



Benefits



City of Los Angeles

NEXT ►

Flex Enrollment 2016

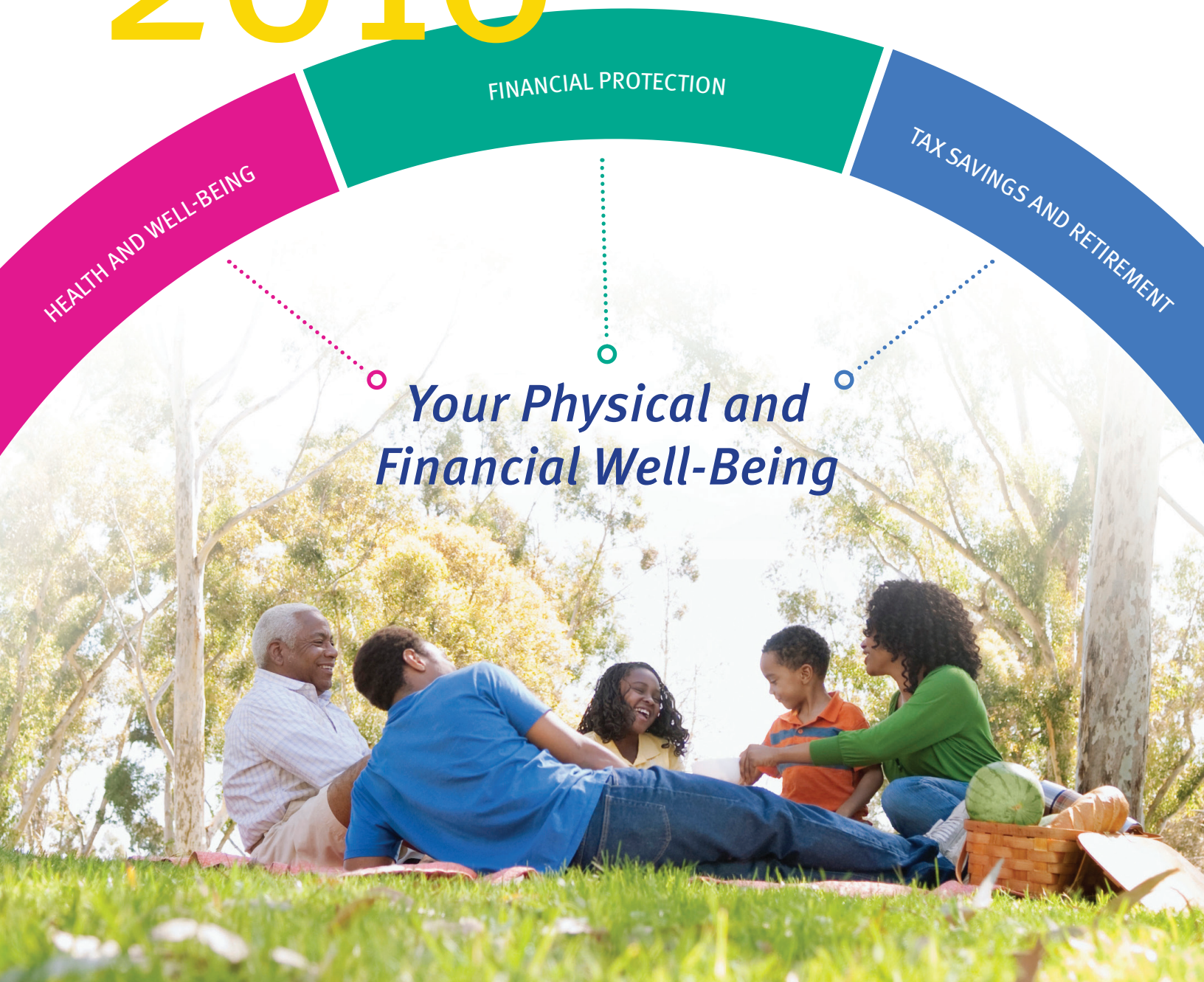
October 1 – 31 at myflexla.com

FINANCIAL PROTECTION

HEALTH AND WELL-BEING

TAX SAVINGS AND RETIREMENT

*Your Physical and
Financial Well-Being*





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 62 for more information.

State premium assistance programs

See page 59 for a notice about state premium assistance programs funded by Medicaid and the Children's Health Insurance Program.

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 2016 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 2015

