2022 CHOOSEwell SWORN ENROLLMENT GUIDE

Open Enrollment is October 1 – 31, 2021

KEEPING LAwell
City of Los Angeles Employee Benefits

Open Enrollment 2022

Why Should You CHOOSEwell?

Your benefit choices are important in supporting the health and wellbeing of you and your dependents. Benefit elections will be in effect for all of 2022 — so choose wisely, and CHOOSEwell!

Top three things you should know about Open Enrollment:

1. Open Enrollment is your **only opportunity to make coverage elections** for yourself and your dependents for 2022 (unless you experience a qualifying life event change or are a newly hired employee).
2. Generally, **your previous year's benefit elections will automatically roll over to the following year**, unless you make a change during Open Enrollment. Enrollment in the Dependent Care Reimbursement Account (DCRA) and/or the Healthcare Flexible Spending Account (HCFSA) **does not automatically roll over** – if you wish to participate in one of these accounts, you will need to elect to do so during Open Enrollment.
3. Some Open Enrollment election actions **require you to submit supporting documentation** to complete the enrollment. A few common examples are: enrolling a new dependent in coverage or enrolling in Cash-in-Lieu. Check your confirmation statement for further details and deadlines.

Important Dates

Open Enrollment:	Last Date to Make Changes:	Documentation Deadline:	Benefit Changes Take Effect:
October 1 – 31, 2021	October 31, 2021	December 10, 2021	January 1, 2022

Your Enrollment Resources

To learn more about your benefit options:

- Visit keepingLAwell.com to access plan information and documents.
- Call/email a medical plan member advocate for one-on-one help with questions:

Kaiser
Phone: **323-219-6704**
Email: LACity.Advocate@kp.org

Anthem
Phone: **213-200-2987**
Email: Lorena.Gomez@anthem.com

To enroll, make changes, and confirm eligibility for your benefits:

- Log in to your **Benefits Central Portal** account at keepingLAwell.com , available 24/7, or
- Call the **LAwell Benefits Service Center** at **833-4LA-WELL** (**833-452-9355**)
  Monday - Friday, 8:00 a.m. to 5:00 p.m.

Extended phone hours are provided on Saturday, October 30, and Sunday, October 31, from 8:00 a.m. to 7:00 p.m.

(For TDD or TTY service, call **800-735-2922**.)

For all other benefits questions or support, contact your Member Services Representative at **per.empbenefits@lacity.org**.

Your Detailed Enrollment Checklist

- [ ] Review your **Annual Personal Enrollment Letter**.
- [ ] Review your options in this **CHOOSEwell Sworn Enrollment Guide** or at keepingLAwell.com. Review your Memorandum of Understanding (MOU) for more information about your health and dental benefits, including your eligible subsidy amounts for 2022.*
- [ ] Review your **dependent information and eligibility rules** (see pages 45-47) to verify current dependents, add new dependents, or remove ineligible dependents.
- [ ] Make your **2022 enrollment elections**!
- [ ] Provide **Social Security numbers or Taxpayer Identification Numbers for your dependents** in the Benefits Central Portal or by calling **833-4LA-WELL** (this is for federal tax reporting purposes).
- [ ] **Document your dependents by December 10, 2021** (see pages 45-47).
- [ ] Review your **confirmation statement** when you receive it.
- [ ] Review this CHOOSEwell Sworn Enrollment Guide to **understand plan rules and successfully manage your benefits** over time.

* The City subsidies shown in this CHOOSEwell Sworn Enrollment Guide are current as of the printing of this book. However, the subsidy amounts are valid through the end of June 2022 and may change effective July 1, 2022. Check your MOU for changes to the subsidy amount that are scheduled to take effect in July.

Table of Contents

Benefit Overview

What's New for 2022

New medical premium and subsidy rates.

All medical plans will experience a rate change that goes into effect on January 1, 2022. The City-paid subsidy will increase for 2022. These premium and subsidy changes across all medical plans will provide financial relief to the net deduction employees pay for their monthly **LAwell** health care premiums, particularly for those enrolling in family-level coverage.

Contribution limits for the tax-advantaged spending accounts:

- **Healthcare Flexible Spending Account —** $2,750
- **Dependent Care Reimbursement Account —** $5,000.

Benefit Options and Costs

Your personal cost options are detailed in your Annual Personal Enrollment Letter. They are also available by logging in to the Benefits Central Portal at keepingLAwell.com. The following table provides a general overview of your benefit options and costs.

	Your Benefit Options	Provider	Your Cost*	See Pages
Medical	HMO health plans PPO health plan	Anthem and Kaiser	Cost varies based on coverage level elected and your MOU	12-19
	Cash-in-Lieu	City	None. Pays you up to $100** each month.	27
Dental	PPO dental plan DHMO dental plan	Delta Dental	Cost varies based on coverage level elected	28-33
Vision	In-Network	EyeMed	Included at no cost	34-37
	Out-of-Network reimbursements			
Tax-Advantaged Spending Accounts	Healthcare Flexible Spending Account (HCFSA)	WageWorks	You elect voluntary contributions up to an annual maximum limit: - HCFSA: $2,750 - DCRA: $5,000	38-41
	Dependent Care Reimbursement Account (DCRA)			
	Transit and Parking Accounts			75-76

* Your personal cost options are detailed in your Annual Personal Enrollment Letter. They are also available by logging in to your account at keepingLAwell.com.

** Amounts represent full-time employment status. For half-time employees, the benefit is reduced 50%.

As a sworn employee, you have the choice to enroll in medical, dental, and vision benefits through the Civilian **LAwell** benefits program or through one of the sworn associations. **You cannot have dual City benefits.** If you are currently enrolled in Union or Association coverage and want to switch to **LAwell**, contact your Union or Association to change plans.

Online Open Enrollment

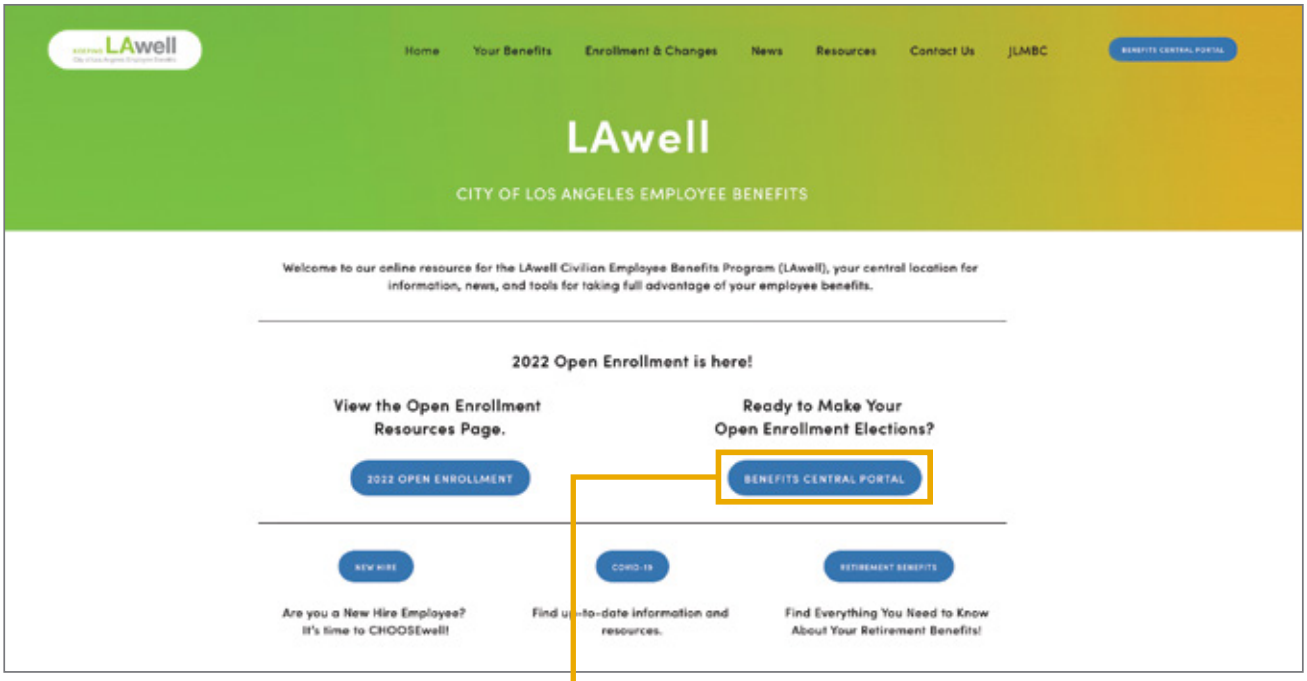
The **LAwell** benefits program offers online and customer support services to make it easier to manage your benefits. The **Benefits Central Portal** allows you easy access to your personal benefits information and to perform transactions. This section provides instructions on accessing and using the Benefits Central Portal.

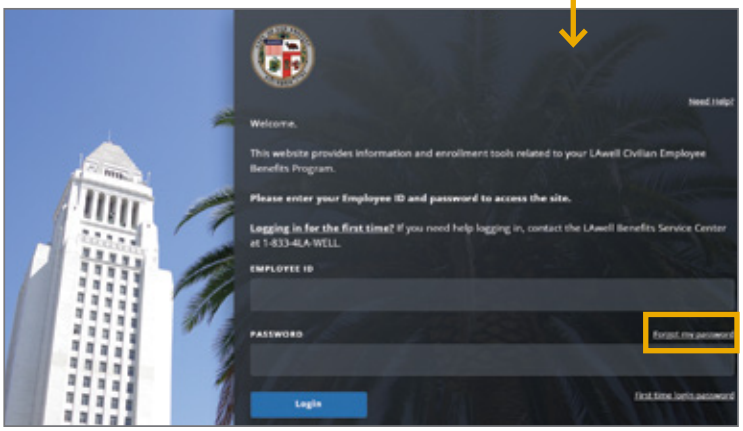
Online Account Registration

If you're a first-time user, register your online account by visiting **keepingLAwell.com** and clicking on the link or button to access the Benefits Central Portal.

Your user name is your Employee ID number. When you first use the system, **your temporary password will be your birthdate and the last four digits of your Social Security number.** If you need help logging in, review the help link information on the login page, or call **833-4LA-WELL** for assistance.

You'll be asked to establish a new password and set security questions to complete your registration. That's it! You'll then have access to all of your current benefits information.



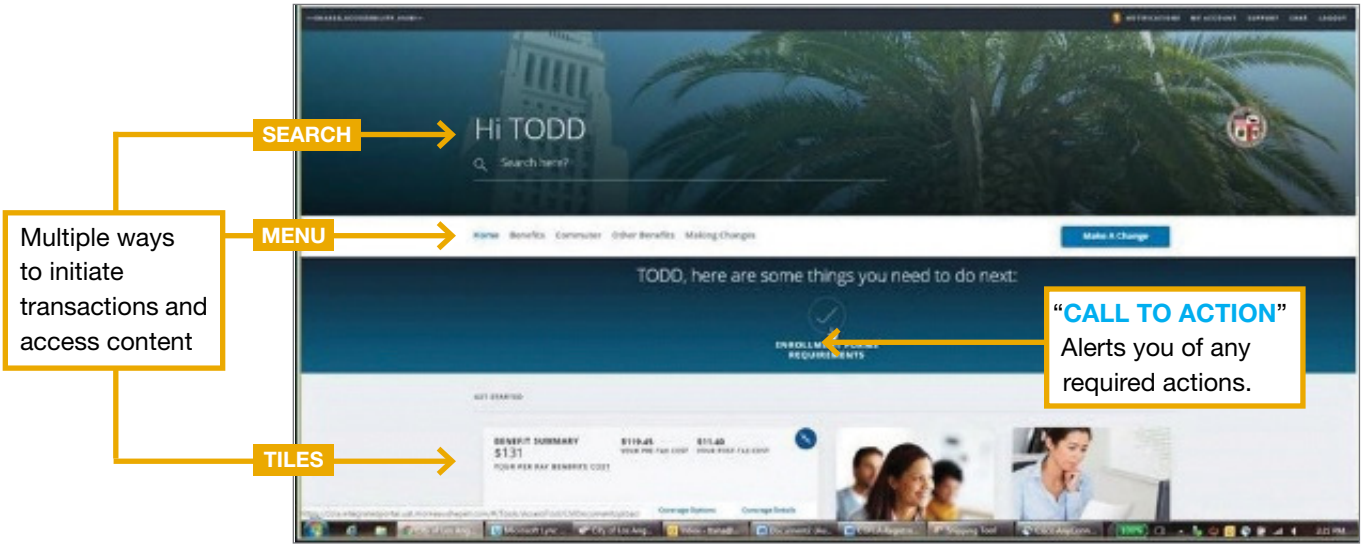


Forgot your password?

If you have forgotten your password, click the "Forgot my password" link to reset your password by email or by answering your personal security questions. You may also call the LAwell Benefits Service Center at **833-4LA-WELL (833-452-9355)**, Monday through Friday, 8:00 a.m. to 5:00 p.m.

Easy-to-Use Navigation

Access the Benefits Central Portal from both your computer and mobile device. The tile-based website is optimized to change its display based on your device. An intuitive design also allows users to access content and start transactions in multiple ways. And a "Call to Action" notification system keeps you informed of any outstanding or required actions.



New City Payroll System for 2022

The City of Los Angeles is moving to a new Human Resources and Payroll (HRP) system in 2022. You'll be able to self-update your home or mailing address, as well as other options, within the new HRP system. Many of those changes will be transmitted to your Keeping LAwell account, along with employment details (job classification, salary, etc.). But please note, the election and management of your **LAwell** benefits — making changes to coverage and adding/removing dependents — will remain completely within the Keeping LAwell system and be separate from the HRP system. You must continue to access the Keeping LAwell system at keepingLAwell.com, or through the Benefits Service Center, for any and all items identified in this guide.

Making Your 2022 Choices Online

The Benefits Central Portal makes it easy to complete your 2022 enrollment online. Use this guide, along with your Annual Personal Enrollment Letter, to learn about rules and restrictions and to compare your 2022 options with your current 2021 coverage.

To review your current 2021 coverage, access your Annual Personal Enrollment Letter through the My Forms and Documents tile or by selecting the "View Benefits Selection" link from your Benefit Summary. Both of these options are located on the home page of your Benefits Central Portal.

To enroll for 2022, follow the instructions on the next two pages to make your Open Enrollment elections online.

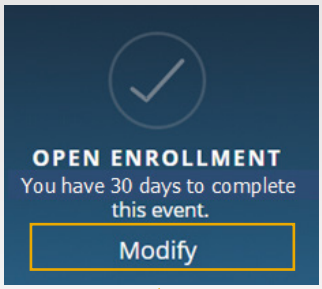
Make Enrollment Elections Online

The Benefits Central Portal enrollment tool is a multiple step, online process that allows you to restart or modify your 2022 choices at any time during the Open Enrollment period (October 1 – 31). Follow these instructions to complete your 2022 enrollment online.

Start Your Open Enrollment Event

LAwell members are automatically (passively) enrolled in benefits for the next year. If you want to keep the same elections, you do not need to enroll; your current elections will automatically continue at the new 2022 per pay period costs.

Select the **Call to Action** banner **OR** Access through the **My Forms and Documents** tile



To change your elections for 2022, **Modify** your Open Enrollment event.

Note: *The Healthcare FSA and Dependent Care Reimbursement Account do not automatically continue. They require an annual election.*

Add Your LAwell Eligible Dependents

In Step 1 you will add your **LAwell** eligible dependents. Continue through all the steps to select or change your **LAwell** coverage elections and to add and remove dependents from coverage.

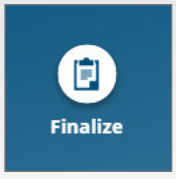
Add and **remove** eligible dependents

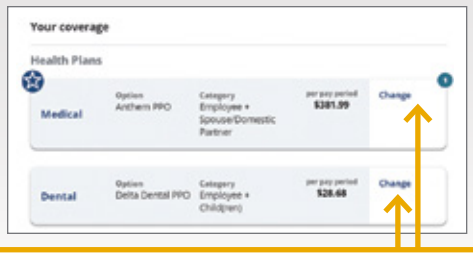
Click **Recalculate** to see how changes to covered dependents impact your per pay period costs.

Finalize and Complete Your Elections

Review your full list of benefit elections on the Finalize screen and ensure your elections are accurate. You can make changes to any benefit by clicking the **Change** link on each associated benefit.

