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HEALTH | FINANCIAL PROTECTION | WELL-BEING

City of Los Angeles

Flex Enrollment 2014

October 1 - 31 at www.myflexla.com

my FLEX | Benefits

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. See page 65 for more information.

This guide is published by the City of Los Angeles Joint Labor Management Benefits Committee. It provides only highlights of the Flex program. 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 2014 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.

September 2013

In This Guide

State premium assistance programs

See page 63 for a notice about state premium assistance programs funded by Medicaid and the Children's Health Insurance Program.

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.)

Annual Enrollment – October 1 - October 31

Annual enrollment is your opportunity to make the most of the Flex benefits program.

There are many tools and resources to help you take advantage of all your Flex coverage has to offer. Start by reading this guide and keeping it as a reference throughout the year. It's important to understand your benefits and how they work to make the best choices for you and your family.

To check health coverage costs for 2014, see page 9.

Choose the Best Options for You

You must go online and enroll during the enrollment period — October 1 - October 31 — if:

- You want to change any of your benefit choices or covered dependents.
- You want to participate in a Health Care Flexible Spending Account or Dependent Care Reimbursement Account for 2014.

New! for 2014

- Blue Shield plans replacing Anthem plans **Page 22**
- Updated health coverage costs **Page 9**

Be sure to make the necessary changes to your benefit options by the deadlines specified and comply with the documentation requirements.

Important Deadlines

Enrollment Period	October 1- October 31, 2013
Last Day to Make Changes	October 31, 2013
Documentation Deadline	December 13, 2013

Under Health Care Reform, nearly everyone will be required to have medical coverage for 2014 or pay a penalty. This is called the "individual mandate." If you enroll in Flex medical benefits, you meet the individual mandate. To learn more about Health Care Reform, go to www.myflexla.com. To learn more about the new health insurance marketplace, visit www.coveredca.com or call 1-888-975-1142.

Your 2014 Benefit Options

As an eligible City civilian employee, you are eligible for benefits that support your health, help you grow and protect your finances, and help you balance life and work. Here is an overview of all your benefit options, including Flex and other benefits.

Health Coverage (Medical, Vision, Prescription Drug)*
- Blue Shield Access+ HMO SaveNet (Narrow)
- Blue Shield Access+ HMO (Full) (except MOUs 22, 23, 24, 25 or 30)
- Kaiser Permanente HMO
- Shield Spectrum PPO
- **New!** Blue Shield replaces Anthem for 2014

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

Employee Assistance Program (EAP)**
- Available 24/7

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

Spending Accounts
- Healthcare Flexible Spending Account
- Dependent Care Reimbursement Account
- Commuter Spending Accounts

* 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 9-13 of this guide and refer to your personal enrollment worksheet for more information.

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

What to Do Now

Each year during annual 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.

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.

Removing a dependent from coverage

If you want to remove a dependent from Flex coverage, you must call the Benefits Service Center at 1-800-778-2133. You cannot go online to remove a dependent from coverage. You must call the Benefits Service Center to make this change.

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 annual enrollment. If you are enrolled in an Anthem health plan,go to **www.myflexla.com** to learn more about Blue Shield.

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 or participate in a Healthcare Flexible Spending Account or Dependent Care Reimbursement Account for 2014. Note: If you are enrolled in an Anthem HMO health plan and you do not go online to enroll, you will be enrolled automatically in the Blue Shield plan that is similar to your current plan. See "Enrollment Highlights" in your package for details.

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.

During annual enrollment, Benefits Service Center representatives will be available until 7 p.m. on October 31 – the last day of enrollment.

8 Things You Need to Know about Flex Coverage

1 Make your 2014 Flex choices to ensure you have the coverage you want.

If you do not enroll during annual enrollment (October 1 – October 31), you will keep your 2013 coverage in 2014 with two exceptions:

- Healthcare Flexible Spending Account or Dependent Care Reimbursement Account enrollment is not automatic. See #6.
- If you are enrolled in an Anthem plan, you will be enrolled automatically in the most similar Blue Shield plan unless you go online and make a different choice.

If you are a new City employee and do not enroll by the deadline, you will receive the default coverage shown on your personal enrollment fact sheet – which includes employee-only health and dental coverage, but no dependent coverage and no coverage in other Flex options.

2 Enroll new dependents by the deadline.

You must enroll a new dependent – such as a new spouse or a new child – during the annual enrollment period (October 1 – October 31) for the next plan year or 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 20 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 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.

5 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.

6 Re-enroll in Healthcare FSA and/or DCRA each year.

You must re-enroll in the Healthcare Flexible Spending Account or Dependent Care Reimbursement Account every year even if you contribute to one of those accounts now.

7 Your Flex choices apply through December 31, 2014.

Under federal rules for plans like the Flex plan, the benefit choices you make during annual enrollment apply for all of 2014. 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.

There is one exception: You can enroll in or change Commuter Spending Accounts any time during 2014. See page 56 for more on this benefit.

8 Some benefit changes require evidence of insurability.

If you change your life insurance or disability coverage choices during annual enrollment, evidence of insurability may be required. If this applies to you, you will receive an insurance company form to complete and submit. See pages 42 and 47 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**.

About Flex

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.

You pay the cost of any pre-tax benefits you choose with pre-tax dollars from your paycheck. Any after-tax benefits you choose are paid with after-tax dollars from your paycheck.

In these cases, you receive Flex dollars to help you buy pre-tax benefits:

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

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.

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 $100 of pre-tax pay and you are in the 15% tax bracket, you save $15 in taxes ($100 x .15 = $15).

2014 HEALTH COVERAGE COSTS

A major portion of the Flex benefit costs are paid by the City's subsidy. By paying a significant share of the cost of coverage through the Flex benefit program, the JLMBC and the City show their commitment to employees and their families – adding up to a valuable part of your total compensation.

Both employees and the City share in the cost of your Flex benefit coverage. The amount of the premium you are responsible for depends on your employment status (full-time or half-time), the MOU that applies to you, the number of dependents (if any) covered, and the specific plan you choose.

The employee portion of the premiums is automatically deducted from your paycheck on a biweekly (per pay period) basis. The tables on the next pages list each benefit plan's per pay period premium cost for both the employee and the City.

Flex Plan Health Costs

The City's subsidy covers costs up to the Kaiser Permanente HMO family rate ($1,408.68 a month) for full-time employees and the Kaiser Permanente HMO employee-only rate ($541.82 a month) for half-time employees. Page 10 shows 2014 health coverage costs for the Flex Plan. Flex Plan costs apply to most City employees who are eligible for Flex.

These are certain MOUs that have different health coverage costs:

- **Flex-Pay Plan 1**
  You have Flex-Pay Plan 1 coverage costs if you are in MOU 0, 1, 19, 20, 21, 32 or 38. Page 11 shows 2014 health coverage costs for the Flex-Pay Plan 1.

- **Flex-Pay Plan 2**
  You have Flex-Pay Plan 2 coverage costs if you are in MOU 26, 27 or 39. Page 12 shows 2014 health coverage costs for the Flex-Pay Plan 2.

  If you have questions regarding your health plan contributions, please refer to your applicable MOU or LAAC Section 4.307 for non-represented employees.

