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JULY - DECEMBER

2011 FLEX Benefits

City of Los Angeles

Benefits effective July 1 - December 31, 2011
www.myflexla.com

2011 Mid-Year Flex Enrollment

This guide is published by the City of Los Angeles Joint Labor Management Benefits Committee. It provides only highlights of the Flex program effective July 1, 2011. It does not change the terms of your benefit plans or the official documents that control them. If there are any inconsistencies between this guide and the official plan documents, the plan documents will govern. Plan documents are the legal papers that spell out the benefit plan rules in detail. They may include insurance policies and similar kinds of documents.

By enrolling in, and/or accepting services under the Civilian Flex Plan, you agree to abide by all terms, conditions and provisions stated in the 2011 Flex Enrollment Guide and Official Plan Documents.

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 Civilian Flex 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.

April 2011

In This Guide

State premium assistance programs

In the "Important Legal Notices" section, there is a notice about state premium assistance programs funded by Medicaid and the Children's Health Insurance Program.
See page 59.

Flex Enrollment Guide

July-December 2011

This is a reference guide to your Flex benefits. It explains the benefits available to you and gives you important information about eligibility and how to enroll.

We know that your benefits are important to you and your family. We also know that you need tools and resources to help you take advantage of all your coverage has to offer. Be sure to read this guide thoroughly and keep it as a reference throughout the year. It's your responsibility to know and understand your benefits and how they work. As you consider your benefit choices, plan ahead and make sure you make the necessary changes to your benefit options by the deadlines specified and comply with the documentation requirements.

As an eligible City civilian employee, here are your Flex benefit options.

Your 2011 Flex Options At-A-Glance

Health Coverage (Medical, Vision, Prescription Drug)*
- Kaiser Permanente HMO
- Anthem Blue Cross HMO
- Anthem Blue Cross PPO

Dental Coverage*
- Delta Dental Preventive Only
- DeltaCare USA DHMO
- Delta Dental PPO

Healthcare Flexible Spending Account

Dependent Care Reimbursement Account

Life Insurance
- Basic life**
- Supplemental life (1-5 times pay)
- Dependent life

Accidental Death and Dismemberment (AD&D) Insurance
- Voluntary AD&D
- Dependent AD&D

Disability Coverage
- Basic disability**
- Supplemental disability

* For health and dental coverage, the City pays a part or all of the cost of coverage depending on the option and level of coverage you choose. See the rates on pages 10-14 of this guide and refer to your personal enrollment fact sheet for more information.

** The City pays the full cost for these benefits.

If you have questions, we are here to help

If you have questions, you can go to the City's Flex Plan Web site at **www.myflexla.com** or call the Benefits Service Center at 1-800-778-2133, Monday through Friday from 8 a.m. to 5 p.m. (For TDD or TTY service, call 1-800-735-2922.)

SUMMARY OF CHANGES TO FLEX BENEFITS EFFECTIVE JULY 1, 2011

Elimination of Flex dollars	You will no longer receive basic Flex dollars – $7.50 a pay period for full-time employees and $3.75 a pay period for regular half-time employees. (This change was made for members of the Engineers and Architects Association (EAA) beginning January 1, 2011.) ***Note: If you are enrolled in Preventive Only dental coverage, you will continue to receive Flex dollars of $2.50 a pay period.***
Increased cost for Flex dental coverage	The City's subsidy for dental coverage will decrease for the Delta Dental PPO plan, so you will pay more per pay period if you are enrolled in this plan starting July 1, 2011. See the dental rates on page 14.
Increased copays for doctor visits	• For the Anthem Blue Cross HMO and the Kaiser Permanente HMO, the copay will increase from $10 to $15 per visit. (If you are an EAA member, your copay will decrease from $20 to $15 per visit.) • For the Anthem Blue Cross PPO, the copay for office visits will increase from $20 to $30 per visit. **Preventive care will still be free!** The plans continue to pay 100% of the costs for covered preventive care* services, including annual physicals, health screenings, and mammograms. ***Note: If you are treated for an illness or injury during the same office visit in which you receive preventive care, a copay may be required.***
Increased copay for emergency room visits	The emergency room copay for all health plans will increase from $50 to $100. You do not have to pay the copay if you are admitted to the hospital.
Increased prescription drug copays	• For the Anthem Blue Cross HMO and PPO, there will be a new drug formulary, which is a preferred list of commonly prescribed brand-name medications. Prescription drug copays for a 30-day supply at a retail pharmacy will change to $10 for generic drugs, $20 for brand-name drugs on the formulary, and $40 for brand-name drugs not on the formulary. Copays for a 90-day supply via mail order will be twice the retail pharmacy copays. • For the Kaiser Permanente HMO, the copays will be $10 for generic drugs and $20 for brand-name drugs for a 30-day supply at a retail pharmacy and $20 for generic drugs and $40 for brand-name drugs for a 100-day supply via mail order. See more information on prescription coverage and the formulary on page 27.
Increased deductibles for the Anthem Blue Cross PPO	For the Anthem Blue Cross PPO, the in-network annual deductibles will increase from $500 to $750 for individual coverage and from $1,000 to $1,500 for family coverage. The out-of-network annual deductibles will also increase. As part of the mid-year transition, any expenses that count toward your deductible through June 30 will continue to count beginning July 1.

** Preventive care coverage includes preventive services rated A or B by the U.S. Preventive Services Task Force and the federal regulations. Go to your health plan's Web site for a list of covered preventive services. For the Anthem Blue Cross HMO and PPO, go to www.anthem.com/ca/cityofla and choose "Preventive Care" under "Health Information." For the Kaiser Permanente HMO, go to http://my.kp.org/ca/cityofla/benefits.html and choose "Your Guide to HCR Preventive Services" under "Miscellaneous Information."*

What to Do Now:

IT'S TIME TO ENROLL

During the special mid-year enrollment, you have an opportunity to consider your Flex benefit options and choose benefits that offer you the best overall value, financial protection and peace of mind. For this enrollment, you cannot make changes to, or enroll in, the Healthcare Flexible Spending Account or the Dependent Care Reimbursement Account.

Check your personal enrollment fact sheet

If your personal information is incorrect, contact your department's personnel section. If any dependent information is incorrect, call the Benefits Service Center. During enrollment, you can make any dependent data changes needed. If you need to correct a dependent's date of birth, a copy of the dependent's birth certificate must be provided.

1

Read your enrollment materials, including your personal enrollment fact sheet. Consider whether you want to make any changes to your benefit choices during this special enrollment.

2

Go to www.myflexla.com and click Enroll In Benefits or Make Changes from the left navigation bar to go to the City's enrollment site and enroll. If you choose to keep the same plans you have now, you do not have to enroll unless you need to add or remove a dependent.

3

Enter your Employee ID number and Personal Identification Number – or PIN – to log in.

- Your PIN is the last four digits of your Social Security number, unless you have changed it.
- If you forgot your PIN, enter your user name and then click on "Forgotten Password (PIN)." You will be asked a few basic questions, like your ZIP code, and prompted to answer a security question.

4

Review your confirmation statement. When you receive your confirmation statement, review it carefully to ensure that all information is correct.

5

Provide any required paperwork to complete your enrollment. If you are required to complete any forms – like documentation for a dependent, Cash-in-Lieu Affidavit, Domestic Partnership Affidavit or Evidence of Insurability (EOI) form – be sure to return your form by the deadline. Required forms will be included with your confirmation statement or you can find forms at **www.myflexla.com**.

If you need help

If you need help logging in, call the Benefits Service Center at 1-800-778-2133 and press **"0#"** two times to speak to a Benefits Service Representative.

8 Things You Need to Know about Flex Coverage

1 Enroll if you want to change your choices.

If you do not enroll during the special mid-year enrollment (May 2-13), you will keep your current benefit choices for July 1 through December 31, 2011.

2 Enroll new dependents by the deadline.

You must enroll a new dependent within **30 calendar days** of the date he or she becomes your dependent. For example, if you have a newborn, you must notify the Benefits Service Center within 30 calendar days. If you miss this deadline, you must wait until the next annual enrollment. See page 18 for details.

3 Provide documentation for dependents.

When you enroll a dependent, documentation is required. For example, if you enroll your biological child, a copy of the child's birth certificate must be submitted. If you do not submit required documents by the deadline, coverage will be canceled and any expenses your dependent has after cancellation will be your responsibility. See pages 16-18 for further information.

4 You can enroll child(ren) up to age 26.

Under the Flex Plan, your child between the ages of 0-26 is an eligible dependent up until your child turns 26 years old. This is a benefit mandated by the new Healthcare Reform law. See page 8 for details.

We are here to help.

If you have any questions about your benefit coverage, please call the Benefits Service Center at 1-800-778-2133 or go online at **www.myflexla.com**.

5

Check the eligibility rules before you enroll.

The eligibility rules explain which City employees are eligible for Flex – and which dependents can be covered. Not everyone who lives with you is your "dependent" under the plan, so it is important to review the rules before you enroll. See pages 16-17 for details.

6

You must remove your ex-spouse from coverage if you divorce.

You must call the Benefits Service Center or go to **www.myflexla.com within 30 calendar days** of the date your divorce is final to remove your ex-spouse from coverage. If you do not meet this deadline, you may be responsible for any health or dental expenses your ex-spouse has after the date your divorce is final. Your ex-spouse will receive information on COBRA continuation coverage after you call or go online to make the change.

7

Your Flex choices apply through December 31, 2011.

Under federal rules for plans like the Flex plan, the benefit choices you make during the special mid-year enrollment apply for the rest of 2011. You can make a change **only if** you have a qualified family status change – such as marriage or the birth of a child. For a complete list of family status changes, see page 20.

8

Some benefit changes require evidence of insurability.

If you change your life insurance or disability coverage choices during the special mid-year enrollment, evidence of insurability may be required. If this applies to you, you will receive an insurance company form to complete and submit. See page 46 and page 51 for details.

About Flex

HEALTHCARE REFORM AND FLEX BENEFITS

The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. It's difficult to gauge how this law will affect the City and our employees, since many significant provisions are not effective until 2014. However, there are changes that took effect in 2011. Keep in mind that we are continuing to receive more detail and guidance on how these changes affect our plans specifically. We'll keep you posted on these and other changes as more information is available.

A summary of the various provisions that went into effect for the Flex 2011 plan year is given below.

Healthcare Reform Changes for Plan Year 2011	What This Means to You
Dependent Coverage for Adult Children up to Age 26	
Adult children up to age 26 may be added as dependents on either individual or group plans. There is no requirement for adult children to be full-time students.	The Flex Plan dependent eligibility rules are updated for 2011 to expand coverage. See page 17 for more information.
In-Network Preventive Care Covered at 100%	
Preventive care must be covered at 100% based on national guidelines.	The Flex health plans cover certain in-network preventive care benefits at 100% with no copay and no deductible.
Lifetime Limits Removed	
Health plans may no longer have lifetime dollar limits on benefits.	Lifetime benefit limits no longer apply for 2011. See pages 24-25 for more information on plan limits.
Denying Coverage to Children with Pre-Existing Conditions	
Health plans cannot drop participants from coverage when they get sick, or deny coverage to children under the age of 19 with pre-existing conditions.	The Flex health plans already met this standard because there is no pre-existing condition limitation for anyone who is eligible.
Restricts Flexible Spending Account Reimbursements for Non-Prescribed Drugs	
Over-the-counter medication are eligible for reimbursement only if the request is accompanied by a doctor's prescription.	WageWorks made this change for plan year 2011 to comply with this new law. See page 39 for more information.

BUYING YOUR BENEFITS

For health and dental coverage, the City pays a part or all of the cost of coverage depending on the option and level of coverage you choose. Beginning July 1, 2011, you will no longer receive basic Flex dollars – $7.50 a pay period for full-time employees and $3.75 a pay period for half-time employees. (This change was made for EAA members beginning January 1, 2011.)

