Frequently Asked Questions

Topic

These frequently asked questions and answers provide only highlights of the Flex program. They do not change the terms of your benefit plans or the official documents that control them. If there are any inconsistencies between the answers in this section and the official plan documents, the plan documents will govern. Plan documents are the legal papers that spell out the benefit plan rules in detail. They may include insurance policies and similar kinds of documents. October 2015

General

1. How do I change the address shown on my personal enrollment fact sheet?

The Personnel Department partnered with the City Controller and Information Technology Agency to create a self-update feature in D-Time to update your mailing address and emergency contact information. To perform a self-update, click on the "My PaySR Profile" icon in D-Time, make the necessary entries, and click "Save". If you're not using D-Time, you can still use the Self-Update feature by going to a personal computer in the City of Los Angeles network, downloading D-Time, and logging in using your employee identification number, department code and last four digits of your Social Security Number.

The My PaySR Profile User Manual (http://ctr.ci.la.ca.us/ctr/paysr/docs/mypaysrprofile/MyPaySRProfile.pdf) gives instructions on how to install and access DTime.NET.

This new feature does not preclude you from continuing to submit address or emergency contact changes to your departmental human resources section.

2. Who is eligible for Flex?

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

- you are eligible for membership in one of the employee representation units for which the civilian modified flexible benefits program (Flex program) has been negotiated in a MOU
- you are not represented by an employee representation unit
- you are a Port Police Officer (MOU 27 or MOU 38) and a member of Tier 5 and Tier 6 of the Fire & Police Pension System
- you are an Elected Official of the City or a full-time Member of the Board of Public Works.

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

3. Who can I cover as a dependent?

If you are eligible for Flex, you can also enroll your eligible family members:

- your spouse or domestic partner
- your children up to age 26 – including your domestic partner's children if your domestic partnership affidavit is approved, legally adopted children or children placed with you for adoption, children for whom you have legal custody or guardianship, foster children placed in your home pending a permanent placement with you, and stepchildren
- your grandchildren up to age 26 – if you have legal custody and provide the Employee Benefits Division with copies of court papers

- your grandchildren – if their parent is your child who
  - – is under age 19, unmarried, and financially dependent on you or
  - – is age 19-26 and meets the full-time student status, is unmarried, and financially dependent on you

If coverage for your child ends, coverage for your grandchildren will end.

An eligible child can be covered up to the end of the month in which he or she reaches age 26. See rules for grandchildren above.

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

You must request a disabled certification package or the required application from your health plan, ask your dependent's primary care physician to complete it, then return it to your health plan for review.

4. What is "evidence of insurability"?

You may be required to provide evidence of insurability – or proof of good health – for some benefit changes. You must provide it for supplemental life insurance if:

- you enroll for supplemental life coverage for the first time to a level of more than three times annual pay or an amount above $750,000.
- you increase coverage by more than one level – or to a level more than three times annual pay or an amount above $750,000.
- you increase spouse/domestic partner life insurance – or choose it for the first time at open enrollment.

Proof of good health is required for basic life coverage in excess of $500,000 for employees represented by an employee representation (collective bargaining) unit for which an Employer-sponsored term life insurance plan has been negotiated in a Memorandum of Understanding (MOU), General Manager (employees hired prior to 7/1/2015), or non-represented Assistant General Manager.

You must also provide it if you are currently enrolled in Flex and choose supplemental disability coverage for the first time during open enrollment.

Evidence of insurability is provided by completing a form that must be approved by the insurance company.

5. What do I do if I have questions about a plan's benefits?

Go to http://per.lacity.org/bens/docforms.htm to find phone numbers and websites for the different plan administrators.

6. What if I have not received my enrollment package?

During Open Enrollment: Call the Employee Benefits Division at 213-978-1655. You can call Monday through Friday, 8 a.m. to 5 p.m. Pacific time.

For new hires: If it has been more than six weeks since your date of hire, call the Employee Benefits Division at 213-978-1655. You can call Monday through Friday, 8 a.m. to 5 p.m. Pacific time.

7. What happens when my child turns 26?

Any Flex health, dental or dependent life insurance coverage your child has will end on the last day of the month in which your child turns age 26.

Dependent children who become totally disabled before age 18 may be eligible for coverage as long as they remain disabled. In this case, you would need to provide the insurance company with evidence of your child's disability. Contact your plan's Member Services and request a disabled certification package. You will need to have your child's physician complete the required forms within the package, and then return the forms to your health plan to obtain disabled certification status from each plan. Please note that your health plan determines how often your dependent has to be recertified in order to continue coverage.