Review your elections and **make changes** if needed

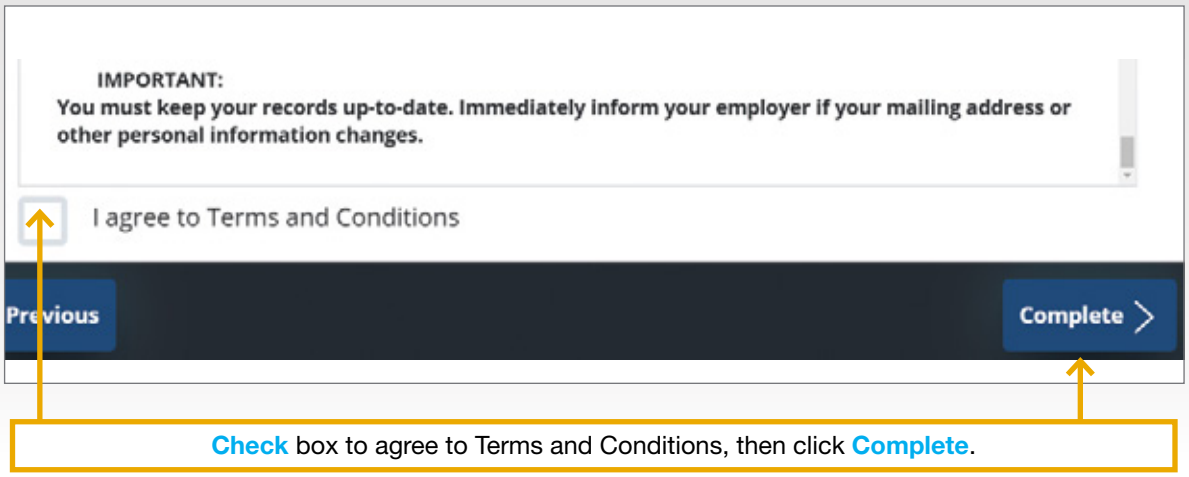




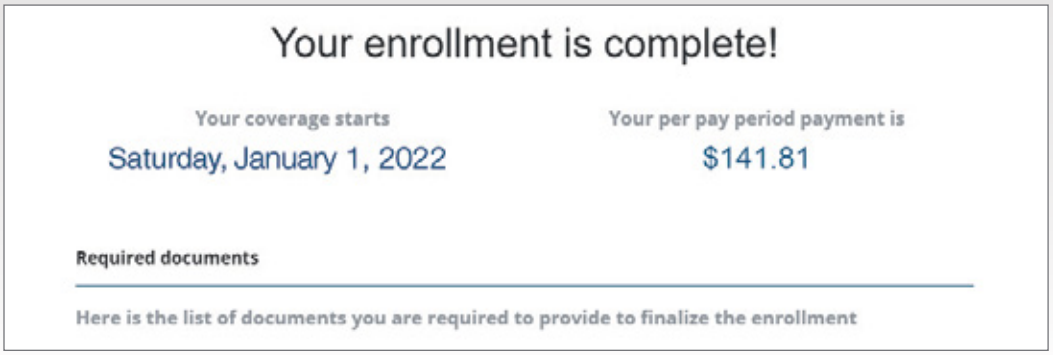
Click **Change** if you want to make changes.

When you are satisfied with your elections, review and accept the Terms and Conditions, then click **Complete** to finish your enrollment and receive confirmation.

Agree to Terms and Conditions; **Complete**



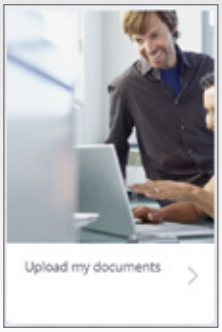
Receive your enrollment confirmation



Submit Documentation

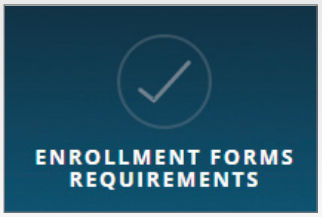
Some election actions, such as adding dependents to coverage, require your submission of supporting documentation. Upload your supporting documents directly to your account using the **Upload my documents** tile, or select the **Enrollment Forms Requirements** Call to Action that should appear after you successfully complete an applicable enrollment event. You can also monitor the status of your uploaded documents.

Select the **Upload my documents** tile



OR

Select the **Enrollment Forms Requirements** Call To Action



Medical Coverage or Cash-in-Lieu

Highlights

- Understanding **the difference between HMOs and PPOs** can help you determine which plan works best for you and your family. Read more about these differences on page 13. Then, compare plan benefits and the coverages they provide on pages 14-19.
- Your total medical plan costs include the **premium** (the monthly amount paid to the insurance company for your coverage) and **out-of-pocket costs** (deductibles, copays, and coinsurance) when you seek care. Read more about medical plan costs on page 20.
- Learn how to **log in to your medical plan online account** on page 26.

Your Medical Plan Choices

Medical Plans

1. Kaiser Permanente (HMO)
2. Anthem Narrow Network (Select) HMO
3. Anthem Vivity (LA & Orange Counties) HMO
4. Anthem Preferred Provider Organization (PPO)

Cash-in-Lieu Option

Cash-in-Lieu: Cash benefit paid to employees who prove medical coverage through a qualifying alternative option in-lieu of enrollment in one of **LAwell's** medical plans.

As a sworn employee, you have the choice to enroll in medical, dental, and vision benefits through the Civilian **LAwell** benefits program or through one of the sworn associations. **You cannot have dual City benefits.** If you are currently enrolled in Union or Association coverage and want to switch to **LAwell**, contact your Union or Association to change plans.

Understanding HMOs and PPOs

Insurance is a product that helps to cover your health expenses. Like auto insurance covers your car if you get into an accident, health insurance covers you if you get sick or injured. It also covers preventive care like doctor's visits, yearly eye exams, regular dental care, and annual screenings. Simply put, health insurance can help you maintain a healthy lifestyle, and protect you when you really need it. But remember, even if you don't use your insurance benefits, you still have to pay your monthly premiums — just like you do to keep your auto insurance current throughout the year.

HMOs

Health Maintenance Organizations (HMOs) provide health care through a network of doctors, hospitals, and other health care providers. With an HMO plan, you must access covered services through a network of physicians and facilities as directed by your primary care physician (PCP), except for emergencies. **LAwell** provides coverage where most City employees live.

Health coverage with an HMO plan is typically restricted to a specific distance from a home or work address. As City employees, your health coverage options discussed in this guide are available to City of Los Angeles work addresses. If you select HMO coverage and you reside outside of the Los Angeles City limits, be sure that you and your dependents are able to receive PCP services in or near your area of residence or that you are capable and willing to travel into the Los Angeles area every time you seek care. To review PCP availability in other areas, review the "Finding Network Providers" section of the provider you are interested in.

PPOs

Preferred Provider Organizations (PPOs) are nationwide networks of doctors, hospitals, and other health care providers that have agreed to offer quality medical care and services at discounted rates. You can use in-network providers for a higher level of reimbursed benefit coverage, or go to a licensed out-of-network provider and receive a lower level of reimbursed benefit coverage.

The following table provides highlights of key differences between the medical plans offered by the City:

	Kaiser Permanente HMO	Anthem Plans		
		Narrow Network (Select HMO)	**Vivity** (LA & Orange Counties HMO)	**PPO**
In-Network Care	You may visit any Kaiser Permanente facility; a primary care physician is recommended but not required.	You designate a primary care physician; you must see this physician first when you need specialty care.		You may visit a network provider of your choice; no primary care physician or specialist referrals required.
Out-Of-Network Care	Not covered unless you need care for a serious medical emergency or urgent care outside of your HMO's network service area.			You may visit any licensed provider you choose, and no primary care physician or specialist referrals are required. However, you will receive a lower level of benefits for out-of-network care.

Medical Plan Coverage Comparisons

The tables on the following pages display only a few highlights of your benefit options. For more information about your coverage, or to get a copy of the complete terms of coverage, visit keepingLAwell.com, anthem.com/ca/cityofla or kp.org/plandocuments.

Benefit Highlights

	Kaiser Permanente HMO	Anthem Narrow Network (Select HMO)	Anthem Vivity (LA & Orange Counties HMO)
Calendar Year Deductible	$0	$0	
Calendar Year Out-of-Pocket Limit	$1,500/person; $3,000/family	$500/person; $1,500/family	
Routine Office Visits (including pediatric visits)	Plan pays 100% after $15 copay/visit[2]	Plan pays 100% after $15 copay/visit[2]	
Virtual Visits	Plan pays 100%	Plan pays 100% after $15 copay/visit[2]	
Preventive Care[1]	Plan pays 100%	Plan pays 100%	
Maternity Care (Office Visits) **& Pregnancy**	Plan pays 100%	Plan pays 100%	
Inpatient Hospitalization	Plan pays 100%	Plan pays 100%	
Outpatient Surgery	Plan pays 100% after $15 copay/procedure	Plan pays 100%	
Diagnostic Lab Work and X-rays	Plan pays 100% at a Kaiser facility	Plan pays 100%	
Emergency Room Care for True Emergencies (severe chest pains, breathing difficulties, severe bleeding, poisoning, etc.)	Plan pays 100% after $100 copay/visit; copay waived if admitted	Plan pays 100% after $100 copay/visit; copay waived if admitted	
Hearing Aid Benefit	Plan pays up to $2,000 for one device per ear every 36 months; covers all visits for fitting, counseling, adjustment, cleaning, and inspection	Plan pays for one hearing aid per ear every 24 months after $15 copay/visit	

1 Preventive care coverage includes preventive services rated A or B by the U.S. Preventive Services Task Force and federal regulations. Go to the website for your health plan or call your health plan if you have questions about coverage.
2 Copay varies by office visit type. See the Evidence of Coverage for more details.

Preventive Care

Your LAwell medical benefits offer no-cost or low-cost preventive care services. For more information on accessing preventive care services, visit keepingLAwell.com or call your health care provider.

Anthem PPO		
	In-Network	**Out-of-Network**
Calendar Year Deductible	$750/person; $1,500/family	$1,250/person; $2,500/family
Calendar Year Out-of-Pocket Limit	$2,000/person; $4,000/family, in-network and out-of-network combined	
Routine Office Visits (including pediatric visits)	Plan pays 100% after $30 copay/visit with no deductible; 90% after deductible for any procedures as part of visit Plan pays 100% for Well-Baby & Well-Child Care	Plan pays 70% of allowed charges[2] after deductible
Online Doctor Visits	Plan pays 100% after $30 copay	N/A
Preventive Care[1]	Plan pays 100%, no deductible	Plan pays 70% of allowed charges[2] after deductible
Maternity Care (Office Visits) **& Pregnancy**	**Prenatal and postnatal office visits for ACA mandated services:** Plan pays 100%; no copay, no deductible **Other prenatal/postnatal office visits:** Plan pays 100% after $30 copay/visit with no deductible. **Other services:** Plan pays 90% after deductible	Plan pays 70% of allowed charges[2] after deductible
Inpatient Hospitalization	Plan pays 90% after deductible; prior authorization needed[3]	Plan pays 70% of allowed charges[2] after deductible, up to $1,500 per day maximum allowed charges. You are responsible for all charges in excess of $1,500 per day. Prior authorization is needed.[3]
Outpatient Surgery	Plan pays 90% after deductible	Plan pays 70% of allowed charges[2] after deductible, up to $350 per day maximum allowed charges. You are responsible for all charges in excess of $350 per day.
Diagnostic Lab Work and X-rays	Plan pays 90% after deductible	Plan pays 70% of allowed charges[2] after deductible
Emergency Room Care for True Emergencies (severe chest pains, breathing difficulties, severe bleeding, poisoning, etc.)	Plan pays 90% after $100 copay/visit; copay waived if admitted and regular hospitalization benefits apply	Plan pays 90% after $100 copay/visit; copay waived if admitted and regular hospitalization benefits apply
Hearing Aid Benefit	Plan pays 80% after deductible for one hearing aid per ear every 24 months	Plan pays 80% of allowed charges[2] after deductible for one hearing aid per ear every 24 months

1 Preventive care coverage includes preventive services rated A or B by the U.S. Preventive Services Task Force and federal regulations. Go to the website for your health plan or call your health plan if you have questions about coverage.
2 When members use non-preferred providers, they must pay the applicable copay and coinsurance plus any amount that exceeds Anthem Blue Cross's allowable amount. Charges above the allowable amount do not count toward the calendar year deductible or out-of-pocket limit.
3 You or your doctor must contact Anthem for preauthorization and approval at a non-participating provider before a hospital stay or you will be responsible for a penalty of $250.

Accessing Care

	Kaiser Permanente HMO	Anthem Narrow Network (Select HMO)	Anthem Vivity (Los Angeles & Orange Counties HMO)
Choice of Physicians and Facilities (hospital, etc.)	Access covered services through the Kaiser network of physicians and facilities, except for emergencies	Access covered services through the Anthem Blue Cross network of physicians and facilities as directed by your PCP, except for emergencies[1]	
Location of Doctors and Providers	Regionally located in nine states	Throughout California	Throughout select locations in Los Angeles and Orange Counties
Primary Care Physician (PCP) Designation	Members will not automatically be assigned a PCP, but may choose and switch PCPs at any time. Members can receive urgent or emergency care services without selecting a PCP.	A PCP designation is required to see a doctor. Members and their dependents may choose their own PCP or medical group, and they do not have to enroll with the same PCP or medical group. New members will automatically be assigned a PCP, but may change their PCP assignment by calling the Anthem Blue Cross Customer Service numbers below. Anthem members are typically allowed to change their PCP designation no more than once a month.	
Changing or Finding a PCP or Network Provider	• Go to my.kp.org/ca/cityofla, choose "Find a Doctor," then choose "Southern California" • Call **800-464-4000** – Open 24 hours a day, 7 days a week • Contact an onsite member advocate	• Go to anthem.com/ca/cityofla, choose "Find Care," then identify your plan • Call Anthem at **844-348-6111**, Monday through Friday, 8:00 a.m. to 8:00 p.m. • Contact an onsite member advocate	• Go to anthem.com/ca/cityofla, choose "Find Care," then identify your plan • Call Anthem Vivity at **844-348-6110**, Monday through Friday, 8:00 a.m. to 8:00 p.m. • Contact an onsite member advocate
Onsite Member Advocates	A Kaiser member advocate is available[2] at: **Los Angeles City Hall** **200 N. Spring Street, Room 867** **Los Angeles, CA 90012** 8:00 a.m. – 4:00 p.m. Tuesday – Thursday Phone: **323-219-6704** Email: LACity.Advocate@kp.org	An Anthem member advocate is available[2] at: **Los Angeles City Hall** **200 N. Spring Street, Room 867** **Los Angeles, CA 90012** 8:00 a.m. – 4:00 p.m., Monday – Friday Phone: **213-200-2987** Email: Lorena.Gomez@anthem.com	
Telemedicine	Kaiser provides phone and video appointments at no additional cost to you. Get quick guidance from a Kaiser Permanente provider, including some prescriptions and 24/7 self-care advice. For more information, visit kp.org/getcare.	Anthem offers LiveHealth Online video visits and the Sydney mobile app. • LiveHealth Online lets you visit a doctor, 24/7, through a smartphone, tablet, or computer with a webcam; no appointment is needed. • Anthem's Sydney health app connects you to everything you need to know about your medical plan. Download the free app via the iPhone App Store or Google Play Store.	
Acupuncture & Chiropractic Care (for assistance in finding a provider, use the Changing or Finding a PCP or Network Provider information above)	Physician-referred acupuncture is covered at a $15 copay per visit. Chiropractic care is not covered, but member discounts are available. For more information, go to kp.org/choosehealthy or call **877-335-2746**.	Anthem plans include coverage for chiropractic care and acupuncture, with some limitations on the number of visits covered each year. You can visit any participating chiropractor from the network without a referral from your primary care physician. Simply call a participating provider to schedule an initial exam.	
LGBTQIA Health Care Providers (for assistance in finding an LGBTQIA provider, use the Changing or Finding a PCP or Network Provider information above)	Kaiser can offer care that is personalized to your sexual orientation, gender identity, or gender expression. You and your provider can decide what information to add to your medical record. For more information, call the Transgender Care line at **323-857-3818**, 8:00 a.m. to 5:00 p.m.	Anthem can offer care that is personalized to your sexual orientation, gender identity, or gender expression. You and your provider can decide what information to add to your medical record that will best meet your care needs.	

1 To find a provider or verify physicians, contact Anthem PPO at **833-597-2362**, Anthem HMO at **844-348-6111**, or Anthem Vivity at **844-348-6110**.
2 In-person availability may vary due to periods of COVID-19 closures.

	Anthem PPO In-Network	Anthem PPO Out-of-Network
Choice of Physicians and Facilities (hospital, etc.)	Access covered services through Prudent Buyer PPO preferred providers	Access covered services through any provider
Location of Doctors and Providers	Available nationally	
Physicians	Members in the Anthem PPO Plan may visit any licensed provider, in or out of network; primary care physician or specialist referrals are not required. However, you will receive a lower level of benefits for out-of-network care.	
Changing or Finding Providers	• Go to anthem.com/ca/cityofla, choose "Find Care," then identify your plan • Call Anthem PPO at **833-597-2362**, Monday through Friday, 8:00 a.m. to 8:00 p.m. • Visit an onsite member advocate	
Onsite Member Advocates	An Anthem member advocate is available[1] at: **Los Angeles City Hall** **200 N. Spring Street, Room 867** **Los Angeles, CA 90012** 8:00 a.m. – 4:00 p.m., Monday – Friday Phone: **213-200-2987** Email: Lorena.Gomez@anthem.com	
Telemedicine	Anthem offers LiveHealth Online video visits and the Sydney mobile app. • LiveHealth Online lets you visit a doctor, 24/7, through a smartphone, tablet, or computer with a webcam; no appointment is needed. • Anthem's Sydney health app connects you to everything you need to know about your medical plan — all in one place. To get started, download the app for free via the iPhone App Store or Google Play Store.	
Acupuncture & Chiropractic Care (for assistance in finding a provider, use the Changing or Finding Providers information above)	Anthem plans include coverage for chiropractic care and acupuncture, with some limitations on the number of visits covered each year. You can visit any participating chiropractor from the network without a referral from your primary care physician. Simply call a participating provider to schedule an initial exam.	
LGBTQIA Health Care Providers (for assistance in finding an LGBTQIA provider, use the Changing or Finding a Providers information above)	Anthem can offer care that is personalized and most relevant to your sexual orientation, gender identity, or gender expression. You and your provider can decide what information to add to your medical record that will best meet your care needs.	

1 In-person availability may vary due to periods of COVID-19 closures.

Mental Health and Substance Abuse Treatment Highlights

The mental health inpatient and outpatient benefits shown here are general benefit provisions. For more information about your coverage, or to get a copy of the complete terms of coverage, visit kp.org/plandocuments or anthem.com/ca/cityofla.