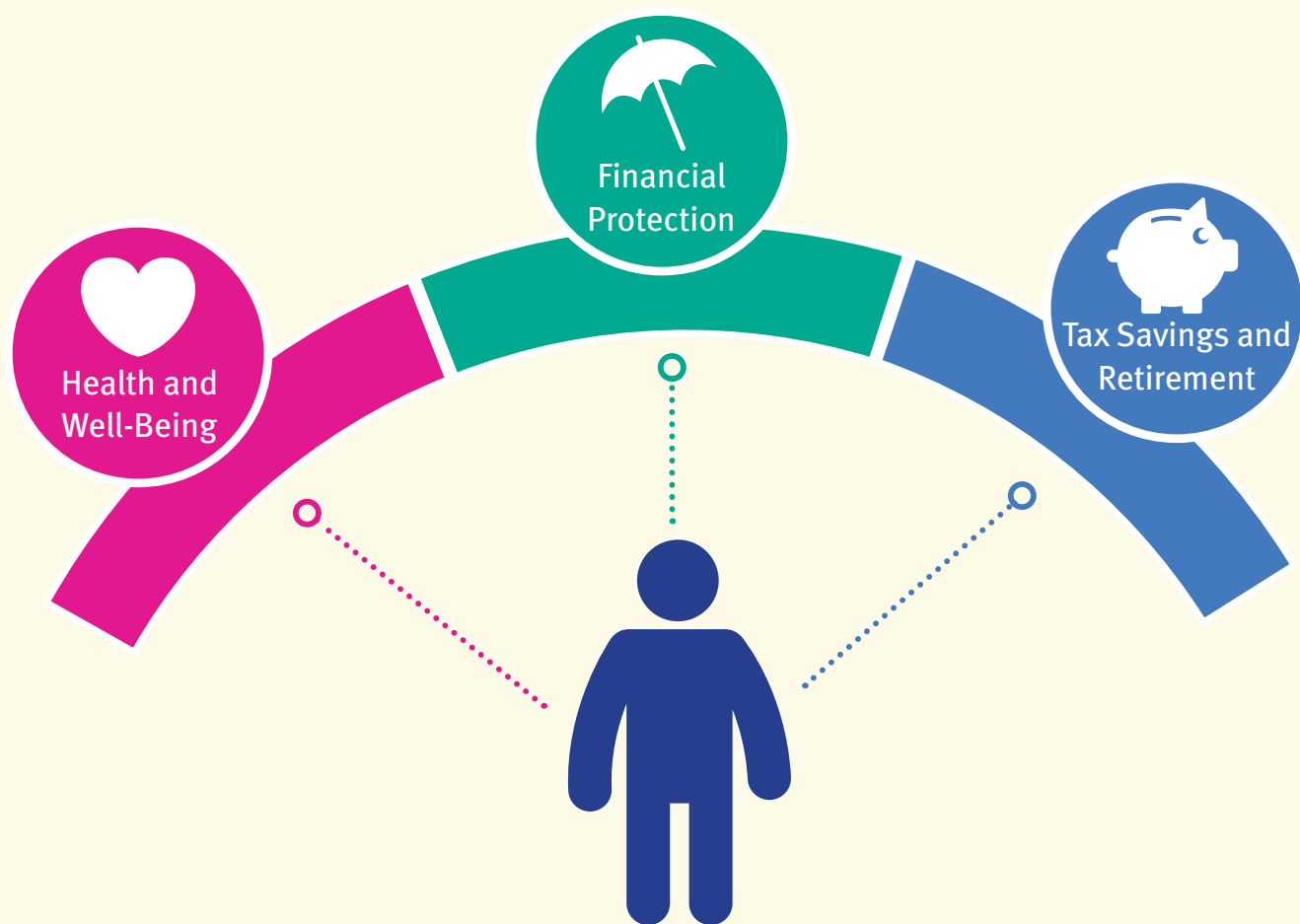
Your Physical and Financial Well-Being

Navigating 2016 Flex Enrollment and Beyond



Why are your Benefit Choices Important?

Because they can make a big impact on your physical and financial well-being, both now and for the future. It's an ongoing journey – and the City offers a range of benefit options and programs to support you along the way.



HEALTH AND WELL-BEING

Providing medical coverage options (including prescription drug and vision benefits) plus choices for dental coverage, and focusing on programs that encourage and enable healthy living.

FINANCIAL PROTECTION

Offering benefits to help protect you and your family from unexpected events, including life insurance, AD&D and disability coverage.

TAX SAVINGS AND RETIREMENT

Giving you access to tax-saving accounts for today and a retirement savings plan for your future.

How to Use This Guide

1

Understand Your Choices

Review details on your benefit options:

- Health and Well-Being – [pages 4-19](#)
- Financial Protection – [pages 20-31](#)
- Tax Savings and Retirement – [pages 32-41](#)

2

Review Coverage Costs

- Learn about Cash-in-Lieu – [page 42](#)
- See [pages 43-47](#) of this guide for medical and dental costs
- See your Personal Enrollment Fact Sheet for all coverage costs
- Understand domestic partner costs – [pages 48-49](#)

3

Confirm Your Dependents Are Eligible

- Learn who is eligible – [pages 50-51](#)
- Provide required documentation by the deadline – [page 52](#)
- Understand special situations for dependents – [page 53](#)

4

Learn About Making Changes During the Year

- Understand the rules for family status changes – [pages 54-55](#)
- Learn about leave, disability or work schedule changes – [pages 56-57](#)

Use Your Enrollment Resources

- Review the enclosed Enrollment Highlights
- Go to the website at myflexla.com
- Call the Benefits Service Center at 1-800-778-2133 (or chat online)

It's all about the choices you make both now and throughout the years. Flex Enrollment provides you with a valuable opportunity to not only make your benefit choices, but also to take a fresh look at how you can plan for a successful future for yourself and your loved ones.



Health Coverage

Your Health Coverage Choices

Under Flex, you can choose 2016 health coverage in:

- Kaiser Permanente HMO
- Blue Shield Access+ HMO SaveNet (Narrow Network)
- Blue Shield Access+ HMO (Full Network – not available to MOUs 22, 23 or 24)
- 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 of Health or Dental Benefits" on **page 42** 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 not currently enrolled in any health plan, you will be automatically enrolled in the Blue Shield Access+ HMO SaveNet (Narrow Network) with Employee Only coverage, unless you choose Cash-in-Lieu during enrollment and submit the Cash-in-Lieu affidavit.

The Affordable Care Act (ACA)

Under the ACA, most people are required to have medical coverage. This is called the individual mandate. If you enroll in Flex medical benefits, you meet the individual mandate. 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. To learn more visit coveredca.com or call 1-888-975-1142.



Using the Networks

| | Blue Shield Access+ HMO SaveNet (Narrow Network) or Blue Shield Access+ HMO (Full Network) | 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
blueshieldca.com/lacity

Kaiser Permanente
<http://my.kp.org/ca/cityofla>

Call

Blue Shield
 1-855-201-2086

Kaiser Permanente
 1-800-464-4000

About Your Personal Physician

If you enroll in a Blue Shield HMO, Blue Shield will automatically assign a new Personal Physician 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, 2016, 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.

Key Terms

A **deductible** is the amount you owe for plan eligible health care services before your plan begins to pay.

Your **out-of-pocket maximum** is the most you will have to pay for covered medical expenses in a plan year through deductible and coinsurance before your insurance plan begins to pay 100 percent of covered medical expenses.



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 8** and "Vision Care" on **page 10**.