8. Will I have to keep verifying that my child is a full-time student to keep him/her covered under my health plan until he/she turns age 26?

No. Under the Patient Protection and Affordable Care Act, you can cover your child even if he/she is not a full-time student. However, for grandchildren, if their parent is your child, you must continue to submit full-time student certification unless you have legal custody of your grandchild and provide the Employee Benefits Division with copies of court papers.

9. During the year, how can I find out what benefits I am enrolled in?

Go to myflexla.com and view your current coverage, or call the Benefits Service Center at 1-800-778-2133. Live Chat is an additional way to contact the Benefits Service Center during regular Service Center hours. With Live Chat, you can type in a question and receive a real time answer from a Benefits Service Center representative.

10. When do my benefits end if I leave the City?

Your Flex benefits end the day after your last day of City service.

If you retire or transfer to DWP, your Flex benefits end on the last day of the month in which you terminate. Please contact the Employee Benefits Division at 213-978-1655 for more information if you are transferring to DWP.

You may be able to continue health and dental benefits through COBRA continuation coverage. You may also be able to continue life insurance through portability or by converting to an individual whole life policy, and you may be able to continue AD&D coverage through portability continuation. You will receive information on continuation coverage at the time your employment ends.

11. When do my benefits begin as a new employee?

If you are a civilian City employee who meets the eligibility requirements for Flex benefits, you will receive an enrollment package for Flex benefits. Your benefits will begin after you go to myflexla.com or call the Benefits Service Center and successfully complete the enrollment process by the date shown on the personal enrollment fact sheet in your enrollment package.

12. How long do I have to enroll as a new employee?

You must enroll by the date shown on the personal enrollment fact sheet in your enrollment package. If you do not enroll during this time, you will receive default coverage and will have to wait until the next open enrollment period to change your benefit choices unless you have a qualifying family status change during the year.

Enrolling/Making Changes

1. When can I make changes to my benefit choices?

You can make changes during Open Enrollment, generally October 1 through October 31. You cannot change your benefit choices at any other time during the year unless you have an eligible family status change, such as a marriage, divorce or birth of a child. See the 2016 Flex Benefits Booklet for more on family status changes.

2. When do the benefit choices I make during Open Enrollment take effect?

Benefit choices take effect January 1, 2016.

3. If I have or adopt a child during the year, how do I add this child to my Flex coverage?

You should go to myflexla.com or call the Benefits Service Center within 30 calendar days of the birth of your child or placement for adoption to add your child to Flex coverage. When you meet the 30 calendar-day deadline, coverage will be effective from the date of birth or placement for adoption. See the 2016 Flex Benefits Booklet for more on enrolling a new child.

4. How can I change coverage for my dependents during Open Enrollment?

You should go to myflexla.com and follow the instructions for changing health or dental choices. You will be asked which dependents you want to enroll or remove from coverage. If you remove health and dental coverage for an eligible dependent, that person will continue to be listed as a dependent, but no coverage will be shown. If you need assistance, call the Benefits Service Center at 1-800-778-2133 between 8 a.m. and 5 p.m. Pacific time, Monday through Friday.

5. If I have a family status change during Open Enrollment, what do I need to do?

There are two important steps you must take:

- *For benefit changes effective through 2015* – go to myflexla.com or call within 30 calendar days of your family status change to make changes in your 2015 benefit choices. Changes will be effective through December 31, 2015 and will not carry over to 2016.
- *For benefit changes effective in 2016* – go to myflexla.com or call during open enrollment – October 1 to October 31, 2015. Changes will be effective January 1, 2016.

6. If I am enrolling for 2015 benefits as a new hire during Open Enrollment, do I need to enroll twice?

You will need to enroll by the date shown on your personal enrollment fact sheet in your new hire package to have benefits effective through December 31, 2015.

The choices you make for 2015 will automatically carry over for 2016 unless you make different choices during Open Enrollment – October 1 to October 31, 2015.

There are two exceptions: If you want to participate in a Healthcare Flexible Spending Account or Dependent Care Reimbursement Account for 2016, you will have to make a new selection during open enrollment to have this benefit for 2016.

7. After enrolling, how do I change my coverage?

After you enroll as a new hire – or after the open enrollment period ends October 31 – you can change your coverage choices only if you have an eligible change in family status – like marriage or the birth of a child. See the 2016 Benefits Booklet for more on family status changes. If you have a family status change, you can change your coverage by calling the Benefits Service Center or going to myflexla.com. ***You must call or go online within 30 calendar days after the family status change to make new benefit choices.*** If you do not call or go online within this time, you will have to wait until the next open enrollment.