	Kaiser Permanente HMO	Anthem Plans			
		Narrow Network (Select HMO)	**Vivity** (Los Angeles & Orange Counties HMO)	**PPO** In-Network	**PPO** Out-of-Network
Inpatient[1]	Plan pays 100%	Plan pays 100%		Plan pays 90% after deductible; prior authorization needed.[3]	Plan pays 70% of allowed charges[2] after deductible; prior authorization needed.[3]
Outpatient[1]	Plan pays 100% after $15 copay/visit for individual visit, $5 – $7 copay/visit for group session[2]	Plan pays 100% for facility-based care; 100% after $15 copay/visit for physician visits[2]		Plan pays 90% after deductible for facility-based care; 100% after $30 copay/visit for physician office visit.	Plan pays 70% of allowed charges[4] after deductible. Plan pays 70% of allowed charges for physician office visit.

1 The mental health inpatient and outpatient benefits shown here are general benefit provisions. Consult with your plan for specific information regarding benefits available.
2 Copay varies by office visit type. See the Evidence of Coverage for more details.
3 You or your doctor must contact Anthem for preauthorization and approval at a non-participating provider before a hospital stay, or you will be responsible for a penalty of $250.
4 When members use non-preferred providers, they must pay the applicable copay and coinsurance plus any amount that exceeds Anthem Blue Cross's allowable amount. Charges above the allowable amount do not count toward the calendar year deductible or out-of-pocket limit.

Prescription Drug Coverage Highlights

	Kaiser Permanente HMO	Anthem Plans		
		Narrow Network (Select HMO)	**Vivity** (Los Angeles & Orange Counties HMO)	**PPO** In-Network/ Out-of-Network
Prescription Drug Coverage	You must fill prescriptions at a Kaiser pharmacy. Simply show your member ID card and pay a copay when you go to a participating Kaiser pharmacy. You do not have to submit claim forms. Prescriptions from non-participating pharmacies are not covered unless they are associated with covered emergency services.	You must fill prescriptions at any retail pharmacy that participates in the Anthem pharmacy network. Prescriptions from non-participating pharmacies are also covered, but your cost share may be significantly higher. To have a prescription filled, simply show your member ID card and pay a copay when you go to a participating Anthem pharmacy. You do not have to submit claim forms. If an Anthem member requests a brand-name drug and a generic equivalent is available, the member is responsible for paying the generic drug copay plus the difference in cost between the brand-name drug and its generic drug equivalent. Some examples of expenses the prescription drug program does not cover include: • Most over-the-counter drugs (except insulin), even if prescribed by your doctor • Vitamins, except those requiring a prescription, like prenatal vitamins • Any drug available through prescription but not medically necessary for treating an illness or injury • Non-FDA-approved drugs, or drugs determined to be used for experimental or investigative indications		
Finding a Pharmacy	To find a Kaiser pharmacy, go to kp.org.	To find a participating pharmacy, go to anthem.com/ca/cityofla.		
Finding the Drug Formulary	To find the Kaiser drug formulary, go to kp.org/formulary.	To find the Anthem drug formulary, go to anthem.com/ca/cityofla. Select "Drug Lists (Formularies)" at the bottom of the page, then select "Anthem National Drug List."		
Pharmacy				
Generic Copay[1]	$10 for up to 30-day supply	$10 for up to 30-day supply		
Brand-name Copay[1]	$20 for up to 30-day supply	Formulary Drug: $20 for up to 30-day supply Non-Formulary Drug: $40 for up to 30-day supply		
Pharmacy Mail Order (Home Delivery Service)				
Generic Copay[1]	$20 for up to 100-day supply	$20 for up to 90-day supply		
Brand-name Copay[1]	$40 for up to 100-day supply	Formulary Drug: $40 for up to 90-day supply Non-Formulary Drug: $80 for up to 90-day supply		

1 Your copay for covered drugs will not exceed the lesser of any applicable copay listed above for the listed supply amount or the actual cost of the drug. The cost for variations from the above list may vary. Contact your health plan or visit your health plan member advocate at City Hall if you have questions about prescription drug copays.

Drug Formulary

Your out-of-pocket costs are lower when you use a drug on the formulary. A formulary is a preferred list of commonly prescribed, FDA-approved medications compiled by an independent group of doctors and pharmacists. It includes medications for most medical conditions that are treated on an outpatient basis.

Medical Plan Costs

When choosing a plan, it's a good idea to think about your total health care costs, not just the premium (the monthly amount paid to the insurance company for your coverage). You may also have to pay out-of-pocket costs — deductibles, copays, and coinsurance — when you seek medical care. While health plan options generally cover the same types of care, the differences in what they pay for covered care have a big impact on out-of-pocket costs and your total spending on health care — sometimes more than the premium itself.

Premium Costs

The majority of health insurance premium costs are paid by the City with the subsidy you receive. This demonstrates the City's commitment to employees and their families — adding up to a valuable part of your total compensation. However, the City's subsidy is subject to eligibility and any premium sharing requirements as provided for by your Memorandum of Understanding (MOU).

Out-of-Pocket (OOP) Costs

A **deductible** is the amount you are responsible for paying for eligible health care services before your plan begins to pay benefits.

Coinsurance is your share of the cost of a covered service you receive.

A **copay** is the dollar amount that you or your eligible dependents must pay directly to a provider at the time services are performed.

Your **out-of-pocket limit** is the most you will have to pay for covered medical expenses in a calendar year through deductibles, copays, and coinsurance before your plan begins to pay 100% of eligible medical expenses.

Compare the plans' out-of-pocket costs on pages 14-15.

Subsidy Eligibility

The employee portion of the premiums, if any, is automatically deducted from your paychecks two times per month. **Your eligibility to receive the City's subsidy for your benefits is evaluated on a biweekly basis. Sworn employees are eligible for LAwell benefits and the City subsidy if they are members of Memorandums of Understanding (MOU) 22, 23, 24, or 25 and work qualifying work time (such as HW, SK, VC, HO, etc.), or the number of qualifying hours specified by their MOU to be considered full-time and eligible for benefits.**

If you do not have sufficient compensated hours in any given pay period, you will be required to pay the full unsubsidized premium for your benefits to continue, and a bill for these outstanding benefit costs will be sent to you by the Personnel Department, Direct Billing Section. Other situations, including benefit termination, may apply. See page 49 for more information.

Restrictions apply to family members who are also City employees. You are also not permitted to be dually covered within **LAwell** benefits, meaning any City employee is not permitted to be simultaneously covered as both an employee and a dependent under **LAwell's** medical, dental, or vision coverages. For additional details, see pages 44-45.

The amount of premium you are responsible for depends on four factors:

1. Your employment status
2. The Memorandum of Understanding (MOU) contribution structure that applies to you
3. The specific medical plan you choose
4. The coverage level you choose (the number of dependents* you cover, if any)
   - Employee Only (Single Party – Employee)
   - Employee & Spouse/Domestic Partner (DP)* (Two Party – Employee and another adult legal spouse or legal DP)
   - Employee + Child(ren)* (Two+ Party – The Employee and any legal child and/or disabled child dependents in the household)
   - Employee + Family* (Three+ Party – The Employee and all legal dependents)

* Eligibility of dependents is subject to **LAwell** program rules. See page 45 for more information on dependent eligibility. Domestic partnerships are not recognized under federal tax law, and enrollment of domestic partner dependents may result in different taxable income treatment of the employee. See page 57 for more information on domestic partner taxable income treatment.

If you have questions regarding your health plan contributions, please refer to your applicable MOU.

LAwell Plan

Your 2022 Medical Plan Coverage Costs per Pay Period (Every Two Weeks)

Premium Rates for Calendar Year 2022. The City subsidy shown applies to 07/01/21 – 06/30/22 and is subject to change based on your applicable MOU. Review your MOU for more information about your subsidy amount.

Sworn Employees (MOUs 22, 23, 24, and 25)			
Coverage Level	**City Pays**…**	**Employee Pays…**	**Total Cost of Coverage Biweekly (per Pay Period)**
Kaiser HMO			
Employee Only	$326.87	$0.00	$326.87
Employee & Spouse/DP*	$719.12	$0.00	$719.12
Employee + Child(ren)*	$653.74	$0.00	$653.74
Employee + Family*	$804.68	$45.18	$849.86
Anthem Narrow Network (Select) HMO			
Employee Only	$320.32	$0.00	$320.32
Employee & Spouse/DP*	$704.74	$0.00	$704.74
Employee + Child(ren)*	$608.65	$0.00	$608.65
Employee + Family*	$804.68	$28.21	$832.89
Anthem Vivity (LA & Orange Counties) HMO			
Employee Only	$268.90	$0.00	$268.90
Employee + Spouse/DP*	$591.60	$0.00	$591.60
Employee + Child(ren)*	$510.92	$0.00	$510.92
Employee + Family*	$699.15	$0.00	$699.15
Anthem PPO			
Employee Only	$532.54	$0.00	$532.54
Employee + Spouse/DP*	$804.68	$366.91	$1,171.59
Employee + Child(ren)*	$804.68	$207.13	$1,011.81
Employee + Family*	$804.68	$579.92	$1,384.60

* Domestic partnerships are not recognized under federal tax law, and enrollment of domestic partner dependents may result in different taxable income treatment of the employee. See page 57 for more information.

** The City subsidy is current as of the printing of this book. The subsidy amount applies through to the end of June 2022 and may change effective July 1, 2022. Check your MOU for changes to the subsidy amount that are scheduled to take effect in July.

Medical Coverage or Cash-in-Lieu

Care While Traveling

Type of Care	Kaiser Permanente HMO	Anthem Plans	
		Narrow Network (Select HMO) **Vivity** (LA & Orange Counties HMO)	**PPO**
Emergency Care in the U.S.	Covered 24 hours a day, 7 days a week. Call **911** or go immediately to the closest emergency facility for medical attention. Emergency room copay will be waived if you are admitted.		
	Call **800-225-8883** immediately if you are admitted to a non-participating hospital.	Within 48 hours of admission, contact Anthem Blue Cross Customer Service at the number listed on your member ID card.	
Emergency Care Outside the U.S.	Go to the nearest emergency facility and call **800-225-8883** if you receive treatment. Request an itemized bill (in English) and save your receipt to file a claim for reimbursement.	Always go to the closest emergency facility; request an itemized bill (in English) before leaving to file a claim for reimbursement. The BlueCross BlueShield Global Core Service Center is available 24 hours a day, 7 days a week, toll-free, at **800-810-BLUE** or by calling collect at **804-673-1177**. An assistant coordinator, along with a medical professional, will arrange doctor or hospitalization needs.	
Urgent Care	**In-Area:** Go to the nearest Kaiser Permanente urgent care facility. You can also call for an appointment or contact the Nurse Help Line at **1-833-574-2273 (TTY 711)**. **Out-of-Area:** Go to the nearest urgent care facility, Concentra urgent care center, or MinuteClinic. Members can use their Kaiser Permanente ID card at Concentra or MinuteClinic locations and only pay their standard copay.	**In-Area:** If you are within 15 miles or 30 minutes from your medical group, call your primary care physician or medical group and follow their instructions. **Out-of-Area:** If you can't wait to return for an appointment with your primary care physician, get the medical help you need right away. If you are admitted, call Anthem Customer Service within 48 hours at the number listed on your member ID card.	Go to the closest urgent care or emergency facility. Contact Anthem Blue Cross Customer Service at the number listed on your member ID card or look up a provider on the Anthem website, anthem.com/ca/cityofla to locate the nearest in-network facility.
Prescription Coverage	**Within the service area**, go to any Kaiser pharmacy. **Outside the service area**, only emergency/urgent prescriptions are covered; ask for an itemized bill (in English) and save your receipt to file a claim for reimbursement.	**In the U.S.:** Call Anthem Blue Cross Customer Service at the number listed on your member ID card or visit anthem.com/ca/cityofla to find a participating pharmacy that accepts your coverage. **Outside the U.S.:** Request an itemized bill (in English) and save your receipt to file a claim for reimbursement.	

Care for Dependents Who Do Not Live with You

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

Health and Wellbeing

To support your current and future health and wellbeing, **LAwell** includes many other benefits. Here are some of the additional — and very important — parts of your benefits package.

	Kaiser Permanente HMO my.kp.org/ca/cityofla	Anthem Plans anthem.com/ca/cityofla
Annual Checkups	Annual physical and other in-network preventive care is generally covered at 100% in-network.	
Nurse Help Line (available 24/7)	**1-833-574-2273 (TTY 711)**	**800-977-0027**
Weight Management and Nutrition Counseling	Visit kp.org/health-wellness to explore wellness resources, including: • Weight loss tools and resources • Healthy Balance Program • Ideas to make exercise enjoyable • Healthy recipes and more	• Diabetes Prevention Program for pre-diabetics. For more information on this free program, call your Anthem plan at the number in the "Learn More" section on page 26. • Online tools and resources to support your diet, fitness, and weight management goals. Log in to your member account at anthem.com/ca/cityofla and select "My Health Dashboard" to get started. • Discounts on gym memberships through Active&Fit Direct™, and weight loss products and programs, including Jenny Craig, Living Lean, nutrition bars, and drinks. Log in to anthem.com/ca/cityofla and select "Discounts" to learn more.
Smoking/Tobacco Cessation	Access Quit Smoking Services: • Contact your doctor • Call Wellness Coaching by phone at **866-862-4295** • Attend an in-person workshop, "Freedom From Tobacco" — visit kp.org/centerforhealthyliving for more information.	• Online smoking/tobacco cessation support. Log in to your member account at anthem.com/ca/cityofla and select "Health and Wellness Center" to learn more. • Coverage for FDA-approved, over-the-counter nicotine replacement medications with no copay, when obtained with a doctor's prescription. • Coverage for FDA-approved prescription smoking cessation medications with no copay. Contact your Anthem provider for more information.
Health Coaching	A phone-based Wellness Coaching program is available to all members focused on health habits, like managing weight, quitting tobacco, reducing stress, becoming more active, and eating healthier. Call **866-862-4295**.	Anthem offers an array of support programs to help manage your condition(s). Contact Anthem at the numbers shown below for assistance with finding the program that's right for you. • Anthem PPO: **833-597-2362** • Anthem Vivity: **844-348-6110** • Anthem Narrow Network (Select HMO) : **844-348-6111**
Exercise	Visit kp.org/exercise for more information about: • Active&Fit Direct™ — provides discounted gym memberships to adult members. • ClassPass — provides on-demand video workouts to adult members.	Active&Fit Direct™ — provides discounted gym memberships. Log in to your member account at anthem.com/ca/cityofla and select "Discounts" to learn more.
Chronic Care Management	Complete Care disease management program is designed to prevent or manage chronic conditions through a combination of clinical care, health education, and self-management tools. Members with specific medical conditions are automatically identified using disease-specific case identification protocols through our clinical information systems. Call Member Services at **800-464-4000**.	Call the 24/7 Nurse Line at **800-977-0027** for access to a nurse care manager who can enroll you and your dependents in valuable health management programs for certain health conditions. Extra Support for PPO Members — Contact ConsumerMedical at **888-361-3494** to receive personalized, one-on-one support from an expert team to understand your medical conditions and available treatment options.
Other Online Tools	Total Health Assessment (THA) begins with a series of questions about your health. You will then be provided personalized recommendations to help reach your health goals. Visit kp.org/tha to get started. To participate, you need to be registered at kp.org/registernow. In addition, adult members have access to the myStrength app and Calm app at no cost. Visit kp.org/selfcareapps to create an account.	Log in to your member account at anthem.com/ca/cityofla and select "My Health Dashboard" to find: • Preventive health guidelines for men, women, children, and seniors • Online information for 200 health topics • Health Assessment • Digital Health Assistant • Personal Health Record • Pregnancy Assistant

COVID-19 Information

Access updated information on COVID-19, including vaccine information, through the following websites:

- **Kaiser Permanente:** kp.org/coronavirus
- **Anthem:** anthem.com/coronavirus
- **Keeping LAwell:** keepingLAwell.com/covid-19

Managing Your Medical Plan Online Account

Kaiser Permanente Online Account

You can go online to view most lab results, refill most prescriptions, email your doctor, schedule and cancel routine appointments, and print vaccination records. Here's how to register online:

1. Go to kp.org/registernow.
2. Select the blue "Create my account" button.
3. Enter your personal information.

Anthem Online Account

You can go online to find doctors and hospitals in your plan, view or update your primary care physician (PCP), review payments and billing, and order and manage prescriptions. Here's how to register online:

1. Go to anthem.com/ca/cityofla.
2. Select the blue profile button on the top right side of the page.
3. Select "Registration" from the drop-down menu.
4. Enter your personal information.

Learn More

Find more information on each of the plans:

- **Kaiser Permanente HMO:** Visit my.kp.org/ca/cityofla or call **800-464-4000**
- **Anthem Narrow Network (Select) HMO:** Visit anthem.com/ca/cityofla or call **844-348-6111**
- **Anthem Vivity:** Visit anthem.com/ca/cityofla or call **844-348-6110**
- **Anthem PPO:** Visit anthem.com/ca/cityofla or call **833-597-2362**
- **All plans:** Visit keepingLAwell.com for information and plan documents like Summaries of Benefits and Coverage (SBCs) and Evidence of Coverage (EOCs), or call **833-4LA-WELL**.

Cash-in-Lieu Option

If you already have eligible medical coverage, you may be able to receive a taxable payment each month in-lieu of enrollment into one of **LAwell's** medical plans.

- **Full-time employees** receive an additional $50 in taxable income in their paycheck each pay day, up to $100 per month.

