County of Los Angeles

Flex
SUMMARY PLAN DESCRIPTION

Effective January 1, 2014

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INTRODUCTION

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

- Medical
- Dental
- Accidental death and dismemberment (AD&D) insurance
- Optional Group Variable Universal Life (GVUL) insurance
  Optional dependent term life insurance
- Medical coverage protection (LTD Health Insurance)
- Spending accounts
  - Health Care Spending Account
  - Dependent Care Spending Account.

In addition, the County provides basic term life insurance.

If you have questions not answered in this Summary Plan Description (SPD), contact the insurance carrier directly (see **Contact Information** on page 49) or the County's Benefits Hotline at **213-388-9982** from 8:00 a.m. to 4:00 p.m., Monday through Friday.

GENERAL INFORMATION

Eligibility

Employee Eligibility

If you are a full-time, permanent employee of the County of Los Angeles and you are in an eligible class of employees approved for *Flex* by the Board of Supervisors, then you are eligible for *Flex*.

Dependent Eligibility for County-Sponsored Plans

If you are eligible to participate in County-sponsored medical, dental, optional group variable universal life (GVUL), and accidental death and dismemberment (AD&D) insurance plans, so are your eligible dependents. Your *eligible dependents*[1] generally include:

- Your spouse/domestic partner (see page 3 for special rules concerning domestic partner eligibility).
- Your children through age 25.

Coverage for a disabled child may continue past age 25 if your health plan determines that your child became disabled before the limiting age (check with your health plan to determine the limiting age). Proof of your child's disability may be required from time to time. Your disabled child's coverage ends when the plan no longer considers your child to be disabled, your child marries or no longer depends on you for support, or you stop coverage for any reason.

Children

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

Ineligible Dependents

Your former spouse/domestic partner, parents, parents-in-law, other relatives, and nondisabled dependent children age 26 and over are not eligible for coverage under your medical and dental plans.[1]

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

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[1] *The optional dependent term life insurance and accidental death and dismemberment plans have different age dependent eligibility requirements. See pages 20 and 23 for details. Different dependent requirements also apply to the spending accounts. See page 27 and 31 for details.*

Rules Governing Domestic Partners

If you are in a domestic partnership and you and your partner both meet **all** of the criteria listed below, you may enroll your domestic partner and his or her legally dependent children in your *Flex* medical, dental, and supplemental accidental death and dismemberment insurance plans. If you enroll in the group variable universal life (GVUL) plan, you may also purchase a limited amount of life insurance for your domestic partner and his or her legally dependent children.

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

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

Cost of Medical/Dental Benefits

If you have coverage for yourself only and you add a domestic partner, or the children of such partner, to your medical and/or dental coverage, your monthly premium (cost of coverage) will increase.

Taxation of Medical/Dental Coverage for Domestic Partners

If you purchase medical or dental coverage for your domestic partner or his/her children who do not qualify as your federal tax dependents for health plan purposes, the cost of that coverage is treated as taxable and is reported on your monthly paycheck as "imputed income." If you currently pay medical or dental premiums for coverage for "you and a child" and you add a child of a domestic partner, your monthly premium will not increase, but you must pay taxes on the fair market value of the additional coverage. The value is set at the "you only" premium rate for your medical or dental plan, no matter how many of your domestic partner's children you enroll. The fair market value will appear as imputed income on your monthly paychecks.

The cost of medical coverage furnished under the LTD Health Insurance program to a domestic partner or his/her children also is treated as taxable and is reported on your monthly paycheck as "imputed income" unless that individual is a federal tax dependent for health plan purposes.

However, if you provide the *Flex* Administrator with a copy of your **registered** State of California *Declaration of Domestic Partnership Form* (or proof of a similar legal union validly formed in another state) your cost for such coverage will be deducted before California state taxes are taken out of your pay. Note that your County of Los Angeles registration alone does not qualify you for this tax break.

If you want to take advantage of the state tax exemption applicable to domestic partners, you must submit a copy of your **registered** State of California *Declaration of Domestic Partnership Form* (or proof of a similar legal union validly formed in another state) to the *Flex* Administrator, P.O. Box 67128, Los Angeles, CA 90067, or fax it to 310-788-8775.

To register your domestic partnership with the State, obtain a State of California *Declaration of Domestic Partnership Form* from the Secretary of State. You may write to Secretary of State, Domestic Partnerships, P.O. Box 942877, Sacramento, CA 94277-0001, or call 916-653-3984, or visit the website at **www.ss.ca.gov/dpregistry.**

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

Enrolling a Domestic Partner
When enrolling a domestic partner for the first time, you must send a completed County of Los Angeles *Declaration of Domestic Partnership Form* and proof of same principal residence to the *Flex* Administrator at P.O. Box 67128, Los Angeles, CA 90067. Coverage for your domestic partner and your domestic partner's eligible dependents will not be activated until the *Flex* Administrator approves your completed and signed form.

Enrolling via the Web? You can download and print the County of Los Angeles *Declaration of Domestic Partnership Form* from the Web enrollment system at **www.mylacountybenefits.com**.

Enrolling by phone? After you enroll over the phone, the County of Los Angeles Benefits Administrator will mail the County of Los Angeles *Declaration of Domestic Partnership Form* to you.

Adding Domestic Partners During the Year
You may add a domestic partner and your domestic partner's children to your medical and/or dental coverage during the year under the rules described in the section **Enrollment Changes During the Plan Year: Changes in Status** (see pages 12-16).

When Coverage for a Domestic Partner Begins
If you are enrolling your domestic partner during annual enrollment, coverage will become effective January 1 of the following year provided the County approves your form. If you are enrolling a domestic partner during the year under the plan's changes in status rules, refer to the section **When Changes Become Effective** on page 15.

STOPPING COVERAGE FOR A DOMESTIC PARTNER DURING THE YEAR
You can stop coverage for your domestic partner and/or your domestic partner's children on the Web or telephone enrollment system under the rules described in the section **Enrollment Changes During the Plan Year: Changes in Status** (see pages 12-16).

If you want to terminate your domestic partnership, go to the Web or telephone enrollment system and indicate that you have a termination of domestic partnership. You must then send your completed *County of Los Angeles Termination of Domestic Partnership Form* or appropriate **registered** State of California document (or proof of similar **valid** documents from another state) to the *Flex* Administrator. Once you terminate a domestic partnership, you must wait **12 months** to enroll a domestic partner for coverage. The 12-month exclusion is waived if you submit a copy of the registered State of California *Notice of Termination of Domestic Partnership Form* to the *Flex* Administrator, P.O. Box 67128, Los Angeles, CA 90067.

Via the Web: Go to www.mylacountybenefits.com, click **Web enrollment system, then click on** life event, and indicate that you have a termination of domestic partnership. **D**ownload and print the *County of Los Angeles Termination of Domestic Partnership Form* from the Web enrollment system.

By phone: The *Flex* Administrator will mail the *County of Los Angeles Termination of Domestic Partnership Form* to you after you request to terminate your domestic partnership on the telephone enrollment system.

Note: There are different rules for adding dependents due to a qualified change in status. Refer to pages 12-16 for details.

Required Proof of Dependent Eligibility

If you choose to add a dependent during annual enrollment, you must provide proof of dependent status and your dependent's Social Security number within 10 calendar days from the date of your enrollment. Documents that serve as proof of dependent eligibility are:

Dependent	Required Documents	Note*
Spouse	Photocopy of your church, county, or state marriage certificate	Marriage certificates must include: ▪ Names of parties, ▪ Signature of solemnizing official, and ▪ Marriage date **Marriage licenses will NOT be accepted**
Child	Photocopy of the hospital, state, county, or foreign (requires notarized translation) birth certificate, OR legal adoption papers** ***Adoptive Placement Agreements or Court-Appointed Guardianship Documents are valid.*	Birth certificates must indicate: ▪ Name of parents ▪ Child's date of birth
Disabled child age 26 and older	Proof of disability requirements may differ by plan and may include certification of the disability from a licensed doctor or the Social Security Administration. See page 2 for eligibility information and contact your health plan for proof documents	

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

Write your name and employee number and Social Security number for the dependent you are adding on each certificate or document and fax all documents to 310-788-8775, or mail them to the *Flex* Administrator at P.O. Box 67128, Los Angeles, CA 90067.

Flex Annual Enrollment

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

- Enroll or re-enroll in the Health Care and Dependent Care Spending Accounts.
- Enroll in or change medical and dental plans.
- Waive medical and/or dental coverage if you meet the criteria (see the **Waiving Medical Coverage** section on page 7 for details).
- Select, change, or cancel accidental death and dismemberment (AD&D) insurance or medical coverage protection (LTD Health Insurance).
- Certify that you meet the requirements to avoid the tobacco user premium. See page 7 for details.
- Add or drop coverage for dependents. If you are adding dependents, you must provide satisfactory documentation before coverage for your newly added dependent may begin (see **Required Proof of Dependent Eligibility** on page 5 for a list of the required proof documents).
- Do nothing and your current coverage will continue, except for the Health Care and Dependent Care Spending Accounts, which will be canceled.
- Select, change, or cancel optional group variable universal life (GVUL) or optional dependent term life.

Monthly Benefit Allowance

As a *Flex* participant, you receive a benefit allowance which you can use to pay for your coverage. Your monthly benefit allowance is equal to 10% of your monthly salary or $809, whichever is greater.

The Taxable Cash Limit and Pensionable Flex

If you previously voluntarily elected to participate in *non-pensionable Flex*, this section does not apply to you.