8. I am currently enrolled in Flex coverage and I enrolled before September 1, 2015. If I do not go online to enroll during Open Enrollment, will I keep the same coverage I have now for 2016?

You will have to enroll during the enrollment period, October 1- October 31, 2015, if you have one of these situations:

- You want to make changes to your benefit choices for 2016.
- You want to contribute to a Healthcare Flexible Spending Account for 2016.
- You want to participate in a Dependent Care Reimbursement Account for 2016.

Otherwise, you do not have to enroll during Open Enrollment. Your health, dental, life insurance, AD&D insurance and disability coverage choices will automatically continue for 2016.

9. Will I complete my enrollment once I make my benefit choices online?

In most cases, you will complete your enrollment once you make your benefit choices online and submit required documentation. There are a few reasons you might need to fill out a form to complete your enrollment.

If you ...	Submit a ...	For open enrollment changes, return by this deadline ...*
Select Cash-in-Lieu for the first time	Cash-in-Lieu Affidavit	December 11, 2015
Enroll a domestic partner who is not currently covered	Affidavit of Domestic Partnership	December 11, 2015
Enroll a spouse who is not currently covered	Copy of your marriage certificate	December 11, 2015
Choose life insurance or disability coverage requiring proof of good health	Life Insurance – Evidence of Insurability Form Disability – Medical History Statement	You must provide proof of good health to the insurance company by March 1, 2016 – or any pending coverage will be removed from your benefits account
Enroll a child who is not currently covered	Copy of birth certificate, hospital verification of birth, or court document	December 11, 2015
Enroll a child age 26 or older who is dependent on you for support and was disabled before age 18 and not currently covered	Disability certification as required by your health plan	December 11, 2015
Enroll a grandchild who is not currently covered with legal custody	Copy of birth certificate, hospital verification of birth, or court document	December 11, 2015
Enroll a grandchild who is not currently covered	Copy of child's and grandchild's birth certificate, valid proof of dependent status and/or full-time student certification for your child	December 11, 2015
Enroll a child of your domestic partner	Copy of birth certificate and Affidavit of Domestic Partnership	December 11, 2015

**If you enroll as a new hire or make changes during the year because of a family status change, see your confirmation statement for the deadline to return required documents.*

After enrollment, you will receive any forms that you must complete and return. You can also view and print the applicable forms at http://per.lacity.org/bens/docforms.htm.

If you do not return forms by the deadline shown, your coverage choices will not take effect.

Remember, you can go to myflexla.com to name or change your beneficiary. Your beneficiary designation will apply to basic and supplemental life insurance and any accidental death and dismemberment insurance you choose. It will also apply to any supplemental basic insurance you have.

Benefits During Leave of Absence or Non-Pay Status

1. What happens to my benefits when I am in a non-pay status?

If you are in a non-pay status – other than a Family Leave or Catastrophic Leave – you can choose to continue your Flex benefits by paying the full premium cost of coverage with after-tax dollars. You will not be eligible for the City subsidy toward health and dental coverage, basic life insurance or basic disability. For your medical benefits, contact the Employee Benefits Division at 213-978-1655 to understand your coverage options and costs.

You can pay the cost of Flex coverage with after-tax dollars through direct billing by the Employee Benefits Division. Direct billing may continue for up to six months. After six months of direct billing,

- your Flex disability coverage ends and you cannot continue that coverage
- Flex health and dental coverage may be continued through COBRA
- you can choose to continue life insurance through portability or converting to an individual whole life policy – and continue AD&D through portability continuation.

Payment for the first pay period you become ineligible for the City subsidy is due within 15 days of the date of your first billing letter. If your payment is not received within that time, your coverage will end. See question 5 below for information on the Benefit Protection Plan.

2. Why do I have to pay the City subsidy along with my coverage cost when I am in a non-pay status? Why does the City not pay the subsidy?

The City subsidy for health, dental, basic life and basic disability coverage is available only to regular full-time or regular half-time employees eligible for Flex who are paid for at least 40 hours a pay period (or the minimum amount specified by the MOU), contribute to the City Employees' Retirement System and meet specific eligibility requirements. The City subsidy is a part of your compensation as a City employee and is provided only when you are in a pay status.

See the General section of these FAQs, question 2, for more on Flex eligibility.

3. How do I apply for Family Leave?

Contact the personnel section of your department to request the Family Medical Leave Application forms. The City may require a doctor's notice as proof of a serious health condition.