See **page 5** for definitions of key terms

| | Blue Shield Access+ HMO SaveNet (Narrow Network) or Blue Shield Access+ HMO (Full Network) | 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 | Plan pays 100% after \$15 copay/visit | Plan pays 100% after \$15 copay/visit |
| Pediatric office visits | Plan pays 100% up to age 5 | Plan pays 100% up to age 5 |
| Preventive Care* | Plan pays 100% | Plan pays 100% |
| Inpatient Hospitalization | Plan pays 100% | Plan pays 100% |
| Outpatient Surgery | Plan pays 100% | Plan pays 100% after \$15 copay/visit |
| Maternity care (office visits) | Plan pays 100% | Plan pays 100% |
| Diagnostic lab work and X-rays | Plan pays 100% | Plan pays 100% at a Kaiser facility |
| Emergency room care for true emergencies (such as severe chest pains or breathing difficulties, severe bleeding, poisoning) | Plan pays 100% after \$100 copay/visit; copay waived if admitted | Plan pays 100% after \$100 copay/visit; copay waived if admitted |
| Mental health | | |
| • Inpatient** | Plan pays 100% | Plan pays 100% |
| • Outpatient** | Plan pays 100% for facility-based care; 100% after \$15 copay/visit for physician visits | Plan pays 100% after \$15 copay/visit; 100% up to age 5 |
| Chemical dependency treatment | | |
| • Inpatient** | Plan pays 100% | Plan pays 100% |
| • Outpatient** | Plan pays 100% for facility-based care; 100% after \$15 copay/visit for physician visits | Plan pays 100% after \$15 copay/visit; 100% up to age 5 |
| Hearing aid benefit | Plan pays for one hearing aid per ear every 24 months after \$15 copay/visit | Plan pays 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 8 for details. | |
| Vision care | See "Vision Care" on page 10 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 | Plan pays 100% after \$30 copay/visit with no deductible; 90% after deductible for any procedures as part of visit | Plan pays 70% of allowed charges*** after deductible |
| Pediatric office visits | Plan pays 100%, no deductible, for routine exams and immunizations up to age 6 | Plan pays 70% of allowed charges*** after deductible |
| Preventive Care* | Plan pays 100%, no deductible | Plan pays 70% of allowed charges*** after deductible |
| Inpatient Hospitalization | Plan pays 90% after deductible; prior authorization needed**** | Plan pays 70% of allowed charges*** after deductible, up to \$1,500 per day maximum allowed charges, plus all charges in excess of \$1,500; must be prior authorized**** |
| Outpatient Surgery | Plan pays 90% after deductible | Plan pays 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) | Plan pays 100% after \$30 copay/visit | Plan pays 70% of allowed charges*** after deductible |
| Diagnostic lab work and X-rays | Plan pays 90% after deductible | Plan pays 70% of allowed charges*** after deductible |
| Emergency room care for true emergencies (such as severe chest pains or breathing difficulties, severe bleeding, poisoning) | Plan pays 90% after \$100 copay/visit; copay waived if admitted and regular hospitalization benefits apply | Plan pays 90% after \$100 copay/visit; copay waived if admitted and regular hospitalization benefits apply |
| Mental health | | |
| • Inpatient** | Plan pays 90% after deductible | Plan pays 70% of allowed charges*** after deductible, up to \$1,500 per day maximum allowed charges, plus all charges in excess of \$1,500; must be prior authorized |
| • Outpatient** | Plan pays 90% after deductible for facility-based care; 100% after \$30 copay/visit for physician visit | Plan pays 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** | Plan pays 90% after deductible | Plan pays 70% of allowed charges*** after deductible, up to \$1,500 per day maximum allowed charges, plus all charges in excess of \$1,500; must be prior authorized |
| • Outpatient** | Plan pays 90% after deductible for facility-based care; 100% after \$30 copay/visit for physician visit | Plan pays 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 | Plan pays 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 8 for details. | |
| Vision care | See "Vision Care" on page 10 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.



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 Network), Blue Shield Access+ HMO (Full Network) 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 blueshieldca.com/lacity and select *Pharmacy Benefits*.
- For the Kaiser Permanente HMO, you must fill prescriptions at any Kaiser pharmacy.

What is the Drug Formulary?

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. A formulary applies under the Blue Shield Access+ HMO SaveNet (Narrow Network), Blue Shield Access+ HMO (Full Network) and the Shield Spectrum PPO. You can access the Blue Shield drug formulary by going to blueshieldca.com/lacity and selecting *Pharmacy Benefits*. You can access the Kaiser drug formulary by going to kp.org/formulary.



Your Copayment When You Enroll in...

| | Blue Shield Access+ HMO SaveNet (Narrow Network), Blue Shield Access+ HMO (Full Network) 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 blueshieldca.com/lacity | 1-800-464-4000 or 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 Network), Blue Shield Access+ HMO (Full Network) and Shield Spectrum PPO | | Kaiser Permanente HMO |
|--|--|-----------------------|---|
| | In-Network | Out-of-Network | |
| One eye exam every 12 months | Plan pays 100% after \$10 copay | Plan pays up to \$49 | Plan pays 100% Every 24 months, \$200 eyewear allowance toward the purchase of covered lenses, frames and/or elective contact lenses at Kaiser Permanente vision centers |
| Lenses | One pair of lenses every 24 months: | | |
| • Single vision | Plan pays 100% after \$10 copay | Plan pays up to \$35 | |
| • Bifocal | Plan pays 100% after \$10 copay | Plan pays up to \$49 | |
| • Trifocal | Plan pays 100% after \$10 copay | Plan pays up to \$74 | |
| • Progressive | Plan pays 100% after \$10 copay + \$65 | Plan pays up to \$49 | |
| One pair of frames every 24 months | Plan pays up to a maximum of \$130 retail value, then 20% discount* | Plan pays up to \$50 | |
| Contacts (instead of frame and lens benefits) | Every 24 months: | | |
| • Non-elective** | Plan pays 100% | Plan pays up to \$250 | |
| • Elective – conventional | Plan pays up to a maximum of \$130 retail value*** | Plan pays up to \$92 | |
| • Elective – disposable lenses | Plan pays up to a maximum of \$130 retail value*** | Plan pays 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 blueshieldca.com/lacity.

Chiropractic Care and Acupuncture

Blue Shield Access+ HMO SaveNet (Narrow Network), Blue Shield Access+ HMO (Full Network) 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 kp.org/healthyroads.



Care While Traveling

| Type of Care | Blue Shield Access+ HMO SaveNet (Narrow Network) and Blue Shield Access+ HMO (Full Network) | Shield Spectrum PPO | Kaiser Permanente HMO |
|---------------------------------|---|--|--|
| Emergency Care in the U.S. | <ul style="list-style-type: none"> 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. | <p>Before traveling, call 1-800-810-BLUE for a list of participating hospitals</p> <p>Always go to the closest emergency facility; request an itemized bill (in English) before leaving to file a claim for reimbursement</p> | | 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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 | | <ul style="list-style-type: none"> 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 Network) and Blue Shield Access+ HMO (Full Network) | Shield Spectrum PPO | Kaiser Permanente HMO |
|---|---|---|--|
| Routine care for a dependent who does not live with you | <ul style="list-style-type: none"> 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 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. | 1-877-304-0504 | 1-888-576-6225 |
| Weight management and nutrition counseling | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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™ |
| Health Coaching | Offers a phone-based and web-based Health Coaching program. It's open to individuals determined to be "high-risk" pursuant to the results of a participant's online "Well-Being Assessment." | Offers a phone-based and web-based Health Coaching program available to all members, allowing its members to receive focus on health habits, like managing weight, quitting tobacco, reducing stress, becoming more active, or eating healthier. |
| Exercise | Offers a web-based walking program that allows members to earn points and join an online community supporting their walking goals. | Offers a web-based walking program called "10,000 Steps" which allows members to set goals and track individual progress. |



| | Blue Shield HMO or PPO 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 is designed to prevent or manage chronic conditions through a combination of clinical care, health education, and self-management tools. Members with specific medical conditions are automatically identified using disease-specific case identification protocols through our clinical information systems. Call Member Services at 1-800-464-4000. |
| Other online tools | Go to blueshieldca.com and select Health & Wellness to find: <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • Total Health Assessment with Succeed™ • Exercise Videos • Physical and Mental health quizzes and calculators • Downloadable podcasts • Fitness widgets • Interactive "Kid Wisdom" site geared for child health |

Stressed Out?