If you are enrolled in **pensionable *Flex,* only a portion of your County allowance is pensionable – that is, included in the compensation that is taken into account when calculating your pension benefits upon retirement (referred to as your "Pensionable Amount").** Unless you sign the waiver discussed on page 7, you may not receive more than this Pensionable Amount as taxable cash from your unspent County allowance**. You lose any unspent allowance dollars that are over your Pensionable Amount.**

Pensionable Amount

If you were first a *Flex* participant or eligible to participate before January 1, 1995, and began or continued participation on January 1, 1995, your Pensionable Amount is limited to the amount you were entitled to receive as a County allowance as of December 31, 1994 based on your salary as of that date.

If you changed your enrollment from *MegaFlex* to *Flex* in 1995 or 1996, your Pensionable Amount is limited to either $442 or 10% of your monthly salary in effect on December 31, 1994, whichever amount is greater.

Example of Loss (Forfeiture) of County Allowance

If your Pensionable Amount is $442 and you are eligible for a pension of 50% of your salary, an additional $221 (50% of $442) will be added to your monthly pension. The maximum amount of cash you can receive from your unspent *Flex* allowance is limited to the same amount as your pensionable amount ($442). *You lose any allowance dollars you do not spend on benefits that are over your $442 taxable cash limit.* For example, if your benefits allowance is $809 and you spend $300 on benefits, $509 remains unspent. Since your taxable cash limit is $442, you will lose $67 per month ($509 - $442 = $67).

Waiver Option
To avoid forfeiting any of your benefits allowance, you may sign a waiver to remove the taxable cash limit. To remove your taxable cash limit, you must sign the *Waiver of Pensionability* form. The *Waiver of Pensionability* form is included in annual enrollment packets for pensionable *Flex* participants with taxable cash limits.

By signing the waiver, you:

- Ensure that all your unspent benefits allowance from the County will be added to your paycheck each month as taxable cash.
- Retain the right to have your Pensionable Amount count as pensionable income.
- Acknowledge that any benefits allowance you receive in excess of your Pensionable Amount is not pensionable.

For example, if your monthly benefits allowance is $809, you spend $300 on benefits, and your pensionable limit is $442, then:

1) The remaining unspent allowance of $509 ($809 - $300) will be added to your paycheck as taxable cash.
2) At the time of your retirement, $442 will be added to your final compensation before your pension is calculated.
3) The $67 ($509 - $442) taxable cash you receive that is **in excess of** $442 is **not** pensionable.

If you do not sign and return the waiver form to the Flex Administrator by the deadline shown on the form, your taxable cash limit will remain equal to your Pensionable Amount.

Tobacco User Premium

If you are enrolled in a County medical plan and used tobacco or tobacco products in the last 12 months, you will pay an additional after-tax charge of $20 per month unless you agree to complete a smoking cessation program, which is available to you free of charge. This does not apply to your spouse/domestic partner or children. You may cancel the tobacco user premium during enrollment only if you certify that you either: (1) have not used tobacco or tobacco products within the last 12 months, or (2) will complete a smoking cessation program during the plan year. Smoking cessation programs are available for Kaiser and Anthem Blue Cross members free of charge. The County may require you to verify your completion of a smoking cessation program.

We will accommodate the recommendations of your personal physician with regard to the standards you must meet in order to avoid the tobacco user premium. Please contact the Department of Human Resources at (213) 388-9982 if you have questions or need to involve your personal physician.

Waiving Medical Coverage

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

1) You are the primary subscriber (and not a dependent) in another employer's group plan, retirement medical plan, or Medicare.
2) You are enrolled in the other plan when you waive coverage under *Flex*, and you stay enrolled in that other plan for the duration of the year.
3) You provide satisfactory proof of other coverage as requested. If you enroll by telephone, you must complete a paper form by the deadline stated on your *Confirmation Statement*.

When you elect to waive medical coverage, you must submit a waiver certification. If you enroll using the Web enrollment system, you will be able to enter your information online. If you elect to waive using the telephone enrollment system, the *Flex* Administrator will mail you a *Waiver Certification Form*. You must submit the form and send it back to the *Flex* Administrator by the deadline date shown on the form.

All waiver requests must be approved. Your request will not be approved if:

- The *Flex* Administrator receives your waiver request after the deadline,
- The information is incomplete, or
- Your request does not meet the waiver requirements.

If your waiver request is not received by the deadline or the information is incomplete or does not satisfy waiver requirements, your waiver request will not be processed, and you will be automatically enrolled in *Flex* with employee-only Anthem Blue Cross Catastrophic medical coverage. This coverage will continue for the rest of the year.

You are not required to have other dental coverage to drop dental coverage during annual enrollment.

After You Enroll

Verifying Payroll Deductions for the Benefits You Elected

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

Your paycheck stub will show the amount of your monthly benefit allowance (CTY-ALLOW) and the cost of the specific benefits you elected. Payroll deduction codes for all benefits are listed below.

Cafeteria Benefits Information						
Cafeteria Category	Cafeteria %	County Contribution	Salary Reduction	Contributed Benefits	Taxable Cash	Taxable Cash Limit
RF005 FLEX CONTRIB	10.00%	809.00	0		511.35	

Benefit Category	Benefit Type	Benefit Plan	County Contributed	Salary Reduction	Benefit Applied	Available Balance YTD
EF124	EF124	KAISER NR 1PTY	254.00	0	254.00	0
EF046	EF046	LTD-H FL	3.00	0	3.00	0
EF410	EF410	AD&D 200K-EE	3.40	0	3.40	0
EF308	EF308	DLTADNT-NR 1PTY	32.25	0	32.25	0
EF006	EF006	FLEX ADM FEE	5.00	0	5.00	0
Total Cafeteria Benefits			**$297.65**	**$0.00**	**$297.65**	**$0.00**

Administrative Fee

You will be assessed a before-tax administrative fee of $5.00 per month to help defray *Flex* administration costs.

Payroll Deduction Codes

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

Medical Insurance

EF108-110 Anthem Blue Cross Prudent Buyer PPO
EF124-126 Kaiser Permanente
EF112-114 Anthem Blue Cross CaliforniaCare HMO
EF116-118 Anthem Blue Cross PLUS POS
EF120-122 Anthem Blue Cross Catastrophic

Dental Insurance

EF308-310 Delta Dental
EF324-326 SafeGuard
EF316-318 DeltaCare

AD&D

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

Spending Accounts

EF500 Health care spending account
EF502/RS506 Dependent care spending account

Life Insurance

EL207, Employee only (.5x - 8x)
EL303 - Dependent Term Life

Miscellaneous

EF047 100% LTD Health Insurance (medical coverage protection)
EF061 Tobacco user premium
EF006 *Flex* administrative fee

MetLife Investment Fund

EL209 MetLife side-fund

When Coverage Ends

For Yourself

Your coverage under *Flex* ends as shown in the table below:

If this event occurs…	Then your coverage ends…
Your employment ends	At the end of the month following the month in which your employment ends, as long as you are in a paid status for at least eight hours during the month your employment ends
Your employment status changes to temporary or part-time	At the end of the month following the month in which your permanent status ends, as long as you receive at least eight hours of pay under permanent status during the month your status changes
You are billed for insurance premiums under the County's self-pay program (see page 15) and you do not pay by the deadline	On the first day of the billed coverage month
You are offered and you elect to pay for coverage under COBRA	When you stop paying your monthly premiums or at the end of the continuation coverage period (see page 44)
You become eligible for a new benefit plan, such as *Choices* or *Options*	On the date your benefits under the new plan begin

For Your Dependents

Your dependent's coverage under *Flex* ends as follows:

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

You and your dependents may continue coverage under certain circumstances when coverage otherwise would end, as described in General Plan Administration: COBRA Continuation of Health Coverage on page 42 Your former spouse or domestic partner is no longer eligible for benefits upon divorce or dissolution of domestic partnership, and you must remove him or her from you medical and/or dental coverage in accordance with the Change in Status rules on pages 12-16.

IMPORTANT NOTE REGARDING CONSEQUENCES OF MISREPRESENTING ELIGIBILITY: When you enroll for coverage under the Plan, you certify that you and anyone you cover under the Plan meet all applicable eligibility requirements for the entire period of enrollment. You must notify the **plan administrator** via mail, facsimile, or email when you or any dependent loses eligibility within [90] days of such event. In addition, the **plan administrator** reserves the right to request information or proof of eligibility for you and your dependents at any time. If you enroll someone who is ineligible, or fail to remove an ineligible dependent from coverage within the time provided, your actions may be considered an intentional misrepresentation and/or fraud.

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

* If you have a Health Care Flexible Spending Account, eligible expenses for your child may be reimbursed from the account until he or she reaches age 27.

Enrollment Changes During the Plan Year: Changes in Status

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

- You qualify for certain special health plan enrollment periods under HIPAA.[2]
- You have a qualified change in status.
- There are certain cost or coverage changes.
- You experience other special circumstances (see page 13 for details).

Special Enrollment Periods for Medical Plans

Special Medical Plan Enrollment Rights for New Dependents

If you have a new dependent due to a mid-year marriage, birth, adoption, or placement for adoption, then you, your new dependent, and your spouse (even if he or she is not the new dependent) may enroll under any *Flex* medical plan option. (See Consistency Rules below for more details.)

HIPAA special enrollment rules allow you to switch plans if you acquire a new dependent. However, you must make any such changes to your coverage carefully to ensure that any costs and claims incurred will be paid because you will be subject to the new plan's continuity/transition-of-care rules. You should check with the new plan you want to elect before the date of your special enrollment.