4. When I am on Family Leave, does the City pay for my benefits?

You may be eligible for the City subsidy while you are on family leave. In this case, you are responsible for paying the amount that is normally deducted from your paycheck. See your MOU's Benefits Section for details.

5. What happens to my benefits if I am disabled for a long period of time?

If you are out on an approved disability, your Flex disability coverage will continue and you will not have to pay the cost of that coverage. If you are on an approved disability beginning January 1, 2006 or later, the Benefit Protection Plan (BPP) allows you to continue the Flex health, dental and basic life insurance you had as an active employee for up to two years of disability. While you are covered by the BPP, the City subsidy continues, so you pay only the coverage cost you paid as an active employee. For other Flex benefits not included in the BPP, you can continue coverage for up to two years by paying the full cost of coverage with after-tax dollars just like someone in non-pay status. You are no longer eligible for the BPP if you leave City service (e.g. service retirement, disability retirement, termination).

After BPP coverage ends, contact the Employee Benefits Division at 213-978-1655 to understand your coverage options and costs.

6. If I am placed on a Workers' Compensation status and I am receiving the State Rate, does the City continue to pay my health and dental subsidy?

No. In this case, your health and dental coverage would end unless you choose COBRA continuation coverage and pay the full cost of coverage.

You may also choose to continue:

- life insurance, including dependent life insurance, through converting to a whole life policy
- AD&D coverage through portability continuation.

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

Health Plans and Prescription Drug Coverage

1. What are the health plan choices this year?

The City will offer two Blue Shield HMOs, a Blue Shield PPO and a Kaiser Permanente HMO in 2016.

2. I understand that everyone has to have insurance under the Affordable Care Act. Does Flex medical coverage meet the requirements?

Yes. The individual mandate in the Affordable Care Act (ACA) states that most people must have medical coverage or pay a penalty. The City of LA Flex medical plans meet or exceed the requirements for affordable employee coverage and benefit value. Because the Flex medical plans meet the ACA requirement, if you and your dependents are eligible for Flex, you are not eligible for a government subsidy to buy coverage through the health insurance marketplace.

If you have a dependent who is not eligible for Flex coverage and needs medical insurance, you may want to check the California health insurance marketplace, called Covered California. Go to coveredca.com to learn more.

3. I am not satisfied with my health plan. Can I make changes?

During open enrollment, you may change your plan ***effective January 1, 2016*** online or by calling the Benefits Service Center. If you wish to change your health plan at any other time during the year, you may only change if you have an eligible qualifying event, such as the birth/adoption/placement for adoption of a child, loss of other coverage by employee or dependent, employee switching from half-time to full-time or from full-time to half-time, or employee moving residence outside of the current plan's service area.

See the 2016 Benefits Booklet for more information on family status changes.

4. Can I choose one health plan for myself and a different health plan for my family?

No. You must select one health plan option for yourself and any dependents you want to enroll. However, if the health plan you choose requires you to select a primary care physician (PCP) – called a Personal Physician by Blue Shield – then each of your dependents can select a different in-network physician.

5. What is the difference between an HMO and a PPO plan?

An HMO pays benefits only when care is provided through the plan's network, unless you need emergency care when you are outside the plan's service area. With the Kaiser Permanente HMO, you may select a primary care physician for each family member, and you can go to any Kaiser facility whenever you need care. With the Blue Shield HMOs, you also choose a primary care physician (called a Personal Physician by Blue Shield) from the network to coordinate your care.

A PPO plan provides coverage for both in-network and out-of-network care, with out-of-network care paid at a lower benefit level. You do not have to choose a primary care physician or get a referral to see a network specialist.

6. For the PPO plan, does the out-of-pocket maximum include the deductible?

Yes, the deductible **does count** toward the out-of-pocket maximum. The out-of-pocket maximum will not include any costs not covered by the plan – like costs above the maximum allowable amount.

7. For the PPO plan, will any combination of expenses for my family meet the family deductible?

Here is an example:

You meet the family deductible when all family members' expenses for covered services equal $1,500. For instance, a family of five would meet the family deductible if each person had $300 in covered expenses ($300 x 5 = $1,500). The only exception is that no person in the family can have more than the individual deductible – $750 – count toward the family deductible.

Once you meet the family deductible, the plan begins paying benefits for all enrolled family members. If any person in the family meets the individual deductible, the plan will begin paying benefits for that person even if the family deductible has not yet been met.

8. Will I have to file claims if I enroll in the PPO plan?

For network office visits (other than preventive care visits), you will pay your $30 copayment and the provider will handle the paperwork for you. For other covered services, you will pay your share of covered expenses, and the network provider will file claims for you. If you have not met your calendar year deductible, your network provider may ask you to pay the cost of covered services and file a claim.