The Employee Assistance Program can help with issues from family conflicts to child care referrals to coordinating home repairs. Go to 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 24, 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 DHMO
- Search provider directories at deltadentalins.com/enrollees/index.html by selecting "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 Open Enrollment, you can change your PCD effective January 1, 2016 by going online at myflexla.com 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 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 (if enrolled in DeltaCare USA DHMO) and the date of eligibility.

A Dental Coverage Comparison

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 DHMO.

| 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 | | | | |
| <ul style="list-style-type: none"> • 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) | Plan pays 100% of R&C* (includes an additional oral exam and routine cleaning during pregnancy) | Plan pays 100% - Covers one series of four bitewing X-rays in any six-month period for children or adults | Cleanings, X-rays and exams; Plan pays 100% with no deductible (includes an additional oral exam and either a routine cleaning or periodontal scaling and root planing during pregnancy paid at 80% after deductible) | Cleanings, X-rays and exams; Plan pays 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 | | | | |
| <ul style="list-style-type: none"> • Amalgam fillings, extractions | Not covered | Plan pays 100% for fillings; you pay up to \$90 for extractions | Plan pays 80% | Plan pays 80% of R&C* |
| <ul style="list-style-type: none"> • Root canal | Not covered | Your copay is \$45-\$205 per procedure | Plan pays 80% | Plan pays 80% of R&C* |
| <ul style="list-style-type: none"> • Periodontal scaling and root planing | Not covered | Plan pays 100% up to 4 quadrants in 12 months | Plan pays 80% once per quadrant every 24 months | Plan pays 80% of R&C* once per quadrant every 24 months |



| 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** | Plan pays 80% | Plan pays 50% of R&C* |
| • Dentures | Not covered | Your copay is \$80-\$170 per procedure | Plan pays 50% | Plan pays 50% of R&C* |
| • Implants | Not covered | Not covered | Plan pays 50% | Plan pays 50% of R&C* |
| Orthodontia | | | | |
| • Children under age 19 | Not covered | Your copay is \$1,000 plus start up fees of \$300 | Plan pays 50% | Plan pays 50% of R&C* |
| • Children age 19 to age 26 | Not covered | Your copay is \$1,350 plus start up fees of \$300 | Plan pays 50% | Plan pays 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 (includes diagnostic and preventive services) | 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 completely 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.

Online Resources

On the Web, go to 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





Issues for Which the EAP Provides Help

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.



Life Insurance

Life insurance offers important financial protection for you and your family. 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:

Online Calculator

Use the online calculator at myflexla.com to help you determine how much life insurance you need.

| | Amount | Your Cost |
|--|---|---|
| Basic Life Insurance for You | \$10,000 for full-time employees \$5,000 for regular half-time employees hired after July 24, 1989 (see MOU if hired before that date) | None – City paid |
| Supplemental Life Insurance for You <i>See page 22 for details</i> | 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 22) |
| Dependent Life Insurance for your spouse or domestic partner <i>See page 25 for details</i> | \$10,000, \$25,000, \$50,000, \$75,000 or \$100,000 | You pay for coverage at group rates |
| Dependent Life Insurance for your children <i>See page 25 for details</i> | \$5,000 per child | 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 2016, your cost for coverage may change because of a change in your age or salary. See "Your Cost for Supplemental Life Insurance" on **page 22** for life insurance rates.



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 25.

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 <http://per.lacity.org/bens/docforms.htm> 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 myflexla.com. You can also 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 Monthly Cost for Supplemental Life Insurance

Here are the 2016 monthly 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.

Example:

An employee is 46 years old and wants supplemental insurance up to \$150,000.

$$\begin{aligned} \$150,000 \div \$1,000 \\ = \$150 \end{aligned}$$

$$\begin{aligned} \$150 \times \$0.126 \\ = \$18.90 \end{aligned}$$

| Age on 9/1/15 | 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 | × | .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 Open 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 Open 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 Open 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, 2016** – 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, 2016** – 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 <http://per.lacity.org/bens/docforms.htm>.



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. You will be the beneficiary for dependent life insurance.

| For your spouse/domestic partner... | For your children... |
|--|--|
| A choice of: <ul style="list-style-type: none"> • \$10,000 • \$25,000 • \$50,000 • \$75,000 • \$100,000 | <ul style="list-style-type: none"> • \$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 Open 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 <http://per.lacity.org/bens/docforms.htm>.

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.

Imputed Income

For 2016, you may be taxed on the value of coverage above \$2,000 under federal law. Imputed income depends on the ages of your dependents and will generally apply only if you cover a spouse over age 55 or more than one child.

Reductions Based on Age

See page 21 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

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.

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 <http://per.lacity.org/bens/docforms.htm> 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 <http://per.lacity.org/bens/docforms.htm> 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.

To name or update your beneficiary, go to myflexla.com. You can also call the Benefits Service Center.



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 \$3,129 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

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 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 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 <http://per.lacity.org/bens/docforms.htm>.

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.

Proof of Good Health

If you are currently enrolled in Flex and are choosing supplemental disability coverage for the first time during Open 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 <http://per.lacity.org/bens/docforms.htm>. 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, 2016** – 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, 2016** – 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.

Active Work Requirement

If you cannot work because of sickness, injury or pregnancy on the day before your disability coverage (or any coverage increase) becomes effective, 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.

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 <http://per.lacity.org/bens/docforms.htm> 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 Can Enroll

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

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

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 (HCFA) | Dependent Care Reimbursement Account (DCRA) | Transit Spending Account | Parking Spending Account |
|--|--|--|--|
| <ul style="list-style-type: none"> • 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 <p>See page 33 for details</p> | <ul style="list-style-type: none"> • 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 <p>See page 35 for details</p> | <ul style="list-style-type: none"> • Use it to purchase eligible public transit expenses, such as bus, train, rail or subway fares. <p>See page 38 for details</p> | <ul style="list-style-type: none"> • 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 <p>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.</p> <p>See page 38 for details</p> |



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 \$2,550 annually in a Healthcare Flexible Spending Account. Your contributions are deducted from your paycheck each pay period.

Examples of Eligible and Ineligible Expenses

| The Healthcare Flexible Spending Account Can be Used to Pay for: | The Healthcare Flexible Spending Account CANNOT be Used to Pay for: |
|---|---|
| <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 not prescribed by a doctor • Nutritional supplements, including vitamins taken for general health • Most over-the-counter medications and products without a prescription such as cosmetics, soaps and toiletries |

Learn More

Go to [wageworks.com](https://www.wageworks.com) and [savesmartspendhealthy.com](https://www.savesmartspendhealthy.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.