Loss of Health Coverage

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

Changes in Status (Life Events)

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

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

Consistency Rules

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

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

- ***For medical and dental coverage:*** If a qualified change in status causes you, your spouse/domestic partner, or a dependent to lose or gain eligibility for coverage under *Flex*, or under a plan sponsored by your spouse's/domestic partner's or dependent's employer, you may make a change in your medical and/or dental coverage as long as the change is because of, and is consistent with, that change in status. For example: If a dependent dies or is no longer eligible for coverage, you may elect to cancel coverage for that dependent; however, you cannot cancel coverage for any other individual.
- ***For AD&D coverage:*** If you have a qualified change in status, you may increase or decrease your life and/or AD&D coverage.
- ***For the Dependent Care Spending Account:*** If you have a qualified change in status, you may make a change in your spending account election as long as that change is consistent with your status change. For example: If you have another baby, you may elect to increase your Dependent Care Spending Account contribution to cover the additional day care costs.

Cost or Coverage Changes

Flex benefits and benefits costs have been agreed to by the County, and the insurance carriers; approved by the Board of Supervisors; and are not expected to change during the year. In the unlikely event that the insurance carriers change benefit premiums during the year, the *Flex* Administrator will adjust the deductions from your monthly paycheck automatically to pay for any mid-year increases or decreases in the cost of the benefits you have elected. If the *Flex* Administrator determines that the cost of the benefit plan you elected has increased significantly, the *Flex* Administrator may allow you to make a corresponding change in your payroll deductions *or* allow you to revoke your existing election and enroll in another benefit plan with similar coverage. If the cost of another *Flex* plan has significantly decreased, the *Flex* Administrator may allow you to change your existing election and enroll in the *Flex* plan that has lower costs. Similarly, if the *Flex* Administrator determines that your existing coverage under a benefit plan has been reduced significantly, the *Flex* Administrator may allow you to revoke your existing election and enroll in another plan that offers increased coverage. Finally, if during the year a new benefit plan is offered or an existing benefit plan is eliminated, the *Flex* Administrator may allow you to enroll in the new benefit plan, or the replacement plan, depending on the circumstances.

Spending Account Cost or Coverage Changes

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

Elections on how much you put in your dependent care account can be adjusted in the middle of the year if your day care expenses change. Mid-year changes are only allowed if the dependent care provider is not your relative. Also, a dependent care election may be changed during the year to reflect a change in your dependent care provider or a change in the number of hours or days you utilize the provider.

Other Special Circumstances

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

Judgment, Decree, or Court Order

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

Medicare or Medicaid Entitlement

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

Change in Coverage under another Employer-Sponsored Plan
You may make a corresponding change to your *Flex* election if you are doing so because of a change that was made during a mid-year open enrollment under another employer-sponsored plan (e.g., your spouse's/domestic partner's employer's plan).

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

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

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

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

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

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

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

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

1) **Go** to the Web enrollment system at **www.mylacountybenefits.com** or **call** the telephone enrollment system, toll-free, at **888-822-0487.** Indicate that you have a qualified change in status and follow the instructions. If you are adding new dependents to your health coverage, you must provide Social Security numbers. (Social Security numbers for newborns must be provided as soon as possible.)
2) **Confirm** your elections and submit your request on the system.
3) **Photocopy** any appropriate "proof" documents, such as a marriage certificate, birth certificate, or divorce decree (see list on page 5). In the case of an election change that involves obtaining coverage under another employer's plan, you will be asked to certify that such coverage was or will be obtained.
4) **Write** your employee number on each certificate and document.
5) **Submit** your proof documents within 90 days of the date of your change in status. Fax them to 310-788-8775 or mail them to *Flex* Administrator, P.O. Box 67128, Los Angeles, CA 90067. Any request for a qualified change in status is not finalized until the *Flex* Administrator receives and approves all necessary proof documents, and processes your request. **Proof documents received after 90 days will not be processed!**

Note: The 90 day time period for an election change due to a change in status is intended to give the participant a reasonable time to make one election that is consistent with his or her change in status. It does not give the participant the right to make multiple election changes.

Getting Changes Approved

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

When Changes Become Effective

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

Coverage While Not Receiving Pay

If, for any reason, you receive no pay for any month, you will not receive the *Flex* benefit allowance the following month.[3] When you do not receive a *Flex* benefit allowance, your insurance premiums cannot be withheld from your paycheck. Thus, to continue your insurance coverage while you are in a "no-pay" status, you must pay the entire monthly insurance premiums for your coverage.

In addition, different rules may apply with regard to your coverage if you are on leave covered by the Family and Medical Leave Act ("FMLA") and the California Family Rights Act ("CFRA"), or on Pregnancy Disability Leave ("PDL"). See page 40 for details.

If you are enrolled in one or more of the following *Flex* plans, you will be billed monthly for your insurance under the County's Self-Pay program:

- Kaiser or Anthem Blue Cross medical.
- DeltaCare, Delta Dental, or SafeGuard dental.
- Accidental death and dismemberment (for a maximum of three years).
- Medical coverage protection (LTD Health Insurance).
- Health Care Spending Account.
- Optional group variable universal life (GVUL).
- Optional dependent term life insurance

Your insurance coverage continues as long as you are employed with the County and you pay your monthly insurance premiums by the given deadlines. You will continue to receive a billing notice each month while you are in a "no pay" status. If you miss making your monthly premium payments, you will no longer receive a billing notice and your coverage will end. You may then receive notice of any additional continuation rights that you may have under a federal law known as COBRA.

You may qualify to waive coverage for AD&D, Optional GVUL and dependent term life insurance.

If you are disabled or unable to work and are in the process of filing a claim or filed a claim for long-term disability (LTD) benefits, you must continue to pay for your medical premiums until you are approved for LTD Health Insurance. LTD Health Insurance benefits begin when you start receiving LTD benefits.

If you are enrolled in optional group variable universal life insurance and you become completely disabled, you may be eligible for a waiver of premium. Please contact MetLife directly for GVUL: 800-846-0124.

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

If you leave County service, you will be offered the opportunity to elect and pay for continued health coverage for up to 18 months (29 months if you are disabled) under a federal law known as COBRA. When federal COBRA coverage ends, you may be entitled to extend coverage further under California law. In addition, under federal COBRA, your dependents may be entitled to elect and pay for continued coverage for up to a total of 36 months if certain “qualifying events” occur during the 18-month period. When you first become covered under a County-sponsored health plan, you should receive a notice that explains your rights and obligations under COBRA as well as a notice explaining your rights and obligations under California law. Please contact the Benefits Hotline at 213-388-9982 if you did not receive your notices or need new copies.

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

Optional group variable universal life (GVUL) is fully portable. You can keep this coverage, at the same group rates, as long as you pay the full premiums after you end employment with the County.

Return to Work

If you return to work, your coverage will resume on the first of the following month. Your benefit allowance resumes and your insurance premiums are withheld from your mid-month paycheck. For Optional Group Universal Life (GVUL), if you do not pay your insurance premiums while you are in a no pay status, your coverage will end and you must contact MetLife within 90 days of returning to work to re-enroll for GVUL coverage.

YOUR MEDICAL PLAN OPTIONS

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

Plans	How They Work
Kaiser Permanente HMO *A group model health maintenance organization (HMO) with its own hospitals, outpatient facilities, doctors, nurses, and other health care professionals*	You receive all care from a Kaiser facility or physician. No benefits are paid for services received from other providers—except for emergencies outside the Kaiser Permanente service area. You choose a Kaiser Permanente primary care physician after coverage begins. (Contact Kaiser directly for details.)
Anthem Blue Cross CaliforniaCare HMO *A health maintenance organization (HMO) that contracts with private hospitals, medical groups and individual private practice physicians for services at negotiated rates*	Each family member may choose his or her own PCP from the Anthem Blue Cross network of private practice physicians. You pay only a small copayment for most services. There's no deductible and no claim forms. Services received from other providers are not covered—except for emergencies outside the Anthem Blue Cross network provider area.
Anthem Blue Cross PLUS POS *A combination point-of-service (POS) plan that offers three levels of coverage*	Each time you need care, you can choose one of the following three coverage levels: ▪ **Tier 1** (HMO) – You choose a PCP that coordinates all of your care. ▪ **Tier 2** (PPO or in-network) – You can choose to visit any doctor in the Anthem Blue Cross provider network and can "self-refer" to any network physician, including specialists. No deductible applies and no claim forms to complete. ▪ **Tier 3** (out-of-network) – You have the freedom to choose any licensed provider regardless if they are part of the Anthem Blue Cross network. Your out-of-pocket costs are higher and you are required to pay an annual deductible. You will also be responsible for filing claim forms.
Anthem Blue Cross Prudent Buyer PPO *A medical plan that allows you to choose an in-network PPO provider or an out-of-network provider each time you need care*	You can see any physician you choose at any time; however, when you use an Anthem Blue Cross preferred provider (doctor or hospital), you receive a higher level of benefits for covered expenses. You pay a deductible and a percentage of the bill. You do not have to complete claim forms if you use a preferred provider.
Anthem Blue Cross Catastrophic Coverage *A high deductible health plan designed to protect you from major, unexpected medical expenses*	Under this plan, you have the freedom to see any physician you choose and are responsible for paying the cost of your care until you reach the annual deductible. Once you satisfy your deductible, most benefits are covered at 75%. This is may be a good option if you have coverage under your spouse's/domestic partner's health plan.

Special Notices Regarding Your Rights under the Health Plans

Statement of Newborns' and Mothers' Rights

Under federal or state law, as applicable, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

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

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

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

Precertification Requirements

The medical plan administrators have the sole and exclusive power to exercise discretion as to claims for coverage for any other items not specifically listed in the *Medical and Dental Plans Comparison Chart* (included in your enrollment packet). You should contact the providers before obtaining a service or treatment if you have a question about whether the Plan covers the service or treatment. See page 49 for a complete list of the insurance carriers and their contact information.