Flex Benefits Average Costs Per Member

The average City contribution toward a full-time employee's Flex Benefits costs are as follows:

Average City Contribution Toward a Full-Time Employee's Flex Benefits Costs		
	Monthly Cost	Annual Cost
Health	$1,010.16	$12,121.90
Dental	$35.00	$420.03
Basic Disability	$23.13	$277.54
Basic Life	$1.84	$22.04
Total	**$1,070.13**	**$12,841.51**

2014 COSTS PER PAY PERIOD (EVERY TWO WEEKS) FOR FLEX HEALTH COVERAGE – Flex Plan

	FULL-TIME EMPLOYEES		HALF-TIME EMPLOYEES		
Coverage Level	**City Pays...**	**Employee Pays...**	**City Pays...**	**Employee Pays...**	**Total Cost of Coverage Bi-Weekly**
Kaiser HMO					
Employee Only	$270.91	$0.00	$270.91	$0.00	$270.91
Employee + Spouse/DP	$595.94	$0.00	$270.91	$325.03	$595.94
Employee + Child(ren)	$541.82	$0.00	$270.91	$270.91	$541.82
Family	$704.34	$0.00	$270.91	$433.43	$704.34
Blue Shield Access+ HMO SaveNet (Narrow)					
Employee Only	$219.20	$0.00	$219.20	$0.00	$219.20
Employee + Spouse/DP	$481.48	$0.00	$270.91	$210.57	$481.48
Employee + Child(ren)	$436.37	$0.00	$270.91	$165.46	$436.37
Family	$599.08	$0.00	$270.91	$328.17	$599.08
Blue Shield Access+ HMO (Full) (not available to MOUs 22, 23, 24, 25 or 30)					
Employee Only	$219.20	$114.76	$219.20	$114.76	$333.96
Employee + Spouse/DP	$481.48	$252.59	$270.91	$463.16	$734.07
Employee + Child(ren)	$436.37	$228.53	$270.91	$393.99	$664.90
Family	$599.08	$313.54	$270.91	$641.71	$912.62
Shield Spectrum PPO					
Employee Only	$329.62	$0.00	$270.91	$58.71	$329.62
Employee + Spouse/DP	$704.34	$23.72	$270.91	$457.15	$728.06
Employee + Child(ren)	$631.81	$0.00	$270.91	$360.90	$631.81
Family	$704.34	$121.68	$270.91	$555.11	$826.02

2014 COSTS PER PAY PERIOD (EVERY TWO WEEKS) FOR FLEX HEALTH COVERAGE – Flex-Pay Plan 1

	FULL-TIME EMPLOYEES (MOU 00, 1, 19, 20, 21, 32 or 38)		HALF-TIME EMPLOYEES (MOU 00, 1, 19, 20, 21, 32 or 38)		
Coverage Level	**City Pays...**	**Employee Pays...**	**City Pays...**	**Employee Pays...**	**Total Cost of Coverage Bi-Weekly**
Kaiser HMO					
Employee Only	$257.36	$13.55	$257.36	$13.55	$270.91
Employee + Spouse/DP	$566.14	$29.80	$257.36	$338.58	$595.94
Employee + Child(ren)	$514.73	$27.09	$257.36	$284.46	$541.82
Family	$669.12	$35.22	$257.36	$446.98	$704.34
Blue Shield Access+ HMO SaveNet (Narrow)					
Employee Only	$208.24	$10.96	$208.24	$10.96	$219.20
Employee + Spouse/DP	$457.41	$24.07	$257.36	$224.12	$481.48
Employee + Child(ren)	$414.55	$21.82	$257.36	$179.01	$436.37
Family	$569.13	$29.95	$257.36	$341.72	$599.08
Blue Shield Access+ HMO (Full) (not available to MOUs 22, 23, 24, 25 or 30)					
Employee Only	$208.24	$125.72	$208.24	$125.72	$333.96
Employee + Spouse/DP	$457.41	$276.66	$257.36	$476.71	$734.07
Employee + Child(ren)	$414.55	$250.35	$257.36	$407.54	$664.90
Family	$569.13	$343.49	$257.36	$655.26	$912.62
Shield Spectrum PPO					
Employee Only	$313.14	$16.48	$257.36	$72.26	$329.62
Employee + Spouse/DP	$669.12	$58.94	$257.36	$470.70	$728.06
Employee + Child(ren)	$600.22	$31.59	$257.36	$374.45	$631.81
Family	$669.12	$156.90	$257.36	$568.66	$826.02

2014 COSTS PER PAY PERIOD (EVERY TWO WEEKS) FOR FLEX HEALTH COVERAGE – Flex-Pay Plan 2

	FULL-TIME EMPLOYEES (MOU 26, 27 or 39)		HALF-TIME EMPLOYEES (MOU 26, 27 or 39)		
Coverage Level	**City Pays...**	**Employee Pays...**	**City Pays...**	**Employee Pays...**	**Total Cost of Coverage Bi-Weekly**
Kaiser HMO					
Employee Only	$243.82	$27.09	$243.82	$27.09	$270.91
Employee + Spouse/DP	$536.35	$59.59	$243.82	$352.12	$595.94
Employee + Child(ren)	$487.64	$54.18	$243.82	$298.00	$541.82
Family	$633.91	$70.43	$243.82	$460.52	$704.34
Blue Shield Access+ HMO SaveNet (Narrow)					
Employee Only	$197.28	$21.92	$197.28	$21.92	$219.20
Employee + Spouse/DP	$433.33	$48.15	$243.82	$237.66	$481.48
Employee + Child(ren)	$392.73	$43.64	$243.82	$192.55	$436.37
Family	$539.17	$59.91	$243.82	$355.26	$599.08
Blue Shield Access+ HMO (Full) (not available to MOUs 22, 23, 24, 25 or 30)					
Employee Only	$197.28	$136.68	$197.28	$136.68	$333.96
Employee + Spouse/DP	$433.33	$300.74	$243.82	$490.25	$734.07
Employee + Child(ren)	$392.73	$272.17	$243.82	$421.08	$664.90
Family	$539.17	$373.45	$243.82	$668.80	$912.62
Shield Spectrum PPO					
Employee Only	$296.66	$32.96	$243.82	$85.80	$329.62
Employee + Spouse/DP	$633.91	$94.15	$243.82	$484.24	$728.06
Employee + Child(ren)	$568.63	$63.18	$243.82	$387.99	$631.81
Family	$633.91	$192.11	$243.82	$582.20	$826.02

2014 COSTS PER PAY PERIOD FOR FLEX DENTAL COVERAGE –

Full-Time Employees (All MOUs)

	FULL-TIME EMPLOYEES (All MOUs)		HALF-TIME EMPLOYEES (All MOUs)		
Coverage Level	**City Pays...**	**Employee Pays...**	**City Pays...**	**Employee Pays...**	**Total Cost**
Delta Dental Preventive Only					
Employee Only	$6.45	($2.50)	$5.20	($1.25)	$3.95
Employee + Spouse/DP	$3.95	$3.29	$3.95	$3.29	$7.24
Employee + Child(ren)	$3.95	$4.17	$3.95	$4.17	$8.12
Family	$3.95	$7.78	$3.95	$7.78	$11.73
DeltaCare USA DHMO					
Employee Only	$8.39	$0.00	$8.39	$0.00	$8.39
Employee + Spouse/DP	$8.39	$7.25	$8.39	$7.25	$15.64
Employee + Child(ren)	$8.39	$5.64	$8.39	$5.64	$14.03
Family	$8.39	$9.73	$8.39	$9.73	$18.12
Delta Dental PPO					
Employee Only	$21.62	$3.81	$12.72	$12.72	$25.43
Employee + Spouse/DP	$21.62	$26.04	$12.72	$34.95	$47.66
Employee + Child(ren)	$21.62	$27.80	$12.72	$36.71	$49.42
Family	$21.62	$44.67	$12.72	$53.58	$66.29

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 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.