You may still receive Flex dollars in these cases:

	Opportunities for Flex Dollars	
	If you decline health coverage with required proof of other coverage and choose Cash-in-Lieu	If you choose employee-only dental coverage under the Preventive Only option
If you are a full-time employee:	$50 a pay period	$2.50 a pay period
If you are a regular half-time employee hired after July 23, 1989:	$25 a pay period	$1.25 a pay period

If you are a regular half-time employee hired before July 24, 1989, please see your MOU's Benefits Section for details on your Flex options and the amount of Flex dollars available to you. Some MOUs provide for additional Flex credits based upon negotiations.

If your pre-tax benefits cost more than your Flex dollars, you will pay the additional cost with pre-tax dollars from your paycheck. Any after-tax benefits you choose are paid with after-tax dollars from your paycheck.

If your pre-tax benefits cost less than your Flex dollars, the unused Flex dollars become taxable income.

Pre-Tax Dollars...A Savings Advantage

Flex offers you tax savings if you choose to purchase additional pre-tax benefits with money from your paycheck. Because state and federal income taxes are not withheld from those pre-tax dollars, every cent of every dollar goes toward meeting your benefit needs. These tax savings stretch the value of your benefit dollars. For example, if you use $10 of pre-tax pay and you are in the 15% tax bracket, you save $1.50 in taxes ($10 x .15 = $1.50).

2011 COSTS PER PAY PERIOD FOR FLEX HEALTH COVERAGE –
Full-Time Employees Who are Not EAA Members

Effective July 1, 2011

Coverage Level	Total Cost	City Pays...	Employee Pays...
Kaiser HMO			
Employee Only	$211.21	$211.21	$0.00
Employee + Spouse/DP	$464.65	$464.65	$0.00
Employee + Child(ren)	$422.41	$422.41	$0.00
Family	$549.13	$549.13	$0.00
Anthem Blue Cross HMO			
Employee Only	$202.71	$202.71	$0.00
Employee + Spouse/DP	$445.21	$445.21	$0.00
Employee + Child(ren)	$403.55	$403.55	$0.00
Family	$554.03	549.13	$4.90
Anthem Blue Cross PPO			
Employee Only	$311.18	$311.18	$0.00
Employee + Spouse/DP	$687.29	$549.13	$138.16
Employee + Child(ren)	$596.47	$549.13	$47.34
Family	$779.83	$549.13	$230.70

The City Subsidy for Health and Dental Costs

A major portion of the Flex program's health and dental coverage cost is paid by the City's subsidy.

For health plan coverage for July 1 to December 31, 2011, the City's subsidy covers costs up to the Kaiser Permanente family rate ($1,098.26 a month) for full-time employees and the Kaiser HMO employee-only rate ($422.42 a month) for half-time employees. By paying a significant share of the cost of coverage through the Flex program, the JLMBC and the City show their commitment to employees and their families – adding up to a valuable part of your total compensation.

2011 COSTS PER PAY PERIOD FOR FLEX HEALTH COVERAGE –
Half-Time Employees Who are Not EAA Members

Effective July 1, 2011

Coverage Level	Total Cost	City Pays...	Employee Pays...
Kaiser HMO			
Employee Only	$211.21	$211.21	$0.00
Employee + Spouse/DP	$464.65	$211.21	$253.44
Employee + Child(ren)	$422.41	$211.21	$211.20
Family	$549.13	$211.21	$337.92
Anthem Blue Cross HMO			
Employee Only	$202.71	$202.71	$0.00
Employee + Spouse/DP	$445.21	$211.21	$234.00
Employee + Child(ren)	$403.55	$211.21	$192.34
Family	$554.03	$211.21	$342.82
Anthem Blue Cross PPO			
Employee Only	$311.18	$211.21	$99.97
Employee + Spouse/DP	$687.29	$211.21	$476.08
Employee + Child(ren)	$596.47	$211.21	$385.26
Family	$779.83	$211.21	$568.62

Average City Contribution Toward An Employees' Flex Benefits Costs		
	Monthly Cost	Annual Cost
Health	$831.73	$9,980.76
Dental	$33.38	$400.56
Basic Disability	$17.21	$206.52
Basic Life	$1.70	$20.40
Total	**$884.02**	**$10,608.24**

2011 COSTS PER PAY PERIOD FOR FLEX HEALTH COVERAGE –

Full-Time Employees Who are EAA Members

Effective July 1, 2011

Coverage Level	Total Cost	City Pays...	Employee Pays...
Kaiser HMO			
Employee Only	$211.21	$200.65	$10.56
Employee + Spouse/DP	$464.65	$441.42	$23.23
Employee + Child(ren)	$422.41	$401.29	$21.12
Family	$549.13	$521.67	$27.46
Anthem Blue Cross HMO			
Employee Only	$202.71	$192.57	$10.14
Employee + Spouse/DP	$445.21	$422.95	$22.26
Employee + Child(ren)	$403.55	$383.37	$20.18
Family	$554.03	$521.43	$32.60
Anthem Blue Cross PPO			
Employee Only	$311.18	$295.62	$15.56
Employee + Spouse/DP	$687.29	$514.77	$172.52
Employee + Child(ren)	$596.47	$519.31	$77.16
Family	$779.83	$510.14	$269.69

2011 COSTS PER PAY PERIOD FOR FLEX HEALTH COVERAGE –

Half-Time Employees Who are EAA Members

Effective July 1, 2011

Coverage Level	Total Cost	City Pays...	Employee Pays...
Kaiser HMO			
Employee Only	$211.21	$200.65	$10.56
Employee + Spouse/DP	$464.65	$187.98	$276.67
Employee + Child(ren)	$422.41	$190.09	$232.32
Family	$549.13	$183.75	$365.38
Anthem Blue Cross HMO			
Employee Only	$202.71	$192.57	$10.14
Employee + Spouse/DP	$445.21	$188.95	$256.26
Employee + Child(ren)	$403.55	$191.03	$212.52
Family	$554.03	$183.51	$370.52
Anthem Blue Cross PPO			
Employee Only	$311.18	$195.65	$115.53
Employee + Spouse/DP	$687.29	$176.85	$510.44
Employee + Child(ren)	$596.47	$181.39	$415.08
Family	$779.83	$172.22	$607.61

2011 COSTS PER PAY PERIOD FOR FLEX DENTAL COVERAGE –

Full-Time Employees

Effective July 1, 2011

Coverage Level	Total Cost	City Pays...	Employee Pays...
Delta Dental Preventive Only			
Employee Only	$2.49	$4.99	($2.50)
Employee + Spouse/DP	$4.56	$2.49	$2.07
Employee + Child(ren)	$5.12	$2.49	$2.63
Family	$7.39	$2.49	$4.90
DeltaCare USA DHMO			
Employee Only	$8.18	$8.18	$0.00
Employee + Spouse/DP	$15.24	$8.18	$7.06
Employee + Child(ren)	$13.67	$8.18	$5.49
Family	$17.66	$8.18	$9.48
Delta Dental PPO			
Employee Only	$24.92	$21.18	$3.74
Employee + Spouse/DP	$46.69	$21.18	$25.51
Employee + Child(ren)	$47.64	$21.18	$26.46
Family	$64.17	$21.18	$42.99

Half-Time Employees

Effective July 1, 2011

Coverage Level	Total Cost	City Pays...	Employee Pays...
Delta Dental Preventive Only			
Employee Only	$2.49	$3.74	($1.25)
Employee + Spouse/DP	$4.56	$2.49	$2.07
Employee + Child(ren)	$5.12	$2.49	$2.63
Family	$7.39	$2.49	$4.90
DeltaCare USA DHMO			
Employee Only	$8.18	$8.18	$0.00
Employee + Spouse/DP	$15.24	$8.18	$7.06
Employee + Child(ren)	$13.67	$8.18	$5.49
Family	$17.66	$8.18	$9.48
Delta Dental PPO			
Employee Only	$24.92	$10.59	$14.33
Employee + Spouse/DP	$46.69	$10.59	$36.10
Employee + Child(ren)	$47.64	$10.59	$37.05
Family	$64.17	$10.59	$53.58

DOMESTIC PARTNER COVERAGE AND PRE-TAX BENEFITS

The City of Los Angeles offers domestic partners of City employees, and their domestic partners' children, equal access to its employee benefits programs, including health and dental plans. To obtain these benefits, you must enroll your dependents during the specified times and provide the required dependent eligibility documentation. Please refer to pages 16-19 for more information on enrolling dependents.

Effect on Taxes

Under federal tax law, pre-tax dollars cannot be used to purchase benefits for a domestic partner or a same-sex spouse who is covered as your domestic partner, or their children. Unless your partner and the partner's children meet the exception described below, you pay your share of the coverage cost with after-tax dollars. The amount the Flex program pays toward the cost of your domestic partner's coverage will be taxable as regular income on 24 paychecks a year.

There is an exception for federal taxes: If your domestic partner and/or his or her children meet certain federal tax law rules and qualify as "health plan tax dependents," you can pay their health and dental coverage cost with pre-tax dollars. You must complete a Declaration of Tax Status form, available under "Forms and Documents" at **www.myflexla.com** to certify that your domestic partner and his or her children qualify as "health plan tax dependents" before pre-tax coverage costs apply for them. There is also an exception for State taxes. If your domestic partnership meets eligibility requirements and is registered with the State of California, the cost of coverage will be excluded from your reported State income if you provide a copy of the approved State certificate.

This chart shows the dollar value of domestic partner coverage paid by Flex that will be reported as additional bi-weekly taxable income in 2011 for full-time employees.

Who is a "health plan tax dependent"?

Under federal tax law, "health plan tax dependent" includes your children and other relatives – 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.

Your additional bi-weekly taxable income when you enroll yourself and these dependents:	And, enroll in…		
	Anthem Blue Cross HMO	Kaiser Permanente HMO	Anthem Blue Cross PPO
Domestic Partner	$242.50	$253.44	$237.95
Domestic Partner's Children	$200.84	$211.20	$237.95
Your Children + Domestic Partner's Children	$0.00	$0.00	$0.00
Domestic Partner + Your Children	$242.50	$253.44	$237.95
Domestic Partner + Domestic Partner's Children	$346.42	$337.92	$237.95
Domestic Partner + Your and Domestic Partner's Children	$242.50	$253.44	$237.95

WHO'S ELIGIBLE

Full-Time Employees:

As a regular full-time civilian City employee, you are eligible if you are a contributing member of the Los Angeles City Employees' Retirement System (LACERS) and are paid for at least 40 hours per pay period, or the number of hours specified by your Memorandum of Understanding (MOU). In addition, you must meet one of these four requirements:

- You are eligible for membership in one of the employee representation units for which the civilian modified flexible benefits program (Flex program) has been negotiated in a MOU
- You are not represented by an employee representation unit
- You are a Port Police Officer (MOU27 or MOU38) and a member of Tier 5 of the Fire & Police Pension System
- You are an Elected Official of the City or a full-time Member of the Board of Public Works.

Changes in employment status

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

Half-Time Employees:

If you are a regular half-time civilian employee, you may be eligible for Flex benefits. An eligible half-time employee must be paid for at least 20 hours per pay period in order to maintain benefits. Employees in part-time, intermittent or similar positions are not eligible.

Family Members of Employees

If you are eligible for Flex, you can also enroll your eligible family members if your dependents meet the criteria listed below and you submit the required documentation by the deadlines.

You MUST review your dependent elections and verify that each dependent enrolled – and dependents you add – continue to meet the Flex eligibility criteria at all times. **You must provide the required documentation to confirm your dependents as determined by the Benefits Division.**

Eligible children

Your children may include legally adopted children or children placed with you for adoption, children for whom you have legal custody or guardianship, foster children placed in your home pending a permanent placement with you, and stepchildren. These children are eligible if they meet the age requirements listed on page 17.