Go to [wageworks.com/employees/support-center/healthcare-fsa-eligible-expenses-table](https://www.wageworks.com/employees/support-center/healthcare-fsa-eligible-expenses-table) to view a searchable list of eligible expenses.

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.



Definition

See “Domestic Partner Coverage and Pre-Tax Benefits” on **page 48** for a definition of “health plan tax dependent.”

Estimating Expenses and Tax Savings

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

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.

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 **<http://per.lacity.org/bens/docforms.htm>**. You can submit claims and upload receipts online and pay your provider directly for some services.

Important Deadline and Restrictions

The Healthcare Flexible Spending Account is not a savings account. You can use the money you set aside in 2016 only for eligible expenses you have during the 2016 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 and will be forfeited. 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 2016. You must file claims for 2016 expenses by April 30, 2017. 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 54** 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 48** 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, 2017 – will be forfeited. To estimate annual expenses, go to **myflexla.com**. As part of the enrollment process, you’ll find links to a calculator for each account.



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 \$3,400 in investment income and your income (or the income of you and your spouse, if you are married filing jointly) is less than the amount set forth for 2015 in the following table depending on your number of children:

| Number of children | Income less than... |
|--------------------|---|
| 1 | \$39,131 (\$44,651 if married filing jointly) |
| 2 | \$44,454 (\$49,974 if married filing jointly) |
| 3 or more | \$47,747 (\$53,267 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 \$41,000 or more (assuming one dependent).

Dollar amounts are based on federal tax law effective for 2015 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 <http://per.lacity.org/bens/docforms.htm>. You can submit claims and upload receipts online, pay your provider directly for some services, and use EZ Receipts mobile application from WageWorks.

Important Deadlines and Restrictions

The Dependent Care Reimbursement Account is not a savings account. You can use the money you set aside in 2016 only for eligible expenses you have during the 2016 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 and will be forfeited. 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 2016. You must file claims for 2016 expenses by April 30, 2017. 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 54** 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 myflexla.com. As part of the enrollment process, 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 Open Enrollment.**
- **Go to myflexla.com to enroll or make changes.**

Transit Spending Account (TSA)

- Transit Spending Accounts allow you to set aside up to \$130 per month on a pre-tax basis to pay for public transit expenses, including bus, rail, train and subway fares.
- 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 \$250 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 Open 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 or transfer to the Department of Water and Power).
- 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>.

Harbor Department and Los Angeles World Airports (LAWA) Employees

If you are a Harbor or LAWA employee, you are not eligible for the Flex TSA and PSA. Instead, your transit and parking benefits are provided through a separate Rideshare Program provided by your Department. Please contact your Human Resources Division for more information about your transit and parking benefits.



Deferred Compensation Plan

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

Why Should I Consider Joining?

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

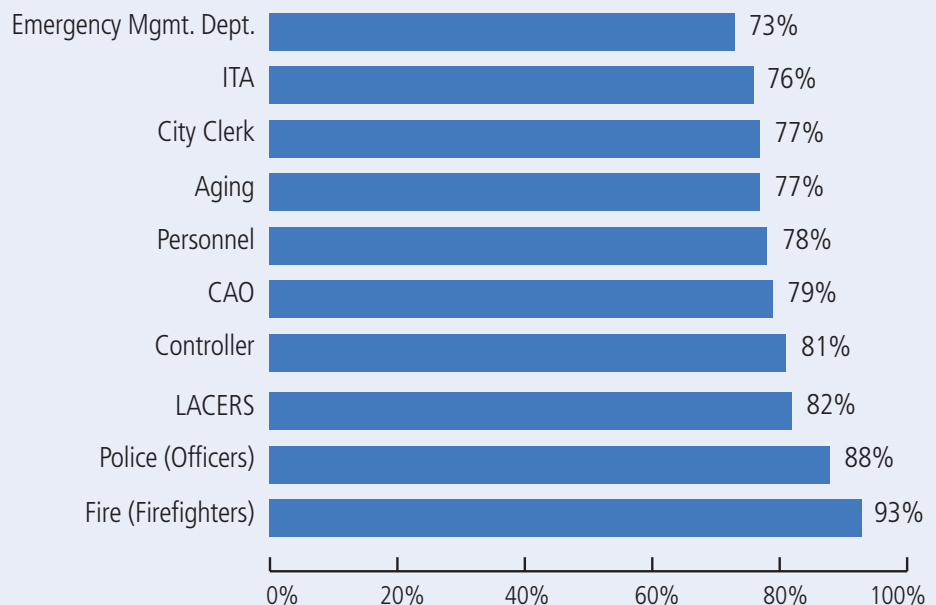
$$\begin{array}{c}
 \text{LACERS Retirement} \\
 \text{Income} \\
 + \\
 \text{Deferred Comp Plan} \\
 \text{Income} \\
 = \\
 \text{Retirement Income} \\
 \text{Security}
 \end{array}$$

- 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. You are eligible for the Deferred Compensation Plan if you are a contributing member of LACERS.

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.

City Departments with Highest Deferred Compensation Plan Participation Rates

The majority of City employees participate in the City's Plan. These employees will receive two income streams upon retirement, instead of one. If you're not enrolled, consider joining. If you are enrolled, consider a modest increase to your contribution to further strengthen your 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 \$18,000 if you're below age 50; \$24,000 if you're age 50 or older; and \$36,000 for participants eligible for Catch-Up. These limits are subject to increase by the Federal Government on an annual basis.

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 Empower Retirement Services. You can obtain enrollment materials by visiting the Plan website at cityofla457.com; calling (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.



Paying for Coverage

Flex Credits

Some MOUs provide for Flex credits based upon negotiations. Flex Credits are additional dollars you can use for pre-tax benefits or take as taxable cash in your paycheck. Please refer to your MOU for specifics.

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.

Cash-in-Lieu of Health or Dental 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 are eligible to opt out of health and/or dental coverage under certain circumstances and receive a cash benefit in lieu of the coverage as follows:

| | Cash-in-Lieu Benefits | |
|---|--|--|
| | 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 24, 1989*: | \$25 a pay period | \$1.25 a pay period |

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 within 30 calendar days after you lose other coverage. See "When You Can Make Changes" on **page 54**.

Selecting Cash-in-Lieu

If you select Cash-in-Lieu for the first time during Open Enrollment or as a new hire, **you must complete and return the Cash-in-Lieu affidavit you receive with your confirmation statement by the following deadlines:**

- By December 11, 2015 if you select Cash-in-Lieu during Open 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 enroll as a new hire. If you do not return the affidavit, Cash-in-Lieu will be canceled effective the 61st day.

*If you are a regular half-time employee hired after 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.



2016 Health Coverage Costs

The majority of health insurance premium costs are paid by the City's subsidy. This demonstrates the City's commitment to employees and their families – adding up to a valuable part of your total compensation.