Who is a "health plan tax dependent"?

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

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

Your additional bi-weekly taxable income in 2014 when you enroll yourself and these dependents:

	Blue Shield Access + HMO SaveNet (Narrow) or Blue Shield Access+ HMO (Full)			Kaiser Permanente HMO			Shield Spectrum PPO		
	Flex Plan	Flex Pay Plan 1	Flex Pay Plan 2	Flex Plan	Flex Pay Plan 1	Flex Pay Plan 2	Flex Plan	Flex Pay Plan 1	Flex Pay Plan 2
Domestic Partner	$262.28	$249.17	$236.05	$325.03	$308.78	$292.53	$374.72	$355.98	$337.25
Domestic Partner's Children	$217.17	$206.31	$195.45	$270.91	$257.37	$243.82	$302.19	$287.08	$271.97
Your Children + Domestic Partner's Children	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Domestic Partner + Your Children	$262.28	$249.17	$236.05	$325.03	$308.78	$292.53	$374.72	$355.98	$337.25
Domestic Partner + Domestic Partner's Children	$379.88	$360.89	$341.89	$433.43	$411.76	$390.09	$374.72	$355.98	$337.25
Domestic Partner + Your and Domestic Partner's Children	$262.28	$249.17	$236.05	$325.03	$308.78	$292.53	$374.72	$355.98	$337.25

If You Marry Your Domestic Partner

You have 30 days from the date of marriage to change your domestic partner's status to spouse. You must call the Benefits Service Center at 1-800-778-2133 to make this change. You must also submit a copy of your marriage certificate. If you don't make this change, you will continue to pay taxes on your domestic partner's coverage and any coverage for his or her children.

WHO'S ELIGIBLE FOR FLEX BENEFITS

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 and Tier 6 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.

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 on page 17 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.**

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.

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.

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.

The following chart describes eligible dependents for health coverage, dental coverage, life insurance and AD&D coverage. See "About Eligible Dependents" on page 52 and 54 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 that verifies your relation to the child (an abstract document is not sufficient in most cases)
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 Criteria 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
Annual Enrollment (October 1- October 31)	If you enroll your dependent who is not currently covered during annual enrollment (October 1- October 31, 2013), documents must be received **by December 13, 2013**	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 annual 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 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 a Post-Secondary Educational Institution

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 (except certain conditions for grandchildren – see page 17).

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

The benefit choices you make during annual enrollment each October stay in effect from January 1 through December 31, 2014. 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. There is one exception: You can enroll in or change Commuter Spending Accounts any time during 2014. See page 56 for more on this benefit.

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.

When You Can Make Changes

You cannot change your choices (other than Commuter Spending Accounts) 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, 2014, you must call or go online to enroll your child by June 30, 2014. 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 2015.

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 or Become Eligible For Premium Assistance

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 eligibility change 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.

Health Coverage

YOUR HEALTH COVERAGE CHOICES

Under Flex, you can choose 2014 health coverage in:

- Blue Shield Access+ HMO SaveNet (Narrow)
- Blue Shield Access+ HMO (Full – not available to MOUs 22, 23, 24, 25 or 30)
- Kaiser Permanente HMO
- Shield Spectrum Preferred Provider Organization (PPO)

You can also decline health coverage – and receive a payment each pay period called 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 plan, you must access covered services through a network of physicians and facilities as directed by your Primary Care Physician (called a Personal Physician by Blue Shield), except for emergencies. 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.

If you are currently enrolled in...	For 2014, unless you make a change during annual enrollment, you will be enrolled automatically in...
Anthem Select HMO	Blue Shield Access+ HMO SaveNet (Narrow)
Anthem HMO+	Blue Shield Access+ HMO (Full)
Anthem PPO	Shield Spectrum PPO
Kaiser Permanente HMO	Kaiser Permanente HMO (no change)

If you are not currently enrolled in any health plan, you will be automatically enrolled in the Blue Shield Access+ HMO SaveNet (Narrow) with Employee Only coverage, unless you choose Cash-in-Lieu during enrollment and submit the Cash-in-Lieu affidavit.

USING THE NETWORKS

	Blue Shield Access+ HMO SaveNet (Narrow) or Blue Shield Access+ HMO (Full)	Kaiser Permanente HMO	Shield Spectrum PPO
In-network care	From a network Personal Physician you choose, using your Personal Physician first when you need medical care	From any Kaiser Permanente facility; a primary care physician (PCP) is recommended but not required	From a 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 Network Providers

Online

Blue Shield
www.blueshieldca.com/lacity

Kaiser Permanente
www.my.kp.org/ca/cityofla

Call

Blue Shield
1-855-201-2086

Kaiser Permanente
1-800-464-4000

If Your PCP/PMG Is Not in the Blue Shield HMO Network

If the current PCP is not in the Blue Shield network, Blue Shield will automatically assign a new PCP (called a Personal Physician by Blue Shield) to you and/or your enrolled dependents based on your zip code.

The Personal Physician assigned to you or your enrolled dependents will be listed on your new Blue Shield Member ID card. Beginning on January 1, 2014, you can change your or your dependent's Personal Physician by calling Blue Shield Member Services at 1-855-201-2086. You will receive a new ID card via U.S. mail within seven to 10 business days.

Continuity of Care

If you are currently receiving care for acute and serious chronic conditions, pregnancy and newborn care, planned surgeries, or terminal illnesses from a provider that is not in the Blue Shield network, continuity of care may be available to you during your transition to a Blue Shield health plan. Continuity of care allows you to continue to see your current non-network provider during the course of your treatment while still receiving the network level of benefits. To request continuity of care, please call Blue Shield Member Services at 1-855-201-2086. You can also download the Continuity of Care application by going to **www.myflexla.com** and clicking *Connect to BlueShield*.

If you do not meet the qualifications for continuity of care, Blue Shield will work with your non-network provider and Medical Group to help you transition to a network provider without disruption of care or services.

If you are seeing a specialist that is part of a Medical Group in the Blue Shield network, Blue Shield can help you find a Personal Physician within the same network medical group. Blue Shield can also help you find a network doctor that can provide the care you need if your current doctor is not part of the Blue Shield network. For any additional questions on the continuity of care or transition process, please call Blue Shield Member Services at 1-855-201-2086.

A HEALTH COVERAGE COMPARISON

The 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.