Ineligible Dependents

The following are examples of individuals who are not considered eligible dependents: your spouse following a divorce; someone else's child (such as your grandchildren, nieces, or nephews), unless you have been awarded legal custody or guardianship; or parents, parents-in-law, or grandparents, regardless of their IRS dependent status.

You must drop coverage for your enrolled dependent within 30 days of the date he or she loses eligibility. For example, if you divorce your spouse or end your domestic partnership relationship, you must call the Benefits Service Center at 1-800-778-2133 to remove your dependent spouse or domestic partner. You must make this call within 30 days of the divorce or end of the domestic partnership.

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

Dependent Eligibility Criteria

Dependent Type	Age	Eligibility Definition	Documents Required for Verifying Eligibility
Spouse	N/A	Person of the opposite or same sex to whom you are legally married	Marriage certificate
Domestic Partner	N/A	Meet City's domestic partner eligibility requirements. See Domestic Partnership Information Sheet and Affidavit form at **www.myflexla.com** in "Forms and Documents."	City of Los Angeles Affidavit of Domestic Partnership, or Declaration of Partnership filed with the California Secretary of State
Biological Child	Up to age 26*	Minor or adult child(ren) of employee who is under age 26	Child's birth certificate, hospital verification of birth or court document
Step Child	Up to age 26*	Minor or adult child of employee's spouse who is under age 26	Child's birth certificate and certificate showing spouse/domestic partner as parent
Child Legally Adopted/ Ward	Up to age 26*	Minor or adult child legally adopted/ ward by employee who is under age 26	Child's birth certificate and court documentation
Child of Domestic Partner	Up to age 26*	Minor or adult child of employee's domestic partner who is under age 26	Child's birth certificate and City of Los Angeles Domestic Partner Affidavit or Declaration of Partnership filed with the California Secretary of State
Disabled Child	Up to age 26*	Child as defined in the child categories above	Same as the child requirements listed above
Disabled Child	Over age 26	Disabled child over the age of 26 who is dependent on you for support and was disabled before age 18. To be eligible, your child must remain unmarried, dependent on you for financial support and disabled as determined by your health plan.	Birth certificate and disability application from your health plan completed by your child's doctor and returned to your health plan for approval each year as requested by the insurance company. See the Disabled Child Critieria on page 19 for more information.
Grandchildren Legal Custody	Up to age 26*	Your grandchildren up to age 26 if you show proof of legal custody	Child's birth certificate and court documentation
Grandchildren	Up to age 26*	Your grandchildren can be added to the plan if their parent is your child who • 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 Please call the Employee Benefits Division for more information.

* Eligibility continues up to the date your dependent turns age 26.

DOCUMENTATION INFORMATION IS REQUIRED

Documentation is required to enroll dependents. If Flex coverage is canceled because you do not provide required information, any expenses your child or spouse/domestic partner has after coverage is canceled will be your financial responsibility, which may include expenses incurred before your cancellation notice. *Contact the Employee Benefits Division at 213-978-1655 with any questions.*

Documentation Deadlines

Where to send required documents

Write your name and employee ID number for the dependent you are adding on each certificate or document and fax documents to 213-978-1623, e-mail to per.empbenefits@lacity.org or mail to:

Personnel Department
Employee Benefits Division
200 N. Spring Street
Room 867
Mail Stop 621
Los Angeles, CA 90012.

If You Added Your Dependent During…	Deadline	Important Considerations
The Special Mid-Year Enrollment (May 2-13)	If you enroll your dependent who is not currently covered during the mid-year enrollment (May 2-13, 2011), documents must be received **by June 3, 2011**	If you fail to provide the required documentation to the Personnel Department Benefits Division by the deadline, your dependent coverage will be canceled. Coverage will not take effect for your added dependent enrolled during the special mid-year enrollment. You will not be able to re-enroll your dropped dependent until the next annual enrollment period or within 30 days of a qualifying life event.
Outside of this Special Mid-Year Enrollment or Annual 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.	If you fail to provide the required documentation to the Personnel Department Benefits Division by the deadline your dependent coverage will be canceled. Coverage will be canceled effective the 61st day after the date on the confirmation statement. You will not be able to re-enroll your dropped dependent until the next annual enrollment period or within 30 days of a qualifying life event.

Dependent Coverage Rules for Special Situations

Important Information About Eligibility Criteria for Disabled Child Over Age 26

You can enroll a disabled child age 26 or older who is dependent on you for support if that child was disabled before age 18. To be eligible, your child must remain unmarried, dependent on you for financial support and disabled as determined by your health plan.

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

When Two Flex-Eligible City Employees Are Married, Are Domestic Partners or Have Dependent Children Together

- For health and dental coverage, you cannot enroll as both an employee and as a dependent of your spouse/domestic partner. Only one spouse/domestic partner can cover dependent children.
  - Health coverage: 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.
  - Dental coverage: Each employee must enroll in his/her own dental plan. Your spouse/domestic partner cannot cover you as a dependent.
- For life insurance, each of you can purchase supplemental life insurance as an employee, or one of you can purchase supplemental life insurance for yourself and dependent life insurance for your spouse/domestic partner. **Also, only one of you can cover dependent children.**
- For AD&D insurance, your spouse/domestic partner cannot cover you as a dependent. Each of you can purchase employee-only coverage. **Only one of you can cover dependent children.**

If you have dependent children with another City employee who is not currently your spouse/domestic partner, only one parent can purchase health coverage, dental coverage, life or AD&D insurance for the dependent children.

Extended coverage for child on medical leave from school

Effective January 1, 2010, the Flex Plan added a special provision to comply with Michelle's Law. This provision applies only to a dependent child who is enrolled in the Flex Plan because of full-time student status. If the dependent child has a serious illness or injury resulting in a medically necessary leave of absence or change in enrollment (such as reduction in hours) that causes a loss of student status, the Flex Plan will extend coverage to the child for up to a year. Beginning January 1, 2011, the Flex Plan does not require full-time student status as a condition of coverage for eligible dependents.

Children who are City employees

Your children who are benefits-eligible employees of the City cannot be covered as dependents; however, they may be beneficiaries of life insurance.

CHANGING YOUR BENEFIT CHOICES

When Your Choices Will Apply

Important deadline

You must make changes to your benefit choices **within 30 calendar days** of an eligible family status change or you will have to wait until the next annual enrollment.

The benefit choices you make during the special mid-year enrollment stay in effect from July 1 through December 31, 2011. If you enroll as a new hire during the year, your benefit choices stay in effect through December of that year. This is a federal government requirement for employee benefit plans.

When You Can Make Changes

You cannot change your choices at other times during the year unless you have a family status change as defined by the Flex program and Section 125 of the Internal Revenue Code. In this case, you may be able to make benefit changes that are consistent with your family status change. You may have an eligible family status change if:

- You get married or divorced
- You begin or end a domestic partner relationship
- You add or lose an eligible dependent
- Your spouse/domestic partner's employment status changes from part-time to full-time or vice versa, significantly changing eligibility or coverage under the other employer's plan
- Your spouse/domestic partner begins or ends employment
- There is a significant change in the health or dental coverage your spouse/domestic partner has through his or her employer
- You move outside your health or dental plan's service area
- You or your dependent loses COBRA or other health coverage.

When you make changes to your benefit choices online or by phone due to a family status change, you will be asked to provide documents showing proof of the family status change within 60 days of the date on the confirmation statement reflecting such change. You will receive confirmation of the benefit change by mail within two weeks of completing the change online or by phone. If you do not provide any required documents by the deadline, Flex coverage changes will be canceled.

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

Important!

Deadline for Making Changes to Benefit Choices with a Family Status Change

Limited Time Period for Making Benefit Changes After A Change In Family Status

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

- Call the Benefits Service Center at 1-800-778-2133 to make new benefit choices for any family status change (see "When You Can Make Changes" on page 20). You will be asked to enter your Employee ID number and PIN (the last four digits of your Social Security number unless you've changed it). If you want to bypass the menu and speak to a representative, press "0#" two times.
- If your status change is marriage, birth or adoption of a child, divorce, or beginning or ending a domestic partnership, you can change your benefit choices by clicking "Enroll in Benefits or Make Changes" at **www.myflexla.com**. For any other types of family status changes, you must call the Benefits Service Center.

Keep in mind that if you have or adopt a child during the year, you must enroll that child for coverage **within 30 calendar days** of the birth or adoption. You can enroll the child only by calling the Benefits Service Center or clicking "Enroll in Benefits or Make Changes" at **www.myflexla.com**. If you do not go online or call **within 30 calendar days**, you must wait until the next annual enrollment to enroll that child. For example, if your child is born on June 1, 2011, you must call or go online to enroll your child by June 30, 2011. If you do not enroll your child within that time, you must wait until the next annual enrollment, and your child will not have coverage until January 2012.

Documents Are Required

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

Contact the Employee Benefits Division at 213-978-1655 if you have questions about family status changes.

If You Lose Medicaid or CHIP Coverage

Employees and dependents who are eligible for but not enrolled in a City health coverage option may enroll if they lose Medicaid or CHIP coverage because they are no longer eligible, or they become eligible for a state's premium assistance program. You have 60 days from the date of the Medicaid/CHIP event to request enrollment under the Plan. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Health Coverage

YOUR HEALTH COVERAGE CHOICES

Under Flex, you can choose 2011 health coverage in Anthem Blue Cross HMO (CaliforniaCare), Kaiser Permanente HMO or Anthem Blue Cross Preferred Provider Organization (PPO).

You can also decline health coverage – and receive Cash-in-Lieu – if you have coverage through your spouse's or domestic partner's employer or a second employer, or if you have retiree health coverage from a former employer. See "Cash-in-Lieu – A Great Idea if You Have Other Coverage" on page 26 for details.

There are important differences in how HMOs and PPOs work.

- HMOs provide healthcare through a network of doctors, hospitals and other healthcare providers. With an HMO, you must use a network provider to receive coverage, except in an emergency. Flex provides coverage based on zip code and covers areas where most City employees live. In limited cases, you may not have a choice of all the HMOs described in this guide.
- A PPO is a network of doctors, hospitals and other healthcare providers that have agreed to offer quality medical care and services at discounted rates. You can use network providers for a higher level of benefit coverage, or go to any licensed provider and receive a lower level of benefits.

USING THE NETWORKS

	Anthem Blue Cross HMO	Kaiser Permanente HMO	Anthem Blue Cross PPO
In-network care	From a network primary care physician (PCP) or primary medical group (PMG) you choose, using your PCP/PMG first when you need medical care	From any Kaiser Permanente facility; a primary care physician (PCP) is recommended but not required	From network provider of your choice; no primary care physician (PCP) or specialist referrals required
Out-of-network care	Not covered unless you need care for a serious medical emergency outside of your HMO's network service area		From any provider you choose, with lower out-of-network benefits

Finding a Network Provider

You can search provider directories online by clicking "Enroll in Benefits or Make Changes" from **www.myflexla.com** and then clicking "Provider Lookup" on the left side of the screen. You can also search provider directories at each health plan's Web site, or you can request a provider directory by calling Member Services for the health plan. See "Contacts" for each plan's Web site address and toll-free telephone number.

Choosing a PCP/PMG for Anthem Blue Cross HMO

You must select a primary care physician (PCP) or primary care medical group (PMG) from the Anthem Blue Cross network to receive HMO benefits. When you enroll yourself or a dependent for the first time, you'll be prompted to select a PCP/PMG. If you do not select a PCP or PMG, Anthem Blue Cross will choose one for you based on your zip code. When you receive your ID cards, please verify that the names of the PCP/PMGs are correct.