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 has three different contribution structures for its health plans: Flex Plan, Flex-Pay Plan 1, and Flex-Pay Plan 2. The City's subsidy covers costs up to the Kaiser Permanente HMO family rate (\$1,480.04 a month) for full-time employees and the Kaiser Permanente HMO employee-only rate (\$569.26 a month) for half-time employees, subject to any premium sharing requirements as provided for by the employee's MOU. **Page 44** shows 2016 health coverage costs for the Flex Plan. Flex Plan costs apply to most City employees who are eligible for Flex.

- **Flex-Pay Plan 1:** You have Flex-Pay Plan 1 coverage costs if you are in MOU 29 or 31. See **page 45**.
- **Flex-Pay Plan 2:** You have Flex-Pay Plan 2 coverage costs if you are in MOU 00, 01, 19, 20, 21, 26, 27, 28, 32, 38, 39, 40 or 61. See **page 46**.

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 | \$1,091.73 | \$13,100.76 |
| Dental | \$35.33 | \$423.96 |
| Basic Disability | \$23.46 | \$281.52 |
| Basic Life | \$1.86 | \$22.32 |
| Total | \$1,152.38 | \$13,828.56 |

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. For example, if you use \$100 of pre-tax pay and you are in the 15% tax bracket, you save \$15 in taxes ($\$100 \times .15 = \15).

Flex Plan Dental Costs

The City offers one contribution structure for its dental plans. **Page 47** shows 2016 dental coverage costs for these plans.

**Flex Plan****2016 Costs Per Pay Period (Every Two Weeks)
for Flex Health Coverage**

| Coverage Level | FULL-TIME EMPLOYEES | | HALF-TIME EMPLOYEES | | Total Cost of Coverage Bi-Weekly |
|--|---------------------|------------------|---------------------|------------------|----------------------------------|
| | City Pays... | Employee Pays... | City Pays... | Employee Pays... | |
| Kaiser HMO | | | | | |
| Employee Only | \$284.63 | \$0.00 | \$284.63 | \$0.00 | \$284.63 |
| Employee + Spouse/DP | \$626.14 | \$0.00 | \$284.63 | \$341.51 | \$626.14 |
| Employee + Child(ren) | \$569.27 | \$0.00 | \$284.63 | \$284.64 | \$569.27 |
| Family | \$740.02 | \$0.00 | \$284.63 | \$455.39 | \$740.02 |
| Blue Shield Access+ HMO SaveNet (Narrow Network) | | | | | |
| Employee Only | \$265.66 | \$0.00 | \$265.66 | \$0.00 | \$265.66 |
| Employee + Spouse/DP | \$583.73 | \$0.00 | \$284.63 | \$299.10 | \$583.73 |
| Employee + Child(ren) | \$528.89 | \$0.00 | \$284.63 | \$244.26 | \$528.89 |
| Family | \$726.02 | \$0.00 | \$284.63 | \$441.39 | \$726.02 |
| Blue Shield Access+ HMO (Full Network) (not available to MOUs 22, 23 or 24) | | | | | |
| Employee Only | \$265.66 | \$139.34 | \$265.66 | \$139.34 | \$405.00 |
| Employee + Spouse/DP | \$583.73 | \$306.69 | \$284.63 | \$605.79 | \$890.42 |
| Employee + Child(ren) | \$528.89 | \$277.48 | \$284.63 | \$521.74 | \$806.37 |
| Family | \$726.02 | \$380.69 | \$284.63 | \$822.08 | \$1,106.71 |
| Shield Spectrum PPO | | | | | |
| Employee Only | \$404.10 | \$0.00 | \$284.63 | \$119.47 | \$404.10 |
| Employee + Spouse/DP | \$740.02 | \$152.78 | \$284.63 | \$608.17 | \$892.80 |
| Employee + Child(ren) | \$740.02 | \$34.55 | \$284.63 | \$489.94 | \$774.57 |
| Family | \$740.02 | \$272.49 | \$284.63 | \$727.88 | \$1,012.51 |

**Flex-Pay Plan 1****2016 Costs Per Pay Period (Every Two Weeks)
for Flex Health Coverage**

| Coverage Level | FULL-TIME EMPLOYEES (MOUs 29 or 31) | | HALF-TIME EMPLOYEES (MOUs 29 or 31) | | Total Cost of Coverage Bi-Weekly |
|--|--|---------------------|--|---------------------|--|
| | City Pays... | Employee Pays... | City Pays... | Employee Pays... | |
| Kaiser HMO | | | | | |
| Employee Only | \$270.40 | \$14.23 | \$270.40 | \$14.23 | \$284.63 |
| Employee + Spouse/DP | \$594.83 | \$31.31 | \$270.40 | \$355.74 | \$626.14 |
| Employee + Child(ren) | \$540.81 | \$28.46 | \$270.40 | \$298.87 | \$569.27 |
| Family | \$703.02 | \$37.00 | \$270.40 | \$469.62 | \$740.02 |
| Blue Shield Access+ HMO SaveNet (Narrow Network) | | | | | |
| Employee Only | \$252.38 | \$13.28 | \$252.38 | \$13.28 | \$265.66 |
| Employee + Spouse/DP | \$554.54 | \$29.19 | \$270.40 | \$313.33 | \$583.73 |
| Employee + Child(ren) | \$502.45 | \$26.44 | \$270.40 | \$258.49 | \$528.89 |
| Family | \$689.72 | \$36.30 | \$270.40 | \$455.62 | \$726.02 |
| Blue Shield Access+ HMO (Full Network) (not available to MOUs 22, 23 or 24) | | | | | |
| Employee Only | \$252.38 | \$152.62 | \$252.38 | \$152.62 | \$405.00 |
| Employee + Spouse/DP | \$554.54 | \$335.88 | \$270.40 | \$620.02 | \$890.42 |
| Employee + Child(ren) | \$502.45 | \$303.92 | \$270.40 | \$535.97 | \$806.37 |
| Family | \$689.72 | \$416.99 | \$270.40 | \$836.31 | \$1,106.71 |
| Shield Spectrum PPO | | | | | |
| Employee Only | \$383.89 | \$20.21 | \$270.40 | \$133.70 | \$404.10 |
| Employee + Spouse/DP | \$703.02 | \$189.78 | \$270.40 | \$622.40 | \$892.80 |
| Employee + Child(ren) | \$703.02 | \$71.55 | \$270.40 | \$504.17 | \$774.57 |
| Family | \$703.02 | \$309.49 | \$270.40 | \$742.11 | \$1,012.51 |



