan, termination of employment, and criminal prosecution. In addition, to the extent permitted by law, your coverage may be terminated retroactively, and you may be required to reimburse the County or the Plan for any premiums or benefits paid due to your fraud or misrepresentations. Medical coverage may not be retroactively terminated unless you have committed fraud or made an intentional misrepresentation of material fact as prohibited under the Plan and you have received at least 30 days advance written notice.