During the special mid-year enrollment, you can change your PCP/PMG **effective July 1, 2011** by going online at **www.myflexla.com** or calling the Benefits Service Center.

If you want to change your PCP/PMG at any other time during the year, call Anthem Blue Cross HMO Member Services at 1-800-288-2539. Because the Anthem Blue Cross HMO does not cover care that is not coordinated by your PCP/PMG, it is important that you do not go to another doctor without first contacting Anthem Blue Cross HMO Member Services.

A HEALTH COVERAGE COMPARISON

The three options generally cover the same types of care, but there are some differences in the way they pay for covered care. The following comparison charts show how each health plan pays for some covered services. To find out if a specific service not shown on the charts is covered, call the plan's Member Services number.

For details on prescription drug and vision coverage, see "Prescription Drug Coverage" on page 27 and "Vision Care" on page 28.

	Anthem Blue Cross HMO	Kaiser Permanente HMO
Calendar year deductible	None	None
Calendar year out-of-pocket maximum	$500/person; $1,500/family	$1,500/person; $3,000/family
Lifetime maximum benefit	Unlimited	Unlimited
Routine office visits	100% after $15 copay/visit	100% after $15 copay/visit
Pediatric office visits	100% up to age 5	100% up to age 5
Preventive Care*	100%	100%
Hospitalization and surgery	100%	100%
Maternity care	100%	100%
Diagnostic lab work and X-rays	100%	100% at a Kaiser facility
Emergency room care for true emergencies (such as severe chest pains or breathing difficulties, severe bleeding, poisoning)	100% after $100 copay/visit; copay waived if admitted	100% after $100 copay/visit; copay waived if admitted
Mental health		
• Inpatient**	100%	100%
• Outpatient**	100% for facility-based care; 100% after $15 copay/visit for physician visits	100% after $15 copay/visit
Chemical dependency treatment		
• Inpatient**	100%	100%
• Outpatient**	100% for facility-based care; 100% after $15 copay/visit for physician visits	100% after $15 copay/visit
Hearing aid benefit	100%; covers medically necessary hearing aids ordered by your PCP and approved by Anthem Blue Cross	Up to $2,000 allowance for one device per ear every 36 months; covers all visits for fitting, counseling, adjustment, cleaning and inspection
Prescription drugs	See "Prescription Drug Coverage" on page 27 for details.	
Vision care	See "Vision Care" on page 28 for details.	

* Preventive care coverage includes preventive services rated A or B by the U.S. Preventive Services Task Force and the federal regulations. Go to the Web site for your health plan or call your health plan if you have questions about coverage.

** The mental health inpatient and outpatient benefits shown here are general benefit provisions. Consult with your plan for specific information regarding benefits available.

	Anthem Blue Cross PPO	
	In-Network	Out-of-Network
Calendar year deductible	$750/person or $1,500/family	$1,250/person or $2,500/family
Calendar year out-of-pocket maximum	$2,000/person or $4,000/family, in-network and out-of-network combined (does not include the deductible)	
Lifetime maximum benefit	Unlimited	
Routine office visits	100% after $30 copay/visit with no deductible; 90% after deductible for any procedures as part of visit	70% of R&C*** after deductible
Pediatric office visits	100% after $30 copay/visit up to age 7; 90% after deductible for immunizations	70% of R&C*** after deductible up to age 7
Preventive Care*	100%, no deductible	70% of R&C*** after deductible
Hospitalization and surgery	90% after deductible; must be precertified****	70% of R&C*** after deductible and $500/stay; must be precertified****
Maternity care	90% after deductible	70% of R&C*** after deductible
Diagnostic lab work and X-rays	90% after deductible	70% of R&C*** after deductible
Emergency room care for true emergencies (such as severe chest pains or breathing difficulties, severe bleeding, poisoning)	90% after $100 copay/visit; copay waived if admitted and regular hospitalization benefits apply	90% after $100 copay/visit; copay waived if admitted and regular hospitalization benefits apply
Mental health		
• Inpatient**	90% after deductible	70% of R&C*** after deductible
• Outpatient**	90% after deductible for facility-based care; 100% after $30 copay/visit for physician visit	70% of R&C*** after deductible
Chemical dependency treatment		
• Inpatient**	90% after deductible	70% of R&C*** after deductible
• Outpatient**	90% after deductible for facility-based care; 100% after $30 copay/visit for physician visit	70% of R&C*** after deductible
Hearing aid benefit	Up to $1,000 allowance (per calendar year); covers hearing aids or services related to the fitting or making of a hearing aid	
Prescription drugs	See "Prescription Drug Coverage" on page 27 for details.	
Vision care	See "Vision Care" on page 28 for details.	

* Preventive care coverage includes preventive services rated A or B by the U.S. Preventive Services Task Force and the federal regulations. Go to the Web site for your health plan or call your health plan if you have questions about coverage.

** The mental health inpatient and outpatient benefits shown here are general benefit provisions. Consult with your plan for specific information regarding benefits available in your situation.

*** R&C is the reasonable and customary charge – the usual charge for specific services in the geographic region where you are treated.

**** You or your doctor must contact Anthem Blue Cross for precertification and approval before a hospital stay or you will be responsible for a penalty of $500.

CASH-IN-LIEU – A GREAT IDEA IF YOU HAVE OTHER COVERAGE

If your spouse or domestic partner has health coverage available at work, it may be worth considering coverage as a dependent under your spouse/domestic partner's plan rather than taking coverage under Flex. Here is why…as a regular, full-time employee, you can receive Cash-in-Lieu in the amount of $50 a pay period ($1,200/year) in taxable income.

Generally, if you are a regular half-time employee hired after July 23, 1989, you can receive $25 a pay period ($600/year) in taxable income. Please see your MOU's Benefits Section to confirm. If you're a regular half-time employee hired before July 24, 1989, see your MOU's Benefits Section for information on Cash-in-Lieu. Cash-in-Lieu will not be included in the two "no deduction" paychecks you receive each year.

If you take Cash-in-Lieu and your spouse/domestic partner later loses health coverage through his or her employer, this would be a family status change. You could enroll yourself and any eligible dependents in Flex coverage by calling the Benefits Service Center within 30 calendar days after you lose other coverage. See "When You Can Make Changes" on page 20 for more on family status changes.

Selecting Cash-in-Lieu

If you select Cash-in-Lieu for the first time during the special mid-year enrollment or as a new hire, you will receive a Cash-in-Lieu affidavit with your confirmation statement. **For Cash-in-Lieu to begin, you must complete and return the affidavit:**

- By June 3, 2011 if you select Cash-in-Lieu during the special mid-year enrollment. If your Cash-in-Lieu affidavit is received after the deadline, you will not receive payments for any pay periods missed.
- Within 60 days of the date on your confirmation statement if you select Cash-in-Lieu as a new hire. If you do not return the Cash-in-Lieu affidavit, Cash-in-Lieu will be canceled effective the 61st day.

To select Cash-in-Lieu...

You must have the option to enroll in health coverage as a dependent through your spouse's or domestic partner's employer. You may be eligible for Cash-in-Lieu if you have retiree health coverage from a former employer, if you have health coverage through a second employer or if you are enrolled in Medicare when you become eligible for Flex. Contact the Employee Benefits Division at 213-978-1655 if you have questions about eligibility for Cash-in-Lieu.

PRESCRIPTION DRUG COVERAGE

Drugs are more advanced than ever, and doctors are relying more on drug therapies to help people manage their conditions. Understanding how the prescription drug program available through your health plan works can help you make good buying decisions and lower your out-of-pocket costs.

Participating Pharmacy

To have a prescription filled, simply show your member ID card and pay a copayment when you go to a participating Anthem Blue Cross or Kaiser pharmacy. You do not have to submit claim forms.

- For the Anthem Blue Cross HMO and Anthem Blue Cross PPO, you can fill prescriptions at any retail pharmacy that participates in the Anthem Blue Cross pharmacy network. Prescriptions from non-participating pharmacies are not covered.
- For the Kaiser Permanente HMO, you must fill prescriptions at any Kaiser pharmacy.

Introducing a Formulary Effective July 1, 2011

A formulary will apply under the Anthem Blue Cross HMO and the Anthem Blue Cross PPO.

A formulary is a preferred list of commonly prescribed brand-name medications compiled by an independent group of doctors and pharmacists. It includes medications for most medical conditions that are treated on an outpatient basis. You pay lower copayments when you use a drug on the formulary. You can access the Anthem Blue Cross formulary at www.anthem.com/ca/cityofla.

Your Copayment When You Enroll in...

	Anthem Blue Cross HMO and Anthem Blue Cross PPO	Kaiser Permanente HMO
Pharmacy		
Generic copay	$10 for up to 30-day supply	$10 for up to 30-day supply
Brand-name copay	**Formulary drug:** $20, up to 30-day supply **Non-formulary drug:** $40, up to 30-day supply	$20 for up to 30-day supply
Mail Order		
Generic copay	$20 for up to 90-day supply	$20 for up to 100-day supply
Brand-name copay	**Formulary drug:** $40, up to 90-day supply **Non-formulary drug:**$80, up to 90-day supply	$40 for up to 100-day supply
Annual Out-of-Pocket Copayment Maximum		
	$1,000/person – pharmacy and mail order combined	No annual maximum
For Questions		
On Retail Pharmacies	1-800-288-2539	Retail or mail order: 1-800-464-4000 or https://members.kaiserpermanente.org
On Mail Order	1-866-274-6825 or www.wellpointnextrx.com	

Some examples of expenses the prescription drug program does not cover include:

- Any over-the-counter drug (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
- Any drugs not purchased through a network pharmacy or mail order program.

VISION CARE

If you enroll in one of the Flex health plans, you also receive vision care benefits.

Benefit	Anthem Blue Cross HMO or PPO		Kaiser Permanente HMO
	In-Network	Out-of-Network	
One eye exam every 12 months	100% after $10 copay	Up to $49	100% after $10 copay
Lenses	One pair of lenses every 24 months:		Every 24 months, $200 eyewear allowance toward the purchase of covered lenses, frames and/or elective contact lenses
• **Single vision**	100% after $10 copay	Up to $35	
• **Bifocal**	100% after $10 copay	Up to $49	
• **Trifocal**	100% after $10 copay	Up to $74	
• **Progressive**	100% after $10 copay + $65	Up to $49	
One pair of frames every 24 months	Up to $130 retail value, then 20% discount	Up to $50	
Contacts (instead of frame and lens benefits)	Every 24 months:		
• **Non-elective***	100%	Up to $250	
• **Elective – conventional or disposable lenses**	Up to $130 retail value, then 15% discount	Up to $92	

* Required as the result of eye surgery or certain eye conditions.

To find an in-network Blue View Vision provider, go to my Flex at **www.myflexla.com** and click on the link to the Anthem Blue Cross Web site under "Contacts." Once there, choose "Find a Doctor" and then "HMO & PPO Vision Provider Finder."

CHIROPRACTIC CARE AND ACUPUNCTURE

Anthem Blue Cross HMO and Anthem Blue Cross PPO include coverage for chiropractic care and acupuncture – with some limitations on the number of visits covered each year. For the Anthem Blue Cross HMO, these services must be approved by your primary care physician or primary medical group. Contact Anthem Blue Cross Member Services if you have questions about coverage for chiropractic care and acupuncture.

Kaiser Permanente HMO does not cover chiropractic care and acupuncture, but member discounts on these services are available. For more information, go to www.kp.org/healthyroads.