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

Exclusions and Limitations for HMO, POS and PPO Medical Plans

The medical plan options limit or exclude some medical treatments, services, and supplies. See the insurance carrier for information about items that are not eligible for reimbursement.

Other Benefits and Programs

Each medical plan carrier has special programs and benefits for members. They may include healthy lifestyle, smoking cessation, and stress management programs, discounts, etc. Visit each plan's website, or contact the member services department, for details.

YOUR DENTAL PLAN OPTIONS

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

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

How to Obtain Dental Benefits

HMO-Style Dental Plans

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

PPO-Style Dental Plans

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

- *The Delta Preferred Provider Option (PPO) network:* This network offers the highest benefit. Most preventive services are covered at 100 percent; many other services are covered at 85 percent. You pay no deductible. **If you receive all your dental care from DPO providers, your maximum annual benefit will be higher.**
- *The Delta Participating Dentist network:* Under this network, Delta pays benefits based on a pre-arranged fee agreed to by the network's dentists. Most routine services are covered at 80 percent.

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

If You Lose Coverage During Treatment

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

Exclusions and Limitations for HMO and PPO Dental Plans

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

Need More Information?

If you have questions about the medical and dental plan options, or need more information about what's covered, contact the insurance carrier directly. See page 49 for carrier contact information.

LIFE INSURANCE BENEFITS

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

Basic Term Life Insurance

The County gives you basic term life insurance at no cost to you.

- *Safety Members of Retirement Plan A, B and General Members of Retirement Plan A, B, C, or D:* You are insured for $2,000.
- *Members of Retirement Plan E:* You are insured for $10,000.

Accidental Death and Dismemberment Insurance

You can purchase accidental death and dismemberment (AD&D) insurance at low monthly group rates. This insurance covers accidental death, or accidental loss of limb, eyesight, speech, hearing, or paralysis. Your *Personalized Enrollment Worksheet* included in your enrollment packet shows available AD&D insurance amounts as well as the **before-tax** monthly premium rates.

Beneficiary Designation

When you designate a specific beneficiary (such as a child) and your personal circumstances change (such as marriage), your beneficiary remains the same as you originally designated unless you request a change. To designate a beneficiary, mail a completed *Request For Change Of Beneficiary* card to CIGNA Life. If you do not have a named beneficiary on file, the plan will pay out your life insurance benefit in the following order:

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

AD&D Coverage for Dependents

If you enroll for AD&D coverage, you may also buy coverage for your spouse/domestic partner and dependent children under age 21 (or through age 24 if full-time students). The amount of coverage you have for yourself determines the amount of coverage your family members may have. Amounts are shown in the table below.

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

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

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

OPTIONAL LIFE INSURANCE

Life insurance offers you and your family financial protection if you or a family member dies. All eligible employees may purchase insurance coverage under the optional Group Variable Universal Life Insurance program. You may be eligible to purchase life insurance coverage from one half to eight times your annual salary.

Optional Group Variable Universal Life (GVUL) Insurance

The GVUL program is available through Metropolitan Life Insurance Company (MetLife). If you purchase optional GVUL insurance for yourself, you may also purchase a limited amount of life insurance coverage for your spouse/domestic partner and dependent children.

The MetLife GVUL program offers:

- Premiums at affordable group rates.
- Permanent (to age 95), and fully portable coverage; which means you can keep this coverage, at the same group rates, if you end employment with the County.
- A tax-advantaged investment opportunity.

Enrolling For Coverage

During Annual Enrollment

If you do not have GVUL coverage now, you may purchase coverage in an amount equal to one times your annual salary. If you already have GVUL coverage, you may increase your current coverage by one level without needing to provide medical information for approval. If you want to increase your coverage in an amount greater than one times your annual salary, you will be asked to complete a medical questionnaire to determine if your coverage can be approved.

You will see your current coverage amount and monthly premium, as well as other coverage options available to you, on the GVUL website. You may enroll for, or increase, your coverage on the GVUL website. It can be accessed by clicking the MetLife GVUL link found on the Web enrollment system at **www.mylacountybenefits.com**. If you do not want to enroll by Web, you may request an enrollment packet by calling MetLife at 800-846-0124.

Calculating Your Monthly Premium

The monthly cost (premium) of your GVUL insurance is calculated using your age and monthly salary. Your life insurance coverage (and corresponding cost) will increase if your salary increases. Your premium may also increase each year on January 1 when your age is recalculated.

You can calculate your monthly premium using the rates shown in the table on page 23. **All premiums are paid on an after-tax basis.** See page 22 for information about how your monthly premium is calculated.

Beneficiary Designation

If you want to name a beneficiary or change your beneficiary for your MetLife GVUL coverage, log on to the GVUL website by clicking on the MetLife link at **www.mylacountybenefits.com** or contact a MetLife group variable universal life (GVUL) Specialist at 800-846-0124 and ask for a form. If you do not have a named beneficiary on file with MetLife, see page 22 for details about how the plan pays benefits.

How the Plan Pays Benefits
If you do not have a named beneficiary on file with MetLife, your GVUL program will pay out your life insurance in the following order:

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

Increasing Your Coverage During the Year
Once you have enrolled in the optional Group Variable Universal Life (GVUL) plan, you can apply to increase your coverage during the year without waiting for future annual enrollments. There are two situations shown below that you should consider:

- If a life event occurs (such as marriage, divorce, birth, adoption, military leave, or a family death), you may increase the amount of insurance you have elected by one level without needing to provide medical information for approval. You may also change the amount of dependent coverage you have elected. You must apply for this increase within 90 days of the date of the life event. To determine if the life event would qualify, and to apply for an increase, contact a MetLife group variable universal life (GVUL) Specialist at 800-846-0124.
- If you have not had a life event but would like to apply for an increase in coverage, you can apply by clicking on the MetLife GVUL link found on the Web enrollment system at **www.mylacountybenefits.com**. You will be asked to complete a medical questionnaire to determine if your increase request can be approved.

Domestic Partner Coverage
To purchase dependent life or AD&D insurance for your domestic partner, you must have a registered County of Los Angeles or State of California *Declaration of Domestic Partnership Form* (or proof of a similar legal union validly formed in another state) on file with the *Flex* Administrator.

Total Disability and Terminal Illness Provisions
If you become totally disabled before age 65 and provide proof of disability to MetLife, your optional group variable life insurance coverage is extended for the period of disability without further premium payment. In addition, if you become terminally ill and have a life expectancy of 12 months or less, you can receive up to 85 percent of the face value of your policy and use it for whatever you choose. Read the plan ***brochure or policy material for details.***

How Your Monthly Premium Is Calculated
The monthly cost (premium) of your GVUL insurance is determined by following the steps shown in the example below. You can calculate your monthly premium using the rates shown in the table on page 23.

Kelly is 44 years old and earns $47,800 per year. She chooses two times her annual salary in GVUL coverage.	**Step 1** Round her salary up to the next highest $1,000 if it is not an even multiple of $1,000 **Step 2** $48,000 x 2 = $96,000 **Step 3** $96,000 ÷ $1,000 = $96 **Step 4** $96 x $.084 = $8.06 **Kelly's net cost per month = $8.06**

Optional Group Variable Universal Life Monthly Premium Rates

Employee Age	Cost Per $1,000 of Insurance*	Employee Age	Cost Per $1,000 of Insurance*	Employee Age	Cost Per $1,000 of Insurance*
20-24	0.038	57	0.283	77*	2.074
25-29	0.047	58	0.319	78*	2.341
30-34	0.055	59	0.357	79*	2.638
35-39	0.056	60	0.400	80*	3.405
40	0.065	61	0.451	81*	3.930
41-42	0.066	62	0.498	82*	4.287
43	0.074	63	0.535	83*	4.674
44	0.084	64	0.593	84*	5.092
45	0.093	65	0.616	85*	5.556
46	0.102	66	0.692	86*	6.042
47	0.110	67	0.736	87*	6.574
48	0.129	68	0.820	88*	7.144
49	0.138	69	0.911	89*	7.730
50	0.147	70	1.003	90*	8.329
51	0.165	71	1.109	91*	8.960
52	0.174	72	1.231	92*	9.607
53	0.191	73	1.352	93*	10.275
54	0.210	74	1.496	94*	10.953
55	0.238	75	1.649		
56	0.256	76*	1.831		

**For Flexible Benefit Plan employees ages 76-94 who remain in County service, the County will subsidize the difference between the employee's cost of coverage using the premium rate shown above for the employee's actual age and the cost for coverage using the age 75 premium rate.*

Optional Dependent Term Life Insurance

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

Amount of Optional Dependent Life Coverage*	Monthly Cost for Dependent Life Coverage
$5,000	$1.12
$10,000	$2.24
$15,000	$3.36
$20,000	$4.48

** Coverage for newborns from birth through 14 days is limited to $500.*

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

Each covered family member over age 14 days is insured for the same coverage amount. Dependent children are eligible to be enrolled in coverage beginning at the age of 15 days through age 18 (or age 25 if a full-time student). Once enrolled, their coverage can continue until they reach age 26.

Additional Feature—Tax-advantaged Investment Opportunity
Group variable universal life (GVUL) offers a tax-advantaged opportunity to program participants. You can choose to contribute additional money into an investment option that can be used during your lifetime. As with all investments, review the information carefully and speak to a tax advisor before you take advantage of this feature. You can learn more about this when you enroll for life insurance coverage through MetLife. **Note: participating in this investment feature is not required for you to enroll in optional group variable universal life (GVUL).**

The tax information contained in this communication is not intended to (and cannot) be used by anyone to avoid IRS penalties. This communication supports the promotion and marketing of GVUL. You should seek tax advice based on your particular circumstances from an independent tax advisor.