	Blue Shield Access+ HMO SaveNet (Narrow) or Blue Shield Access+ HMO (Full)	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
Choice of physicians and facilities (hospitals, etc.)	Access covered services through the Blue Shield network of physicians and facilities as directed by your Personal Physician, except for emergencies***	Access covered services through the Kaiser network of physicians and facilities except for emergencies
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* (see page 67 for information on women's preventive services covered January 1, 2013)	100%	100%
Inpatient Hospitalization	100%	100%
Outpatient Surgery	100%	100%
Maternity care (office visits)	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	One hearing aid per ear every 24 months up to $2,000	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.

***To find a provider or verify physicians, contact Blue Shield Member Services at 1-855-201-2086.

	Shield Spectrum 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	
Lifetime maximum benefit	Unlimited	
Choice of physicians and facilities (hospitals, etc.)	Access covered services through Shield Spectrum PPO preferred providers	Access covered services through any provider
Routine office visits	100% after $30 copay/visit with no deductible; 90% after deductible for any procedures as part of visit	70% of allowed charges*** after deductible
Pediatric office visits	100%, no deductible, for routine exams and immunizations up to age 6	70% of allowed charges*** after deductible
Preventive Care* (see page 67 for information on women's preventive services covered January 1, 2013)	100%, no deductible	70% of allowed charges*** after deductible
Inpatient Hospitalization	90% after deductible; prior authorization needed****	70% of allowed charges*** after deductible, up to $600 per day maximum allowed charges, plus all charges in excess of $600; must be prior authorized****
Outpatient Surgery	90% after deductible	70% of allowed charges*** after deductible, up to $350 per day maximum allowed charges, plus all charges in excess of $350
Maternity care (office visits)	100% after $30 copay/visit	70% of allowed charges*** after deductible
Diagnostic lab work and X-rays	90% after deductible	70% of allowed charges*** 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 allowed charges*** after deductible, up to $600 per day maximum allowed charges, plus all charges in excess of $600; must be prior authorized
• Outpatient**	90% after deductible for facility-based care; 100% after $30 copay/visit for physician visit	70% of allowed charges*** after deductible, up to $350 per day maximum allowed charges, plus all charges in excess of $350 for facility based care; 70% of allowed charges for physician office visit
Chemical dependency treatment		
• Inpatient**	90% after deductible	70% of allowed charges*** after deductible, up to $600 per day maximum allowed charges, plus all charges in excess of $600; must be prior authorized
• Outpatient**	90% after deductible for facility-based care; 100% after $30 copay/visit for physician visit	70% of allowed charges*** after deductible, up to $350 per day maximum allowed charges, plus all charges in excess of $350 for facility based care; 70% of allowed charges for physician office visit
Hearing aid benefit	Up to a maximum of $2,000 per member every 24 months for hearing aid and ancillary equipment	
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.

*** When members use non-preferred providers, they must pay the applicable copayment and coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or copayment maximum.

**** You or your doctor must contact Blue Shield for preauthorization and approval before a hospital stay or you will be responsible for a penalty of $250.

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

The Affordable Care Act (ACA)

Under the ACA, most people are required to have medical coverage beginning January 1, 2014. If you plan to enroll in coverage through another plan, it's a good idea to confirm that other coverage meets ACA requirements for the individual mandate.

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 $50 a pay period ($1,200/year) in taxable income. This payment is called Cash-in-Lieu.

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 annual 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 December 13, 2013 if you select Cash-in-Lieu during annual 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 Blue Shield or Kaiser pharmacy. You do not have to submit claim forms.

- For the Blue Shield Access+ HMO SaveNet (Narrow), Blue Shield Access+ HMO (Full) and the Shield Spectrum PPO, you can fill prescriptions at any retail pharmacy that participates in the Blue Shield pharmacy network. Prescriptions from non-participating pharmacies are not covered. To find a participating pharmacy, go to www.blueshieldca.com/lacity and select *Pharmacy Benefits*.
- For the Kaiser Permanente HMO, you must fill prescriptions at any Kaiser pharmacy.

Understanding the Drug Formulary

A formulary applies under the Blue Shield Access+ HMO SaveNet (Narrow), Blue Shield Access+ HMO (Full) and the Shield Spectrum 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 Blue Shield drug formulary by going to www.blueshieldca.com/lacity and selecting *Pharmacy Benefits*.

Your Copayment When You Enroll in...

	Blue Shield Access+ HMO SaveNet (Narrow), Blue Shield Access+ HMO (Full) and the Shield Spectrum 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
For Questions		
On Retail Pharmacies or Mail Order	1-855-201-2086 or www.blueshieldca.com/lacity	1-800-464-4000 or www.kp.org

For Blue Shield members: If a member requests a brand-name drug and a generic equivalent is available, the member is responsible for paying the generic drug copayment plus the difference in cost between the brand-name drug and its generic drug equivalent.

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

- 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	Blue Shield Access+ HMO SaveNet (Narrow), Blue Shield Access+ HMO (Full) and Shield Spectrum 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 at Kaiser Permanente vision centers
• **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 a maximum of $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**	Up to a maximum of $130 retail value***	Up to $92	
• **Elective – disposable lenses**	Up to a maximum of $130 retail value***	Up to $92	

* The maximum varies for network providers offering wholesale or warehouse pricing, including Wal-Mart and Costco.

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

*** If you reach the maximum, additional discounts are available by ordering through MESvisionoptics.com. Call Blue Shield at 1-855-201-2086 with questions.

To find an in-network Blue Shield vision provider, call Member Services at 1-855-201-2086 or go to my Flex at **www.myflexla.com** and click on the link to the Blue Shield Web site under "Contacts." Once there, choose "Find a Provider."

CHIROPRACTIC CARE AND ACUPUNCTURE

Blue Shield Access+ HMO SaveNet (Narrow), Blue Shield Access+ HMO (Full) and Shield Spectrum PPO include coverage for chiropractic care and acupuncture – with some limitations on the number of visits covered each year. You can visit any participating chiropractor from the network without a referral from your Personal Physician. Simply call a participating provider to schedule an initial exam. Contact Blue Shield 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	Blue Shield Access+ HMO SaveNet (Narrow) and Blue Shield Access+ HMO (Full)	Shield Spectrum 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 your Personal Physician	Within 48 hours of admission, contact Blue Shield 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-BLUE 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) before leaving to file a claim for reimbursement.
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 Blue Shield Member Services at 1-855-201-2086 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

CARE FOR DEPENDENTS WHO DO NOT LIVE WITH YOU

Type of Care	Blue Shield Access+ HMO SaveNet (Narrow) and Blue Shield Access+ HMO (Full)	Shield Spectrum PPO	Kaiser Permanente HMO
Routine care for a dependent who does not live with you	• In California: Select a Personal Physician by calling Member Services • Outside California: Submit Away From Home Care 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 care is covered

For more information, call your plan's Member Services number. For Blue Shield HMO Away From Home Care assistance, call 1-855-201-2086.

Wellness Resources

Living healthy is a choice – from taking preventive measures and knowing your risks to eating the right foods and establishing an exercise routine that works. Here are some important steps you can take – and ways Flex can help.