CARE WHILE TRAVELING

Type of Care	Anthem Blue Cross HMO	Anthem Blue Cross PPO	Kaiser Permanente HMO
Emergency Care in the U.S.	• Covered 24 hours a day, 7 days a week • Go immediately to the closest emergency facility for medical attention • Emergency room copayment will be waived if you are admitted		
	Within 48 hours of admission, contact Anthem Blue Cross and your medical group at the numbers on your member ID card	Within 48 hours of admission, contact Anthem Blue Cross Review Center at the number on your member ID card	Call 1-800-225-8883 immediately if you are admitted to a non-participating hospital
Emergency Care outside the U.S.	Before traveling, call 1-800-810-2583 for a list of participating hospitals Always go to the closest emergency facility; request an itemized bill (in English) before leaving to file a claim for reimbursement		Go to the nearest emergency facility and call 1-800-225-8883 if you receive treatment. Request an itemized bill (in English)
Urgent Care	• In California: Go to the closest urgent care or emergency facility; if within 20 miles of your medical group, call first for a referral to the closest facility • Outside California but in the U.S.: Call number on member ID card for provider referrals	Go to the closest urgent care or emergency facility. Contact Member Services to locate the nearest network facility to receive in-network benefits	• Within service area, call appointment or advice nurse at number listed in Your Guidebook • Outside service area but in California, call 1-800-225-8883 for assistance
Prescription Coverage	• In the U.S.: Call WellPoint at 1-800-700-2541 to find a participating pharmacy that accepts your copayment • Outside the U.S.: Ask for an itemized bill (in English) and save your receipt to file a claim for reimbursement		• Within the service area, go to any Kaiser pharmacy • Outside the service area, only emergency/urgent prescriptions covered; ask for an itemized bill (in English) and save your receipt to file a claim for reimbursement

For more information, call your plan's Member Services number:

- Anthem Blue Cross HMO – 1-800-288-2539
- Kaiser Permanente HMO – 1-800-464-4000
- Anthem Blue Cross PPO – 1-800-288-2539

CARE FOR DEPENDENTS WHO DO NOT LIVE WITH YOU

Type of Care	Anthem Blue Cross HMO	Anthem Blue Cross PPO	Kaiser Permanente HMO
Routine care for a dependent who does not live with you	• In California: Select a PCP or PMG by calling Member Services • Outside California: Submit Guest Membership Application for access to network; if no network, only emergency/urgent care is covered	Contact Member Services to locate the nearest network providers for highest level of benefit coverage	Go to any Kaiser facility for covered care. If no Kaiser facility is available, only emergency/urgent care is covered

For more information, call your plan's Member Services number. For Anthem Blue Cross HMO Guest Membership assistance, call 1-800-827-6422.

5

THE EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Employee Assistance Program

The Employee Assistance Program (EAP) is designed to help you manage life's challenges – from crisis situations to everyday concerns. The City of Los Angeles EAP is administered by Managed Health Network (MHN).

How It Works

The EAP – which is confidential and voluntary – offers telephone and face-to-face counseling by licensed providers. You can call the EAP anytime – 24 hours a day, 7 days a week – toll-free at 1-800-213-5813. English and Spanish-speaking counselors are available. Any of your household family members can also use the EAP. This includes dependents who are away from home at college.

When you call, an EAP intake specialist will ask questions to assess your needs. You are eligible for unlimited telephone counseling and, if needed, up to five face-to-face sessions per issue at no cost to you.

After you have used all your available EAP benefits, charges for services will be your responsibility. The health plan you choose may provide mental health coverage. To receive benefits, however, you may be required to have a referral and use a participating network provider. If you receive counseling through the EAP, make sure you understand how many visits are covered. Contact your health plan for information on how that plan covers mental health services.

When to Call

The EAP can help you with crisis situations as well as everyday concerns. It's a good idea to call before a concern becomes a serious problem. The EAP can provide help with:

- Marriage, family and relationship problems, including domestic violence
- Stress and anxiety
- Alcohol and drug dependency
- Depression, grief or loss
- Legal concerns related to family law, divorce, real estate, wills and contracts, estate planning, criminal law, personal injury and consumer law
- Financial and credit issues, including budgeting, saving and pre-retirement planning
- Preparing for a baby's arrival, including special "Baby Kits"
- Child care and elder care assistance, including referrals to providers
- Federal tax consultation and representation related to an audit, late return or other IRS problem
- Referrals for travel, event planning and more
- Issues around identity theft
- Organizing important personal paperwork and financial records.

Harbor Department Employees

If you are a Harbor Department employee, you are not eligible for the Flex EAP. Instead, your EAP coverage is provided through a separate program of the Harbor Department. Please contact your Human Resources Division or 1-310-732-7678 (1-310-SEA-PORT) for more information about your EAP coverage.

Online resources

On the Web, go to www.members.mhn.com and type "cityoflosangeles" as the company code. You can:

- Search for an MHN counselor and get a referral
- Ask experts questions
- Use self-help programs for stress, depression, anxiety, and more
- Use estate planning tools

Dental Coverage

YOUR DENTAL COVERAGE CHOICES

You have a choice of three dental options administered by Delta Dental:

- Delta Dental Preventive Only covers preventive dental care that can help prevent problems. There is no coverage for other services like fillings, crowns and orthodontia. If you choose employee-only coverage under the Preventive Only option, you will get additional pre-tax Flex dollars of $2.50 a pay period – or $1.25 a pay period if you are a regular half-time employee hired after July 23, 1989.
- DeltaCare USA DHMO is a dental HMO; you choose a primary care dentist (PCD) and see this dentist first whenever you need care.
- Delta Dental PPO provides care through a network of dentists who have agreed to offer covered services at discounted rates.

A Dental Plan Comparison

Comparing...	Preventive Only	DeltaCare USA DHMO	Delta Dental PPO
Features a network of providers	Yes	Yes	Yes
Offers flexibility to use non-network providers	Yes	No	Yes - paid at out-of-network level
Covers preventive care	Yes	Yes	Yes
Covers services other than preventive care – such as basic and major services	No	Yes	Yes
Has a calendar year deductible	No	No	Yes
Has an annual maximum benefit	No	No	Yes
Includes set copayments for most services	No	Yes	No
Requires you to choose a primary care dentist	No	Yes	No
Covers emergency care outside the provider network*	No	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 1-800-765-6003 for PPO or at 1-800-422-4234 for DeltaCare USA DHMO.

** Contact your primary care dentist (PCD) or Delta Dental Customer Service at 1-800-422-4234 before receiving treatment. If you do not, you may be responsible for any charges related to treatment.

USE THE DELTA DENTAL NETWORK AND SAVE

If you enroll in the DeltaCare USA DHMO option, you must use network providers to receive benefits. With the Preventive Only option and the Delta Dental PPO, you can choose a network or non-network provider each time you need care. Here's how using the network helps you save with each option.

Preventive Only	DeltaCare USA DHMO	Delta Dental PPO
No charges above reasonable and customary (R&C) limits	Benefits paid for network services only	Plan pays highest level of benefit when you use network providers
Network providers offer discounted fees	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

Dentists who are not part of Delta's PPO network may still be Delta dentists and agree to accept Delta's R&C fee. In California, 92% of dentists belong to a Delta network.

Finding a Network Provider

You can request a provider directory for the Preventive Only, DeltaCare USA DHMO or PPO option by:

- Calling Delta Dental Customer Service at 1-800-765-6003 for Preventive Only and PPO or 1-800-422-4234 for DeltaCare USA
- Searching provider directories at **www.myflexla.com** by choosing "Enroll in Benefits or Make Changes," then "Provider Lookup" on the left side of the screen. You will be prompted to search providers and choose a PCD if you enroll in DeltaCare USA.

You can also go to **http://www.deltadentalins.com/enrollees/index.html** and select "Find a Dentist." Then, from the drop-down menu, choose DeltaCare USA for the DHMO option or Delta Dental PPO for the Preventive Only or PPO option.

Choosing a Primary Care Dentist (PCD)

If you enroll in DeltaCare USA DHMO, you must select a PCD from the DeltaCare USA network to receive benefits. When you enroll yourself or a dependent for the first time, you'll be prompted to select a PCD. If you want to change your PCD during the year, call Delta Dental Customer Service at 1-800-422-4234. Because the DeltaCare USA DHMO option does not cover care that is not coordinated by your PCD, it is important that you do not go to another dentist without first contacting Delta Dental Customer Service.

HOW TO REGISTER FOR AN ONLINE ACCOUNT

Online information

The site will provide a list of everyone you have enrolled in dental coverage, the assigned dentist for each person and the date of eligibility.

You can go online to verify your assigned dentist and other information, such as eligibility, your enrolled family members, claim status and benefit specifics by registering online.

- Go to www.deltadentalins.com/enrollees/index.html
- Select "Register for an online account" from the right side of the page
- Select "Enrollee" from the pull-down menu
- Enter your personal information.

HOW THE OPTIONS PAY BENEFITS

This chart shows how the three options pay for some covered services. If you have questions about how a specific service is covered, call Delta Dental at 1-800-765-6003 for Preventive Only and PPO or 1-800-422-4234 for DeltaCare USA. Please note: When you call Delta Dental, you may hear the recording refer to the Delta Vision Plan. City employees do not have coverage through the Delta Vision Plan.

How Benefits Are Paid	Preventive Only	DeltaCare USA DHMO	DeltaCare USA PPO	
			In-Network	Out-of-Network
Calendar year deductible	None	None	$25/person, $75/family	
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 (not covered by Preventive Only)	100% of R&C* (includes an additional oral exam and routine cleaning during pregnancy)	100% - Covers one series of four bitewing X-rays in any six-month period for children or adults	Cleanings, X-rays and exams; 100% with no deductible (includes an additional oral exam and either a routine cleaning or periodontal scaling and root planing during pregnancy paid at 80% after deductible)	Cleanings, X-rays and exams; 80% of R&C* with no deductible (includes an additional oral exam and either a routine cleaning or periodontal scaling and root planing during pregnancy paid at 80% of R&C* after deductible)
Basic Services				
• Amalgam fillings, extractions	Not covered	100% for fillings; you pay up to $90 for extraction	80%	80% of R&C*
• Root canal	Not covered	Your copay is $45-$205 per procedure	80%	80% of R&C*
• Periodontal scaling and root planing	Not covered	100% up to 4 quadrants in 12 months	80% once every 24 months	80% of R&C* once every 24 months

How Benefits Are Paid	Preventive Only	DeltaCare USA DHMO	DeltaCare USA PPO	
			In-Network	Out-of-Network
Major services				
• Crown	Not covered	Your copay is $55-$195 per procedure**	80%	80% of R&C*
• Dentures	Not covered	Your copay is $80-$170 per procedure	50%	50% of R&C*
• Implants	Not covered	Not covered	50%	50% of R&C*
Orthodontia				
• Children under age 19	Not covered	Your copay is $1,000 plus start up fees of $300	50%	50% of R&C*
• Children age 19 to age 26	Not covered	Your copay is $1,350 plus start up fees of $300	50%	50% of R&C*
• Adults	Not covered	Your copay is $1,350 plus start up fees of $300	Not covered	Not covered
Plan Maximums				
Annual maximum benefit	Not applicable	None	$1,500/person***	$1,250/person***
Lifetime orthodontia maximum benefit	Not applicable	None	$1,500/person	$1,500/person

* 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 the in-network maximum.

Accounts for Tax Savings

The City offers two types of accounts for tax savings on eligible expenses:

- A Healthcare Flexible Spending Account
- A Dependent Care Reimbursement Account.

When you enroll in either type of account, you set aside pre-tax dollars from your pay to cover either eligible healthcare or dependent day care expenses.

During the special mid-year enrollment, you cannot make changes to, or enroll in, the Healthcare Flexible Spending Account or the Dependent Care Reimbursement Account. If you are currently enrolled, your contributions will continue through December 31, 2011.