Flex-Pay Plan 2

2016 Costs Per Pay Period (Every Two Weeks) for Flex Health Coverage

| Coverage Level | FULL-TIME EMPLOYEES (MOUs 00, 01, 19, 20, 21, 26, 27, 28, 32, 38, 39, 40 or 61) | | HALF-TIME EMPLOYEES (MOUs 00, 01, 19, 20, 21, 26, 27, 28, 32, 38, 39, 40 or 61) | | Total Cost of Coverage Bi-Weekly |
|--|---|---------------------|---|---------------------|--|
| | City Pays... | Employee Pays... | City Pays... | Employee Pays... | |
| Kaiser HMO | | | | | |
| Employee Only | \$256.17 | \$28.46 | \$256.17 | \$28.46 | \$284.63 |
| Employee + Spouse/DP | \$563.53 | \$62.61 | \$256.17 | \$369.97 | \$626.14 |
| Employee + Child(ren) | \$512.34 | \$56.93 | \$256.17 | \$313.10 | \$569.27 |
| Family | \$666.02 | \$74.00 | \$256.17 | \$483.85 | \$740.02 |
| Blue Shield Access+ HMO SaveNet (Narrow Network) | | | | | |
| Employee Only | \$239.09 | \$26.57 | \$239.09 | \$26.57 | \$265.66 |
| Employee + Spouse/DP | \$525.36 | \$58.37 | \$256.17 | \$327.56 | \$583.73 |
| Employee + Child(ren) | \$476.00 | \$52.89 | \$256.17 | \$272.72 | \$528.89 |
| Family | \$653.42 | \$72.60 | \$256.17 | \$469.85 | \$726.02 |
| Blue Shield Access+ HMO (Full Network) (not available to MOUs 22, 23 or 24) | | | | | |
| Employee Only | \$239.09 | \$165.91 | \$239.09 | \$165.91 | \$405.00 |
| Employee + Spouse/DP | \$525.36 | \$365.06 | \$256.17 | \$634.25 | \$890.42 |
| Employee + Child(ren) | \$476.00 | \$330.37 | \$256.17 | \$550.20 | \$806.37 |
| Family | \$653.42 | \$453.29 | \$256.17 | \$850.54 | \$1,106.71 |
| Shield Spectrum PPO | | | | | |
| Employee Only | \$363.69 | \$40.41 | \$256.17 | \$147.93 | \$404.10 |
| Employee + Spouse/DP | \$666.02 | \$226.78 | \$256.17 | \$636.63 | \$892.80 |
| Employee + Child(ren) | \$666.02 | \$108.55 | \$256.17 | \$518.40 | \$774.57 |
| Family | \$666.02 | \$346.49 | \$256.17 | \$756.34 | \$1,012.51 |



2016 Costs Per Pay Period for Flex Dental Coverage

| Coverage Level | FULL-TIME EMPLOYEES (All MOUs) | | HALF-TIME EMPLOYEES (All MOUs) | | Total Cost of Coverage Bi-Weekly |
|------------------------------|-----------------------------------|---------------------|-----------------------------------|---------------------|--|
| | City Pays... | Employee Pays... | City Pays... | Employee Pays... | |
| 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 benefit 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 50-53** 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. 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 2016 when you enroll yourself and these dependents:

| | Kaiser Permanente HMO | | | Blue Shield Access+ HMO SaveNet (Narrow Network) or Blue Shield Access+ HMO (Full Network) | | | 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 | \$341.51 | \$324.43 | \$307.36 | \$318.07 | \$302.16 | \$286.27 | \$335.92 | \$319.13 | \$302.33 |
| Domestic Partner's Children | \$284.64 | \$270.41 | \$256.17 | \$263.23 | \$250.07 | \$236.91 | \$335.92 | \$319.13 | \$302.33 |
| 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 | \$341.51 | \$324.43 | \$307.36 | \$318.07 | \$302.16 | \$286.27 | \$335.92 | \$319.13 | \$302.33 |
| Domestic Partner + Domestic Partner's Children | \$455.39 | \$432.62 | \$409.85 | \$460.36 | \$437.34 | \$414.33 | \$335.92 | \$319.13 | \$302.33 |
| Domestic Partner + Your and Domestic Partner's Children | \$341.51 | \$324.43 | \$307.36 | \$318.07 | \$302.16 | \$286.27 | \$335.92 | \$319.13 | \$302.33 |

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.



Eligibility

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 51.

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 (MOU 27 or MOU 38) 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 51** 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 within 30 days of the divorce or end of your domestic partnership. If you fail to remove ineligible dependents, you will be required to pay all costs for any benefits that were paid on their behalf and may be subject to disciplinary action.



The following chart describes eligible dependents for health coverage, dental coverage, life insurance and AD&D coverage. See "About Eligible Dependents" on **pages 34-37** 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 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 53 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 <ul style="list-style-type: none"> • 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 end of the month in which your dependent turns age 26 effective January 1, 2016.



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 |
|---|--|--|
| Open Enrollment (October 1-October 31) | If you enroll your dependent who is not currently covered during Open Enrollment (October 1- October 31, 2015), documents must be received by December 11, 2015 . | 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 Open Enrollment. You will not be able to re-enroll your dropped dependent until the next Open Enrollment period or within 30 days of a qualifying life event. |
| Outside Open Enrollment | If you enroll your dependent during the year, documents must be received within 60 days of the date on the confirmation statement you receive after enrolling. | 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 Open 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.

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.

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 51**).



Changing Your Benefit Choices

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 Open Enrollment.

When Your Choices Will Apply

The benefit choices you make during Open Enrollment each October stay in effect from January 1 through December 31 of the following year. 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. The exceptions are: You can enroll in or change your participation in the Deferred Compensation Plan or the Commuter Spending Accounts any time during 2016. See **page 38** and **40** for more on these benefits.

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 54**). 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 visiting **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 going to **myflexla.com**. If you do not go online or call **within 30 calendar days**, you must wait until the next Open Enrollment to enroll that child. For example, if your child is born on June 1, 2016, you must call or go online to enroll your child by June 30, 2016. If you do not enroll your child within that time, you must wait until the next Open Enrollment, and your child will not have coverage until January 2017.

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 Children’s Health Insurance Program (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. See **page 59** for details on CHIP.



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 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.

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 non-medical 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. For your medical benefits, please contact the Employee Benefits Division at 213-978-1655 to understand your coverage options and costs.

If, in the same calendar year, you return to working the required number of hours, you will need to contact the Employee Benefits Division 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 20** for more information on life insurance and **page 26** 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. After Benefit Protection Plan coverage ends, contact the Employee Benefits Division at 213-978-1655 to understand your coverage options and costs.

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

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

You are considered in a non-pay status if you take a leave of absence that does not include a Family Medical Leave (FMLA) or Catastrophic Leave. You can choose to continue your non-medical 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. For your medical benefits, please contact the Employee Benefits Division at 213-978-1655 to understand your coverage options and costs. 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.

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.



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 the Employee Benefits Division at 213-978-1655 to understand your coverage options and costs.