For services from non-network providers, you will generally have to pay the cost of covered services and file a claim. Some non-network providers may file claims for you.

9. Do I have a vision benefit through Flex?

Yes. Vision care benefits are included in all the health coverage options. This includes an eye exam every 12 months, and glasses or contacts every 24 months. The amount the plan pays for glasses or contacts depends on which health plan you enroll in and the type of lenses. See the 2016 Benefits Booklet or contact your plan directly for more details.

10. How can I find out if my health plan covers a particular service?

You can contact Member Services for your health plan for questions about how a specific service is covered. You can also obtain an explanation of plan coverage – called an evidence of coverage booklet – at http://per.lacity.org/bens/docforms.htm. In addition, the health plan comparison chart in the 2016 Benefits Booklet shows how some services are covered by the health plans.

11. How do I find network providers for my health plan?

You can search for a provider on your plan's website.

For Kaiser, go to http://my.kp.org/ca/cityofla/ and choose "Find a Doctor."

For Blue Shield go to blueshieldca.com/lacity. Then select "Find a Provider" and choose the plan for the network you would like to search.

You can also call the plan's Member Services number.

12. What happens if my doctor drops out of the network?

If you are enrolled in a Blue Shield HMO and your primary care physician (PCP) drops out of the network, you must select another PCP in the plan's network to coordinate your care. If you are enrolled in the Kaiser Permanente HMO and your doctor drops out of the network, you can see any doctor at a Kaiser facility. The HMO options do not pay benefits if you go outside the network.

13. How do I change my primary care physician (PCP)?

To change your Blue Shield PCP, contact Blue Shield Member Services at 1-855-201-2086. If you make a change, a new ID card will be sent to you via U.S. mail within seven to 10 business days.

You can change your Kaiser Permanente PCP at any time by contacting your local Appointment Center number or by calling the Member Services at 1-800-464-4000. Your request is effective immediately.

14. What if my spouse/domestic partner and I both work for the City or I have dependent children with another City employee who is not my spouse/domestic partner? How will our health benefits be affected?

You cannot enroll as both an employee and a dependent of your spouse/domestic partner. If your spouse/domestic partner chooses family coverage, you must choose Cash-in-Lieu in order to be covered as a dependent of your spouse/domestic partner. Only one spouse/domestic partner can enroll dependent children in health coverage. If you have dependent children with another City employee who is not currently your spouse/domestic partner, only one parent can purchase health coverage for the dependent children.

15. What if my child is also a City employee?

Employees who are children of City employees are not eligible to be covered under their parent's insurance. Your child must enroll in Flex coverage as an employee if he or she is eligible.

16. If I take Cash-in-Lieu and my spouse/domestic partner loses health coverage through his or her employer, can I enroll for Flex health coverage?

Yes. This would be a change in family status. You must call the Benefits Service Center at 1-800-778-2133 **within 30 calendar days** of the date your spouse/domestic partner's coverage ends to enroll in Flex health coverage. If you do not call **within 30 calendar days**, you have to wait until the next Open Enrollment.

17. Will I receive a new health plan ID card for 2016?

You will receive a new ID card if you enroll in a Blue Shield plan or if you enroll in the Kaiser HMO for the first time. You will receive your new card directly from the carrier by early January.

18. When do I receive my health plan ID card after I enroll as a new hire?

You will receive your ID card about four to six weeks after you enroll. If you need health care before you receive your ID card, your doctor can contact Member Services for your health plan to confirm your coverage.

For Kaiser Permanente, if you need to schedule an appointment as soon as your coverage becomes effective and you do not have your ID card yet, simply call the Appointment Center and you will be assigned a member ID number over the phone.

It takes approximately 2 to 2 1/2 weeks for your eligibility to be transmitted by the Employee Benefits Division to your health plan. If you need to verify whether your eligibility has been sent to your health plan before making an appointment, please contact the Employee Benefits Division.

19. I lost my ID card. How can I get a new one?

Call the toll-free number for Member Services for your health plan.

Kaiser Permanente allows you to request an ID Card through their Members Only site.

20. How much do I pay for prescriptions?

Your copayment depends on the plan you choose.

For the Blue Shield HMOs or Blue Shield PPO:

You receive up to a 30-day supply at a retail pharmacy for copayments of:

- $10 for generic drugs
- $20 for brand-name drugs on the formulary
- $40 for brand-name drugs not on the formulary.

You receive up to a 90-day supply by mail order for copayments of:

- $20 for generic drugs
- $40 for brand name drugs on the formulary
- $80 for brand name drugs not on the formulary.