HOW THE ACCOUNTS ARE DIFFERENT

Healthcare Flexible Spending Account (HCFSA)

- Use it to reimburse yourself for eligible healthcare expenses for you and for your eligible dependents
- Eligible healthcare expenses include medically necessary expenses that are not covered by any medical, dental or vision plan

See page 39 for details.

Dependent Care Reimbursement Account (DCRA)

- Use it to reimburse yourself for day care expenses for your eligible dependents
- Eligible dependents generally include your dependent children under age 13 and a disabled spouse or dependent who is incapable of self-care

See page 40 for details.

Administrative Fee

If you choose to contribute to a Healthcare Flexible Spending Account and/or Dependent Care Reimbursement Account, a per pay period administrative fee of $2.25 will automatically be deducted from your paycheck. Only one administrative fee applies if you contribute to both accounts.

About Eligible Dependents for These Accounts

IRS rules determine who is an eligible dependent for these accounts. You may use a Healthcare Flexible Spending Account for healthcare expenses of:

- Your opposite-sex 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.

You may use a Dependent Care Reimbursement Account for day care expenses of:

- Any child under age 13 you claim as a dependent on your tax return
- Anyone age 13 or older who meets the IRS definition of "health plan tax dependent," lives with you for more than half the year, and is physically or mentally unable to care for themselves.

Definition

See "Domestic Partner Coverage and Pre-Tax Benefits" on page 15 for a definition of "health plan tax dependent."

FILING CLAIMS

Generally, you pay eligible healthcare and dependent care expenses out of your pocket first – then file a claim to be reimbursed from your account, including documentation of your expenses described on the claim form.

For the Healthcare Flexible Spending Account, 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 expenses you or an eligible family member have while you are contributing to the account.

For the Dependent Care Reimbursement Account, you may be reimbursed 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 **www.myflexla.com** and choose "Forms and Documents." Beginning in 2011, you can submit claims and upload receipts online and pay your provider directly for some services.

IMPORTANT DEADLINE

The Healthcare Flexible Spending Account and Dependent Care Reimbursement Account are not savings accounts. You can use the money you set aside in 2011 only for eligible expenses you have during the 2011 plan year while you are contributing to the account. If you have unused contributions at the end of the plan year, those contributions will not carry forward. Also, if you leave your employment with the City mid-year – including transfers to the Department of Water and Power (DWP) – you can file claims and receive reimbursement only for expenses you had up to your date of termination or transfer, and you will forfeit any additional amount left in your account. You may be able to continue a Healthcare Flexible Spending Account under COBRA if your employment ends, with some limitations. You must file claims for 2011 expenses by April 30, 2012. If you do not file claims by this deadline, you forfeit any money left in your account. This is an IRS rule and the Flex program cannot make exceptions.

HOW THE ACCOUNTS HELP YOU SAVE ON TAXES

When you enroll, you decide your annual contribution to a Healthcare Flexible Spending Account and/or a Dependent Care Reimbursement Account. You contribute to the account(s) with pre-tax dollars deducted from your paycheck, so no federal or state taxes are taken from your contribution.

Take a look at how tax savings could work for one expense. Assume you:

- **Are in the 15% federal income tax bracket**
- **Have an eligible expense of $150.**

Your true cost for that $150 expense will be:

$176	**$150**
…with after-tax dollars	**…with pre-tax dollars**

With the pre-tax advantage, you increase your buying power because the entire $150 you put into the account goes to meet your needs. If you pay the same expense with after-tax dollars, you must actually earn $176 to take home $150 after taxes for this expense.

ESTIMATE EXPENSES CAREFULLY

Estimating expenses and tax savings

To estimate your annual expenses and the tax savings of setting up a Healthcare Flexible Spending Account and/or a Dependent Care Reimbursement Account, go to **www.myflexla.com** and click "Enroll in Benefits or Make Changes." Under "From here, you can," you'll find links to a calculator for each account.

It is important to estimate expenses carefully and set aside only the amount you think you will need while you are contributing to the account during 2011.

Because these accounts offer tax advantages, the Internal Revenue Code provides rules for how they can work. You can change the amount you are contributing during the year only in certain circumstances. The following chart provides an overview.

When you may be able to change the amount elected:	Healthcare Flexible Spending Account Examples	Dependent Care Reimbursement Account Examples
A family status change (see "When You Can Make Changes" on page 20 for more on family status change)	You have a family status change such as getting married or divorced or having a baby	A spouse who was working is no longer working and can care for your child
A change in day care providers	Does not apply	In the summer, your child begins a new all-day program that is more expensive than previous care
A change in cost of day care	Does not apply	Your day care center increases costs during the year – or you take your child out of day care temporarily

Changing contributions

To make a change in your contribution, you must go online to **www.myflexla.com** or call 1-800-778-2133 within 30 calendar days of the event that is the basis for your change.

ABOUT THE HEALTHCARE FLEXIBLE SPENDING ACCOUNT

Use the Healthcare Flexible Spending Account to pay for eligible healthcare expenses that are not covered by any medical, dental or vision coverage.

How Much You Can Set Aside

You can set aside from $300 up to $4,992 annually in a Healthcare Flexible Spending Account. Your contributions are deducted from your paycheck each pay period.

Your Expenses

The Healthcare Flexible Spending Account Can be Used to Pay for:	The Healthcare Flexible Spending Account CANNOT be Used to Pay for:
• Acupuncture • Chiropractic services • Crutches and wheel chairs • Eye exams, eyeglasses • Laser eye surgery • Hearing aids • Lamaze classes • Mental health and substance abuse treatment • Orthodontia • Copayments, coinsurance and deductibles you pay out of your pocket for medical, prescription drug, dental and vision care • Over-the-counter medications with a doctor's prescription and insulin	• Cosmetic surgery or procedures, including teeth whitening or bleaching • Your per-pay-period 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 • Nutritional supplements, including vitamins taken for general health • Over-the-counter medications without a prescription, saline solutions and contact lens cleaner, and other over-the-counter products, such as cosmetics, medicated shampoos and soaps, topical creams and toiletries

Over-the-counter medications

Due to healthcare reform, over-the-counter medications without a prescription (other than insulin), saline solutions and contact lens cleaner are no longer allowed expenses.

Go to **www.wageworks.com** to view a complete list of eligible expenses. Click "Eligible Expenses" under "Participants/Employees." Look under the "Standard FSA" column.

Debit Cards

A Convenient Way to Access Money in Your Healthcare Flexible Spending Account

You will automatically receive a debit card to use for eligible healthcare expenses at any provider or retailer that accepts debit cards.

ABOUT THE DEPENDENT CARE REIMBURSEMENT ACCOUNT

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 health plan tax dependent requirement, 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 spouse or 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.

Under IRS rules, to be reimbursed through your account, day care must be provided by a person you can give a Social Security number for or 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 $4,992 annually in a Dependent Care Reimbursement Account. 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. And 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 $4,992.

Based on your tax status...	You can set aside...
If single or married filing jointly	Up to $4,992
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

Estimate expenses carefully

Any money left in your account after the plan year claim deadline – April 30, 2012 – will be forfeited. To estimate annual expenses, go to **www.myflexla.com** and click "Enroll in Benefits or Make Changes." Under "From here, you can," you will find links to a calculator.

About the Reimbursement Account and Taxes

As you consider a Dependent Care Reimbursement Account, think about what works best for you – the reimbursement account or the dependent care tax credit provided by federal law. It is 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.

Generally, you will save more on federal taxes using the Dependent Care Reimbursement Account in these situations:

- You are eligible for the Earned Income Tax Credit if you have less than $3,100 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 in the following table depending on your number of children:

Number of children	Income less than...
1	$35,535 ($40,545 if married filing jointly)
2	$40,363 ($45,373 if married filing jointly)
3 or more	$43,353 ($48,362 if married filing jointly)

- You are single, you file your taxes as head of household and your household taxable income is over $45,550.
- You are married, you file a joint return and your household taxable income is over $68,000.

Dollar amounts are based on federal tax law effective for 2010 federal income taxes. These are just guidelines and do not take into account state taxes, which might affect your decision.

If you have questions about tax savings, you may want to consult a tax advisor.

Life Insurance

LIFE INSURANCE FOR YOU

Because life insurance offers important financial protection for families of civilian City employees, the Flex program provides core coverage of $10,000 in basic life insurance at no cost to you. If you are a regular half-time employee hired after July 23, 1989, you have $5,000 in basic coverage provided at no cost to you. If you are a regular half-time employee hired before July 24, 1989, please refer to your MOU's Benefits Section for information on your coverage amount.

To help you put together a package of benefits that meets your personal needs, Flex lets you buy supplemental life insurance for yourself with pre-tax dollars from your pay. You decide whether you want this additional protection – and how much you need. See "Your Cost for Supplemental Life Insurance" on page 44 for life insurance rates.

YOUR SUPPLEMENTAL LIFE INSURANCE CHOICES

You can choose from these coverage levels:

- One times annual base pay
- Two times annual base pay
- Three times annual base pay
- Four times annual base pay
- Five times annual base pay

…up to a maximum of $1,000,000.

Your supplemental life insurance amount will be a multiple of $1,000. If the coverage level you choose times your pay does not equal a multiple of $1,000, the amount will be rounded up. Here is an example for an employee who chooses coverage of four times pay:

Employee's pay	$43,552
multiplied by	× 4
equals	$174,208
	Rounded to $175,000 coverage amount

Online Calculator

Use the online calculator under "Enroll in Benefits or Make Changes" at **www.myflexla.com** to help you determine how much life insurance you need.

An Important Note About Reductions Based on Age

Life insurance amounts for you (basic and supplemental) and your spouse/domestic partner are reduced based on age. From age 65 to 69, coverage amounts will be reduced to 65%. At age 70, coverage amounts will be reduced to 35%. The reduction is effective on the first day of the month of your 65th or 70th birthday for your basic and supplemental life insurance coverage and the first day of the month of your spouse/domestic partner's 65th or 70th birthday for spouse/domestic partner dependent life insurance coverage. Those employees in MOUs 00, 31,32, and 36 have additional basic life benefits that will be reduced to 50% at age 70.

For example, assume an employee with pay of $52,280 chooses supplemental coverage of three times pay. The employee has $10,000 in basic coverage and $157,000 in supplemental coverage ($52,280 x 3, rounded up). At age 65, coverage is reduced to:

- Basic coverage – $6,500 (.65 x $10,000)
- Supplemental coverage – $102,050 (.65 x $157,000)

Assume the same employee's spouse/domestic partner has a coverage amount of $100,000. At age 65, coverage is reduced to:

- Dependent coverage – $65,000 (.65 x $100,000)

Dependent Life Insurance Coverage Limits

Dependent life insurance coverage for your spouse/domestic partner cannot be more than your total life insurance coverage (basic and supplemental). If your life insurance coverage is reduced based on your age, coverage for your spouse/domestic partner may be affected. For more about dependent life insurance, see page 47.

About Portability and Conversion

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

Portability

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

Conversion

If your coverage ends or reduces for any reason except failure to pay premium or payment of an Accelerated Benefit, you can convert your life insurance to an individual policy without evidence of insurability. Because group rates will no longer apply, this individual conversion policy will cost substantially more than coverage you have as a City employee through Flex.

Conversion is the only option available if you do not qualify for portability.

What You Need to Do

To select portable coverage or to convert coverage, you must complete a form available online at **www.myflexla.com** under "Forms and Documents" or from the Employee Benefits Division and submit the form to the Employee Benefits Division within two weeks of the date your coverage or employment ends, whichever is earlier.
Call 213-978-1655 for more information.

Your Beneficiary

You can name anyone as the beneficiary of your basic and supplemental life insurance. If you have had a recent change in your family status – such as marriage or divorce – you may need to update your beneficiary. Keep in mind that if you have not done so, you will need to name a beneficiary for the basic life insurance coverage the City provides – even if you do not choose supplemental coverage. It is important to name a beneficiary so benefits can be paid to the person of your choice if you were to die.