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.

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.



Important Legal Notices

Women's Health and 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 to <http://per.lacity.org/bens/docforms.htm>.

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.

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

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

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

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

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



If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2015. Contact your State for more information on eligibility.

ALABAMA – MedicaidWebsite: www.myalhipp.com

Phone: 1-855-692-5447

ALASKA – MedicaidWebsite: <http://health.hss.state.ak.us/dpa/programs/medicaid/>

Phone (Outside of Anchorage): 1-888-318-8890

Phone (Anchorage): 907-269-6529

COLORADO – MedicaidMedicaid Website: <http://www.colorado.gov/hcpf>

Medicaid Phone: 1-800-221-3943

FLORIDA – MedicaidWebsite: <https://www.flmedicaidprecovery.com/>

Phone: 1-877-357-3268

GEORGIA – MedicaidWebsite: <http://dch.georgia.gov/> - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)

Phone: 404-656-4507

INDIANA – MedicaidWebsite: <http://www.in.gov/fssa>

Phone: 1-800-889-9949

IOWA – MedicaidWebsite: www.dhs.state.ia.us/hipp/

Phone: 1-888-346-9562

KANSAS – MedicaidWebsite: <http://www.kdheks.gov/hcf/>

Phone: 1-800-792-4884

KENTUCKY – MedicaidWebsite: <http://chfs.ky.gov/dms/default.htm>

Phone: 1-800-635-2570

LOUISIANA – MedicaidWebsite: <http://dhh.louisiana.gov/index.cfm/subhome/1/n/331>

Phone: 1-888-695-2447

MAINE – MedicaidWebsite: <http://www.maine.gov/dhhs/ofipublic-assistance/index.html>

Phone: 1-800-977-6740

TTY 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIPWebsite: <http://www.mass.gov/MassHealth>

Phone: 1-800-462-1120

MINNESOTA – MedicaidWebsite: http://www.dhs.state.mn.us/id_006254

Click on Health Care, then Medical Assistance

Phone: 1-800-657-3739

MISSOURI – MedicaidWebsite: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

MONTANA – MedicaidWebsite: <http://medicaid.mt.gov/member>

Phone: 1-800-694-3084

NEBRASKA – MedicaidWebsite: www.ACCESSNebraska.ne.gov

Phone: 1-855-632-7633

NEVADA – MedicaidMedicaid Website: <http://dwss.nv.gov/>

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – MedicaidWebsite: <http://www.dhhs.nh.gov/oii/documents/hippapp.pdf>

Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIPMedicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Medicaid Phone: 609-631-2392

CHIP Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710

NEW YORK – MedicaidWebsite: http://www.nyhealth.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – MedicaidWebsite: <http://www.ncdhhs.gov/dma>

Phone: 919-855-4100

NORTH DAKOTA – MedicaidWebsite: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>

Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIPWebsite: <http://www.insureoklahoma.org>

Phone: 1-888-365-3742

OREGON – MedicaidWebsite: <http://www.oregonhealthykids.gov><http://www.hijossaludablesoregon.gov>

Phone: 1-800-699-9075

PENNSYLVANIA – MedicaidWebsite: <http://www.dhs.state.pa.us/hipp>

Phone: 1-800-692-7462

RHODE ISLAND – MedicaidWebsite: www.eohhs.ri.gov

Phone: 401-462-5300

**SOUTH CAROLINA** – MedicaidWebsite: <http://www.scdhhs.gov>

Phone: 1-888-549-0820

SOUTH DAKOTA – MedicaidWebsite: <http://dss.sd.gov>

Phone: 1-888-828-0059

TEXAS – MedicaidWebsite: <http://gethipptexas.com/>

Phone: 1-800-440-0493

UTAH – Medicaid and CHIPMedicaid Website: <http://health.utah.gov/medicaid>CHIP Website: <http://health.utah.gov/chip>

Phone: 1-866-435-7414

VERMONT – MedicaidWebsite: <http://www.greenmountaincare.org/>

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIPMedicaid Website: http://www.coverva.org/programs_premium_assistance.cfm

Medicaid Phone: 1-800-432-5924

CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm

CHIP Phone: 1-855-242-8282

WASHINGTON – MedicaidWebsite: <http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx>

Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – MedicaidWebsite: www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx

Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – MedicaidWebsite: <http://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>

Phone: 1-800-362-3002

WYOMING – MedicaidWebsite: <https://wyequalitycare.acs-inc.com/>

Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2015, 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, Menu Option 4, Ext. 61565

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 <http://per.lacity.org/bens/docforms.htm>. A paper copy is also available, free of charge, by calling the Benefits Service Center at 1-800-778-2133.



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 2016. 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 1-800-779-8328 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 2016 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 1-213-978-1655.

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: 10/01/2015
 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: 1-213-978-1655
 E-Mail: per.empbenefits@lacity.org

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



Contacts

| Plan/Program/Contact | Web Site | Phone Number |
|--|---|---|
| Blue Shield Access+ HMO SaveNet (Narrow Network) and Blue Shield Access+ HMO (Full Network) | 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 | blueshieldca.com/lacity | 1-855-201-2086 |
| Delta Dental PPO or Preventive Only | deltadentalins.com/enrollees/index.html | 1-800-765-6003 |
| DeltaCare USA DHMO | deltadentalins.com/enrollees/index.html | 1-800-422-4234 |
| Employee Assistance Program | members.mhn.com (company code "cityoflosangeles") | 1-800-213-5813 |
| Healthcare Flexible Spending Account or Dependent Care Reimbursement Account | wageworks.com | 1-877-924-3967 |
| Commuter Spending Accounts | wageworks.com | 1-877-924-3967 |
| The Standard Insurance Company: life insurance, AD&D and disability insurance | 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 | myflexla.com to enroll or make changes to your Flex benefits | 1-800-778-2133 and immediately press "0#" two times to speak with a representative or 1-800-735-2922 if hearing or speech impaired (Monday – Friday, 8 a.m. to 5 p.m. Pacific time) |
| Employee Benefits Division | 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 | lacers.org | 1-800-779-8328 |
| Deferred Compensation Plan | cityofla457.com | 1-888-466-0381 (Empower) or 213-978-1636 (Employee Benefits Division) |
| Parking/Transit reimbursement/ Rideshare programs | http://per.lacity.org/bens/commuteoptions.htm | 213-978-1655 |
| City Employees Club of Los Angeles | cityemployeesclub.com | 213-620-0388 |
| All City Employees Benefits Services Association | acebsa.org | 213-485-2485 |
| City MOUs | http://cao.lacity.org/MOUS | 213-978-7676 |

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City of Los Angeles

Flex Enrollment 2016

Reminder

Write your employee ID number and name on each document you submit to complete your enrollment. See [pages 51 and 52](#) of this booklet for more about required documentation.