Coverage Eligible for Cash-in-Lieu

The eligible medical coverage options include:

- Dependent coverage through your spouse's or domestic partner's employer
- Dependent coverage (if you're under age 26) through your parent's plan that qualifies as minimum essential coverage (MEC) in accordance with the individual shared responsibility provision of the Affordable Care Act (ACA)
- Individual/Family coverage through your second employer
- Retiree coverage through your previous employer
- Medicare
- Medi-Cal
- TRICARE

Coverage NOT Eligible for Cash-in-Lieu

Coverage you and/or your spouse obtain through the Covered California Marketplace or any other program that is not an employer-offered health plan does not qualify as eligible coverage for the Cash-in-Lieu program.

How to Enroll in Cash-in-Lieu

To continue your current Cash-in-Lieu election, nothing is required. Cash-in-Lieu will continue until you notify us of a qualifying life event change.

To elect Cash-in-Lieu for the first-time:

1. Select Cash-in-Lieu during Open Enrollment.
2. Complete the **Cash-In-Lieu Affidavit**, providing required supporting documentation of your eligible medical coverage, by the **December 10, 2021 deadline.** If you do not submit a **Cash-In-Lieu Affidavit** by the deadline, your participation in Cash-in-Lieu will be canceled and you will be enrolled in employee-only medical coverage for 2022.

Approval of your Cash-In-Lieu Affidavit is subject to review and verification by the Employee Benefits Division, and your participation in the Cash-in-Lieu program may also be canceled based on the information you provide on your affidavit.

Download the affidavit at keepingLAwell.com. You will also receive a copy along with your confirmation statement.

Additional First-Time Enrollment Rules

If you enroll during Open Enrollment for 2022, participation is effective January 1, 2022, and your current **LAwell** medical coverage will terminate December 31, 2021. Your first "Cash-in-Lieu" payment will be reflected in your gross wages on the paycheck you receive on January 12, 2022, for the pay period ending January 1, 2022.

Learn More

Find more information on Cash-in-Lieu.

- Visit keepingLAwell.com or call **833-4LA-WELL**.

Dental Coverage

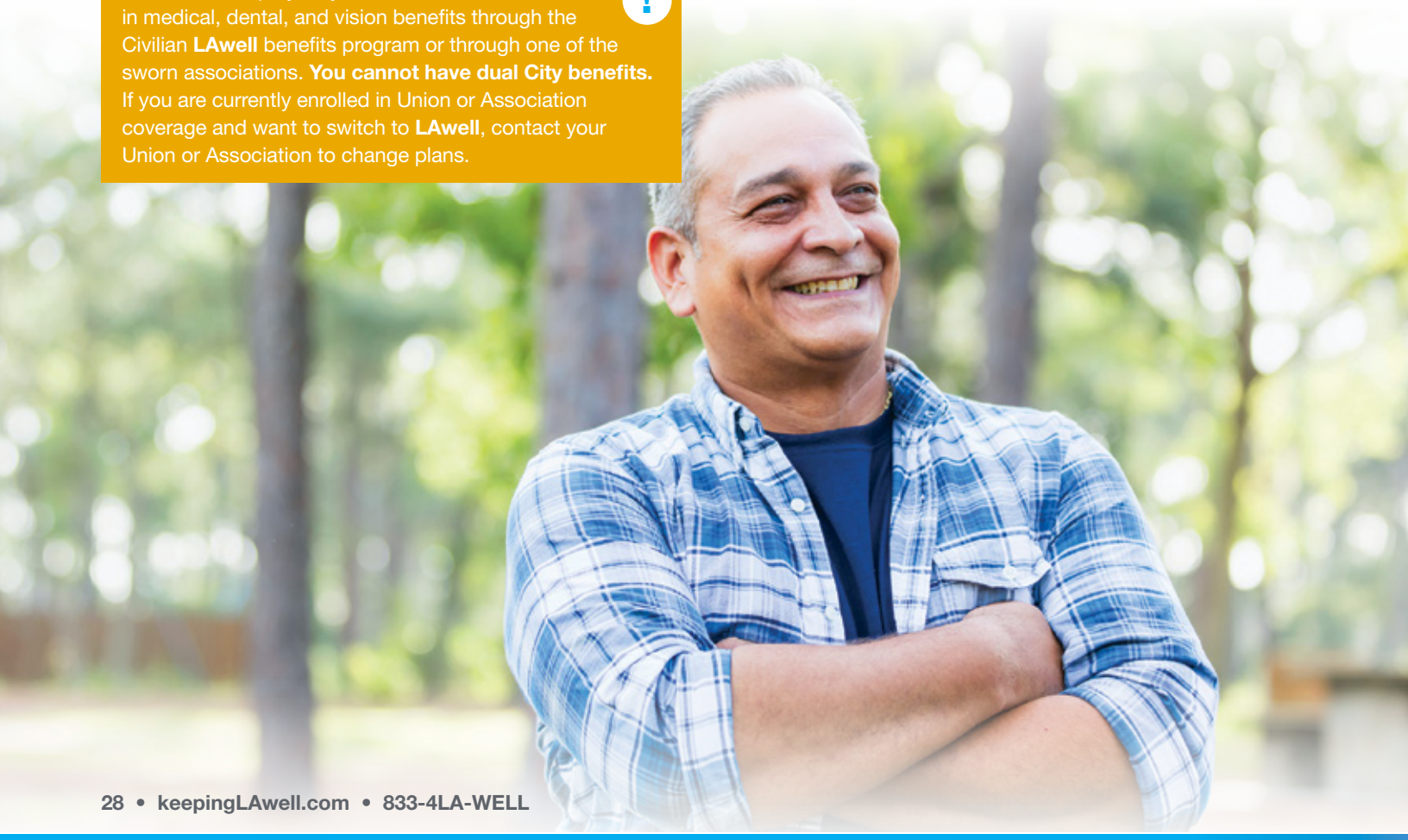
Highlights

- You may choose from two dental plan options administered by Delta Dental. Compare plan benefits and the coverages they provide on pages 29-31.
- Your total dental plan costs include the **premium** (the monthly amount paid to the insurance company for your coverage) and **out-of-pocket costs** (deductibles and copays) when you seek care. Read more about dental plan costs on pages 32-33.
- Learn how to log in to your Delta online account on page 33.

Your Dental Plan Choices

1. **DeltaCare USA DHMO** is a dental HMO; you must choose a primary care dentist (PCD) and see this dentist first whenever you need care. You must use that network's providers to receive benefits.
2. **Delta Dental PPO** provides care through a network of dentists who have agreed to offer covered services at discounted rates. You can choose a network or non-network provider each time you need care.

As a sworn employee, you have the choice to enroll in medical, dental, and vision benefits through the Civilian **LAwell** benefits program or through one of the sworn associations. **You cannot have dual City benefits.** If you are currently enrolled in Union or Association coverage and want to switch to **LAwell**, contact your Union or Association to change plans.



Dental Plan Coverage Comparisons

The tables that follow display only a few highlights of your dental benefit options. For more information about your coverage, or to get a copy of the complete terms of coverage, log in to your Delta Dental account at **deltadentalins.com** and view "Benefit Details." Additional information is available through **keepingLAwell.com**.

Dental Plan Highlights

	DeltaCare USA DHMO	Delta Dental PPO
Features a network of providers	Yes	Yes
Offers flexibility to use non-network providers	No	Yes – paid at out-of-network level
Covers preventive care	Yes	Yes
Covers services other than preventive care – such as basic and major services	Yes	Yes
Has a calendar year deductible	No	Yes
Has an annual maximum benefit	No	Yes
Includes set copays for most services	Yes	No
Requires you to choose a primary care dentist	Yes	No
Covers emergency care outside the provider network*	Yes – up to $100 per incident after any copay**	Yes – paid at out-of-network level

* For emergency care provided by a dentist who is not part of Delta's network, you must pay for services and submit a claim. For claim instructions, contact Delta Dental Customer Service at **800-765-6003** for PPO or **800-422-4234** for DeltaCare USA DHMO.

** Contact your primary care dentist (PCD) or Delta Dental Customer Service at **800-422-4234** before receiving treatment. If you do not, you may be responsible for any charges related to treatment.

Preventive Care

Your LAwell dental benefit offers no-cost or low-cost preventive care services.

For more information on accessing preventive care services, visit **keepingLAwell.com** or call your dental care provider.

The Delta Dental Network

In California, 89.9% of dentists belong to a Delta network. Dentists who are not part of Delta's PPO network may still be Delta dentists and agree to accept Delta's reasonable and customary (R&C) fee.

DeltaCare USA DHMO	Delta Dental PPO
Benefits paid for network services only	Plan pays highest level of benefit when you use network providers
You must select a primary care dentist (PCD) from the DeltaCare USA network	Network providers offer discounted fees. No charges above reasonable and customary (R&C) limits

To find a Delta Dental network provider near you:

- Search Delta's online provider directories by visiting deltadentalins.com and selecting "Find a Dentist." From the drop-down menu, choose Delta Dental PPO for the PPO option, or DeltaCare USA for the DHMO option.
- Request a provider directory (at no cost) by calling **800-765-6003** for the Delta Dental PPO option or **800-422-4234** for the DeltaCare USA DHMO option.

Teledentistry

Your dentist can determine through consultation whether you have an emergency dental problem, and can provide instructions on how to treat conditions.

Follow these simple steps to explore teledentistry as a care option with your dentist:

1. Contact your dental office to find out if teledentistry services are offered.
2. Ensure that you have the technology used by your dentist office.
3. Fill out any required paperwork, such as patient consent forms, and understand your patient rights.

Dental Benefit Highlights

This table shows a brief summary of how the two dental options pay for certain services. If you have questions about how a specific service is covered, call **800-765-6003** for the Delta Dental PPO or **800-422-4234** for the DeltaCare USA DHMO.

How Benefits Are Paid	DeltaCare USA DHMO	Delta Dental PPO	
		In-Network	**Out-of-Network**
Calendar Year Deductible	None	$25/person; $75/family	$50/person; $150/family
Diagnostic and Preventive Care			
• Two cleanings and exams/year • Two sets of bitewing X-rays/year for children up to age 18; one set/year for adults • Two fluoride treatments/year for children up to age 19	Plan pays 100% — covers one series of four bitewing X-rays in any six-month period for children or adults	Cleanings, X-rays and exams: Plan pays 100% with no deductible (includes an additional oral exam and a routine cleaning during pregnancy). Diagnostic and Preventive Care charges are not applied to the annual maximum.	Cleanings, X-rays and exams: Plan pays 80% of R&C* with no deductible (includes an additional oral exam and a routine cleaning during pregnancy). Diagnostic and Preventive Care charges are not applied to the annual maximum.
Basic Services			
Amalgam fillings, extractions	Plan pays 100% for fillings; you pay up to $90 for extractions	Plan pays 80%	Plan pays 80% of R&C*
Root canal	Your copay is $45 – $220 per procedure	Plan pays 80%	Plan pays 80% of R&C*
Periodontal scaling and root planing	Plan pays 100% up to 4 quadrants in 12 months	Plan pays 80% once per quadrant every 24 months	Plan pays 80% of R&C,* once per quadrant every 24 months
Major Services			
Crowns	Your copay is $55 – $195 per procedure**	Plan pays 80%	Plan pays 50% of R&C*
Dentures	Your copay is $80 – $170 per procedure	Plan pays 50%	Plan pays 50% of R&C*
Implants	Not covered	Plan pays 50%	Plan pays 50% of R&C*
Orthodontia			
Children under age 19	Your copay is $1,000 plus start-up fees of $300	Plan pays 50%	Plan pays 50% of R&C*
Children age 19 to age 26	Your copay is $1,350 plus start-up fees of $300	Plan pays 50%	Plan pays 50% of R&C*
Adults	Your copay is $1,350 plus start-up fees of $300	Not covered	Not covered
Plan Maximums			
Annual maximum benefit (does not include diagnostic and preventive services)	None	$1,500/person***	
Lifetime orthodontia maximum benefit	None	$1,500/child	

* R&C is the reasonable and customary charge – the usual charge for specific services in the geographic area where you are treated.
** When there are more than six crowns in the same treatment plan, an enrollee may be charged an additional $100 per crown beyond the sixth unit.
*** If you use both in-network and out-of-network dentists, your total annual maximum benefit will never be more than $1,500 per person.

Dental Plan Costs

Premium Costs

Dental insurance premium costs are paid, in part, by the City's subsidy and by the employee portion. However, the City's subsidy is subject to eligibility.

Subsidy Eligibility

The employee portion of the premiums, if any, is automatically deducted from your paychecks two times per month. **Your eligibility to receive the City's subsidy for your benefits is evaluated on a biweekly basis. Sworn employees are eligible for LAwell if they are members of Memorandums of Understanding (MOU) 22, 23, 24, or 25 and work qualifying work time (such as HW, SK, VC, HO, etc.), or the number of qualifying hours specified by their MOU to be considered full-time and eligible for benefits.**

If you do not have sufficient compensated hours in any given pay period, you will be required to pay the full unsubsidized premium for your benefits to continue, and a bill for these outstanding benefits costs will be sent to you by the Personnel Department, Direct Billing Section. Other situations, including benefit termination, may apply. See page 49 for more information.

For 2022, the maximum DHMO dental plan subsidy is $16.78 per month for all employees. The maximum PPO dental plan subsidy is $44.60 per month for full-time employees and $26.24 per month for half-time employees.

The amount of premium you are responsible for depends on four factors:

1. Your employment status
2. The Memorandum of Understanding (MOU) contribution structure that applies to you
3. The specific dental plan you choose
4. The coverage level you choose (the number of dependents* you cover, if any)

* Eligibility of dependents is subject to **LAwell** program rules. See page 45 for more information on dependent eligibility.

Restrictions apply to family members who are also City employees. You are also not permitted to be dually covered within **LAwell** benefits, meaning any City employee is not permitted to be simultaneously covered as both an employee and a dependent under **LAwell's** medical, dental, or vision coverages. For additional details, see pages 44-45.

Out-of-Pocket Costs

A **deductible** is the amount you are responsible for paying for eligible health care services before your plan begins to pay benefits.

Coinsurance is your share of the cost of a covered service you receive.

A **copay** is the dollar amount that you or your eligible dependents must pay directly to a provider at the time services are performed.

Reasonable and Customary (R&C)

The reasonable and customary (R&C) charge is the amount quoted for a dental service that is based on what is typically charged within a specific geographic area. **Use Delta Dental's Cost Estimator tool to check out-of-pocket expenses and find the average submitted costs for dental procedures.** Log in to your Delta Dental online account at deltadentalins.com to access the tool.

Learn More

Find more information on each of the plans:

- **Delta Dental PPO:** Visit deltadentalins.com or call **800-765-6003**.
- **DeltaCare USA DHMO:** Visit deltadentalins.com or call **800-422-4234**.
- **All plans:** Visit keepingLAwell.com for plan information and Evidence of Coverage (EOC) documents, or call **833-4LA-WELL**.

2022 Dental Plan Premiums

Your 2022 Dental Plan Coverage Costs Per Pay Period (Every Two Weeks)					
	MOU 23		MOUs 22, 24, and 25		
Coverage Level	City Pays**…	Employee Pays…	City Pays**…	Employee Pays…	Total Cost of Coverage Biweekly (per Pay Period)
DeltaCare USA DHMO					
Employee Only	$8.39	$0.00	$8.39	$0.00	$8.39
Employee + Spouse/DP*	$8.39	$7.25	$15.64	$0.00	$15.64
Employee + Child(ren)*	$8.39	$5.64	$14.03	$0.00	$14.03
Employee + Family*	$8.39	$9.73	$18.12	$0.00	$18.12
Delta Dental PPO					
Employee Only	$26.23	$0.00	$26.23	$0.00	$26.23
Employee + Spouse/DP*	$26.23	$22.94	$44.00	$5.17	$49.17
Employee + Child(ren)*	$26.23	$24.75	$44.00	$6.98	$50.98
Employee + Family*	$26.23	$42.16	$44.00	$24.39	$68.39

* Domestic partnerships are not recognized under federal tax law, and enrollment of domestic partner dependents may result in different taxable income treatment of the employee. See page 57 for more information.

** The City subsidy is current as of the printing of this book. The subsidy amount applies through to the end of June 2022 and may change effective July 1, 2022. Check your MOU for changes to the subsidy amount that are scheduled to take effect in July.

Managing Your Delta Dental Online Account

You can go online to verify your assigned dentist and other information, such as eligibility, your enrolled family members, claim status, and benefit specifics. You can also use Delta Dental's Cost Estimator tool to check out-of-pocket expenses and find the average submitted costs for dental procedures.

Here's how to register online:

1. Go to deltadentalins.com.
2. Select "Log in" at the top right side of the page.
3. Select "Create an account."
4. Select "Enrollee/Adult Dependent" from the drop-down menu. Then select "Next."
5. Enter your personal information.

Vision Coverage

Highlights

- The **EyeMed Insight network** has over 98,000 providers, but you can visit a vision care provider who does not participate in the EyeMed network. Read this page for more about the EyeMed network and out-of-network providers.
- Your total vision insurance plan costs include the **premium** (the monthly amount paid to the insurance company for your coverage) and **out-of-pocket costs** (copays) when you seek care. Vision insurance premium costs are paid by the City's subsidy. See page 35 for vision plan costs.
- Your benefits through EyeMed, including exams, frames, and either eyeglass lenses or contact lenses, are available to you and your covered dependents **once every 12 months**. See page 36 for details.

Vision Coverage Levels

Enrollment in vision coverage is automatic:

- Employees and their eligible dependents enrolled in **LAwell** medical coverage will automatically be enrolled in the vision plan.

Dual Vision Coverage

Dual coverage is not allowed within the **LAwell** plan, meaning two City employees cannot cover each other as dependents. See page 45 for more information on dual coverage limitations within **LAwell** for City employees.

Dual vision coverage is permitted with outside, non-**LAwell** plans under certain circumstances. For more information about using dual vision benefits, contact the EyeMed Customer Care Center at **855-695-5418**.