To name or update your beneficiary information, go to "Forms and Documents" at **www.myflexla.com** or call the Benefits Service Center.

An Accelerated Benefit

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

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

YOUR COST FOR SUPPLEMENTAL LIFE INSURANCE

Here are the 2011 rates for supplemental life insurance for each $1,000 in coverage. The personal fact sheet you receive for enrollment or as a new hire shows your coverage cost.

Age on 9/1/10	Rate per $1,000 of coverage
Under 20	$0.046
20 – 24	$0.046
25 – 29	$0.054
30 – 34	$0.072
35 – 39	$0.082
40 – 44	$0.090
45 – 49	$0.126
50 – 54	$0.198
55 – 59	$0.370
60 – 64	$0.540
65 – 69	$1.101
70 or above	$1.786

Active Work Requirement

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

About Life Insurance and Imputed Income

Under federal tax law, you are taxed on the value of employer-provided life insurance over $50,000. Benefit amounts in excess of $50,000 of employer-paid basic term life and employee-paid supplemental life might both be considered employer-sponsored and therefore subject to being taxable as imputed income. If your basic life insurance plus your supplemental life insurance gives you coverage above $50,000, imputed income will be shown on your pay stub each pay period and included in your W-2 statement as taxable income. Members should consult their tax advisors for more information.

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

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

IRS table for calculating imputed income:

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

PROOF OF GOOD HEALTH

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

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

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

If you choose coverage that requires proof of good health, you will receive an Evidence of Insurability form with the confirmation statement you receive in the mail. You must complete and return this form as soon as possible, and it must be approved by the insurance company before your coverage change takes effect. If proof of good health has not been provided within six months of your enrollment for any coverage requiring it, any pending coverage will be removed from your benefits account and the City will send a confirmation statement of this change to you. If the insurance company approves coverage for you after the six-month period, your coverage will become effective on the date of approval. The City will not make payroll deductions until the insurance company provides a date of approval.

The Evidence of Insurability form is available on **www.myflexla.com** under "Forms and Documents."

DEPENDENT LIFE INSURANCE

If you choose supplemental life insurance for yourself, you can choose to purchase dependent life insurance coverage for your spouse/domestic partner, your children, or both.

For your spouse/domestic partner...	For your children...
A choice of: • $10,000 • $25,000 • $50,000 • $75,000 • $100,000	• $5,000 per child A newborn dependent child becomes eligible for life insurance at the age of 14 days. Children are eligible up to age 26.

Under California law, the spouse/domestic partner coverage you choose cannot be more than your total life insurance coverage (basic plus supplemental). So, if you want to purchase $50,000 in spouse/domestic partner life insurance, you must have at least $50,000 in Flex life insurance.

- If you are currently enrolled in Flex, you will have to provide proof of good health – or evidence of insurability – for your spouse/domestic partner if you are purchasing spouse/domestic partner life insurance for the first time or increasing coverage during the special mid-year enrollment.
- If you are enrolling for the first time as a new hire within the time shown on your personal enrollment fact sheet, proof of good health is not required for spouse/domestic partner life insurance. During future enrollments, proof of good health will be required to enroll in spouse/domestic partner life insurance for the first time or to increase coverage.
- For coverage changes during the year because of a family status change, proof of good health is required for spouse/domestic partner insurance – unless you are adding a spouse/domestic partner within 30 calendar days of marriage or beginning a domestic partner relationship.

If you choose coverage that requires proof of good health, you'll receive an Evidence of Insurability form with the confirmation statement you receive in the mail. When you receive the form, you must complete and return it. This form must be approved by the insurance company before your coverage change takes effect. You can also download the form from **www.myflexla.com** under "Forms and Documents."

About Portability and Conversion

Portability: If you choose portable coverage for your basic and supplemental life insurance when your City employment ends, you may also take any dependent coverage with you as portable coverage if your dependents meet the age requirements. Your spouse is eligible up to age 65 and any children are eligible up to age 26.

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

Beneficiary for dependent life insurance

If you enroll your family members for life insurance coverage, you will automatically be the beneficiary of that coverage.

Reductions Based on Age

See page 43 for an important note about reductions of life insurance coverage amounts when your spouse/domestic partner becomes age 65 or older.

Selecting portable or conversion coverage

To select portable or conversion coverage, you have 60 days from the date your employment or dependent coverage ends to complete a form available online or from the Employee Benefits Division and submit it to The Standard. See "About Portability and Conversion" on this page for more on portability and conversion.

AD&D Insurance

Accidental Death and Dismemberment (AD&D) is available at additional cost to you. AD&D insurance pays a benefit to you if you suffer a covered loss or to your beneficiary if you die in an accident. Flex gives you a choice of AD&D insurance for yourself only, or for you and your family.

If you want coverage for yourself, you can choose any amount between $50,000 and $500,000, in multiples of $50,000. AD&D pays a percentage of your total coverage amount for injuries, depending on the type of injury. For your accidental death, AD&D pays 100% of your coverage amount, plus an additional $3,000 – up to a maximum of $503,000.

The AD&D insurance certificate of coverage is available online at **www.myflexla.com** under "Forms and Documents" or from the Employee Benefits Division. It provides a detailed list of covered losses, benefit amounts and additional features.

If you cover yourself, you can also cover your family. Coverage amounts for your family members will depend on the amount of coverage you choose for yourself and on your family make-up. If you choose family coverage, you will be covering all Flex-eligible persons in your family, not just those who are covered as dependents under your benefits.

If your family includes...	AD&D benefit equals...
Spouse/domestic partner only	60% of the amount you selected for yourself
Eligible children only	20% of the amount you selected for yourself for each child
Spouse/domestic partner and eligible children	50% of the amount you selected for yourself for your spouse/domestic partner and 10% of the amount you selected for yourself for each child

From age 65 to 69, your AD&D coverage will be reduced to 65% of your selected coverage amount. At age 70, your AD&D coverage will be reduced to 35% of your selected coverage amount.

If your coverage or your employment with the City ends, you have the option to take your AD&D coverage with you. To select this portable coverage, you have 60 days from the date your employment ends to complete a form available online at **www.myflexla.com** under "Forms and Documents" or from the Employee Benefits Division and submit it to MetLife.

Beneficiary for AD&D Insurance

- Your beneficiary for AD&D will be the same as your life insurance beneficiary.
- You will automatically be the beneficiary of any family AD&D insurance you choose.

Keep in mind that you can go to **www.myflexla.com** and choose "Forms and Documents" or call the Benefits Service Center to make a new beneficiary designation during annual enrollment.

Benefits for your spouse and children

If you die by accidental means due to either an on-the-job accident or a non-occupational accident, your AD&D insurance provides special benefits to your family in addition to your coverage amount. These may include education benefits for your spouse and child and child care benefits in some cases. For more information, contact MetLife at 1-800-638-6420.

Disability Coverage

BASIC AND SUPPLEMENTAL DISABILITY COVERAGE

Basic disability coverage is provided at no cost to you. If you want additional financial protection in case of a disability, you can purchase supplemental coverage. The supplemental coverage pays a higher monthly benefit than basic coverage – and supplemental disability benefits are payable beyond the 24-month limit (STD and LTD combined) for basic disability coverage if you remain disabled. While rates for supplemental disability coverage are not changing, your cost may increase because of your age and your annual salary at the time that enrollment costs are calculated.

This summary is not intended to provide a detailed description of coverage. Please refer to your Certificate of Insurance for more information, including definitions, exclusions, limitations and terminating events.

	Benefit	When Benefits Begin	How Long Benefits Last
Basic disability coverage	50% of pre-disability earnings, up to $2,998 a month*	When 100% and 75% sick leave is completely used and you apply for benefits and are approved	Up to 24 months of disability
Supplemental disability coverage	66 2/3 % of pre-disability earnings, up to $12,000 a month*	When 100% and 75% sick leave is completely used and you apply for benefits and are approved	Generally, until you are no longer disabled or age 65, whichever is earlier**

* Benefits may be reduced by income you receive from other sources.

** LTD benefits last up to 18 months during your entire lifetime for disabilities related to a mental disorder, alcohol use, alcoholism or drug use or drug addiction.

About Your Basic and Supplemental Disability Benefits

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

Disability Retirement Income

For employees who have five or more years of continuous City service, Standard Insurance Company (The Standard) is required to notify you that the opportunity to file for disability retirement is limited to individuals who were paid by their employing department within the last six months prior to filing. In addition, disability retirement income may cause a reduction in disability benefits from Standard Insurance Company.

Definition of Disability

For short-term disability (STD) benefits – your first 180 days of disability after exhausting 100% and 75% sick leave – you are disabled if:

- You are unable to perform with reasonable continuity the material duties of your own occupation because of sickness, injury or pregnancy, or
- You are working and you are unable to earn more than 80% of your pre-disability earnings because of sickness, injury or pregnancy.

For long-term disability (LTD) benefits – the benefits you receive after you have exhausted all sick leave and been disabled for 180 days beyond the exhaustion of your 100% and 75% sick leave – you are disabled if because of physical disease, injury, pregnancy or mental disorder:

- For the first 24 months of LTD benefits –
  - – You are unable to perform with reasonable continuity the material duties of your own occupation, or
  - – You are working in your own occupation, and you are unable to earn at least 80% of your pre-disability earnings.
- After 24 months – you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience – or you are able to work in an occupation, and you are unable to earn at least 66 2/3% of your pre-disability earnings in that or any other occupation for which you are reasonably fitted by education, training or experience.

For more details, see your Certificate of Insurance, available from the Employee Benefits Division or online at **www.myflexla.com** under "Forms and Documents."

Disability Benefits Require Approval

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

Taxes and Your Disability Benefits

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

Benefits under the supplemental plan are less than 100% taxable and only taxable for the first 18 months that you receive benefits. The taxable percentage under the supplemental plan will vary depending on your pre-disability earnings. The explanation of benefits you receive with your disability check will reflect the amount of benefits that are considered taxable.

Active work requirement

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

PROOF OF GOOD HEALTH

If you are currently enrolled in Flex and are choosing supplemental disability coverage for the first time during the special mid-year enrollment, you will have to provide proof of good health to become insured. Proof of good health is not required if you are enrolling for the first time as a new hire within the time shown on your personal enrollment fact sheet, but it will be required to enroll in disability coverage for the first time during future enrollments. For coverage changes during the year because of an eligible family status change, proof of good health is not required.

To provide proof of good health, you will receive a Medical History Statement after enrollment. This Medical History Statement is also available online at **www.myflexla.com** under "Enroll in Benefits or Make Changes" on the left side of the screen. Your completed form must be approved by the insurance company before your coverage takes effect. If any required proof of good health has not been provided within six months of your enrollment, any pending coverage will be removed from your benefits account, and the City will send a confirmation statement of this change to you. If Standard Insurance Company approves coverage for you after the six-month period, your coverage will become effective on the date of approval. The City will not make payroll deductions and your supplemental coverage will not become effective until the insurance company provides a date of approval.

Benefit Protection Plan

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

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

Definition of Pre-Disability Earnings for Disability Coverage

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

Disability Coverage and Pre-Existing Conditions

Long-term disability benefits are not payable for a disability caused or contributed to by a pre-existing condition until you have been enrolled for coverage for at least 12 months and are actively at work at the end of those 12 months or you have been without treatment for the pre-existing condition for six months. Long-term disability benefits are the benefits you receive after you have exhausted all of your 100% and 75% sick leave and been disabled for an additional 180 days – and have applied for benefits and been approved. A pre-existing condition is a mental or physical condition causing or contributing to your disability for which you have consulted a doctor, been treated or taken prescription drugs during the 90 days before coverage takes effect.