Prospectuses for Group Variable Universal Life insurance and its underlying portfolios can be obtained by calling 800- 685-0124. You should carefully consider the information in the prospectuses about the contract's features, risks, charges and expenses, and the investment objectives, risks and policies of the underlying portfolios, as well as other information about the underlying funding choices. Please read the prospectuses and consider this information carefully before investing. Product availability and features may vary by state. All product guarantees are subject to the financial strength and claims-paying ability of Metropolitan Life Insurance Company.

Variable products issued by Metropolitan Life Insurance Company, New York, NY 10166, and distributed by MetLife Investors Distribution Company (member NASD), Irvine, CA 92614. Securities, including variable products, offered through MetLife Securities, Inc. (member NASD/SIPC), New York, NY10166. Metropolitan Life Insurance Company, MetLife Investors Distribution Company, and MetLife Securities, Inc. are affiliates.

Domestic Partner Coverage
To purchase dependent life for your domestic partner, you must have a registered County of Los Angeles or State of California *Declaration of Domestic Partnership Form* (or proof of a similar legal union validly formed in another state) on file with the *MegaFlex* Administrator.

MEDICAL COVERAGE PROTECTION (LTD HEALTH INSURANCE)

You must be enrolled in a County-sponsored Anthem Blue Cross or Kaiser medical plan to participate in the LTD health insurance plan. Please refer to the Long-Term Disability booklet for a more detailed explanation of the LTD plan provisions. You can get a copy of the booklet by going to the Chief Executive Office website at **http://ceo.lacounty.gov/rtw/rtw_default.htm**.

The LTD Health Insurance plan is designed to help you continue your medical insurance coverage if you are eligible for Long-Term Disability and become totally and permanently disabled. If you meet the eligibility requirements listed below and become totally disabled, the LTD Health Insurance plan continues your County medical insurance coverage while you are receiving County LTD benefits. The cost of medical coverage furnished under the LTD Health Insurance program to a domestic partner or his/her children will be paid with after-tax dollars for federal tax purposes (unless the individual qualifies as a federal tax dependent for health plan purposes).

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

- You are a General Member of Retirement Plan A, B, C, D, or E of the Los Angeles County Employees Retirement Association (LACERA).
- You are enrolled in Kaiser or any of the County-sponsored Anthem Blue Cross health plans available within *Flex*.

If you meet the eligibility requirements, and you experience a disability on or after the later of January 1, 2007 or the date your medical coverage begins, the LTD Health Insurance plan pays 75 percent of your monthly medical premium while you are disabled and receiving LTD benefits. You must pay the other 25 percent of the monthly

medical premium. For disabilities occurring after January 1, 2007, this coverage is provided automatically at no cost to you.

For disabilities occurring on or after January 1, 2007, eligible employees can elect to “buy up” to 100 percent LTD Health Insurance at a cost of $3.00 per month. Under this optional coverage, the LTD Health Insurance plan will pay 100 percent of the monthly medical plan premium while you receive LTD benefits. **If you do not elect to purchase (or you cancel) the optional 100 percent coverage for a Plan Year, you cannot elect this coverage for the next Plan Year. You must wait two plan years before you again have the option to elect this coverage.**

When Coverage Begins

If you meet the LTD Health Insurance eligibility requirements described on page 24, your medical coverage protection under the LTD Health Insurance plan begins after you satisfy the long term disability plan’s eligibility waiting period (five years of continuous County service **OR** total disability as a result of a work-related injury or illness).

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

When Benefits Begin and End

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

Increasing Your Coverage During Annual Enrollment

If you are currently receiving long term disability benefits, and during annual enrollment you increase your LTD coverage or choose LTD Health Insurance for the first time, neither the LTD benefit increase or the LTD Health Insurance will become effective until you return to work. In such case, your return to work must be for a minimum of six months if you are totally disabled for the same cause. If you had previously enrolled in LTD Health Insurance, you will receive 75% medical coverage protection while you are on LTD.

Survivor Coverage

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

HEALTH CARE AND DEPENDENT CARE SPENDING ACCOUNTS

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

The Spending Account Tax Advantage

When you elect to participate in a spending account, you set aside part of your salary on a before-tax basis to pay certain eligible expenses. In addition, the County will make contributions to a Dependent Care Spending Account on your behalf if you elect to participate. (See pages 32 for information on the County contribution.) You would normally pay these expenses out of your own pocket with after-tax dollars. But when you make contributions to a spending account, you pay no taxes on the money you contribute. This means you lower your taxable income and pay less in taxes.

How Spending Accounts Work

- First, you need to estimate your eligible out-of-pocket health care and dependent care expenses for the coming calendar year. These are the expenses not covered by your health plans, such as deductibles, co-payments, over-the-counter medication expenses, day care costs, etc. Use the handy worksheets on pages 30 and 36 of this SPD to help you in estimating expenses. When you have an eligible health care or dependent care expense, pay the bill as usual and then submit your claim for reimbursement. You may also submit unpaid bills for eligible expenses. See page 38 of this SPD for information on submitting a claim for eligible spending account expenses.
- You are paid back from your spending account with tax-free dollars:
  - Anytime during the year you may file a health care claim and be reimbursed for the maximum annual amount that you elected to be deposited into your Health Care Spending Account, even if the full amount has not yet been deposited into your account.
  - Dependent care expenses are reimbursed up to the amount in your account at the time the claim is filed.
- Remember, these are separate accounts. You may not use money from your health care account to pay dependent care expenses, and you may not use money from your dependent care account to pay health care expenses.

Careful planning is the key to saving taxes through spending accounts. You should contribute money only for eligible expenses you are sure you will have during the calendar year—do not deposit money for unanticipated expenses. You will forfeit any money in your spending accounts that is not used to reimburse you for eligible expenses incurred during the plan year. IRS rules do not allow you to carry over a spending account balance from one year to the next, so be sure to estimate your expenses carefully AND submit your claims on time. You have until June 30 of the following year to file a claim for reimbursement of eligible expenses that you incurred as a spending account participant in the calendar year in which the money was deposited in your account.

Eligibility

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

Enrolling in a Spending Account

Annual Enrollment: If you would like to participate in a spending account, you may elect to participate in one or both accounts during annual enrollment. You must re-enroll each year you wish to participate. You will have an opportunity to elect a spending account when you use the Web or telephone enrollment system. If you enroll during annual enrollment, you will begin participating in your spending accounts—and contributing to your spending accounts—in January.

Health Care Spending Account

The Health Care Spending Account helps you save tax dollars on eligible medical, dental, vision, and hearing expenses not covered by any benefit plan. You may submit claims for yourself, your spouse, and your eligible federal tax dependents.

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

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

Under applicable federal tax rules, domestic partners and his or her dependents who do not qualify as your federal tax dependents may not participate in your Health Care Spending Account[4]. Details on federal tax dependents are defined by Section 105(b) and Notice 2010-38.

Eligible expenses include the following items, if they are not covered by your insurance. See the worksheet on page 30 for additional eligible expenses:

- Medical and dental deductibles and co-payments.
- Routine physical exams.
- Orthodontia treatment not covered by your dental insurance.
- Vision care—including prescription eyeglasses, contact lenses and solution, laser eye surgery, and nonprescription reading glasses.
- Insulin
- Prescribed over-the-counter medications and drugs, such as pain relievers, antacids, allergy and cold medicines (not covered without a doctor's prescription).
- Hearing aids.
- Special equipment prescribed by a doctor for family members with mental or physical disabilities.
- Smoking cessation programs.
- Nicotine patches and nicotine gum (with a doctor's prescription).

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

- Cosmetic surgery and procedures if not medically necessary, including teeth whitening.
- Cotton balls, bandages, rubbing alcohol.

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

- Diaper service (unless medically required).
- Electrolysis.
- Expenses reimbursed by any other health care plan including Medicare or Medicaid.
- Funeral expenses.
- Health club dues (unless prescribed by a doctor for a medical condition).
- Herbal remedies.
- Health foods.
- Insurance premiums, including long term care insurance premiums.
- Long-term care services.
- Nonprescription dietary supplements or vitamins.
- Nonprescription glasses.
- Vaseline, toothpaste, cosmetics.
- Weight loss medications, or weight control programs that are not prescribed to treat a specific condition or disease.
- Dependent care expenses.

An Example of How You Can Save Money Using Your Health Care Spending Account

Suppose that you paid $350 for new prescription sunglasses, which are not considered a covered expense under your medical plan. So you wrote a check for $350 and gave it to your optometrist. If you paid 25 percent in federal income taxes when you earned this $350, **your real cost for the** prescription sunglasses **was $437.50** ($350.00 + $87.50 federal income taxes = $437.50).

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

Contributing to Your Health Care Spending Account

You may put from $10 to $200 each month (up to $2,400 each calendar year) into your Health Care Spending Account. To calculate your monthly contribution amount, estimate your eligible out-of-pocket health care expenses for the plan year and divide that number by 12. Your contributions must be stated in whole dollars.

Example: Let's assume you estimate that your annual eligible out-of-pocket health care expenses will come to $800. To determine your monthly contribution amount, simply divide $800 by 12 (the number of months in a calendar year). In this example, you would be contributing $66.67 a month to your Health Care Spending Account.

Remember, the money in your spending account is yours to use for eligible health care expenses that you incur while you are a participant *and* in the same calendar year in which you contributed money to your account.