For the Kaiser Permanente HMO:

You receive up to a 30-day supply at a pharmacy for copayments of:

- $10 for generic drugs
- $20 for brand-name drugs.

You receive up to a 100-day supply by mail order for a copayment of:

- $20 for generic drugs
- $40 for brand-name drugs.

Due to a provision of the Affordable Care Act (ACA) – also known as Health Care Reform – as of January 1, 2015 your copays for prescription drugs will now count towards your medical out-of-pocket maximum. This new provision can help you reach the out-of-pocket maximum sooner.

21. What is the difference between generic and brand-name drugs?

The main difference is cost. The generic name of a drug is its chemical name. The brand-name is the trade name under which it is advertised or sold.

By law, generic and brand-name drugs must meet the same standards for safety, purity, strength, and effectiveness. When authorized by your doctor and permitted by law, a pharmacy is able to dispense a generic drug when one is available. This saves you money. When you need a prescription drug, ask your doctor whether a generic can be substituted for a brand-name drug.

22. Will I still have to pay the brand-name copayment if there is not a generic alternative for my prescription?

Yes, you will.

23. What is a prescription drug formulary?

A formulary is a preferred list of commonly prescribed brand-name medications compiled by an independent group of doctors and pharmacists. It includes medications for most medical conditions that are treated on an outpatient basis. You pay lower copayments when you use a drug on the formulary.

24. How do I know whether my prescription is on the formulary?

You can access the formulary for Blue Shield at blueshieldca.com/lacity. Click "Pharmacy Benefits" on the left-hand side. You can also contact Member Services.

You can access the formulary for Kaiser at kp.org/formulary. You can also contact Member Services.

If you are on a medication that is not on the formulary, contact your doctor to see if it makes sense for you to make a change.

25. What if my doctor specifically prescribes a drug that is not on the formulary? Do I still pay the higher copayment?

Generally, if your doctor prescribes a drug that is not on the formulary, you will pay the higher copayment. Work with your doctor to see if there is a formulary drug that will accomplish the same results. Also, you can contact Member Services to initiate a review. Under certain circumstances, you may receive prior authorization to pay the lower formulary copayment for a drug that is not on the formulary.

26. How will using the mail-order prescription service save me money?

Mail-order is typically more cost-effective than filling your prescription for maintenance drugs at a retail pharmacy. That is because you can receive a longer supply for less than the cost of multiple refills at the pharmacy. Also, your prescriptions will be mailed free of charge (unless you want expedited shipping).

Dental Plans

1. How can I find a Delta Dental network dentist?

You may contact Delta Dental directly for a dentist directory by calling:

- **Delta Dental PPO** or **Preventive Only** – 1-800-765-6003
- **DeltaCare USA DHMO** – 1-800-422-4234

You may also go to Delta Dental's website deltadentalins.com. Select "Find a Dentist."

2. Can I choose one dental plan for myself and a different dental plan for my family?

No. You must select one dental plan option for yourself and any dependents you want to enroll.

3. Do I have to go to a network dentist with the Delta Dental plans?

- **Delta Dental PPO or Preventive Only** – These plans allow you the freedom to see any dentist of your choice. We encourage you to seek a Delta Dental PPO dentist to receive the highest level of benefits with the lowest out-of-pocket expenses.
- **DeltaCare USA DHMO** – You must select a primary care dentist (PCD) from the DeltaCare USA network to receive benefits. For specialist and orthodontic care, your assigned PCD will coordinate any necessary referrals.

4. What is the advantage of using a network dentist?

- **Preventive Only plan** – You will have no out-of-pocket expenses for covered services. Benefits are paid at 100% of reasonable and customary limits when you use a network dentist.
- **Delta Dental PPO** – This plan pays the highest level of benefits for network care, including 100% for cleanings with no deductible and a higher annual maximum. You will not have any charges above reasonable and customary limits from network providers, and network providers offer discounted fees so your share of the cost is lower. When you go outside the network, you pay any cost above reasonable and customary limits.
- **DeltaCare USA DHMO** – Benefits are only available when you visit your assigned PCD.

5. Can I choose a different dentist for myself and family members?

Yes, you and each of your family members may select a different dentist. If you have DeltaCare USA DHMO, you and your dependents collectively may select no more than three primary care dentists (PCD). If you would like to change your dentist during the year, please contact DeltaCare USA to make a PCD change. Please see question 8 for more information.