Vision Plan Costs

The City's subsidy (payment) toward your EyeMed premium costs is evaluated every biweekly pay period. For any pay period in which you do not meet eligibility requirements, you may be billed for the full cost of your EyeMed vision coverage. Other situations, including benefit termination, may apply. See page 49 for more information.

The EyeMed Network

EyeMed provides care through a network of vision care specialists who have agreed to offer covered services at discounted rates. The EyeMed Insight network has over 98,000 providers, including 50,000 independent providers plus national retail chains such as LensCrafters®, Target Optical®, and most Pearle Vision® locations.

To access benefits, just provide your name and date of birth to an in-network EyeMed provider. ID cards are not needed, but you can print an ID card by visiting eyemedvisioncare.com/cityofla.

Network Providers

To find a network provider near you:

- Visit eyemedvisioncare.com/cityofla and click the "Provider Locator" button.
- Download the EyeMed mobile app (available in the App Store and Google Play) and choose the Insight network from the list of network options.
- Call the EyeMed Customer Care Center at **855-695-5418**.

Out-of-Network Providers

You can visit a vision care provider who does not participate in the EyeMed network and still receive benefits for covered services. You will be reimbursed up to a maximum dollar amount if you provide EyeMed with an itemized receipt and a completed claim form. Claim forms are available at eyemedvisioncare.com/cityofla or by calling the EyeMed Customer Care Center at **855-695-5418**.

Annual Benefit Details

The benefits through EyeMed, including exams, frames, and either lenses or contacts, are available to you and your covered dependents **once every 12 months**.

Benefits	EyeMed In-Network Provider (What you pay)	Out-of-Network Provider (What the Plan reimburses)
Routine Eye Exam[1]	$10 copay	$45 reimbursement maximum*
Exam Options:		
Standard Contact Lens Fit & Follow-up	Up to $40	N/A
Premium Contact Lens Fit & Follow-up	90% of retail price	
Retinal Screening	$10 copay	$21 reimbursement maximum*
Frames[2]	$150 allowance, 80% of balance over $150	$104 reimbursement maximum*
Eyeglass Lenses[2]		
Lenses[2]		
Single Vision	$10 copay	$35 reimbursement maximum*
Bifocal	$10 copay	$50 reimbursement maximum*
Trifocal	$10 copay	$65 reimbursement maximum*
Standard Progressive†	$75 copay	$70 reimbursement maximum*
Premium Progressive Tier 1†	$95 copay	$70 reimbursement maximum*
Premium Progressive Tier 2†	$105 copay	$70 reimbursement maximum*
Premium Progressive Tier 3†	$120 copay	$70 reimbursement maximum*
Premium Progressive Tier 4†	$75 copay, 80% of charge less $120 allowance	$70 reimbursement maximum*
Contact Lenses		
Lens Options[2]		
UV Treatment	$15	N/A
Tint (Solid & Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate – Adults	$40	N/A
Standard Polycarbonate – Kids under 19	$0 copay	$28 reimbursement maximum*
Standard Anti-Reflective Coating†	$45	N/A
Premium Anti-Reflective Tier 1†	$57	N/A
Premium Anti-Reflective Tier 2†	$68	N/A
Premium Anti-Reflective Tier 3†	80% of charge	N/A
Polarized	80% of retail price	N/A
Photochromic/Transitions Plastic	$75	N/A
Other Add-ons	80% of retail price	N/A
Contact Lenses[2]		
Conventional	$150 allowance	$120 reimbursement maximum*
Disposable	$150 allowance	$120 reimbursement maximum*
Medically Necessary	$0 copay, paid in full	$210 reimbursement maximum

* Subject to review and approval of a completed claim form with an itemized receipt submitted to EyeMed
† Tier levels reflect Name Brand categories.
1 Eye Exam coverage through EyeMed applies to a routine eye exam for a vision prescription. Medical eye exams are typically covered through your health care provider. See the table on page 37 and visit keepingLAwell.com for more information.
2 The Frame allowance can be used with either the Contact Lenses allowance OR the Lenses/Lens Options copay options during a calendar year. Contact Lenses and Eyewear Lens benefits cannot be used together in the same calendar year. Visit keepingLAwell.com for more information.

Eyeglasses & Contacts Benefit

Your benefits through EyeMed include either eyeglass lenses or contact lenses every 12 months. You may select one of the two options below.

Annual Benefit to Purchase Eyeglasses & Contacts		
	Covered	**Not Covered**
Option 1	$150 contact lens allowance + $150 frame allowance	Eyeglass lenses
Option 2	Eyeglass lens copay benefit options + $150 frame allowance	Contact lenses

Retinal Imaging Benefit

Retinal imaging uses a laser to scan the eyes and then produces digital images of the retinas. The images can be useful in finding abnormalities and comparing the condition of retinas from year to year. You may receive one retinal screening every 12 months for an additional $10 copay.

Diabetic Eye Care Benefit

Your vision coverage includes follow-up care and supplementary diagnostic testing for members with type 1 or type 2 diabetes. With this benefit, eligible members can obtain an additional vision evaluation every six months to detect or monitor signs of diabetic complications. Diagnostic testing once every six months, including fundus photography (retinal imaging), extended ophthalmoscopy, gonioscopy, and laser scanning, is available with no in-network copay, subject to provider determination. An out-of-network reimbursement is also available.

Managing Your EyeMed Online Account

You can go online to locate an in-network provider, check claim status, view benefit coverage details, download an ID card, and check your service level eligibility (such as your $150 allowance). You can also view special offers and additional resources, such as eyeRewards — a new vision wellness program that educates, engages, and rewards members.

Here's how to register online:

1. Visit eyemedvisioncare.com/cityofla.
2. Select "Create an Account."
3. Follow the registration steps and provide all required personal information.

Preventive Care

Your **LAwell** vision benefits offer no-cost or low-cost preventive care services. For more information on accessing preventive care services, visit **keepingLAwell.com** or call your vision care provider.

How EyeMed Benefits Work with Medical Plan Vision Benefits

Anthem and Kaiser members who prefer to receive an annual vision exam through their medical plan providers may do so but are not entitled to an eyewear allowance through their medical plan. Eyewear (frames, lenses, and contacts) received from a medical plan provider may be submitted to EyeMed for reimbursement as an out-of-network provider. Members may also visit an EyeMed in-network provider using their medical plan provider prescription and purchase eyewear using their EyeMed materials benefit.

The table below outlines how your EyeMed benefit can be used with your medical plan. Note that allowances may vary per specific benefit, based on the type of benefit item purchased, and do not apply to all benefits.

Description	EyeMed	Kaiser	Anthem
Routine Eye Exam	**Covered with copay**	**Covered with copay**	**Not covered**
Eyewear – Frames, Lenses, or Contacts	**Up to $150** allowance every year (does not roll over if not used)	Not covered (Partial reimbursement available from EyeMed if member files an out-of-network claim.)	
Medical Eye Exams (e.g., screening for medical vision conditions like glaucoma and cataracts)	Check with EyeMed provider **before** seeking medical/ ophthalmology-related services	Covered with copay	Covered with copay Primary care physician (PCP) referral and/or medical group authorization may be required under HMO plans. Please contact your PCP for information regarding their referral process **before** seeking care from a specialist.
Treatment of Vision Conditions (e.g., glaucoma and cataracts)	Not covered	Covered with copay	Covered with copay Primary care physician(PCP) referral and/or medical group authorization may be required under HMO plans. Please contact your PCP for information regarding their referral process **before** seeking care from a specialist.

Learn More

For more information about EyeMed:

- Visit eyemedvisioncare.com/cityofla.
- Call the EyeMed Customer Care Center at **855-695-5418**.
- Visit keepingLAwell.com for plan information and the Certificate of Insurance document, or call **833-4LA-WELL.**

Health and Dependent Care Spending Accounts

Highlights

Tax-Advantaged Spending Accounts allow you to **set aside pre-tax dollars** from your paycheck to reimburse yourself for eligible expenses. The City offers the following accounts for tax savings on eligible expenses:

- A Healthcare Flexible Spending Account (HCFSA) allows you to **reimburse yourself for eligible health care expenses** for you and your eligible dependents. For 2022, you can set aside $2,750. See page 39 for more about the HCFSA.
- A Dependent Care Reimbursement Account (DCRA) allows you to **reimburse yourself for day care expenses** for your eligible dependents. For 2022, you can set aside $5,000. See page 40 for more about the DCRA.
- HCFSAs and DCRAs must follow **strict Internal Revenue Code rules**. It's important to estimate your annual expenses carefully and know the important deadlines. See pages 39-41 for more details.

Requirements to Enroll

You can enroll in the Healthcare Flexible Spending Account and the Dependent Care Reimbursement Account during Open Enrollment. You can only make a change to your account or enroll during the year if you have a qualifying life event. If you want to continue to participate, you must re-enroll each year during Open Enrollment.

Administrative Fee

If you choose to contribute to one of these accounts, a per pay period administrative fee of $1.50 will automatically be deducted from your paycheck each pay period. Only one administrative fee applies if you contribute to more than one account.

Eligible Health Plan Tax Dependents

IRS rules determine who is an eligible dependent. Under federal tax law, "health plan tax dependent" includes your children (biological, adopted, step-, and foster) through the end of the year in which they turn age 26. It also includes other covered individuals for whom you can claim an exemption on your federal taxes. In addition, it includes family members — or an unrelated person who lives with you for the entire year — if they receive more than half of their support from you; are a U.S. citizen, resident or national, or a citizen of Mexico or Canada; and are not claimed as a "qualifying child" dependent on anyone else's tax return. These rules are complex and may require the assistance of your tax advisor.

Filing Claims

Generally, you pay eligible health care and dependent care expenses out of your pocket first, then file a claim with documentation of your expenses in order to be reimbursed from your account.

You can file claims in several ways:

1. **Online at wageworks.com.** You can submit claims and upload receipts online. Generally, you receive a reimbursement within one to two days for an online claim.
2. **Using the "WageWorks EZ Receipts" mobile application**. Through the app, you can submit claims, upload receipts, and pay your provider directly for some services. Download the free mobile app in the App Store or Google Play.
3. Using a paper claim form via fax or mail. Generally, you receive a reimbursement check within two weeks for a paper claim. For claim forms, go to keepingLAwell.com.

Account	Reimbursement
HCFSA	You may be reimbursed the full amount of your claim (including tax) when you file a claim for an eligible expense, up to the amount you have chosen to put into your account. This applies even if your account does not yet have enough in it to cover the expense. However, you will be reimbursed only for eligible expenses while you are contributing to the account.
DCRA	You may be reimbursed for your claim up to the amount in your account at the time of the claim. Any unpaid claims will remain in "pending" status and will be reimbursed as you make additional contributions to your account through payroll deduction.

As long as you file claims regularly, you can receive reimbursement promptly. Generally, you receive a reimbursement check within two weeks for a paper claim or one to two days for an online claim. For claim forms, go to keepingLAwell.com. You can also submit claims and upload receipts online, and pay your provider directly for some services, using the "WageWorks EZ Receipts" mobile application. Download the free mobile app in the App Store or Google Play.

Debit Card

You will automatically receive a debit card to use for eligible health care expenses at any provider or retailer that accepts debit cards. The debit card is an additional convenience option and is not intended to replace the traditional claim process. Some eligible health care expenses may not be available through the debit card and will only be eligible through filing a traditional claim. There is no debit card option for the Dependent Care Reimbursement Account.

Healthcare Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs)

The **LAwell** program does not offer a high-deductible health plan, and the Healthcare Flexible Spending Account offered through the **LAwell** program is not established as an HSA-compatible option. If you are enrolled in a high-deductible health plan with your spouse/domestic partner, former employer, or other organization and are enrolled (or plan to enroll) in a Health Savings Account (HSA) for 2022, you should consult with your tax advisor before enrolling in **LAwell**'s HCFSA. Enrolling in an FSA is considered an irrevocable election; see ""Estimating Expenses and Tax Savings"" below and "Estimating Annual Expenses and Important Deadlines" on page 41 for more information.

About the Healthcare Flexible Spending Account (HCFSA)

Use the HCFSA to pay for eligible health care expenses that are not covered by any medical, dental, or vision coverage. Generally, eligible health care expenses are claimable only for expenses incurred during the period when you are enrolled in a City-sponsored medical plan. You may use an HCFSA for health care expenses of:

- Your spouse and any child you claim as a dependent on your tax return.
- Anyone who is your "health plan tax dependent" as defined by the IRS.

How Much You Can Set Aside

You can set aside from $300 up to $2,750 (maximum amounts subject to federal law revision) annually in a Healthcare Flexible Spending Account. Your contributions are deducted from your paycheck (pre-tax) each pay period.

Examples of Eligible and Ineligible Expenses

The Healthcare Flexible Spending Account Can Be Used to Pay For:

- Copays, coinsurance, and deductibles you pay out of your pocket for medical, prescription drug, dental, and vision care
- Over-the-counter medications and insulin
- Acupuncture and Chiropractic services
- Crutches and wheelchairs
- Eye exams, eyeglasses, and laser eye surgery
- Hearing aids
- Lamaze classes
- Mental health and substance abuse treatment
- Orthodontia
- Menstrual products

Go to wageworks.com/employees/support-center/healthcare-fsa-eligible-expenses-table/ to view a searchable list of HCFSA-eligible expenses.

The Healthcare Flexible Spending Account CANNOT Be Used to Pay For:

- Cosmetic surgery or procedures, including teeth whitening or bleaching
- Your biweekly premium contributions for health and dental insurance
- Procedures or expenses not medically necessary
- Weight loss programs not prescribed by a doctor
- Exercise equipment and health club dues not prescribed by a doctor
- Nutritional supplements not prescribed by a doctor, such as vitamins taken for general health
- Most over-the-counter medications and products without a prescription, such as cosmetics, soaps, and toiletries

Estimating Expenses and Tax Savings

To estimate your annual expenses and the tax savings of setting up a Healthcare Flexible Spending Account, go to keepingLAwell.com. As part of the enrollment process, you'll find links to a calculator for each account.

About the Dependent Care Reimbursement Account (DCRA)

You can use a Dependent Care Reimbursement Account for day care expenses you have for your eligible dependents while you and your spouse work or go to school full-time. Your eligible dependents are:

- Children under age 13 you claim as dependents on your tax return.
- Anyone age 13 or older who meets the IRS definition of "health plan tax dependent," lives with you more than half the year, and is physically or mentally unable to care for themselves. This may include an elderly parent or disabled dependent.

Generally, dependent day care expenses are claimable only on days you work. There are exceptions. For a short absence, such as a minor illness or vacation, day care expenses are claimable if those expenses are paid on a weekly or longer basis. In addition, if you work part-time, expenses are claimable if you are required to pay a fixed rate — such as a full weekly rate — rather than paying for only the time you are working.

To be reimbursed, day care must be provided by a person for whom you can provide a Social Security number or by a day care facility with a Taxpayer Identification Number. Day care provided by any sitter who you or your spouse claims as a dependent on your tax return cannot be reimbursed through your account. This includes day care services provided by your children or stepchildren under age 19. In addition, day care provided by your spouse or former spouse is not eligible for reimbursement.

How Much You Can Set Aside

Generally, you can set aside from $600 up to $5,000 (maximum amounts subject to federal law revision) annually. Your contributions come out of your check each pay period. The total amount you can set aside may change depending on your tax filing status and whether your spouse's employer offers a similar Dependent Care Reimbursement Account. If you and your spouse both work, your maximum contribution cannot be more than the income of the lower-paid individual — you or your spouse — and cannot exceed $5,000.

Based on your tax status...	You can set aside...
If single or married filing jointly	Up to $5,000
If married filing jointly and your spouse's employer offers a dependent care account	Up to $5,000 in total to the two accounts
If married filing separate returns	Up to $2,500

About the DCRA and Taxes

As you consider a DCRA, think about what works best for you — the reimbursement account or the dependent care tax credit provided by federal law. It's important to keep in mind that you cannot take the tax credit for any amounts that are reimbursed through a reimbursement account. In some cases, the tax credit may provide more savings than a reimbursement account. If you have more than one qualifying child, in some cases, you may be able to use the DCRA for some of the expenses and the credit for some of the other expenses; however, you may not use the same expense for both reimbursement from the Account and as qualifying for the credit.

The tax consequences regarding the taxation of child care expenses is complex, so it is strongly recommended that you discuss your taxes with a qualified advisor.

Generally, you may save more on federal taxes using the DCRA in these situations:

- You are eligible for the Earned Income Tax Credit. You are eligible for the credit if you have less than $3,650 in investment income and your income (or the income of you and your spouse, if you are married filing jointly) is less than the amount set forth for 2022, depending on the number of your qualifying children. (Note that amounts below relate to the 2021 tax year and will be indexed for 2022 later this year.) Taking advantage of the DCRA will lower your income for purposes of the Earned Income Tax Credit and, thus, increase your Earned Income Tax Credit.

Number of Children	Income less than...
1	$41,756 ($47,646 if married filing jointly)
2	$47,440 ($53,330 if married filing jointly)
3 or more	$50,594 ($56,844 if married filing jointly)

- You are single, you file your taxes as head of household, and your household taxable income is approximately $41,000 or more (assuming one dependent).
- You are married, you file a joint return, and your household taxable income is approximately $46,000 or more (assuming one dependent).

The figures in the last two bullets are approximate and can vary based on your own tax situation. As mentioned previously, dollar amounts for the Earned Income Tax Credit are based on federal tax law applicable for when you are filing taxes in 2022 for the 2021 tax year, rather than for the 2022 tax year and are adjusted each year to reflect increase in inflation. These are just general guidelines and do not take into account state taxes.

The information provided above is for illustrative purposes only. Because everyone's taxes are different, if you have questions about tax savings, please consult a tax advisor.