TIP: To help you estimate your health care expenses, use the worksheet on page 30. You should also review the important rules below.

Important Rules on Health Care Spending Accounts

- **Plan carefully**—The IRS says that your election to put a specific amount of money each month into a Health Care Spending Account is an "irrevocable" decision. This means that once you make your election for the year, you may not change your mind unless you experience a qualified change in status and your change is consistent with the change in status. The change-in-status rules are explained in this SPD. Please note that the beginning or ending of an unpaid leave of absence is not treated as a qualified change in status for purposes of your Health Care Spending Account. If you take an unpaid leave of absence, you will be billed directly for your monthly contribution to your Health Care Spending Account while you are on leave and, upon your return, your contribution amounts will resume at the level in effect before your leave. Unless you have a qualified change in status, you may not change your election even if you do not incur an estimated expense or an expense turns out to be ineligible for reimbursement. See page 39 for special rules when you take FMLA leave
- **Forfeiture of Unused Amounts**—don't put more money into your account than you think you'll need. Why? Because the IRS says you must forfeit (lose) any money that you don't spend on unreimbursed, eligible expenses that are incurred within the Plan Year. You cannot deduct any unclaimed account money from your federal income taxes.
- **Expenses must be incurred during the Plan Year and while you are a participant**—You may not submit claims for reimbursement of expenses that are incurred before the date you become a participant in an account, or after December 31 (end of the Plan Year).
- **Expenses are "incurred" at point of service**—An expense is "incurred" when a service is provided or a product is received, not when a bill is sent or paid. A Health Care Spending Account cannot make advance reimbursements of future or projected expenses.
- **Expenses must not be reimbursed or reimbursable from other sources**—Any eligible expenses for which you are not otherwise reimbursed may be paid from your account.
- **Be an active participant**—You may submit claims for expenses incurred only for those months in the Plan Year in which you are an "active participant" in the Health Care Spending Account. You are considered an active participant during any month that you make a contribution to the account.
- **COBRA participation is available**—If you take a leave of absence or leave County service while you are a participant, you may continue participation in a Health Care Spending Account for the rest of the year by making your monthly payments through COBRA. Also see the rules at page 39 regarding the special rules that apply while you are on FMLA leave.
- **Accounts must be kept separate**—Dollars you put into your Health Care Spending Account may not be transferred to a Dependent Care Spending Account, or vice versa. These accounts must be kept separate. In addition, dependent care expenses may not be reimbursed from your Health Care Spending Account.
- **No double tax shelter**—You may not take a tax deduction on your income tax return for expenses paid through your Health Care Spending Account.
- **You must enroll every year**—Participation in a Health Care Spending Account does not continue automatically from one year to the next. If you want an account, you must enroll every year.
- **Termination of participation**—Your participation in the Health Care Spending Account terminates when you stop making contributions to the account, for example, because you terminate from County service and you elect not to continue your coverage under COBRA. Expenses incurred when you are not a participant are not eligible for reimbursement. If you return to County service in the same year in which your employment terminated and within 30 days of your termination, you must make the same election that was in effect at the time of your termination unless you experience a qualified change in status during your unemployment. If you return to County service 30 or more days after your termination, you can make a new election for coverage under the account.

Health Care Spending Account Worksheet

Your health care flexible spending account may reimburse only those expenses that are medical expenses as defined in Code Section 213(d). Please note, however, that some expenses (such as insurance premiums) that are eligible for purposes of Code Section 213 are not eligible for reimbursement from your Health Care Spending Account. In addition, while expenses are reimbursable from your health care spending account based on the year in which they are *incurred* – that is, when the services or products are provided -- expenses are deductible in the year paid. Refer to Internal Revenue Service (IRS) Publication 502 for the types of expenses that qualify for a tax deduction under Internal Revenue Code Section 213. Call your local IRS office to obtain a copy of Publication 502 or access the list through the IRS website at **www.irs.gov/formspubs/index.html**. The following is a partial list of expenses eligible for reimbursement.

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

Type of Expense	Expense Amount
Smoking cessation programs; and nicotine patches, and nicotine gum (with doctor's prescriptions)	_____
Special equipment and treatment for the mentally or physically disabled	_____
Sterilization	_____
Substance abuse and alcohol treatment programs	_____
Surgery	_____
Therapy	_____
Transplants	_____
Weight loss programs as prescribed by a physician to treat a specific medical condition	_____
Wheelchairs	_____
X-ray fees	_____
A. Total annual eligible health care expenses:	A. $_____
B. Decide how much of the total annual amount in Line A you want to put into your individual account for the year:	B. $_____
C. Divide the annual amount in Line B above by the number of months during the year that you can put money into your Health Care Spending Account. This will give you your monthly contribution amount (must be between $10 and $400):	C. $_____

Dependent Care Spending Account

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

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

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

Eligible expenses include, but are not limited to:

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

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

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

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

Contributing to Your Dependent Care Spending Account

Your Dependent Care Spending Account may be funded on a tax-free basis with County contributions and, if you elect, with deductions from your own pay. **You do not need to contribute amounts from your own pay to receive a County contribution.** If the County contribution is not large enough to cover your dependent care expenses, you may elect to have an additional amount deducted from your pay and contributed to your Dependent Care Spending Account on a pre-tax basis. If you elect to participate in the Dependent Care Spending Account, the County will make a non-taxable monthly contribution of up to the following amount (subject to an annual cap[1]) to your account based on your annual base pay:

Your Annual Base Pay	**County's Monthly Contribution** (subject to annual cap on contribution[1])
Less than $30,000	$375
$30,000 - $34,999	$300
$35,000 - $39,999	$275
$40,000 - $44,999	$200
$45,000 - $49,999	$125
$50,000 or more	$75

If you do not elect to participate in a Dependent Care Spending Account, you will NOT receive any portion of the County contribution in cash.

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

If the County contribution is reduced and/or stopped because of the cap, you may have the opportunity to increase the contribution amount deducted from your pay in order to keep the same total contribution level for the remainder of the Plan Year. In addition, you may be allowed to make other changes that are consistent with a qualified change in status, cost, or coverage (for example, revoking your election if your dependent care provider quits or terminates its contract with you). (See pages 12-16 for a discussion of the changes in status and cost and coverage rules.)

The County will not make a contribution on your behalf if you work less than eight hours per month or receive less than eight hours of leave benefits. The County also will not make a contribution on your behalf beginning on the first day of the second month after you otherwise become ineligible to participate in *Flex* (e.g., because you terminate employment). If you change flexible benefits program eligibility in the middle of a Plan Year (e.g., from *Flex* to *Options*) and do not complete your enrollment on time, you will be defaulted into a Dependent Care Spending Account under the new flexible benefits program as of the first day of the second month after the enrollment period ends. You then will be subject to the County contribution cap that applies under the new plan.

Limits on Total Contributions to Your Dependent Care Spending Account

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

Single or Married Filing a Joint Federal Tax Return?

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

Married Filing Separate Federal Tax Returns?

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

For any month that your spouse is a full-time student or incapable of self-care, your spouse is deemed to be gainfully employed with an earned income of $250 (or $500 if you have more than one qualifying individual as described on page 31).

Calculating Your Monthly Contribution Amount

To calculate your monthly contribution amount, estimate your annual eligible, out-of-pocket dependent care expenses and divide that number by 12 months. This number is the total monthly contribution that should be made to your account. If this number exceeds your monthly County contribution, subtract the monthly County contribution from this total amount to determine the amount you should deduct from your own pay. Your contribution must be stated in whole dollars.

Example: Assume that you make $47,000 per year and your estimated out-of-pocket dependent care expenses for the Plan Year come to $2,400. To determine how much you should contribute to the Dependent Care Spending Account, divide $2,400 by 12, or $200. Because this amount exceeds the County contribution ($125 for someone making $47,000), subtract the monthly County contribution to determine the monthly amount you should have deducted from your own pay ($200 - $125 = $75). This means you would elect to contribute $75 per month, which will be deducted from your pay and deposited into your Dependent Care Spending Account. The County will contribute $125 each month, for a total of $200 per month.

Note: Use Worksheet #1 on page 36 to determine your monthly contribution amount.

How Does a Dependent Care Spending Account Save You Money?

Taking the facts from the example above, assume that you pay 25 percent in federal income taxes. This means that, without the Dependent Care Spending Account, your real cost for dependent care would be $3,000 ($2,400 + $600 in federal taxes). However, if you elect to participate in a County Dependent Care Spending Account, your dependent care will only cost you $900 for the year ($75 x 12 = $900) because you receive a County subsidy and you do not pay federal income taxes on amounts contributed to and distributed from your account.

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

TIP: To help you determine the amount you should contribute to a Dependent Care Spending Account to cover your estimated dependent care expenses, use the worksheet on page 36. You should also review the important rules in the next section.

Important Rules on Dependent Care Spending Accounts

- **Plan carefully**—The IRS says that your election to put a specific amount of money each month into a Dependent Care Spending Account is an "irrevocable" decision. This means that once you make your election for the year, you cannot change or cancel your monthly contribution amount unless you experience a qualified change in status or certain cost or coverage changes. And you cannot change your monthly contribution amount just because your expenses turn out to be ineligible for reimbursement. The changes in status, cost, and coverage rules that are applicable to you are explained on pages 12-16. Please note that to change your contributions to your Dependent Care Spending Account, your change must be consistent with a qualified change in status. Generally, you may be permitted to change your monthly contribution amount if, for example, you:

  - Experience an increase or decrease in day care fees charged by a dependent care provider who is not your relative.
  - Change day care providers and this change causes your day care fees to change.
  - Have a change in your work schedule (e.g., from full-time to part-time or vice versa), which causes a change in the number of hours or days worked by a provider.