	Blue Shield HMO or PPO www.blueshieldca.com/lacity	Kaiser Permanente HMO http://my.kp.org/ca/cityofla
Annual checkups	Annual physical and other in-network preventive care is generally covered at 100% in-network	
Nurse Help Line: 24 hours a day, 7 days a week. Registered nurses are available to answer your questions and offer guidance	Call 1-877-304-0504	1-888-576-6225
Weight management and nutrition counseling	• Nutrition counseling for diabetics or if recommended by Bariatric provider after surgery, subject to medical necessity • Diabetic Care self-management training (after copay) • For Weight Watchers and gym discounts, go online and select Programs and Services, then Wellness Discounts • Bariatric surgery if authorized	• Nutrition counseling available with doctor referral. Copay applies. • Lifestyle Weight Management Course plus other health education programs • A free online personalized Weight Management Program • Weight Watchers discounts • Bariatric surgery referral to a specialist for weight loss surgery
Smoking/tobacco cessation	• Coverage of prescription smoking cessation medication (one 12-week course per lifetime) • Quit for Life Web-based and telephone coaching • Acupuncture offered at 25% discount through Blue Shield's Alternative Health Provider Network • Medications prescribed by physician	• Nicotine patches at regular drug copayment for up to six months when registered for a smoking cessation class • Stop smoking classes offered at no fee to members • Members can meet with a Clinical Health Educator for one-on-one counseling at regular office visit copay • Free, online personalized Stop Smoking Program • Quit smoking with Breathe™

	Blue Shield HMO or PPO www.blueshieldca.com/lacity	Kaiser Permanente HMO http://my.kp.org/ca/cityofla
Chronic Care Management	If you have a chronic condition, such as diabetes, asthma, COPD, and heart disease, Blue Shield's condition management programs can help you improve your quality of life by showing you how to take an active role in managing your health. After you become a member and enroll in one of the programs, you will have access to a nurse who will work closely with you one-on-one to answer your questions. You will also receive educational materials, self-management tools, and interactive online tools and support.	Complete Care disease management program designed to prevent or manage chronic conditions through a combination of clinical care, health education, and self-management tools. Members with specific medical conditions are automatically identified using disease-specific case identification protocols through our clinical information systems. Call Member Services at 1-800 464-4000.
Other online tools	Go to blueshieldca.com and select Health & Wellness to find: • Preventive health guidelines for men, women, children and seniors • Videos on a range of wellness topics • Articles on alternatives to Western medicine • First aid information • Comprehensive health library	• Total Health Assessment with Succeed™ • Exercise Videos • Physical and Mental health quizzes & calculators • Downloadable podcasts • Fitness widgets • Interactive "Kid Wisdom" site geared for child health

For more tools and resources, go to **www.myflexla.com** and choose "Get Healthy, Stay Healthy" from the left.

Stressed Out?

The Employee Assistance Program can help with issues from family conflicts to child care referrals to coordinating home repairs. Go to www.members.mhn.com (company code "cityoflosangeles") or call 1-800-213-5813.

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. During annual enrollment, you can change your PCD effective January 1, 2014 by going online at **www.myflexla.com** and choosing "Enroll in Benefits or Make Changes," or calling the Benefits Service Center. If you want to change your PCD at any other time 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 A DELTA ONLINE ACCOUNT

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

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.

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	Delta Dental PPO	
			In-Network	Out-of-Network
Calendar year deductible	None	None	$25/person, $75/family	$50/person, $150/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	Delta Dental PPO	
			In-Network	Out-of-Network
Major services				
• Crown	Not covered	Your copay is $55-$195 per procedure**	80%	50% 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.

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, web-video 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 and Web-video consultations and, if needed, up to five face-to-face sessions per issue at no cost to you. EAP sessions must be pre-authorized by MHN.

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 1-800-213-5813

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.

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
- Search child and elder care databases

Life Insurance

Because life insurance offers important financial protection for families of civilian City employees, the Flex program provides basic life insurance at no cost to you and gives you options for supplemental and dependent life insurance. Here is an overview:

	Amount	Your Cost
Basic Life Insurance for You	$10,000 for full-time employees $5,000 for regular half-time employees hired after July 23, 1989 (see MOU if hired before that date)	None – City paid
Supplemental Life Insurance for You *See pages 38-42 for details*	1, 2, 3, 4 or 5 times annual base pay, up to a maximum of $1,000,000	You pay for coverage at group rates (see page 40)
Dependent Life Insurance for your spouse or domestic partner *See page 43 for details*	$10,000, $25,000, $50,000, $75,000 or $100,000	You pay for coverage at group rates
Dependent Life Insurance for your children *See page 43 for details*	You pay for coverage at group rates	You pay for coverage at group rates

About Supplemental Life Insurance

Your supplemental life insurance amount will be the multiple of annual base pay you choose – one times pay up to five times pay – rounded up to the nearest $1,000. 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

You buy any supplemental life insurance you choose with pre-tax dollars from your pay. While supplemental life insurance rates are staying the same for 2014, your cost for coverage may change because of a change in your age or salary. See "Your Cost for Supplemental Life Insurance" on page 40 for life insurance rates.

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 your 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 date of your 65th or 70th birthday for your basic and supplemental life insurance coverage and 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. When the employee reaches 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 will be reduced. For more about dependent life insurance, see page 43.

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.

* Effective 1/1/13, MOU 32 new hires will no longer receive City-paid additional basic life insurance. MOU 32 employees will continue to receive basic life insurance. Please refer to your MOU for more details.

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 2014 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 9/1/13	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 annual enrollment to a level of more than three times annual base pay or $750,000	Yes
Increasing your coverage by more than one level during annual enrollment – 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 during annual enrollment (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 by **March 1, 2014** – or within 60 days of your enrollment as a new hire – 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 **March 1, 2014** – or after the 60-day period if you enroll as a new hire – 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 live birth. 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 annual 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 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 39 for an important note about reductions of life insurance coverage amounts when you are 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 an 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 continue AD&D coverage. To select this portability continuation 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 The Standard.

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 The Standard at 1-800-524-0450.

Disability Coverage

BASIC AND SUPPLEMENTAL DISABILITY COVERAGE

Disability coverage provides replacement income to you in the event of a qualified disability.

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	Cost to You
Basic disability coverage	50% of pre-disability earnings, up to $3,059 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	$0
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**	Varies (refer to your personal enrollment worksheet)

* 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 12 months prior to filing. Please contact Los Angeles City Employees Retirement Section at 1-800-779-8328 for information regarding disability retirement eligibility. 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 substantial and material acts of any gainful occupation for which you are reasonably fitted due to Physical Disease, Injury, Pregnancy or Mental Disorder.

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. 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 becomes effective, 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 annual 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 by **March 1, 2014** – or within 60 days of your enrollment as a new hire – 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 **March 1, 2014** – or after the 60-day period if you enroll as a new hire – 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.

Accounts for Tax Savings

The City offers accounts for tax savings on eligible expenses:

- A Healthcare Flexible Spending Account for eligible healthcare expenses
- A Dependent Care Reimbursement Account for dependent day care expenses
- Commuter Spending Accounts
  - Transit Spending Account for public transit expenses
  - Parking Spending Account

When you enroll in any of these accounts, you set aside pre-tax dollars from your pay to cover eligible expenses.