Estimating Annual Expenses and Important Deadlines

It is important to estimate HCFSA and DCRA expenses carefully and elect an amount you think you will need for eligible expenses you will have during the 2022 plan year, **while you are contributing to the account**. HCFSAs and DCRAs are not savings accounts. If you have unused contributions at the end of the plan year, those contributions will not carry forward and will be forfeited.

The funds you deposit must be used by the end of the grace period (March 15, 2023), or you will forfeit any unclaimed balance. Claims for expenses incurred between January 1, 2022 and March 15, 2023 must be filed by April 30, 2023. If you do not file claims by this deadline, you forfeit any money left in your account. This is an Internal Revenue Code rule, and the **LAwell** program cannot make exceptions.

The election amounts you make for the HCFSA or DCRA are valid for contributions made during the 12-month plan year. Changes are not permitted outside of a qualifying life event as approved by the **LAwell** program (see pages 52-53 for more on life events). For example, for the DCRA, certain changes to your day care provider or the cost of care may qualify as a qualifying life event, subject to approval of the **LAwell** program. This is an Internal Revenue Code rule, and the **LAwell** program cannot make exceptions.

Leaving City Employment

If you resign your position with the City — including transfers to the Department of Water and Power (DWP) — you may only use any remaining balance toward eligible expenses that were incurred up to the last day of your City employment.

If you retire, you may only use any remaining balance toward eligible expenses that were incurred up to midnight on the last day of the calendar month in which you retire.

Any expenses you incur after the last day of your City employment are not eligible for reimbursement. Under IRS regulations, any remaining funds will be forfeited. You will not receive a refund of any remaining balance you have in your HCFSA and/or DCRA.

Employees who terminate employment, transfer to DWP, or retire and then subsequently return to the City within the same calendar year may have their account re-established based on their prior elections, subject to review and approval by the **LAwell** program and subject to applicable Internal Revenue Code rules.

For more information on when benefits end, refer to the "Losing Eligibility for LAwell Benefits" section on page 48.

Terms and Conditions

By enrolling in an **LAwell** Healthcare Flexible Spending Account (HCFSA) and/or Dependent Care Reimbursement Account (DCRA), you understand that:

- The annual amount you have elected is irrevocable.
- Expenses incurred outside your enrollment dates are ineligible for reimbursement.
- Your per pay period deduction may be adjusted to meet your annual election amount if you miss any payroll contributions during the calendar year.
- The funds you deposit must be used by the end of the grace period (or March 15 of the next calendar year), or you will forfeit any unclaimed balance.
- The deadline for filing claims for eligible expenses is April 30 of the next calendar year, or you will forfeit any unclaimed balance.
- You must keep sufficient documentation (such as invoices and receipts) for all expenses, including HCFSA transactions paid with the debit card, and you will provide documentation when requested.
- The available HCFSA debit card is an optional convenience, and not all eligible expenses are available to purchase through the debit card. You may still need to file a paper claim in certain expense situations.
- You have read, agree to, and will abide by all HCFSA and DCRA rules of the **LAwell** program and the City's flexible spending accounts administrator, WageWorks. These full rules are available at keepingLAwell.com and at wageworks.com.

Special Midyear Changes Due to COVID-19

In 2021, the Department of Labor (DOL) and the Internal Revenue Service (IRS) permitted employee-sponsored benefit programs to make specific changes to midyear changes, as follows.

As part of the nation's continued response to the 2019 novel coronavirus outbreak (COVID-19), new COVID-19 relief legislation under the Consolidated Appropriations Act is providing additional flexibility to employees in employer-sponsored benefit programs. Under this legislation, the City's **LAwell** Civilian Employee Benefits Program (**LAwell** program) allows midyear election changes to a Healthcare Flexible Spending Account (HCFSA) or a Dependent Care Reimbursement Account (DCRA) effective March 1, 2021 and continuing for the remainder of 2021.

The above guidance expired in 2021. At the time of printing this 2022 CHOOSEwell Sworn Enrollment Guide, there has been no additional guidance from the DOL/IRS permitting similar midyear changes for 2022. The rules for HCFSAs and DCRAs, as listed previously, remain in effect for 2022. Should the DOL/IRS issue midyear change guidance for 2022, you will be notified by mail and through postings at keepingLAwell.com of any **LAwell** plan adopted midyear change.

Additional information about changes permitted in calendar years 2020 and 2021, rules for each change, and use of benefits can be found at keepingLAwell.com.

City Subsidy

Highlights

- The City provides a subsidy for your medical, dental, and vision benefits. This **subsidy pays for the majority of your insurance premium costs** and demonstrates the City's commitment to you and your family.
- The amount of subsidy paid toward your health insurance is authorized and outlined through your Memorandum of Understanding (MOU).
- The City subsidy is **subject to eligibility** (see below for details).
- The employee portion of the premiums, if any, is automatically deducted from your paychecks two times per month.

Eligibility for the City Subsidy

Your eligibility to receive the City's subsidy for your benefits is evaluated on a biweekly basis (every pay period). You must have minimum compensated hours (such as HW, SK, VC, HO, etc.) per pay period for the City to continue to pay the subsidy for your benefits.

If you do not have sufficient compensated hours in any given pay period, the City subsidy will not be applied for that pay period. You will be required to pay the full unsubsidized premium for your benefits to continue. A bill for these outstanding benefit costs will be sent to you by the Personnel Department, Direct Billing Section.

2022 Maximum City Subsidy Amounts – Biweekly

	Maximum biweekly amount the City will pay for…	
	MOU 23	**MOUs 22, 24, and 25**
Medical	$804.68 An amount equal to the Kaiser Permanente HMO family premium	$804.68 An amount equal to the Kaiser Permanente HMO family premium
Dental DHMO	$8.39	$18.12
Dental PPO	$26.23	$44.00
Vision	$4.68	$4.68

State Rate – Workers' Compensation

State Rate is not generally considered an "active" payroll status, because while on State Rate, income is paid by the state's workers' compensation insurance and not by City payroll. Therefore, the City subsidy for benefits — which is determined by City payroll status — will not be paid.

However, the City will continue to pay the subsidy for benefits only if your State Rate income is supplemented with a City payroll paycheck with a minimum number of compensated time off hours (sick, vacation, or overtime) in a two-week pay period for full-time employees.

Learn More

For more information regarding the City's subsidy, your coverage options, and costs:

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

Eligibility for LAwell Benefits

Highlights

- Your eligibility for **LAwell** benefits is **evaluated on a biweekly basis**, each and every pay period. See below for more details.
- Documentation is required to **verify any newly enrolled dependents**. If you do not provide the required documentation (see table on page 45) as verification of dependent status, your dependent will be ineligible and removed from coverage.
- Review your dependents and **verify that each dependent enrolled continues to meet the LAwell eligibility criteria** at all times. You must drop coverage for your enrolled dependents within 30 days of the date they no longer meet the City's eligibility requirements (see page 46).

Eligibility for Sworn Employees

Sworn employees are eligible for **LAwell** if they are members of MOUs 22, 23, 24, or 25 and work qualifying work time (such as HW, SK, VC, HO, etc.), or the number of qualifying hours specified by their MOU to be considered full-time and eligible for benefits. **Sworn employees have the choice to enroll in medical, dental, and vision benefits through the Civilian LAwell benefits program or through one of the sworn associations. Sworn employees cannot have dual City benefits.**

When do my benefits start?

- Open Enrollment elections for current employees are effective January 1, 2022.
- Newly hired employee elections are effective the date you enroll.
- Employees who return to work from leave have varied benefit start dates; see the "Leaves of Absence" section on page 50.

Eligibility for Dependents

If you are eligible for **LAwell** benefits, you can also enroll your eligible family members (your eligible dependents). However, not everyone who lives with you is an eligible dependent. Before you request enrollment of a dependent, see below to ensure your dependents meet the eligibility criteria; and see Life Events on page 52 to read about when you can enroll eligible dependents.

In addition, you must review your dependent elections and verify that each dependent enrolled — and dependents you add — continue to meet the **LAwell** eligibility criteria at all times. You must drop coverage for your enrolled dependents within **30 days** of the date they no longer meet the City's eligibility requirements. If you fail to remove ineligible dependents, you will be required to pay all costs for any benefits that were paid on their behalf, and you may be subject to disciplinary action. Leaving an ineligible dependent on City coverage may be considered fraud.

Dependents Who Are Eligible

Your dependents are eligible if they meet the criteria listed in the table below and you have provided the required documentation to confirm your dependents, as determined by the Employee Benefits Division. Once you have added an eligible dependent, that individual is not entitled to coverage unless the City receives the required documentation of eligibility (e.g., birth certificate, marriage certificate) within **60 days** of your election.

Restrictions apply to family members who are also City employees. You are also not permitted to be dually covered in **LAwell** benefits, meaning any City employee is not permitted to be simultaneously covered as both an employee and a dependent under **LAwell**'s medical, vision, and dental coverages.

Sworn members are also not allowed to be dually covered under both **LAwell** and sworn association coverages. See page 44 for more information.

Dependent Type	Age	Eligibility Definition	Documents Required for Verifying Eligibility
Spouse	N/A	Person of the opposite or same sex to whom you are legally married	Marriage certificate
Domestic Partner	N/A	Meet City's domestic partner eligibility requirements. See Domestic Partnership Information Sheet and Affidavit form at keepingLAwell.com	City of Los Angeles Affidavit of Domestic Partnership, or Declaration of Partnership filed with the California Secretary of State
Biological Child (Natural child)	Up to age 26*	Employee's married or unmarried child(ren) under age 26	Child's birth certificate, hospital verification of birth, or court document that verifies your relation to the child (an abstract document is not sufficient in most cases)
Stepchild	Up to age 26*	Employee's spouse's married or unmarried child(ren) under age 26	Child's birth certificate and certificate showing spouse/domestic partner as parent
Adopted child or child placed for adoption	Up to age 26*	Minor or adult child legally adopted by employee, foster child, or child placed for adoption with employee under age 26 (married or unmarried)	Child's birth certificate and court documentation
Child of Domestic Partner	Up to age 26*	Minor or adult child of employee's domestic partner under age 26 (married or unmarried)	Child's birth certificate and City of Los Angeles Domestic Partner Affidavit or Declaration of Partnership filed with the California Secretary of State
Disabled Child	Age 26 and older	Disabled child over the age of 26 who is dependent on you for support and was disabled before age 26. To be eligible, your child must remain unmarried, dependent on you for financial support, and disabled as determined by your health plan.	Birth certificate and disability application from your health plan, completed by your child's doctor and returned to your health plan for approval each year, or as requested by the insurance company
Child under a legal guardianship	Up to age 26*	Child (unmarried) up to age 26 if you show proof of legal custody	Child's birth certificate and court documentation
Grandchildren	Up to age 26*	Your grandchildren can be added to the plan if their parent is your child who • is under age 19, unmarried, and financially dependent on you or • is age 19-26 and meets the full-time student status, is unmarried, and financially dependent on you If coverage for your child ends, coverage for your grandchildren will end.	Child's and grandchild's birth certificates; valid proof of dependent status and/or full-time student certification for your child

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

Dependents Who Are Ineligible

Examples of individuals who are not considered eligible dependents are:

- Your spouse following a divorce
- Someone else's child (such as your nieces or nephews), unless you have been awarded legal custody or guardianship
- Your parents, parents-in-law, or grandparents, regardless of their IRS dependent status

The following table illustrates some common examples of individuals who are not considered eligible dependents. However, this is not an exhaustive list.

Dependent Type	What Is an Eligible Termination Life Event?	When Coverage Can Terminate	Documents* Required for Verifying Termination (must be submitted within 60 days of reporting)
Spouse	A final divorce	The date you report, as long as the report date is on or after the event date	Signed divorce judgment
	Notes • Hiring an attorney to initiate the divorce process does not qualify as a termination life event. • A divorce event will also terminate coverage of any covered stepchild.		
Domestic Partner (DP)	• Terminating your relationship • Marrying your DP	The date you report, as long as the report date is on or after the event date	• City of Los Angeles Termination of Domestic Partnership • Marriage certificate
Child	Turning age 26	Coverage will terminate the end of the month that your child turns 26	None
	Legal change in custody; disabled child age 26 and older is no longer disabled	The date you report, as long as the report date is on or after the event date	Court order or other official documentation
Grandchildren	Your child (parent of grandchild) turns 26	Coverage will terminate the end of the month that your child turns 26	None

* Documents listed serve as examples. Other documents may apply. See page 53 or call **833-4LA-WELL** or email per.empbenefits@lacity.org to ask what documents apply to your specific life event.

Required Documents for Dependent Verification

Documentation is required to verify any enrolled dependents. If you do not provide the required documentation as verification of dependent status, your dependent will be ineligible for coverage. Contact the Benefits Service Center at **833-4LA-WELL** with any questions.

Deadlines for LAwell to Receive Required Documents

If You Added Your Dependent During…	Deadline	Important Considerations
New Hire Enrollment	If you enroll your dependent during the year, documents must be received within **60 days** of your election.	If you fail to provide the required documentation to the Personnel Department, Employee Benefits Division by the deadline, your dependent coverage will not take effect. You will not be able to re-enroll your dependent until the next Open Enrollment period or within **30 days** of a qualifying life event.
Open Enrollment (October 1 – 31)	If you enroll your dependent who is not currently covered during Open Enrollment (October 1 – 31, 2021), documents must be received by December 10, 2021.	If you fail to provide the required documentation to the Personnel Department, Employee Benefits Division by the deadline, your dependent coverage will not take effect on January 1, 2022 for your added dependent who was enrolled during Open Enrollment. You will not be able to re-enroll your dropped dependent until the next Open Enrollment period or within **30 days** of a qualifying life event.
Outside Open Enrollment	If you enroll your dependent during the year, documents must be received within **60 days** of the date on the confirmation statement you receive after enrolling the dependent.	If you fail to provide the required documentation to the Personnel Department, Employee Benefits Division by the deadline, your dependent coverage will not take effect. You will not be able to re-enroll your dependent until the next Open Enrollment period or within **30 days** of a qualifying life event.

Where to Send Required Documents

There are several ways to submit required documents:

- **Online:** Log in to the Benefits Central Portal and upload your documents.
- **Email or Fax:** Write your name and Employee ID number on each document and send.

  Email: per.empbenefits@lacity.org
  Fax: **213-978-1623**
- **Mail: LAwell Benefits Service Center**
  PO Box 530477
  St. Petersburg, FL 33747-4077
- **In person:** Deliver to the drop box outside the Employee Benefits Division at:

  Los Angeles City Hall
  200 N Spring Street, Room 867
  Los Angeles, CA 90012

Learn More

For more information about your eligibility, contact your department's Human Resources/ Personnel Division. To enroll, terminate, or verify dependent coverage, call **833-4LA-WELL**. You may also visit keepingLAwell.com for information and key plan documents.

Losing Eligibility for LAwell Benefits

Highlights

- If you lose eligibility for the City subsidy (see page 42) through a reduction of hours, or a paid or non-paid leave of absence, you may be able to continue certain benefits through **Direct Bill** (see the next page for more information).
- If you lose eligibility for **LAwell** benefits through termination, transfer to DWP, or retirement, you may be able to **continue certain benefits through COBRA** (see below and next page).
- Various types of **leaves of absence** may allow **LAwell** benefits and the City subsidy to continue (see page 51).

Termination, Transfer to DWP, or Retirement

If you lose eligibility for **LAwell** benefits through termination, transfer to DWP, or retirement, **you only have one option to continue your medical, dental, and/or vision benefits — COBRA.** COBRA enrollment requires you to pay the full cost of your benefit, plus any COBRA administrative fees.

If you lose eligibility through…	Your benefits will end…
Termination	When you end your employment with the City, voluntarily or through City action, your **LAwell** benefits will end the day your employment ends.
Transfer to DWP	When you accept and begin employment with the Department of Water and Power (DWP), your **LAwell** benefits will end the last day of the month in which you transfer to DWP.
Retirement	When you end your employment with the City, due to the start of your retirement benefits through Los Angeles Fire and Police Pensions (PENSIONS), your **LAwell** benefits will end the last day of the month in which you retire. (A non-PENSIONS retirement is considered a termination.)

Direct Bill

Employees who are eligible for **LAwell** benefits (see page 44) but lose eligibility for the City subsidy (see page 42) may continue their benefits through Direct Bill by paying the full unsubsidized premium. Additionally, employees who do not receive enough compensation through City payroll to pay their share of benefit premiums may also continue their benefits through Direct Bill. The following benefits may be continued:

- Medical Insurance
- Dental Insurance
- Vision Insurance

City employees on or off payroll may continue **LAwell** benefits through Direct Bill for a period not to exceed six months. After a continuous six-month period of Direct Billing, employees may continue benefits through COBRA. Direct bills will be sent to you by the Personnel Department, Direct Billing Section. Your payment must be received within **15 days** of the date of the billing letter or benefits **may** be terminated back to the last date for which premiums were paid.

Please Note: Direct Bill allows an employee to continue coverage currently in force under certain conditions. Direct Bill status is not a qualifying life event, and members are not allowed to add coverage or modify covered dependents based on their Direct Bill eligibility status.

COBRA

Employees who lose eligibility for **LAwell** benefits (see page 42) may continue their benefits through COBRA. The following benefits may be continued:

- Medical Insurance
- Dental Insurance
- Vision Insurance

If you leave the City, and in other special situations, you may be able to continue medical, dental, and vision coverage through COBRA. City employees receiving a COBRA offer pay the full premium cost of the benefit, plus any administration fee. You have **60 days** from the date of COBRA notification to enroll and **45 days** from your enrollment to pay your first premium to the appropriate insurance company. For more information, see pages 64-66 or contact the **LAwell** COBRA Coordinator at **213-978-1655** when you know that you will be leaving City service.