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

- **Accounts must be kept separate**—Dollars you put into your Dependent Care Spending Account cannot be transferred to a Health Care Spending Account, or vice versa. These accounts must be kept separate. In addition, eligible health care expenses cannot be reimbursed from your Dependent Care Spending Account.
- **There is no double tax shelter**—You cannot take a tax deduction on your income tax return for expenses paid through your Dependent Care Spending Account.
- **Expenses must not be reimbursed from other sources**—Only eligible expenses for which you are not otherwise reimbursed may be paid from your account.
- **You must enroll every year**—Participation in a Dependent Care Spending Account does not continue automatically from one year to the next. If you want to participate in the Dependent Care Spending Account, you must enroll every year.
- **Termination of participation**—Your participation in the Dependent Care Spending Account terminates on the first day of the second month after you are no longer eligible to participate in a County flexible benefits program, for example, because you terminate from County service. Expenses incurred when you are not a participant are not eligible for reimbursement. If you return to County service in the same year in which your employment terminated and within 30 days of your termination, you must make the same election that was in effect at the time of your termination, unless you experience a qualified change in status during your unemployment. If you return to County service 30 or more days after your termination, you can make a new election for coverage under the account.

Dependent Care Spending Account vs. Child and Dependent Care Expense Tax Credit
Your eligible dependent care expenses are the same expenses that can qualify for a tax credit for child and dependent care expenses on your federal income tax return. Therefore, before signing up for a Dependent Care Spending Account, you should consider whether the tax credit for child dependent care expenses taken on your tax return would provide you with a greater tax benefit. This determination depends on your specific income and tax situation. Some things to consider:

- Generally, if you receive your full County contribution for the whole Plan Year, that County contribution should be more valuable than the maximum tax credit you could receive *unless* you make $50,000 or more per year. If you make $50,000 or more per year and make pre-tax contributions from your own pay, the Dependent Care Spending Account still might be a better choice because you may receive an added tax advantage from the Dependent Care Spending Account that, together with the County contribution, may outweigh the value of the tax credit.
- You cannot take a tax credit on your income tax return for expenses reimbursed by your Dependent Care Spending Account. Any expenses you do not claim through your Dependent Care Spending Account are eligible to be claimed as part of your tax credit at the end of the year. However, the maximum tax credit is reduced for any benefits received from your Dependent Care Spending Account.
- You can participate in a Dependent Care Spending Account even if you and your spouse file separate tax returns. However, to claim an income tax credit, married couples generally have to file a joint return.

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

Dependent Care Spending Account Worksheets

The following worksheets illustrate possible tax savings if you elect to participate in a Dependent Care Spending Account—be sure to complete both worksheets before deciding that you want to participate. First, calculate your Dependent Care Spending Account contribution for the Plan Year using Worksheet #1 below. Then, using Worksheet #2, estimate your tax savings. If appropriate, compare this amount to your possible savings from the child and dependent care tax credit. Refer to IRS Publication 503 or Form 2441 for information on how to calculate this amount. You might want to refer to your latest tax return for information as you complete these worksheets.

Worksheet #1: Determine Your Depending Care Spending Account Contribution	
A. Estimate what you plan to spend on eligible dependent care:	A. $_____
B. If you are married and filing a joint return, enter your estimated earned income or your spouse's estimated earned income for the year, or $4,800 whichever is less:	B. $_____
C. If you are married and filing separately, enter your estimated earned income for the year or $2,500, whichever is less:	C. $_____
D. If you are a single/head of household, enter your estimated earned income for the year or $4,800, whichever is less:	D. $_____
E. Enter the lesser of A or either B, C, or D, whichever applies:	E. $_____
F. Divide the amount in E by the number of months during the Plan Year that you can put money into a Dependent Care Spending Account; this will give you your monthly contribution amount (this amount must be at least $10 and no more than $400 a month and must be stated in whole dollars); this is the **total** monthly contribution that should be made to your account to cover your estimated dependent care expenses:	F. $_____
G. Subtract the monthly County contribution from the amount in F; this is the monthly amount that you should elect to have deducted from your pay to cover your estimated dependent care expenses:	G. $_____

Estimating Your Dependent Care Spending Account Tax Savings

We are providing the 2013 federal tax tables below to help you determine your estimated tax bracket this year:

If You Are	**And Your Income Is**		**Your Tax Is**		
	Over	*But Not Over*		*PLUS*	*Of Amount Over*
Single	$0	$8,925	.....	10%	$0
	$8,925	$36,250	$892.50	+ 15%	$8,925
	$36,250	$87,850	$4,991.25	+ 25%	$36,250
	$87,850	$183,250	$17,891.25	+ 28%	$87,850
	$183,250	$398,350	$44,603.25	+ 33%	$183,250
	$398,350	$400,000	$115,586.25	+ 35%	$398,350
	$400,000	.....	$116,163.75	+ 39.6%	$400,000
Married filing jointly, or qualified widow(er)	$0	$17,850	.....	10%	$0
	$17,850	$72,500	$1,785.00	+ 15%	$17,850
	$72,500	$146,400	$9,982.50	+ 25%	$72,500
	$146,400	$223,050	$28,457.50	+ 28%	$146,400
	$223,050	$398,350	$49,919.50	+ 33%	$223,050
	$398,350	$450,000	$107,768.50	+ 35%	$398,350
	$450,000	.....	$125,846.00	+ 39.6%	$450,000
Head of household	$0	$12,750	.....	10%	$0
	$12,750	$48,600	$1,275.00	+ 15%	$12,750
	$48,600	$125,450	$6,652.50	+ 25%	$48,600
	$125,450	$203,150	$25,865.00	+ 28%	$125,450
	$203,150	$398,350	$47,621.00	+ 33%	$203,150
	$398,350	$425,000	$112,037.00	+ 35%	$398,350
	$425,000	.....	$121,364.50	+ 35%	$425,000
Married filing separately	$0	$8,925	.....	10%	$0
	$8,925	$36,250	$892.50	+ 15%	$8,925
	$36,250	$73,200	$4,991.25	+ 25%	$36,250
	$73,200	$111,525	$14,228,75	+ 28%	$73,200
	$111,525	$199,175	$24,959.25	+ 33%	$111,525
	$199,175	$225,000	$53,884.25	+ 35%	$199,175
	$225,000	.....	$62,923.00	+ 35%	$225,000

A. Enter the amount on Line G from Worksheet # 1: A. $_____

B. Estimate your taxable income and enter your estimated federal income tax bracket percentage from the table above: B. _____%

C. Multiply Line A times Line B times the number of months in the year that you will be contributing to the Dependent Care Spending Account. This is your estimated tax savings from participation in a Dependent Care Spending Account: C. $_____

Keep in mind that, in addition to possible tax savings, the County saves you money by making a contribution to your Dependent Care Spending Account on your behalf.

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

Submitting Your Spending Account Expense Claims

1. When you have a claim under the **Health Care Spending Account**, you have to complete the *Health Care Spending Account Claim Form*. Fax your form and documentation toll-free to **866-629-6390,** or mail your completed form and documentation to Spending Account Plan Administrator, P.O. Box 67128, Los Angeles, CA 90067. The Spending Account Plan Administrator will not process your claim unless you include itemized bills or receipts from the provider of the services, and the explanation of benefits statement you received for each claim you are submitting. Canceled checks will not be accepted.

   An itemized bill or receipt must include all of these items:

   - Name of provider.
   - Patient's name.
   - Date of service.
   - Description of service.
   - Charge for service.

2. When you have a claim under the **Dependent Care Spending Account**, you have to complete the *Dependent Care Spending Account Claim Form*. Fax your form and documentation toll-free to **866-629-6390,** or mail your completed form and documentation to Spending Account Plan Administrator, P.O. Box 67128, Los Angeles, CA 90067. The Spending Account Plan Administrator will not process your claim unless you include itemized bills or receipts as proof of each expense. Canceled checks will not be accepted. If you are not including bills or receipts, you must provide the following information on your reimbursement form:

   - Provider signature.
   - Provider address.
   - Provider social security number or tax identification number.
   - The date of service.
   - The amount paid.

   Submit this information when you send in your claim for reimbursement.

3. Claims are processed as they are received. You will either receive a check in the mail or (if you prefer) your reimbursement will be deposited directly into your bank account. To initiate direct deposit of your reimbursements, complete the *Spending Account Direct Deposit Authorization Form* and fax it toll-free to **866-629-6390,** or mail your completed form to Spending Account Plan Administrator, P.O. Box 67128, Los Angeles, CA 90067.
4. You can check the balance in your account at any time by going to **www.mylacountybenefits.com, and by clicking on Spending Accounts under *my tools*.**
5. Each time you submit a claim, you will receive a statement that shows the amount of your reimbursement and your current account balance.
6. Every three months, you will receive an additional statement to help you monitor your account balance. Review these statements carefully.
7. You must submit your claims for all eligible expenses incurred while you are a participant during the Plan Year by June 30 of the following year. If you submit a claim that is postmarked after this date, the claim will not be paid and you will forfeit any money left in your spending accounts.
8. If you leave County service during the Plan Year, you may continue to submit claims for eligible expenses incurred during the Plan Year until June 30 of the following year. However, these claims must be for eligible expenses incurred during the Plan Year while you were actively participating in the applicable spending account.