When You Can Enroll

You can enroll for one or more of these accounts during annual enrollment.

For the Healthcare Flexible Spending Account and the Dependent Care Reimbursement Account, you can only make a change to your account or enroll during the year if you have an eligible family status change. **If you want to continue to participate, you must re-enroll each year at annual enrollment.**

For the Transit Spending Account and the Parking Spending Account, you can make a change to your account or enroll any time during the year. A family status change is not required to enroll, change or cancel your election during the year. However, if you want to begin participating January 1, you must enroll during annual enrollment.

Administrative Fee

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

How the Accounts are Different

Healthcare Flexible Spending Account (HCFSA)	Dependent Care Reimbursement Account (DCRA)	Transit Spending Account	Parking Spending Account
• 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 51 for details	• 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 53 for details	• Use it to reimburse yourself for eligible public transit expenses, such as bus, train, rail or subway fares. See pages 56-57 for details	• Use it to reimburse yourself for eligible expenses for parking at or near work, or at or near public transportation lots if you park and ride **Does not apply to parking provided by City of Los Angeles to its employees at City owned or leased lots, such as at City Hall or Figueroa Plaza.** See pages 56-57 for details

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 $2,500 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

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.

Learn More

View the "Save Smart, Spend Healthy" video series at www.wageworks.com to learn more about the benefits of using a Healthcare Flexible Spending Account. Get tips and guidance to help you decide whether to participate in a Healthcare FSA. You can learn how to stretch your budget if you choose to participate.

About Eligible Dependents

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

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

Definition

See "Domestic Partner Coverage and Pre-Tax Benefits" on page 14 for a definition of "health plan tax dependent."

Filing Claims

Generally, you pay eligible healthcare 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. 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.

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." You can submit claims and upload receipts online and pay your provider directly for some services.

Estimating Expenses and Tax Savings

To estimate your annual expenses and the tax savings of setting up a Healthcare Flexible Spending 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.

Important Deadline and Restrictions

The Healthcare Flexible Spending Account is not a savings account. You can use the money you set aside in 2014 only for eligible expenses you have during the 2014 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.

Estimate Expenses Carefully

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 2014. You must file claims for 2014 expenses by April 30, 2015. 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.

You may be able to change the amount elected if you have a family status change (see "When You Can Make Changes" on page 20 for more on family status change).

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 IRS definition of "health plan tax dependent," lives with you more than half the year, and is physically or mentally unable to care for themselves. This may include an elderly parent or disabled dependent.

See "Domestic Partner Coverage and Pre-Tax Benefits" on page 14 for a definition of "health plan tax 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, 2015 – 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. You are eligible for the credit if you have less than $3,300 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	$37,870 ($43,210 if married filing jointly)
2	$43,380 ($48,378 if married filing jointly)
3 or more	$46,227 ($51,567 if married filing jointly)

- You are single, you file your taxes as head of household and your household taxable income is approximately $40,000 or more (assuming one dependent).
- You are married, you file a joint return and your household taxable income is approximately $42,000 or more (assuming one dependent).

Dollar amounts are based on federal tax law effective for 2013 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.

Filing Claims

Generally, you pay eligible 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.

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." You can submit claims and upload receipts online and pay your provider directly for some services.

Important Deadline and Restrictions

The Dependent Care Reimbursement Account is not a savings account. You can use the money you set aside in 2014 only for eligible expenses you have during the 2014 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.

Estimate Expenses Carefully

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 2014. You must file claims for 2014 expenses by April 30, 2015. 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.

You may be able to change the amount elected if you have a family status change (see "When You Can Make Changes" on page 20 for more on family status change) or if you have a change in day care providers or a change in the cost of day care.

Estimating Expenses and Tax Savings

To estimate your annual expenses and the tax savings of setting up 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.

ABOUT THE COMMUTER SPENDING ACCOUNTS

- Transit Spending Account
- Parking Spending Account

The City offers two programs to help you save on the cost of **public transportation** or **parking** as part of commuting to work. These programs allow you to set aside pre-tax dollars and use them for qualified expenses, reducing your net cost. The programs also allow for certain conveniences when making transit/parking purchases.

- **Current participants in TSA and/or PSA are not required to re-enroll in these programs in order to continue participating. Unlike other benefit programs, elections to participate in TSA and PSA may be modified throughout the year, not just during Annual Enrollment.**
- **New participants** may use Annual Enrollment to initiate contributions beginning in January 2014.

Transit Spending Account (TSA)

- Transit Spending Accounts allow you to set aside up to $125 per month on a pre-tax basis to pay for public transit expenses, including bus, rail, train and subway fares. This amount may increase later in 2014, but as of January 1, 2014 will be $125.
- Transit media (e.g. passes, tickets, etc.) can, in most cases, be purchased directly through WageWorks. Make your purchases by the 10th of the month and those media will then be mailed to your home prior to the month they will be used.
- The City offers up to $50 in the form of a "Transit Match" for eligible City employees who meet all requirements of the Transit Match program.

Parking Spending Account (PSA)

- Parking Spending Accounts allow you to set aside up to $245 per month on a pre-tax basis to pay for parking expenses related to commuting from home to work. **Note that these accounts cannot be used for parking provided by the City of Los Angeles to its employees at City owned or leased lots (e.g., lots at City Hall East, Figueroa Plaza, Police Administration Building, etc.).**
- Parking passes can, in certain instances, be purchased directly through WageWorks. Alternatively, you can make your parking purchases at a garage/lot and file a claim in order to receive reimbursement from your account.

Important Information About the TSA and PSA

- Unlike other employee benefit programs, you can enroll, suspend or modify your participation in these programs at any time of year, including during the annual enrollment period.
- The minimum contribution to either account is $10 per payday.
- There are no "use it or lose it" provisions that happen at year-end; funds roll over to subsequent years indefinitely (until you terminate employment with the City).
- You are not required to make your transit purchases in the month you make your contribution; funds can be accumulated and used whenever you wish.

For more information about TSA and PSA accounts, please visit the City of Los Angeles Personnel Department/Commute Options web page at http://per.lacity.org/Bens/CommuteOptions.htm.

Your Flex Benefits and Changes

Leave, Disability or Work Schedule Changes

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 continuation.

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.

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 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 may be continued through portability and/or conversion and **AD&D coverage** may be continued through portability continuation. You have 60 days from the date coverage ends to submit the required form to The Standard. See page 38 for more information on life insurance and page 44 for more information on AD&D insurance.

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.

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 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 continuation.

You Begin Receiving Workers' Compensation (State Rate) Benefits

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 continuation.

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.

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.

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 continuation.

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 retirement. This is a voluntary retirement savings plan. It supplements benefits available to you through your primary retirement plan.

Why Should I Consider Joining?

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

- **Los Angeles City Employees Retirement System (LACERS)** — Benefits are determined based on factors such as how long you work for the City and your salary near retirement. They are also based on the plan you're a member of (Tier 1 for employees hired prior to July 1, 2013; and Tier 2 for employees hired on or after July 1, 2013) and the benefit formulas that apply to each Tier.
- **Deferred Compensation Plan** — Benefits are based on the total balance (contributions + earnings) you accumulate in your account. You can begin drawing upon retirement; there are several withdrawal options, although ideally you would convert your balance into a steady income stream over many years to supplement your LACERS income.