6. What does the Preventive Only plan cover?

The Preventive Only plan covers preventive services:

- Two cleanings and exams each year (includes an additional oral exam and routine cleaning during pregnancy).
- Two sets of bitewing X-rays each year.

If you need any other dental services, those services will not be covered by the Preventive Only plan.

7. If I enroll in the Preventive Only plan and find out during the year that I need dental care that is not covered by that plan, can I change to a different plan?

No. You can change your dental plan choice during Open Enrollment each fall. The only other time you can change your dental plan is if you have a change in family status during the year. In that case, your dental plan change must be consistent with your family status change. See the 2016 Flex Benefits Booklet for more information.

8. How can I change my primary care dentist for the DeltaCare USA DHMO Plan?

If you want to change your PCD, call DeltaCare USA Customer Service at 1-800-422-4234, or submit a request form via the DeltaCare USA website. Contact DeltaCare USA by the 21st of the month for the change to become effective by the first of the following month.

Healthcare Flexible Spending Account

1. How much can I contribute to a Healthcare Flexible Spending Account?

You may set aside from $300 up to $2,550 annually in a Healthcare Flexible Spending Account. Your contributions come out of your check each pay period. Your per pay period contribution must be a whole dollar amount. The maximum deducted per pay period will vary based upon whether you enroll during Open Enrollment or in response to an eligible family status change during the year.

2. May I change my Healthcare Flexible Spending Account contributions during the year?

Yes, as long as you have a change in family status and the change in your contributions is consistent with your family status change. See the 2016 Flex Benefits Booklet for more information.

3. If I do not enroll in a Healthcare Flexible Spending Account now, but I (or my spouse or domestic partner) have a baby during the year, can I set up an account then?

Yes. When the child is born or adopted, you may open a Healthcare Flexible Spending Account or increase the amount you are already contributing. A child born to a domestic partner is eligible only if you claim the child as a dependent on your tax return or if the child is your "health plan tax dependent" as defined by the IRS.

The IRS defines a "health plan tax dependent" as your children and other relatives – or an unrelated person who lives with you for the entire year – if the child, relative or other person receives more than half of his or her support from you; is a US citizen, resident or national, or a citizen of Mexico or Canada; and is not claimed as a dependent on anyone else's tax return.

For more information, please contact the Employee Benefits Division.

4. Can I use my Healthcare Flexible Spending Account for my domestic partner's health expenses?

If your domestic partner meets the IRS definition of "health plan tax dependent," you can use your account for his or her eligible expenses.

The IRS defines a "health plan tax dependent" as your children and other relatives – or an unrelated person who lives with you for the entire year – if the child, relative or other person receives more than half of his or her support from you; is a US citizen, resident or national, or a citizen of Mexico or Canada; and is not claimed as a dependent on anyone else's tax return.

For more information, please contact the Employee Benefits Division.

5. If I do not use up my full balance, what happens to the money?

Any money left in your account at the end of the calendar year may be used to cover eligible expenses you had while you were contributing to the account during that calendar year. **You must file a claim by April 30 of the following year. Then, any money that is left will be forfeited, according to IRS regulations.**

6. What happens to my Healthcare Flexible Spending Account if I leave employment with the City mid-year?

Please contact the Employee Benefits Division at 213-978-1655 regarding continuation rights under the Healthcare Flexible Spending Account. If you choose to continue participation in the program, **all claims for reimbursement still must be submitted by April 30 of the following year.**

7. How do I know which of my expenses are eligible for reimbursement from a Healthcare Flexible Spending Account?

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

8. Can I participate in a Healthcare Flexible Spending Account even if I am not enrolled in Flex medical coverage?

Yes, any out-of-pocket expense that you have – or your spouse or any eligible dependent, as defined in questions 3 and 4, has – may be considered an eligible Healthcare Flexible Spending Account expense even if you or your dependents are not enrolled in Flex medical coverage.

9. Can I use my Healthcare Flexible Spending Account for over-the-counter medications?

You cannot use your account for non-prescribed drugs other than insulin. Over-the-counter medications, such as aspirin, ibuprofen, allergy medications, etc., will not be reimbursable unless they are prescribed by your doctor.

10. Can I file a claim for services I receive before the calendar year begins if I am not billed until after the calendar year starts?

No. Based on IRS guidelines, a qualified expense is "incurred" at the time the service is provided, not when you are billed or when you pay for the service. As a result, you can file claims only for eligible expenses you have during the calendar year while you are enrolled and contributing to the account.

11. How often will I be reimbursed?

You will be reimbursed whenever you submit a claim – until you have been reimbursed up to the amount you elected to contribute for the year. Reimbursements are processed immediately upon claims approval.