American Rescue Plan Act of 2021 (ARP)

The temporary premium assistance for COBRA continuation coverage provided by the American Rescue Plan Act of 2021 (ARP) took place from April 1, 2021 to September 30, 2021 only. COBRA monthly premiums for the months you are covered outside of this time frame are your responsibility to pay.

Benefits Not Eligible to Continue

The Healthcare Flexible Spending Account (HCFSA) and Dependent Care Reimbursement Account (DCRA) cannot be continued while you are on leave, while you are in a non-pay status, or if you lose eligibility for **LAwell** benefits. The HCFSA and DCRA are tax-advantaged spending accounts that provide for deductions to be taken through City payroll. Your ability to use these accounts will end when you terminate employment. You may use any remaining balance only toward eligible expenses that were incurred up to the last day of your City employment.

Leaves of Absence

Rehire and Reinstate Employees

Employees who terminate City employment, or who otherwise terminate **LAwell** benefits at any time, and subsequently return to City employment in a different plan year, are considered "Rehire" employees. Rehired employees will receive a new benefits package in the mail when they become benefit-eligible.* If you do not enroll in **LAwell** benefits by the deadline identified in your benefits package, you will be defaulted into the default coverage identified in your benefits package. Rehired employees do not have **LAwell** benefits coverage until they enroll or default into **LAwell** coverage. Contact the Employee Benefits Division at **213-978-1655** if you do not receive a benefits package within four to six weeks after returning to work or to confirm your effective date.

Employees who terminate City employment, or who otherwise terminate **LAwell** benefits at any time, and subsequently return to City employment in the same plan year, are considered "Reinstate" employees and will have their former benefit elections reinstated once they become benefit-eligible.* Reinstate employees will receive a confirmation statement in the mail and will have a period of time to make corrections/changes to their reinstated benefits. Reinstate employees do not have **LAwell** benefits coverage until the **LAwell** program has determined the effective date. Log in to your Benefits Central Portal account, or call the Employee Benefits Division at **213-978-1655** to confirm your effective date.

* Returning to City employment in a new job classification will not be considered as new hire employment status for benefits purposes. Benefits enrollment requirements will be reflected as a continued employment.

Learn More

For more information about the rules in this section:

- Visit **keepingLAwell.com**.
- Call the Employee Benefits Division at **213-978-1655**.

Leave of Absence Types

The table below shows various types of leaves of absence and how benefits and the City subsidy may continue for each type.

Type of Leave	What is it?	How can my benefits continue?	Can my City subsidy continue?
Family and Medical Leave	Family and Medical Leave Act (FMLA) is approved protected leave for qualified employees that falls under the provisions of the FMLA. Your department must approve an FMLA absence.	Your benefits can continue through Direct Bill* as long as you are on FMLA status if your approved leave is properly recorded through the City's payroll system.	Yes. City subsidy can continue for any FMLA approved leave, both paid leave and unpaid leave. The maximum duration of City subsidy should not exceed the approved FMLA period, as determined by your department. Generally, this is for a maximum of 9 pay periods* within a 12-month period, regardless of the number of incidents. Please contact your department for further details on your FMLA eligibility. * **Exception:** Maternity leave — up to 9 pay periods for childbirth disability and up to an additional 9 pay periods for purposes of bonding. The aggregate period for parents who both work for the City is limited to the time allowed for one employee.
Workers' Compensation Leave Through IOD	An approved leave for a work-related injury or illness, and you are receiving injury or disability "IOD" pay through the City's payroll.	Your benefits can continue through Direct Bill.*	Only if your approved leave is supplemented with a minimum number of compensated hours.
Workers' Compensation Leave Through State Rate	An approved leave for a work-related injury or illness, and you are receiving injury or disability pay through State Rate from Workers' Compensation.	Your benefits can continue through COBRA.* However, if you continue to receive a City payroll paycheck, without any lapse, your benefits can continue through Direct Bill.*	Only if your approved leave is supplemented with a minimum number of compensated hours.
Military Leave	An approved leave to actively serve in a branch of the military.	Your benefits can continue through Direct Bill.*	Eligibility for the City subsidy is based on classification of your approved military leave type, as determined by your personnel division. Military leave types vary. Ask your human resources or personnel division for more information.

* See page 49 for Direct Bill information and pages 49 and 64 for COBRA information.

Life Events

Highlights

- A qualifying life event under the **LAwell** program is an event change or a family status change, as defined by the **LAwell** program, that **allows employees to make benefit changes during the year**. Without a qualifying life event, employees can only make changes during Open Enrollment or as a newly hired City employee.
- Life event changes will only go into effect the day you report the change **IF your event meets all requirements AND you complete all the requirements** detailed below.

Life Event Requirements

Life event changes will go into effect the day you report the change **IF** your event meets all requirements **AND** you complete all the requirements detailed below. In compliance with federal rules and **LAwell** program requirements, the **LAwell** program will determine if your change request is permitted.

1. Report the Change Within 30 Days

All changes must be reported within **30 days** of the life event date in order to be considered for eligibility. Failure to give LAwell timely notice may cause coverage of a dependent to not start or to end, and may result in your liability to repay the **LAwell** program if any benefits are paid to an ineligible person.

In general, changes you can make during a qualifying life event must be consistent with that type of life event change. For example, if you are reporting a divorce life event, you are typically able to only remove your ineligible spouse from the **LAwell** benefits for which he/she is currently covered. Making changes to your own **LAwell** benefits coverage, or the coverage of another dependent, may not be allowed.

2. Submit Required Documentation

In most cases, supporting documentation will be required within **60 days** of the date on your confirmation statement. If you do not submit required documents by the deadline, any change you made online or by calling the Benefits Service Center will not take effect. See page 53 for more information on how to submit required documentation.

For example, if you add a dependent to your health coverage, you will receive a confirmation statement showing the change you made. If you fail to provide the required documentation within **60 days** of the date on your confirmation statement, that dependent's coverage will not take effect. Any medical, vision, or dental expenses your dependent incurred before the dependent became properly enrolled will be your financial responsibility.

Not All Events Are Qualifying Life Events

The following are examples of situations that are not considered qualifying life events and do not permit you to make midyear changes: promoting or changing jobs/departments; changes to network physicians or facilities; a diagnosis or changes to your or your dependent's health; or your dependent child attending an out-of-state school.

Reporting a Life Event

Some common life events and their reporting requirements are shown in the table below. This is not an exhaustive list and is subject to change.

Life Event	Report the Life Event within 30 days of the…	Where to Report	Supporting Documents required 60 days from date on Confirmation Statement?
Marriage	…date of the marriage	Online: keepingLAwell.com OR Phone: **833-4LA-WELL**	Yes: Marriage Certificate
Domestic Partnership, start or end	…effective date		Yes: **LAwell** Domestic Partnership Affidavit
Divorce	…date divorce is final		Yes: Signed Divorce Judgment
Additions due to Birth, Adoption, Legal Custody, etc.	…date of birth …date of legal custody		Yes: Medicare proof
Entitled to or lose eligibility for Medicare	…first day of coverage		Yes: Birth Certificate
Dependent loses non-City or COBRA coverage	…last day of coverage		Yes: Confirmation letter of loss of coverage
Death of a Dependent	…date of the death	Phone Only: **833-4LA-WELL**	Yes: Death Certificate
Move outside Medical or Dental plan's service area	…day you move		May be required: Change of Address
Half-time to Full-time (Employee)	Not Applicable		Depends on benefit change requested
Go on leave (see Direct Bill, page 49), or Return to work after leave	Not Applicable		Depends on benefit change requested

* Documents listed serve as examples. Other documents may apply. See pages 45-46 or call **833-4LA-WELL** or email per.empbenefits@lacity.org to ask what documents apply to your specific life event.

Learn More

To report a life event:

- Log in to your Benefits Central Portal account at keepingLAwell.com.
- Call the Benefits Service Center at **833-4LA-WELL**.

For questions about life events, contact the Employee Benefits Division at **213-978-1655**.

Dependent Coverage Rules for Special Situations

Employees who enroll dependents in violation of the rules in this section, or as otherwise listed in this guide, are considered to be making an improper use of their benefits. The **LAwell** program will have authority to take corrective action to any employee's coverage, or the employee's applicable dependent coverage, if the employee is found to have made an improper use of benefits.

Disabled Child Over Age 26

You can continue coverage for a disabled child age 26 or older who is dependent on you for support if that child was disabled before age 26. To be eligible, your child must remain unmarried, dependent on you for financial support, and disabled as determined by your medical plan.

You must request a disability certification package or the required application from your medical plan, ask your dependent's primary care physician to complete it, and then return it to your medical plan for review. The Employee Benefits Division must be notified of the medical plan's determination regarding the disabled certification application.

Two LAwell-Eligible City Employees Are Married or Are Domestic Partners

If you are married or domestic partners with another **LAwell**-eligible City Employee (with or without children):

- **Medical and vision coverage:** You cannot enroll as both an employee and as a dependent of your spouse/domestic partner. If your spouse/domestic partner chooses family coverage, you must choose Cash-in-Lieu and you can be covered as a dependent of your spouse/domestic partner. Only one spouse/domestic partner can cover dependent children.
- **Dental coverage:** Each employee must enroll in his/her own dental plan. Your spouse/domestic partner cannot cover you as a dependent. Only one spouse/domestic partner can cover dependent children.

Two LAwell-Eligible City Employees Have Dependent Children Together

If you have dependent children with another City employee who is not currently your spouse/domestic partner:

- **Medical, dental, and vision coverage:** Only one parent can purchase coverage for your dependent child(ren).

Children Who Are City Employees

Children who are also benefit-eligible employees of the City cannot be covered as both employees and as dependents under their City employee parents.

Learn More

For more information regarding this section:

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

Domestic Partnership

The City of Los Angeles offers domestic partners of City employees, and domestic partners' children, equal access to its employee benefit programs, including medical, dental, and vision plans. To obtain these benefits, you must enroll your dependents during the specified times and provide the required dependent eligibility documentation. Please see page 45 for more information on enrolling dependents.

Domestic Partnership – New Process

On May 1, 2021, the Personnel Department, Employee Benefits Division (Personnel-EBD), implemented an updated procedure and form for registering a new domestic partnership.

- The new *Declaration of Domestic Partnership Affidavit* requires that you and your domestic partner attest to various statements about your relationship. Only the completed affidavit is required; no supporting documentation or additional requirements apply.
- Personnel-EBD will also accept any previous version of the City's *Domestic Partnership Affidavit* until April 30, 2022. Starting May 1, 2022, only the *Declaration of Domestic Partnership Affidavit* will be accepted.
- If you are already registered in a Domestic Partnership with Personnel- EBD or if you have registered with the State of California, you **DO NOT** need to resubmit a *Declaration of Domestic Partnership,* and no further action is necessary.

State Taxes vs. Federal Taxes

Under California state law, pre-tax dollars can be used to purchase health or dental coverage for a domestic partner and/or their dependents, if your domestic partnership meets eligibility requirements and is registered with the State of California. You must provide a copy of the approved State certificate to receive this tax benefit. The amount the City of Los Angeles pays toward coverage cost will be excluded from your reported State income.

Under federal tax law, pre-tax dollars cannot be used to purchase benefits for a domestic partner or their children. Unless your partner and the partner's children meet an exception, you pay your share of the coverage cost with after-tax dollars. The amount the City pays toward the cost of your domestic partner's coverage will be taxable as regular income on 24 paychecks per year.

Learn More

For more information regarding this section, including how to register a domestic partner:

- Visit keepingLAwell.com.
- Contact the City's Domestic Partnership Coordinator at **213-978-1591**.

Important Legal Notices

Medicare Notice of Creditable Coverage Reminder

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

To find out whether the prescription drug coverage under the medical plan options offered by the City are or are not creditable, you should review the Plan's Medicare Part D Notice of Creditable Coverage available on page 67.

Binding Arbitration

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

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

NOTICE: BY ENROLLING IN A HEALTH CARE PLAN, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHTS TO A JURY OR COURT TRIAL AND TO ASSERT OR PARTICIPATE IN A CLASS ACTION. (Such enrollment serves as your electronic signature for agreement to the above provisions for the purposes of California Health and Safety Code Section 1361.1 and Code of Civil Procedure Section 1295.)

Women's Health and Cancer Rights Act

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

About Hospital Stays for Mothers and Newborns

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

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

Privacy and Your Health Coverage

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

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

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

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

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

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

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

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

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

LAwell Plan Document

This enrollment guide is published by the City of Los Angeles Personnel Department. It provides only highlights of the **LAwell** program, and supplements the program rules identified in the **LAwell** Plan Document. This guide does not change the terms of your benefits or the official documents that control them. Copies of the **LAwell** Plan Document and official benefit documents are available at **keepingLAwell.com**.

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within **60 days** of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **1-866-444-EBSA** (**3272**).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your state for more information on eligibility.

ALABAMA – Medicaid
Website: **myalhipp.com**
Phone: 1-855-692-5447

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

ARKANSAS – Medicaid
Website: **myarhipp.com**
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA — Medicaid
Website: **dhcs.ca.gov/hipp**
Phone: 916-445-8322

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

FLORIDA – Medicaid
Website: **flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: **medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: 678-564-1162 ext 2131

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

IOWA – Medicaid and CPHP (Hawki)
Medicaid Website: **dhs.iowa.gov/ime/members**
Medicaid Phone: 1-800-338-8366
Hawki Website: **dhs.iowa.gov/Hawki**
Hawki Phone: 1-800-257-8563

KANSAS – Medicaid
Website: **kancare.ks.gov**
Phone: 1-800-792-4884

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

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

MAINE – Medicaid
Website: **maine.gov/dhhs/ofi/public-assistance/index.html**
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: mass.gov/eohhs/gov/departments/masshealth
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: state.nj.us/humanservices/dmahs/clients/medicaid
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/default.aspx
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: health.ny.gov/health_care/medicaid
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: nd.gov/dhs/services/medicalserv/medicaid
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: healthcare.oregon.gov/Pages/index.aspx or oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: eohhs.ri.gov
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: gethipptexas.com
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: medicaid.utah.gov
CHIP Website: health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: greenmountaincare.org
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: coverva.org/en/famis-select or coverva.org/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: hca.wa.gov
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: mywvhipp.com
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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

Other California Premium Assistance Resources:

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

Paperwork Reduction Act Statement

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

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

Health Insurance Marketplace

New Health Insurance Marketplace Coverage Options and Your Health Coverage.

PART A: General Information

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

What Is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

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

California Healthcare Mandate (CHM)

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

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

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

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

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

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

Important Information About Your COBRA Continuation Coverage Rights

What is continuation coverage?

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

Who are the qualified beneficiaries?

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

Are there other coverage options besides COBRA continuation coverage?

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

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

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

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

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

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

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

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your medical and/or dental plan of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event (see additional information on page 65) may affect the right to extend the period of continuation coverage.

Disability

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

Second Qualifying Event

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

How can you elect COBRA continuation coverage?

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

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within **30 days** after your group health coverage ends. You also have special enrollment rights to enroll in the Health Insurance Marketplace within **60 days** after your group health coverage ends. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

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

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

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

First payment for continuation coverage

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

Periodic payments for continuation coverage

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

Grace periods for periodic payments

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

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

For more information

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

For more information about health insurance options available through the Health Insurance Marketplace, and to locate assistance in your area who you can talk to about the different options, visit **HealthCare.gov** or **CoveredCA.com**.

CalCOBRA Coverage for Medical Benefits Only

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

Keep Your Plan Informed of Address Changes

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

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

Availability of Summary of Benefits and Coverage (SBC)

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

The most current SBC documents for the **LAwell** medical plan options are available online at **keepingLAwell.com**, or contact the Benefits Service Center at **833-4LA-WELL** to get a free copy.

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

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

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

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

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

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

Important Notice from the City of Los Angeles for LAwell-Eligible Employees and Dependents About Prescription Drug Coverage for People Who Are Already Medicare-Eligible or May Become Medicare-Eligible During 2022

Medicare and the City

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

- If you have enough service credits, you will receive Medicare Part A at age 65 at no cost. You will be contacted by Social Security and will receive a Medicare ID card. At this time you may be asked if you would like to enroll in Medicare Part B, C and/or D. If you are not retired or planning to retire at or around age 65, you may not want to purchase Medicare since you have City benefits.
- To prevent errors in coverage and payments, we recommend that you do not enroll in Medicare Part B or Part D as long as you have City of Los Angeles **LAwell** benefits (active employee coverage). When you are planning to retire, please contact PENSIONS at **844-885-2377** so that they can help you sign up for Medicare and to ensure you do not experience a lapse in coverage. As long as you had the City's creditable active employee coverage beginning from the time you became eligible for Medicare (for most people, age 65) through the date your Medicare enrollment becomes effective (typically after age 65), you will not be charged a late-enrollment penalty for signing up after becoming eligible.
- If you do decide to enroll in Medicare as an active employee and you also retain your enrollment with **LAwell** coverage, it is important that you remember to use your Medicare coverage as a secondary insurance provider. Medicare will not pay primary insurer costs for individuals with dual coverage.
- If you have already signed up for Medicare and also have **LAwell** coverage, please inform your doctor(s) so that there are no issues with payments. Some doctors do not accept Medicare patients. When you are filling out your claim information, please provide the Employee Benefits Division address as your work location. Do not provide the address of your actual work location or that of your department's administrative office.
- The federal government does not recognize domestic partners as eligible dependents. Domestic partners being covered under **LAwell** benefits will receive a penalty for late enrollment in Medicare if they do not sign up when they become eligible. Domestic partners should consider enrolling in Medicare when they become eligible.
- Reimbursements of Medicare Part B premiums for actively employed members are subject to the provisions of the Los Angeles Administrative Code and the policies of the **LAwell** Program.