Your optimal goal should be to produce income from both programs to equal or exceed 100% of the amount of salary you're actually living off at the time you retire.

Lacers Retirement Income

+

Deferred Comp Plan Income

=

Retirement Income Security

What Decisions Are Required to Enroll?

Enrolling in the Plan requires making a few basic decisions:

1. How much do I want to contribute each payday?

You can contribute as little as $15 per payday, but you should contribute as much as you can afford while still meeting your ongoing living expenses. The annual contribution limits are $17,500 if you're below age 50; $23,000 if you're age 50 or older; and $35,000 for participants eligible for Catch-Up. These limits may increase in 2014.

2. Do I want to save pre-tax or after-tax?

- Pre-tax contributions are made before federal and state taxes are withheld. Earnings grow tax-deferred. You do not pay taxes on these amounts until you withdraw them from the Plan.
- After-Tax (Roth) contributions are made after federal and state taxes are withheld. Earnings grow tax-free. No taxes are paid on distributions (if your account has been held for at least five years and you're at least age 59 1/2).

3. How do I want to invest my account?

The Plan offers a wide variety of investment options, ranging from interest-bearing savings accounts to stock and bond mutual funds. You can choose an investment profile that matches your risk tolerance and investment objective. Plan representatives are available to help you decide. In addition to a core menu of investment options, a brokerage window through Charles Schwab is available offering access to a wider universe of stocks, bonds and mutual funds.

What if I Need to Access My Account While Working?

Although generally these funds are not available to you until after you end employment with the City, there are a few exceptions. The Plan offers a loan program which allows you to borrow from your account up to certain limits and then pay yourself back. In addition, if you experience a financial emergency and meet federal guidelines, you may be eligible for a hardship withdrawal.

How Do I Enroll?

The Plan is administered by Great-West Retirement Services. You can obtain enrollment materials by visiting the Plan website at www.cityofla457.gwrs.com; calling Great-West at (888) 457-9460; or by visiting the Plan Service Center located in the Employee Benefits Division, Room 867 City Hall, Monday through Friday from 8 a.m. to 4 p.m.

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. These rules have been revised to reflect changes in the law which 1) expand and clarify the circumstances under which the plan needs your written authorization to use protected health information and 2) require a description of your rights if we discover a breach of your unsecured protected 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.

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

The Blue Shield HMOs generally require the designation of a Personal Physician. You have the right to designate any Personal Physician who participates in the particular HMO network and who is available to accept you or your family members. Until you make this designation, Blue Shield designates one for you. You do not need prior authorization from the Blue Shield HMO or from any other person (including a Personal Physician) 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 Personal Physician, and for a list of the participating Personal Physician and health care professionals who specialize in obstetrics or gynecology, contact Blue Shield at 1-855-201-2086.

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 64, 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.

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 January 31, 2013. You should contact your state for further information on eligibility.

ARIZONA – CHIP	MISSOURI – Medicaid
Website: http://www.azahcccs.gov/applicants Phone: 1-877-764-5437 (outside Maricopa County) 602-417-5437 (Maricopa County)	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
COLORADO – Medicaid	MONTANA – Medicaid
Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In-state): 1-800-866-3513 Medicaid Phone (Out-of-state): 1-800-221-3943	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
FLORIDA – Medicaid	NEVADA – Medicaid
Website: http://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
GEORGIA – Medicaid	NEW YORK – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
IDAHO – Medicaid and CHIP	OREGON – Medicaid and CHIP
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Medicaid & CHIP Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Medicaid & CHIP Phone: 1-877-314-5678
KENTUCKY – Medicaid	TEXAS – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493
LOUISIANA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	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
MASSACHUSETTS – Medicaid and CHIP	WASHINGTON – Medicaid
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473

To see if any more States have added a premium assistance program since January 31, 2013, 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

Important Notice from the City of Los Angeles for Flex-Eligible Employees and Dependents Who are Already Medicare-Eligible or May Soon Become Medicare-Eligible

Your Prescription Drug Coverage and Medicare

As the sponsor of an active group medical plan, the City of Los Angeles Flex Benefits Plan is required to provide all Medicare-eligible participants with the following notice from the federal government in conjunction with the Medicare Prescription Drug, Improvement and Modernization Act of 2003. This notice has information about your current prescription drug coverage with the City of Los Angeles and about your options under Medicare's prescription drug coverage. Please read this notice carefully and keep it where you can find it.

If you, the City employee, and/or your dependents are/or may soon become Medicare-eligible based upon age (65 years), disability and/or end-stage renal disease, this notice applies to you. Please read this notice carefully to determine if you will need to contact Medicare, Social Security, the Los Angeles City Employees' Retirement System (LACERS), or the Employee Benefits Division. You may not need to do anything as a result of this information.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The City of Los Angeles has determined that the prescription drug coverage offered by the City's Flex benefits program through Kaiser Permanente and Blue Shield of California is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage in 2014. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Please keep this notice as proof of having creditable coverage under the City's Flex Plan.

In most cases, the City of Los Angeles' Flex Benefits Plan is the primary insurance plan for employees and federally recognized dependents; Medicare is typically secondary. The City suggests that active City employees and federally recognized dependents with Flex coverage do not enroll in Medicare Part B and Part D until the City employee is planning on leaving City service (e.g., retirement). The City of Los Angeles' Flex Benefits Plan is, on average, at least as good as the standard Medicare prescription drug coverage. City employees and federally recognized dependents that maintain City Flex Benefits coverage will not pay a higher premium if they decide to join a Medicare drug plan after they are first eligible.

The Federal government does not recognize domestic partners as eligible dependents of active group health coverage for Medicare purposes. If you are a domestic partner and you are eligible for Medicare, you may want to consider enrolling in Medicare and dropping Flex Benefits coverage at the time of eligibility. If you do not enroll in Medicare Part B and Part D when you first become eligible, you will be charged a higher premium (a penalty) for your Medicare coverage.

You may contact LACERS at (800) 779-8328 to discuss your retirement and to assist you with your Medicare enrollment, when appropriate.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible to join a Part D plan for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan while still an active City employee with benefits, you will continue to receive the City's Flex coverage as your primary insurance provider. Please be aware that enrolling in Medicare simultaneously with the City's Flex Benefits may cause payment errors and in most cases will not increase your benefits. Please refer to the 2014 Flex Enrollment Guide regarding your prescription and medical benefits with the City Flex Benefits Program.

If you are an active City employee, you cannot discontinue participation in the City of Los Angeles Flex Benefits Plan in order to enroll in Medicare Part B and Part D. If you had Medicare prior to becoming eligible for Flex Benefits, then you may receive Cash-in-Lieu and disenroll from your Flex medical coverage. If you are a Medicare-eligible dependent of an active City employee, you may discontinue participation in the City of Los Angeles Flex Benefits Plan and enroll in Medicare Part B and Part D based upon Medicare's guidelines.