9. To submit a claim you can:

   - Fax your completed form and documentation toll-free to **866-629-6390**, or
   - Log onto mylacountybenefits.com and submit electronically, or
   - Mail your form and supporting documentation, using the mailing label included in your claims kit, to:

   Spending Account Plan Administrator
   P.O. Box 67128
   Los Angeles, CA 90067

10. If you have any questions about claims administration of the spending accounts, call the Spending Account Plan Administrator (Ceridian) toll-free at **866-629-6436.**

Miscellaneous

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

GENERAL PLAN ADMINISTRATION

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

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

CONTINUING COVERAGE UNDER CERTAIN CIRCUMSTANCES

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

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

- If you are in pay status for at least eight hours in any month, the County will pay your full *Flex* contribution.
- If you are not in pay status during the month FMLA/CFRA leave is taken, the County will continue to pay the portion of the County contribution allocated to the County-sponsored medical plan, the County-sponsored dental plan, and the Health Care Spending Account.
- If you paid any portion of the premium for your medical, dental and Health Care Spending Account coverage prior to the FMLA/CFRA leave, you will be billed for the same amount while on leave.

If you choose not to continue your coverage by paying your premium, or otherwise fail to timely pay your share of the premium, your coverage will be suspended as of the first day of the month following the last month for which the premium was paid. You will not be entitled to payment or reimbursement of expenses incurred during any period your coverage is suspended.

Under FMLA and CFRA, the County is entitled to recover any premium payments made on your behalf if you fail to return from FMLA/CFRA leave after the leave entitlement has been exhausted or the leave expires, unless:

- You are unable to return to work because of the continuation, recurrence, or onset of a serious health condition which would entitle you to continue FMLA/CFRA leave.
- You are unable to return to work due to unexpected circumstance(s) beyond your control.

Likewise, under the PDL law, the County is entitled to recover any premium payments made on your behalf if you fail to return from PDL after the leave entitlement has been exhausted or the leave expires, unless:

- You are unable to return to work because you are taking CFRA leave,
- You are unable to return to work because of the continuation, recurrence or onset of a health condition which would entitle you to continue PDL,
- You are unable to return to work due to non-pregnancy related medical conditions requiring further leave,
- You are unable to return to work due to unexpected circumstance(s) beyond your control.

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

Reinstatement of Benefits Upon a Return From Leave of Absence
Benefits that have terminated during a leave of absence will be reinstated on the first of the month following the month you return to work. When you are reinstated in your Health Care Spending Account and your Dependent Care Spending Account, you will resume premium payments at the level in effect before the leave with a corresponding reduction in the total level of coverage for the remainder of the Plan Year. Alternatively, with regard to the reinstatement of your Health Care Spending Account only, you may elect to resume coverage for the remainder of the Plan Year at the level in effect before your leave with a corresponding increase in your premium payments. Any other change in your pre-tax premiums may only be made in accordance with Change in Status rules described on pages 12-16.

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

Colin will resume Health Care Spending Account coverage at a level that is reduced on a pro rata basis for the period during the leave for which no contributions were paid (that is, reduced for 3 months or 1/4 of the Plan Year) less prior reimbursements ($0) with contribution payments due in the same monthly amount payable before the leave ($100 per month). Thus, Colin's coverage for the remainder of the plan year would equal $900 and Colin would resume making contribution payments of $100 per month for the remainder of the plan year. Alternatively, Colin could elect to resume coverage at the level in effect before the leave ($1,200) and making up the unpaid contribution payments ($300). If Colin chooses to resume coverage at the level in effect before the leave, Colin's coverage for the remainder of the plan year would equal $1,200 and Colin's monthly contributions would be increased to $150 per month for the remainder of the plan year, to make up the $300 in contributions missed ($100 per month plus $50 per month ($300 divided by the remaining 6 months.))

Continuation of Coverage During Active Military Service

If you are ordered to active military duty, you are entitled to receive benefits for a period not to exceed 720 days. As of October 16, 2012 the Board of Supervisors approved the suspension of the 720-day limit on County-provided paid military benefits through calendar year 2015. The County will comply with any obligation to continue benefits in accordance with the federal law known as USERRA.

While on active military duty, you may participate in annual enrollment for benefits. Any benefit changes you make during annual enrollment will be effective on January 1 of the next year. If you make no changes, your benefits will continue except for Health Care and Dependent Care Spending Accounts, which will be canceled. **If you are away from home during the annual enrollment period, you may designate someone to enroll for you.** Your enrollment packet contains your employee number and PIN code needed to make your benefit elections using the Web or automated telephone enrollment system. If you use a designee, please ensure that person enrolls for you by the annual enrollment deadline.

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

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

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

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

Health Care and Dependent Care Spending Accounts—Provided you continue to make contributions to your spending accounts you may continue to participate in these accounts while on active duty. Remember, claims for reimbursement for services used during the year in which you are participant must be claimed by June 30 of the following year. See **Submitting your Spending Account Expense Claims** on page 38.

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

COBRA Continuation of Health Coverage

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

What is COBRA Continuation Coverage?

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

Qualifying Events

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

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

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

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

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

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

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

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

For the other qualifying events (*annulment*, *divorce* or *legal separation* of the employee and spouse, or a *dependent child's losing eligibility for coverage* as a dependent child), **you (or the qualified beneficiary) must notify the Plan Administrator in writing within 60 days after the later of (1) the qualifying event, or (2) the date coverage will end as a result of the event.** ***The procedure for notifying the Plan Administrator of a qualifying event is explained on page 45.***

How is COBRA Coverage Provided?

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

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

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

How Long Will COBRA Coverage Be Provided?

The law requires that you be afforded the opportunity to maintain continuation coverage for a period of three years from the date of the qualifying event that made you eligible to elect continuation coverage, unless the qualifying event was the end of County employment or a reduction in hours of employment. In that case, the required continuation coverage period is 18 months from the date of the qualifying event. If, however, the employee becomes entitled to Medicare benefits less than 18 months before the employee's end of employment or reduction in hours, the employee's spouse and dependent children may continue coverage for up to 36 months from the date of the employee's Medicare entitlement. For example, if the employee became entitled to Medicare 8 months before the date his or her employment ends, COBRA continuation coverage for the employee's spouse and children may last up to 36 months after the date of Medicare entitlement, which equals 28 months after the qualifying event (36 months minus 8 months).

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

Disability Extension of 18-month Continuation Coverage Period

If any qualified beneficiary is determined by the Social Security Administration (SSA) to have been disabled at any time before the 60th day of continuation coverage (or, for a newborn or adopted child, within 60 days of the birth or adoption), the 18-month continuation coverage period may be extended to 29 months for each qualified beneficiary, if the disability lasts at least until the end of the 18-month period of continuation coverage. **However, in order for the extended coverage to apply, you must notify the Plan Administrator about the disability determination before the end of the 18-month continuation coverage period and within 60 days after the latest of (1) the date of the SSA determination; (2) the date of the qualifying event; or (3) the date on which the disabled qualified beneficiary loses (or will lose) coverage as a result of the qualifying event.** The procedure for notifying the Plan Administrator of a disability determination is explained on page 45.

If the SSA later determines that the disabled qualified beneficiary is no longer disabled, you must notify the Plan Administrator of that fact within 30 days of the SSA's determination following the procedure on page 45. The plan may end the extended continuation coverage for all qualified beneficiaries as of the first month that begins more than 30 days after the SSA's final determination.

Second Qualifying Event Extension of 18-month Continuation Coverage Period

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

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

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

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

If you are notifying the Plan Administrator of a disability determination, you must also include a copy of the SSA's determination with the completed Form. If the SSA later determines that the disabled qualified beneficiary is no longer disabled, you must notify the Plan Administrator using the *Notice of Qualifying Event or Disability Form*, and should include a copy of the SSA's final determination.

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

Can COBRA Coverage Ever be Cut Off Early?

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

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

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

Special Rules for Health Care Spending Accounts

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

Electing and Paying for COBRA Continuation Coverage

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

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

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

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

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

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

After COBRA Continuation Coverage Ends

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

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

COUNTY OF LOS ANGELES
Department of Human Resources
Employee Benefits Division – COBRA Unit
3333 Wilshire Boulevard, 10th Floor
Los Angeles, CA 90010
213-388-9982

Extended Medical Coverage Under California Law After Exhaustion Of Federal COBRA

Eligibility Period and Extended Coverage

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

The extended medical coverage ends automatically on the earlier of:

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

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

Electing and Paying for Extended Coverage

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

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

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

Conversion Option after Extended Coverage Ends

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

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

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

KEEP THE COUNTY INFORMED OF ADDRESS CHANGES

To protect your and your family's rights, you should keep your departmental Personnel Office informed of any change in your address.

Contact Information

Contact	Phone Number	Website
County Department of Human Resources		
Benefits Hotline	213-388-9982	**http://dhr.lacounty.info/**
Benefit System		
Web enrollment	N/A	**www.mylacountybenefits.com**
Telephone enrollment	888-822-0487	N/A
Fax	310-788-8775	N/A
Medical		
Kaiser Permanente	800-464-4000	**www.kp.org/countyofla**
Anthem Blue Cross	866-940-8303	**www.anthem.com/ca/countyoflosangeles**
Dental		
SafeGuard	800-880-1800	**www.safeguard.net**
DeltaCare	800-422-4234	**www.deltadentalins.com**
Delta Dental	888-335-8227	**www.deltadentalins.com**
Health Care and Dependent Care Spending Accounts		
Administrator (Benefit Concepts Inc.)	866-629-6436	**www.mylacountybenefits.com**
Fax	866-629-6390	N/A
Life		
MetLife	800-846-0124	**www.mylacountybenefits.com** *click on the MetLife link*
AD&D		
CIGNA	800-842-6635	**www.mycigna.com**

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

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

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

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