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

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

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

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

When Can You Join a Medicare Drug Plan?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Contact the Employee Benefits Division at **213-978-1655**. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Los Angeles, Personnel Department changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Terms and Conditions

The Terms and Conditions of the **LAwell** program are subject to change without notice and are provided in their entirety at keepingLAwell.com. To complete your enrollment, you must provide any required paperwork to the **LAwell** Benefits Service Center at **PO Box 534077, St. Petersburg, FL 33747-4077** or to the Personnel Department, Employee Benefits Division **within 60 days of the date on the confirmation statement** you receive after enrolling.

By enrolling in **LAwell** benefits, you have read, agreed to, and will abide by the full Terms and Conditions for **LAwell** program members as follows:

- Making changes to your elections and dependent information requires you to provide an electronic signature of the choices you enter. If you prefer not to make changes electronically, call the Benefits Service Center for assistance at **833-4LA-WELL (833-452-9355)**, Monday – Friday, 8:00 a.m. to 5:00 p.m. (For TDD or TTY service, call **800-735-2922**.)
- If you decide to make changes electronically, completion of an event will serve as your consent.
- If you are required to complete any forms, like a Cash-In-Lieu Affidavit or Affidavit of Domestic Partnership, be sure to return your forms by the deadline on your confirmation statement. You can find forms at keepingLAwell.com.
- You agree that your information, and the information you provided for your eligible dependents, is true and accurate to the best of your knowledge.
- Your enrollment, and the enrollment of any of your dependents, is conditional and may require further action. Any required documentation to complete your or your dependents' enrollment, such as birth certificates or **LAwell** affidavits, must be submitted to the **LAwell** program by the deadline on your confirmation statement. Failure to comply with these required actions will result in the cancellation of your conditional coverage, and any expenses incurred after coverage is canceled, including expenses incurred before your cancellation notice, will be your responsibility.
- Only the dependent relationships identified by the **LAwell** program are permissible eligible dependents, and they can only be added/removed to **LAwell** coverage as specified by the **LAwell** program rules or by specific court order.
- You must drop coverage for any enrolled dependents within **30 days** of the date they lose eligibility (e.g., within 30 days of a divorce). If you fail to remove ineligible dependents, or otherwise fraudulently obtain **LAwell** program benefits for yourself or your dependents, you will be required to pay all costs for any benefits that were paid on their behalf; you will have your coverage retroactively terminated; and at the sole discretion of the City of Los Angeles, you may be subject to disciplinary action.
- You will not be able to re-enroll your dropped dependents until the next Open Enrollment period or within 30 days of another qualifying life event.
- Your eligibility for **LAwell** benefits is evaluated on a biweekly basis per pay period as outlined in this CHOOSEwell Sworn Enrollment Guide and on keepingLAwell.com. Not meeting eligibility requirements in any pay period will result in either 1) the discontinuation of the City subsidy applied to your **LAwell** benefits or 2) the termination of your **LAwell** benefits.
- Dual **LAwell** coverage by **LAwell** employees in a relationship with or as a parent of another LAwell employee is not permissible.

By enrolling in an **LAwell** health plan, you consent to binding arbitration. Read the binding arbitration on page 58.

Index

Other City Benefits

Deferred Compensation Plan

The City of Los Angeles Deferred Compensation Plan plays a vital role in creating your future retirement income security. This voluntary retirement savings plan supplements benefits available to you through your primary City retirement plan.

Why Should I Consider Joining?

The purpose of saving for retirement is creating income security after your working years are over. The ideal goal is to have sufficient income at retirement to maintain the standard of living you had while working. At the City of Los Angeles, you have two resources for creating retirement income security:

- **Los Angeles Fire and Police Pensions (PENSIONS)** — Benefits are determined based on factors such as how long you work for the City and your salary near retirement. They are also based on your retirement Tier (Tier 1 for employees hired prior to February 21, 2016; Tier 3 for employees hired on or after February 21, 2016) and the benefit formulas that apply to each Tier. For most employees, this benefit will not replace 100% of their working income.
- **Deferred Compensation Plan** — Benefits are based on the total balance (contributions + earnings) you accumulate in your account. You can begin drawing on your balance when you retire. You have multiple withdrawal options, including taking a steady income stream over many years to supplement your PENSIONS income.

Your optimal goal should be to produce income from both programs to equal or exceed 100% of the amount of salary you're actually living off at the time you retire. The Plan helps you with easy-to-use investment options, convenient saving via payroll deduction, and a robust retirement calculator that will give you a projection of your retirement income needs. A loan program provides the ability to borrow from your account while working and repay those funds to your account.

Learn More

To enroll today or learn more about the Plan:

- Visit the Plan website at LA457.com.
- Email LA457@lacity.org.
- Call **844-523-2457**.
- Visit the Plan Service Center located in the Employee Benefits Division, Room 867, City Hall, Monday through Friday from 8:00 a.m. to 4:00 p.m.

COMMUTEwell

The City of Los Angeles offers the following transportation benefits to eligible employees:

- **Transit Spending Account (TSA) and Parking Spending Account (PSA)** — A contribution match of up to $50/month is provided for participating in the TSA program. Refer to the TSA and PSA Spending Accounts section below.
- **Transit Reimbursement Program** — Provides a monthly reimbursement of up to $50 per month for using public transportation. Reimbursement is subject to the completion of a quarterly transit subsidy reimbursement form and providing the appropriate documentation and receipts.
- **Vanpool/Carpool Program** — Assists with joining/forming a vanpool or obtaining a carpool parking permit (subject to the availability of parking spaces at an employee's work location).
- **City-sponsored parking** — Provides a parking lot permit upon meeting all program terms and conditions. Costs vary by permit type and work location, and the permit is subject to the availability of parking spaces at an employee's work location.
- **Bike/Walk to Work** — Provides a monthly subsidy of up to $50 per month for biking/walking to work. The subsidy is subject to the completion of a quarterly bike/walk subsidy reimbursement form and applicable signatures.

The COMMUTEwell program is not available to employees of the Los Angeles World Airports, Harbor Department, or Department of Water and Power, as they coordinate their own transportation benefits program.

Transit (TSA) and Parking (PSA) Spending Accounts

The City offers a TSA and PSA program to help employees save on the cost of using public transportation and/or non-City sponsored parking. These programs allow employees to set aside pre-tax dollars and use them for qualified expenses. Unlike other benefit programs, participation in the TSA and/or PSA program may be modified at any time throughout the year. An employee may enroll, suspend, or modify their participation in these programs by logging in to the Benefits Central Portal at keepingLAwell.com.

- **TSA** — Provides a contribution match of up to $50 per month. An employee may set aside up to $270 per month on a pre-tax basis to pay for public transit expenses, including bus, rail, train, and subway fares.
- **PSA** — An employee may set aside up to $270 per month on a pre-tax basis to pay for parking expenses related to commuting from home to work.

TSA and PSA Terms and Conditions

By enrolling in the TSA and/or PSA program, you understand and consent to the following terms and conditions:

- Per Internal Revenue Code regulations, any funds that you contribute through pre-tax payroll deductions cannot be refunded.
- You may enroll, suspend, or modify your participation in the TSA/PSA programs at any time during the year. Any changes must be requested in accordance with the TSA/PSA payroll change schedule. You are not entitled to a refund of contributions for late change requests.
- A $1.50 administrative fee will be deducted from each paycheck. This is a flat fee for any combination of flexible spending accounts (FSA) administered by the City's FSA administrator, WageWorks. Only one administrative fee applies if you are enrolled in more than one account (e.g., TSA/PSA program; Healthcare Flexible Spending Account; Dependent Care Reimbursement Account).

- The minimum contribution to the TSA/PSA is $10 per pay period.
- You are not required to make your transit purchases in the month you make your contribution. Funds can be accumulated and used whenever you wish.
- The TSA/PSA balance in your WageWorks account cannot exceed $1,500 total. The program administrator may suspend TSA/PSA payroll deductions if they exceed the TSA/PSA maximum account balance.
- Once you have your first payroll deduction, you must create an account via the WageWorks website at **wageworks.com** and place an order to use your available funds. Please note that it may take up to two pay periods from your initial payroll deduction before you are able to create an online account and place your first order.
- TSA/PSA orders must be placed by the 10th of the month via the WageWorks website for funding to be placed on your card or to have your name added to the list of authorized users at your chosen lot for the following month.
- There are no "use it or lose it" provisions that happen at year-end; funds roll over to subsequent years until you terminate from the City or transfer to DWP, at which point:
  - Any balance remaining in your PSA will be forfeited.
  - You will have **90 days** to use any balance remaining in your TSA before it is forfeited.
- You have read, agree to, and will abide by all TSA and/or PSA rules of the **LAwell** and COMMUTEwell programs and by WageWorks. These rules are available at **keepingLAwell.com**, **LACOMMUTEwell.com**, and **wageworks.com**.

Additionally, the following terms and conditions apply to the PSA:

- The PSA program cannot be used by employees at City-owned or leased lots (e.g., lots at City Hall East, Fig. Plaza, Police Admin. Building), as parking is provided directly to eligible employees, subject to availability of spaces, and is a pre-tax benefit.
- In certain instances, parking passes can be purchased directly through WageWorks. You must purchase your parking pass by the 10th of the month to have your name added to the list of authorized users at your chosen lot for the following month. Your PSA will automatically be debited in the amount you select. You may also use your debit or credit card to cover the costs of a purchase if you have not yet accumulated enough in your PSA.
- Employees can make a parking purchase directly at a garage/parking lot and file a claim to receive reimbursement from available PSA funds. In order to file a claim, employees must notify WageWorks before the 10th of the month and indicate the amount that they plan to spend in the following month. Claims may be filed up to six months after purchase through WageWorks. An employee's PSA will be debited and a reimbursement check will be mailed to the address on file.

The Terms and Conditions of the COMMUTEwell program are subject to change without notice and are provided in their entirety at **LACOMMUTEwell.com**.

You must keep your records up to date. Please inform COMMUTEwell program staff if you have any of the following changes: work address change, vehicle change, employment change (e.g., changing departments, retiring, resigning, and work schedule change (day shift/night shift).

Learn More

To learn more about the program:

- Visit the website at **LACOMMUTEwell.com**.
- Email **lacommutewell@lacity.org**.
- Call **213-978-1634**.

Long-Term Care Insurance

Your **LAwell** benefits do not include Long-Term Care (LTC) insurance. However, several City employee organization associations and government agencies provide LTC insurance coverage that you may purchase for yourself and your family members, if you are eligible and interested. It could provide you with valuable financial security and peace of mind, so take a few minutes to learn more about long-term care insurance and consider your options.

About Long-Term Care

Long-term care refers to the non-medical care that supports someone who has a chronic illness or disability. This includes personal care assistance with everyday activities like getting dressed, bathing, using the bathroom, or eating, as well as services like home-delivered meals, adult day health care, and other assistance. Long-term care can be provided at home, in the community, in an assisted living facility, or in a nursing home.

This type of care is often quite expensive and is not covered by regular health insurance, Medicare, or disability insurance. And that's where LTC insurance comes in. Buying an LTC insurance policy is one way you can pay for this care in the future, should you need it, without drawing on your retirement savings or leaning on family members for financial assistance. It's important to plan for long-term care as early as you can to maintain your independence in the future, and to make sure you get the care you may need — in the setting that you want.

How Much Does Long-Term Care Cost?

Long-term care can be expensive. The cost depends on the amount and type of care you need, as well as the setting in which you receive care. Here are some national average costs from 2018:*

- Nursing home care: approximately $90,000 per year for a semi-private room
- Assisted living facilities: $4,000 per month (for a one-bedroom unit), or $48,000 per year
- Home care: $22 per hour for a home health aide (adding up to $34,320 per year for an aide who visits six hours a day, five days a week)

Long-term care insurance can help pay for these costs by providing you with a regular benefit that can lower your out-of-pocket costs, should you need this type of care.

* *A Shopper's Guide to Long-Term Care Insurance*, 2019, National Association of Insurance Commissioners

Will You Need Long-Term Care?

It's hard to know if and when you'll need long-term care, but according to the federal government, at least 70% of people ages 65 or older will require long-term care services at some point in their lives.*

An unexpected illness or accident can happen at any time, leading to health-related issues that require long-term care. People of all ages require such care for lots of different reasons.

It's important to think about and choose the type of LTC coverage that best suits your lifestyle and your needs. Consider the average cost of care in the area where you live, or where you plan to live upon retirement. Think about your family health history, life expectancy, and likelihood of developing a disease or illness. Then, do your research to see whether you're eligible for different insurance plan options, and compare the terms and costs.

* *A Shopper's Guide to Long-Term Care Insurance*, 2019, National Association of Insurance Commissioners

Is Long-Term Care Insurance Right for You?

LTC insurance is not for everyone. You should ***not*** buy LTC insurance if you:

- Can't afford the premiums
- Don't have many assets
- Only have a Social Security benefit or Supplemental Security Income (SSI) as your source of income
- Often have trouble paying for utilities, food, medicine, or other important immediate or short-term needs
- Are on Medicaid

You may want to consider buying long-term care insurance if you:

- Have many assets and/or a good income
- Don't want to use most or all of your assets and income to pay for long-term care
- Can afford to pay the insurance premiums, including possible premium increases
- Don't want to burden family or friends
- Want to be able to choose where you receive care

Where to Buy Long-Term Care Insurance

As a City employee, you have access to several LTC insurance policies that are available through federal or state programs, or through associations like the All City Employees Benefits Service Association, the City Employees Club, or the Engineers & Architects Association (EAA). Or, you can investigate purchasing an individual policy outside of the City of LA affiliations.

Tap into these resources for more information:

- **Visit** longtermcare.gov to learn more about planning for long-term care.
- **Get a copy of** ***A Shopper's Guide to Long-Term Care Insurance*** from the National Association of Insurance Commissioners at naic.org/documents/prod_serv_consumer_ltc_lp.pdf.
- **Call your State Health Insurance Assistance Program (SHIP).** For California, it's the California Health Insurance Counseling & Advocacy Program at **800-434-0222** or **916-419-7500**.
- Consider the LTC coverage offered by these City-affiliated organizations:
  - **All City Employees Benefits Service Association (ACEBSA)**
    https://www.acebsa.org/
    213-485-2485
  - **Employees Club of California**
    https://www.cityemployeesclub.com/LACEA/ins_LTC.aspx
    help@employeesclub.com
    800-464-0452
  - **Engineers & Architects Association (EAA)**
    https://eaaunion.org/
    213-620-6920

Important Websites and Phone Numbers

Employee Benefits Division

keepingLAwell.com

per.empbenefits@lacity.org

213-978-1655
Monday – Friday
8:00 a.m. to 4:00 p.m.

Benefits Service Center

keepingLAwell.com to enroll or make changes to your LAwell benefits

833-4LA-WELL
(**800-735-2922** if hearing or speech impaired)
Monday – Friday
8:00 a.m. to 5:00 p.m.

Extended phone hours are provided on Saturday, October 30, and Sunday, October 31, from 8:00 a.m. to 7:00 p.m.

Health Plan Member Advocates

Anthem: Monday – Friday
8:00 a.m. to 4:00 p.m.

213-200-2987
Lorena.Gomez@anthem.com

Kaiser: Tuesday – Thursday
8:00 a.m. to 4:00 p.m.

323-219-6704
LACity.Advocate@kp.org

LAwell Program Benefit	Pages	Website	Phone Number
Anthem PPO **Anthem HMO (Narrow Network)** **Anthem Vivity**	12 – 26	anthem.com/ca/cityofla	Anthem PPO: **833-597-2362** Anthem HMO: **844-348-6111** Anthem Vivity: **844-348-6110**
Kaiser Permanente HMO		my.kp.org/ca/cityofla	**800-464-4000**
Delta Dental PPO	28 – 33	deltadentalins.com	**800-765-6003**
DeltaCare USA DHMO		deltadentalins.com	**800-422-4234**
EyeMed Vision Care	34 – 37	eyemedvisioncare.com/cityofla	**855-695-5418**
Healthcare Flexible Spending Account (HCFSA)	52 – 55	wageworks.com	**877-924-3967**
Dependent Care Reimbursement Account (DCRA)			
Transit (TSA) or Parking (PSA) Spending Accounts	90 – 91	wageworks.com	**877-924-3967**

Other City Benefit Contacts		
COMMUTEwell Program	LACOMMUTEwell.com	**213-978-1634**
Deferred Compensation Plan	LA457.com	**844-523-2457** (Voya) or **213-978-1601** (Retirement Counselor)
City Employees Club of Los Angeles	cityemployeesclub.com	**213-620-0388**
All City Employees Benefits Services Association	acebsa.org	**213-485-2485**
City MOUs	cao.lacity.org/MOUS	**213-978-7676**
Los Angeles Fire and Police Pensions	lafpp.com	**844-885-2377**
Los Angeles Firemen's Relief Association	lafra.org	**323-259-5200**
Los Angeles Police Protective League	lapd.com	**213-251-4554**
Los Angeles Police Relief Association	lapra.org	**213-674-3701**
United Firefighters of Los Angeles City	uflac.org	**213-977-9001**

*This guide is published by the City of Los Angeles Personnel Department. It provides only highlights of the **LAwell** program. It does not change the terms of your benefits or the official documents that control them. This guide outlines the insured plan benefits provided by the Insurance Companies whose names and contact information are listed on the Important Websites and Phone Numbers section of this document. Where this guide deviates from the certificate of coverage and summary of benefits produced by the insurance company, the insurance company documents will prevail. Contact the Benefits Service Center for a copy of insurance coverage documents.*

*By enrolling in, and/or accepting services under the **LAwell Plan**, you agree to abide by all terms, conditions and provisions stated in the 2022 CHOOSEwell Sworn Enrollment Guide.*

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

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