If you are a domestic partner and you are eligible for Medicare, you may want to consider enrolling in Medicare and dropping Flex Benefits coverage at the time of eligibility (age 65). The Federal government does not recognize domestic partners as eligible dependents of active group health coverage for Medicare purposes. If you do not enroll in Medicare Part B and Part D when you first become eligible, you will be charged a higher premium (a penalty) for your Medicare coverage.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

If you drop or lose your coverage with the City of Los Angeles and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join. City employees and their federally recognized eligible dependents will not be subject to higher premiums if they maintain creditable coverage with the City.

For more information about this notice or your current prescription drug coverage please contact the Employee Benefits Division at (213) 978-1655.

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	10/01/2013
Name of Entity/Sender:	City of Los Angeles, Personnel Department
Contact--Position/Office:	Employee Benefits Division
Address:	200 North Spring Street, City Hall, Room 867
Phone Number:	(213) 978-1655
E-Mail:	per.empbenefits@lacity.org

NOTE: You will receive this notice each year. You may also request a copy if needed.

Health Care Reform

Additional Women's Preventive Services

To ensure compliance with the Patient Protection and Affordable Care Act (PPACA) signed into law on March 23, 2010, the City provides Flex coverage for additional women's preventive services at 100% when care is provided by an in-network provider, effective January 1, 2013. The following additional women's preventive services are covered at no cost to you in-network:

Additional women's preventive services	Frequency of coverage
Well-woman office visit to obtain recommended preventive services that are age- and developmentally appropriate, including preconception and prenatal care; where appropriate, the visit should include other recommended preventive services	After the initial visit, additional visits may be covered if a woman and her provider determine they are necessary for her to obtain all recommended preventive services
Contraceptive methods approved by the Food and Drug Administration, sterilization procedures, and patient education and counseling for women with reproductive capacity, excluding drugs that induce abortion	As prescribed
Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period; coverage includes cost of renting breast pumps and nursing-related supplies	With each birth
Human papillomavirus (HPV) DNA testing as part of cervical cancer screenings for women age 30 and older	Women 30 years and older every three years, regardless of Pap smear results
Human immune-deficiency virus (HIV) counseling and screening for all sexually active women	Annual
Interpersonal and domestic violence screening and counseling	Annual
Counseling on sexually transmitted infections for all sexually active women	Annual
Screening for gestational diabetes	Between 24 and 28 weeks of gestation; at first prenatal visit for pregnant women at high risk for diabetes

Availability of Summary Health Information

Flex offers a series of health coverage options. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available online at **www.myflexla.com**. Click Summary of Benefits and Coverage from the left navigation bar. A paper copy is also available, free of charge, by calling the Benefits Service Center at 1-800-778-2133.

Travel Assistance

AND OTHER LIFE INSURANCE SERVICES

The Life Services Toolkit through Standard Life Insurance provides access to services that help you and your loved ones prepare for and manage life's major events. These services are available to your spouse or domestic partner and your children up to age 26, anytime, 24 hours, 7 days a week. The Life Services Toolkit is included in your Flex life insurance. There's no cost to you, and enrollment is not required to participate.

Travel Assistance

The MEDEX Travel Assist program provides help coping with emergencies when you travel more than 100 miles from home, domestically or internationally, for trips of up to 180 days. The program can also help you with non-emergencies, such as planning a trip.

Services include:

- Pre-trip Assistance including passport, visa, weather and currency exchange information, health hazards advice and inoculation requirements
- Medical Assistance Services including locating medical care providers and interpreter services
- Travel Assistance Services including emergency ticket, credit card and passport replacement assistance, funds transfer assistance and missing baggage assistance
- Legal Assistance Services including locating a local attorney, consular office or bail bond services
- Emergency Transportation Services including arranging and paying for emergency evacuation to the nearest adequate medical facility
- Personal Security Services including evacuation and logistical arrangements in the event of political unrest, social instability, weather conditions or environmental hazards.

You can contact MEDEX Travel Assist by:

Email: operations@frontiermedex.com

Phone:

– Toll-free 1-800-527-0218 (U.S., Canada, Puerto Rico, U.S. Virgin Islands and Bermuda

– Collect 1-410-453-6330 (Other locations)

Other Life Toolkit Services

Additional services to help you handle important life events include:

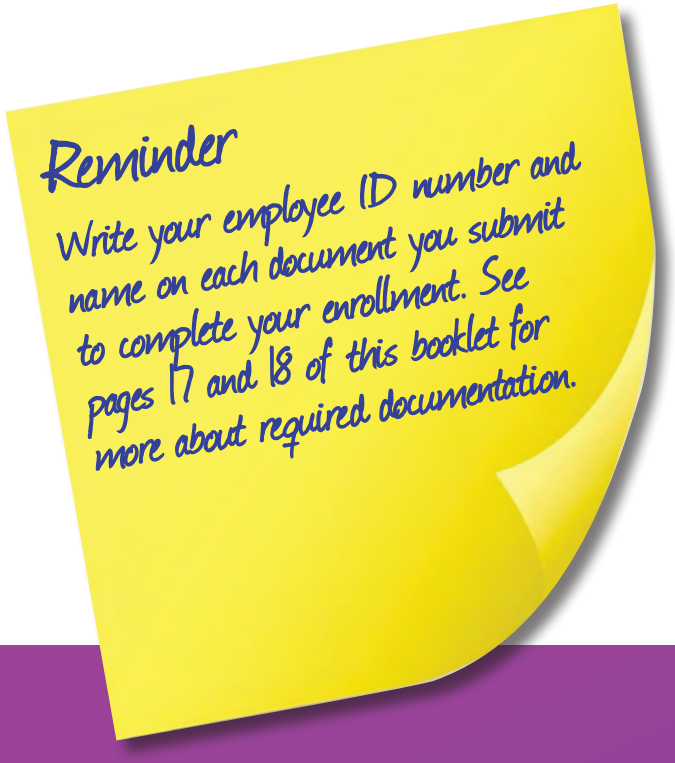
- Funeral Planning Services providing personalized assistance with funeral-related matters, both before and during your need, including local funeral home price comparisons and the negotiation of final funeral service costs with the funeral home your family chooses
- Digital Identity Archive providing a secure Web site for recording, storing and updating items like usernames and passwords; this makes retrieving personal information by your designee easy after your death
- Online estate planning offering access to an online library of legal forms, including a will, that lets you prepare, view and print documents that can be notarized and stored in a secure place.

Plan/Program/Contact	Web Site	Phone Number
Blue Shield Access+ HMO SaveNet (Narrow) and Blue Shield Access+ HMO (Full)	www.blueshieldca.com/lacity	1-855-201-2086
Kaiser Permanente HMO health plan	http://my.kp.org/ca/cityofla/	1-800-464-4000
Shield Spectrum PPO health plan	www.blueshieldca.com/lacity	1-855-201-2086
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	1-877-924-3967
Commuter Spending Accounts	www.wageworks.com	1-877-924-3967
The Standard Insurance Company: life insurance, AD&D and disability insurance	**www.myflexla.com**	1-800-524-0450 for general questions 1-800-843-7979 for evidence of insurability 1-800-527-0218 for travel assistance
Benefits 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 programs	https://cityofla457.gwrs.com	1-888-466-0381 (Great West) or 213-978-1636 (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

my FLEX | Benefits



City of Los Angeles

Flex Enrollment 2014

www.myflexla.com