Other Benefits to Consider

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

Benefit Exclusions

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

FILING A DISABILITY CLAIM

If you have a disabling condition that may use up your 100% and 75% sick leave, contact the Employee Benefits Division as early as possible to find out what you will need to do to file a claim. It takes a minimum of one week to process a disability claim so approved payments can begin. Generally, you will receive a claim package with forms to be completed by you, your doctor and the City – plus an authorization form allowing Standard Insurance Company to contact your doctor for more information. Once Standard receives your completed forms, the review process will begin. Approval may take longer if more information is needed. By starting the process early, you can allow yourself time to complete the paperwork and avoid a lengthy gap in income between the time your sick leave ends and the time disability benefits begin.

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

Sick Leave and Disability – What's the Difference?

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

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

Your Flex Benefits and Changes

Leave, Disability or Work Schedule Changes

When benefits end

If you were compensated for the minimum required hours based on your status, benefits end the last day of the pay period. If you were not compensated for the required minimum hours, benefits end the day after your last day of work.

YOUR BENEFITS CAN BE AFFECTED WHEN...

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

Your Flex benefits end on the last day of the pay period or the day after your last day of City service. You may be able to continue:

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

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

Your Work Schedule Changes

You may be eligible for Flex benefits if your work schedule falls below 40 hours a pay period if you are a full-time employee – or below 20 hours a pay period or the amount specified in your MOU if you are a half-time employee. You are no longer eligible, however, to receive the City subsidy toward health and dental coverage, basic life insurance or basic disability. You can continue Flex benefits by paying the entire cost. In this case, you will be billed by the Employee Benefits Division. Your payment must be received within 15 days of the date of the billing letter or benefits will end.

If, in the same calendar year, you return to working the required number of hours, you will need to contact the Employee Benefits Division at 213-978-1655 to request reinstatement of your Flex coverage.

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

About Continuation Coverage

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

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

Life insurance and AD&D coverage may be continued through portability and/or conversion. You have 60 days from the date coverage ends to submit the required form to The Standard or MetLife. See "Life Insurance for You" on page 42 for more information.

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

You Are Disabled

Your Flex disability coverage will continue if you are out for a disability approved by Standard Insurance Company. If you are on an approved disability, the Benefit Protection Plan allows you to continue the Flex health, dental and basic life insurance you had as an active employee for up to two years of disability. While you are covered by the Benefit Protection Plan, the City subsidy continues, so you pay only the coverage cost you paid as an active employee. Participation in the Benefit Protection Plan ends if you retire or leave City service for any reason.

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

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

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

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

Benefits while on leave or in non-pay status

Healthcare Flexible Spending Account and Dependent Care Reimbursement Account contributions and disability coverage cannot be continued while you are on leave or in non-pay status.

You Begin Receiving Workers' Compensation (State Rate) Benefits

If State Rate is supplemented with at least 40 hours of sick, vacation or overtime (CTO) in a two-week pay period (20 hours of compensation in a two-week pay period for half time employees), the City will continue to pay for benefits. Please contact your Department Personnel Section for further details on this program.

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

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

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

You Retire from the City

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

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

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

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

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

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

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

Deferred Compensation Plan

The City of Los Angeles Deferred Compensation Plan helps you build financial resources for your future by saving pre-tax dollars today. This is a voluntary benefit offered in addition to Retirement System benefits.

Plan Highlights

The Deferred Compensation Plan features:

- Tax-deferred contributions and earnings
- Easy automatic payroll deductions
- A wide range of investment options
- Professional, personalized assistance

Tax Benefits

All of your contributions to the plan are made with pre-tax dollars – before federal and state taxes are withheld – so every cent of every dollar goes to work for you. Earnings grow tax-deferred as well. You do not pay taxes until your account is paid out to you.

Contributing through Payroll Deductions

You decide how much you wish to contribute to the plan. You can contribute as little as $15 per pay period, with a maximum contribution of $16,500 annually in 2010 ($22,000 if you are age 50 or older). These limits may increase in future years.

Investment Choices

The Plan offers a wide variety of investment options – from more conservative savings options to more aggressive stock mutual funds – so you can choose the investments that work best for you. You are free to change your investment choices at any time. In addition to a core menu of investment options, a brokerage window through Charles Schwab is available offering access to a wider universe of choices.

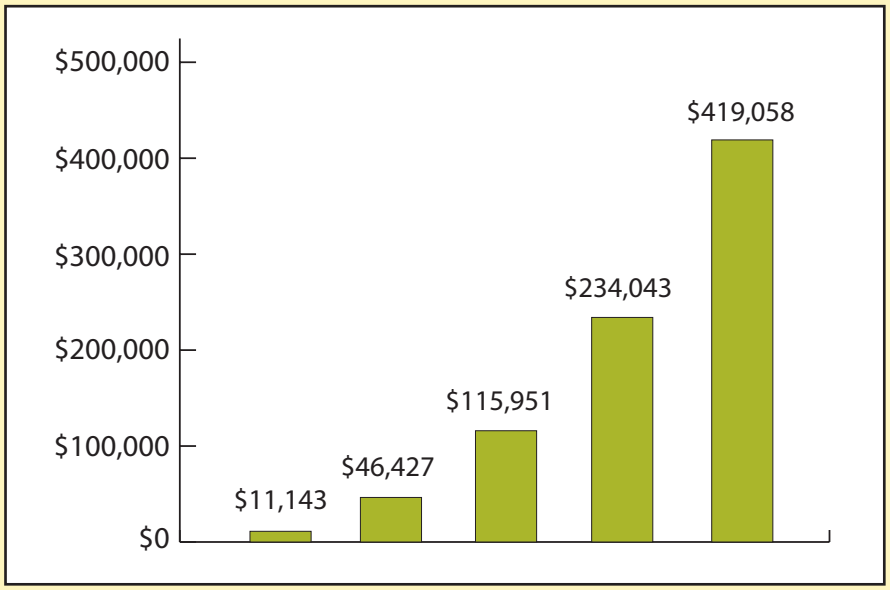
Plan Administration

The Plan is governed by the City's Board of Deferred Compensation Administration and administered by Great-West Retirement Services. Great-West offers local personalized assistance, low administrative costs, state-of-the-art account services through their toll-free line and Web site, and quarterly account statements so that you can track your investments.

Let Time Work for You

Retirement planning has become more important than ever. The Deferred Compensation Plan can put time on your side through tax-advantaged investing. The earlier you begin, the more your savings grow.

If you are not participating in the Plan, enrolling and beginning by contributing even a small amount is the most important step. Then try to increase your contributions on a regular basis.



This example shows how an account can grow if you contributed $25 per paycheck and increased your contribution by $25 a paycheck every year over a 25-year career.

This example is illustrative only and does not represent the performance of any investment options. It assumes 26 pay periods, a 7% rate of return, a $25 increase in contributions per pay period each year, an estimated federal income tax bracket of 25% and no withdrawals. Any charges, expenses or fees that may be associated with the Plan are not reflected.

How to Enroll

You can contact Great-West at 1-888-466-0381 to request enrollment materials or to ask questions about the Plan. You can also enroll in person at the Deferred Compensation Plan Service Center located in the Employee Benefits Division, Room 867 City Hall, Monday through Friday from 8 a.m. to 4 p.m. To learn more about the Plan online, go to **https://cityofla457.gwrs.com/**.

Important Legal Notices

Women's Health & Cancer Rights Act

As required by federal law, all Flex health plan options cover reconstructive breast surgery needed after mastectomy surgery, and reconstruction of the other breast to produce a symmetrical appearance, as well as prostheses and treatment of any physical complications of the surgery. These services are covered in the same way as other surgery and services under each option.

About Hospital Stays for Mothers and Newborns

Health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). 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).

Privacy and Your Health Coverage

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require that the Flex health plans periodically remind you about the availability of the privacy notice and how to obtain that notice. The privacy notice explains your rights and the plans' legal duties with respect to personal health information and how the Flex health plans may use or disclose your personal health information.

To obtain a copy of the privacy notice or for any questions about the plans' privacy policies, please contact the Employee Benefits Division at 213-978-1655. You can also go online at **www.myflexla.com** and select "Forms and Documents" to view a copy of the notice.

PCP Designations and OB/GYN Visits in the Anthem Blue Cross HMO

The Anthem Blue Cross HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the 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 primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For information on how to select a primary care provider, and for a list of the participating primary care providers and health care professionals who specialize in obstetrics or gynecology, contact Anthem Blue Cross at 1-800-288-2539.

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed on page 60, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

13 IMPORTANT LEGAL NOTICES

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 April 16, 2010. You should contact your state for further information on eligibility.

ARIZONA – CHIP	MASSACHUSETTS – Medicaid and CHIP
Website: http://www.azahcccs.gov/applicants/default.aspx Phone: 1-877-764-5437	Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120
ARKANSAS – CHIP	MISSOURI – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944
CALIFORNIA – Medicaid	MONTANA – Medicaid
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
COLORADO – Medicaid and CHIP	NEVADA – Medicaid and CHIP
Medicaid Website: http://www.colorado.gov/ Medicaid Phone: 1-800-866-3513 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
FLORIDA – Medicaid	NEW YORK – Medicaid
Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
GEORGIA – Medicaid	OREGON – Medicaid and CHIP
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678
IDAHO – Medicaid and CHIP	TEXAS – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493
KENTUCKY – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
LOUISIANA – Medicaid	WASHINGTON – Medicaid
Website: http://www.la.hipp.dhh.louisiana.gov Phone: 1-888-342-6207	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-877-543-7669

To see if any more States have added a premium assistance program since April 16, 2010, or for more information on special enrollment rights, you can contact either:

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

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

Plan/Program/Contact	Web Site	Phone Number
Anthem Blue Cross HMO health plan	www.anthem.com/ca/cityofla	1-800-288-2539
Kaiser Permanente HMO health plan	http://my.kp.org/ca/cityofla/	1-800-464-4000
Anthem Blue Cross PPO health plan	www.anthem.com/ca/cityofla	1-800-288-2539
Delta Dental PPO or Preventive Only	www.deltadentalins.com/enrollees/index.html	1-800-765-6003
DeltaCare USA DHMO	www.deltadentalins.com/enrollees/index.html	1-800-422-4234
Employee Assistance Program	www.members.mhn.com (company code "cityoflosangeles")	1-800-213-5813
Healthcare Flexible Spending Account or Dependent Care Reimbursement Account	www.wageworks.com	1-888-295-5656 (for 2010 accounts) 1-877-924-3967 (for 2011 accounts)
MetLife AD&D insurance	No City-related plan information	1-800-638-6420
The Standard Insurance Company: life insurance and disability insurance	No City-related plan information	1-800-524-0450 for general questions 1-800-368-2859 for evidence of insurability
Benefit Service Center	**www.myflexla.com** to enroll or make changes to your Flex benefits	1-800-778-2133 or 1-800-735-2922 if hearing or speech impaired (Monday – Friday, 8 a.m. to 5 p.m. Pacific time)
Employee Benefits Division	**www.myflexla.com** or send e-mail to per.EmpBenefits@lacity.org	213-978-1655 (Monday through Friday, 8 a.m. to 4 p.m. Pacific time)

Other Contacts

Plan/Program	Web Site	Phone Number
City retirement benefits	www.lacers.org	213-473-7200 or 1-800-779-8328
Deferred compensation program	https://cityofla457.gwrs.com	1-888-466-0381 (Great West) or 213-978-1655 (Employee Benefits Division)
Parking/Transit reimbursement/ Rideshare programs	www.lacity.org/per/commuter.htm	213-978-1655
City Employees Club of Los Angeles	www.cityemployeesclub.com	213-620-0388
All City Employees Benefits Services Association	http://www.acebsa.org	213-485-2485
City MOUs	http://www.lacity.org/cao/mous/	213-978-7676

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