12. Can I submit a claim online?

Yes. Through WageWorks Enterprise platform at wageworks.com, you can submit claims and upload receipts online – with reimbursements processed in one to two days (you can still use a paper claim form if you prefer). WageWorks also offers EZ Receipts Mobile applications. Check current health care and dependent care account balance. Download mobile applications directly from WageWorks.

13. Can I receive my reimbursement via Direct Deposit?

Yes. You can authorize direct deposit to your checking account online. Simply log in to your account and go to "Profile" then "Reimbursement Method".

14. How do I get a debit (payment) card for my Healthcare Flexible Spending Account?

You will automatically receive a debit card if you enroll for 2016. You may call and request additional cards for family members or place an order from your account online at wageworks.com.

Please note that there is no charge for using this option.

15. What happens if I have a debit card and my expense at the register exceeds the current balance in my Healthcare Flexible Spending Account?

The debit card will not allow a transaction for any amount exceeding the available account balance. You will need to either pay the expense and file a claim for reimbursement or charge the remaining balance left on the card and pay the difference to the merchant.

16. Do I have to use two forms of payment if I have a debit card and want to use it at the store, but my purchases are a combination of healthcare eligible and non-eligible expenses?

Yes, the debit card cannot be used for non-eligible expenses. With the inventory control system that the IRS requires merchants to utilize, stores are able to advise you regarding what items may be charged on the debit card and what must be paid with an alternative form of payment.

IRS regulations allow this debit card to only be used at grocery or drug stores that have an inventory control system in place that can identify eligible purchases and apply them to the card accordingly. You will not be able to use the card at locations that do not have the required system in place. Most major chains have implemented the required system.

17. If I participate in both the Healthcare Flexible Spending Account and the Dependent Care Reimbursement Account, can I use the debit card for both accounts if my day care provider accepts debit cards?

No. The debit card is available for the Healthcare FSA only.

18. If I submit a claim for reimbursement and do not have enough money in my Healthcare Flexible Spending Account, what happens?

Based on IRS rules, you are allowed to receive reimbursement up to your full annual election regardless of the amount contributed to date. Please note that the debit (payment) card cannot be used to claim money in excess of your current account balance. Claims in excess of your current account balance must be submitted using the other options described in questions 12 and 13.

19. How can I check my account balance?

You are able to check your balance through the automated telephone system by calling 877-924-3967 or by logging into your account at wageworks.com. You can also set up monthly balance reminders via e-mail. The balance reminders are also sent following any account activity. For participants who do not provide an e-mail address, the administrator sends quarterly account statements to the address on file.

20. Can I receive an e-mail if my account balance falls below a certain amount?

WageWorks will send out an end of the year communication to you automatically if you still have a balance of at least $20 left in your Healthcare and Dependent Care account.

21. Can I transfer money from my Healthcare Flexible Spending Account to my Dependent Care Reimbursement Account or vice versa?

No. The accounts work separately. Based on IRS rules, you cannot transfer money between the accounts.

Dependent Care Reimbursement Account

1. How much can I contribute to a Dependent Care Reimbursement Account?

You may set aside from $600 up to $4,992 annually in a Dependent Care Reimbursement Account if single or married filing jointly. If you are married and filing separate tax returns, you can set aside up to $2,500. You may set aside up to $5,000 in total to the two accounts if married, filing jointly and your spouse's employer offers a dependent care account. Your contributions come out of your check each pay period. The maximum deduction per pay period will vary if you enroll during open enrollment or due to an eligible family status change during the year.

2. May I change my Dependent Care Reimbursement Account contributions during the year?

Yes, as long as you have a change in family status and the change in your contributions is consistent with your family status change. You may also be eligible to change your contributions based on day care provider changes. See the 2016 Flex Benefits Booklet for more information.

3. If I do not enroll in a Dependent Care Reimbursement Account now, but I (or my spouse or domestic partner) has a baby during the year, can I set up an account then?

Yes. When the child is born or adopted, you may open an account or increase the amount you are already contributing. A child born to a domestic partner is eligible only if you claim the child as a dependent on your tax return. If you are on leave after the birth or adoption of a child, new or increased contributions can begin when you return to work.

4. If I do not use up my full account balance, what happens to the money?

Any money left in your account at the end of the calendar year may be used to cover eligible expenses you had while you were contributing to the account during that calendar year. **You must file a claim by April 30 of the following year. Then, any money that is left will be forfeited, according to IRS regulations.**

5. How often will I be reimbursed?

You will be reimbursed whenever you submit a claim as long as funds deposited in your account cover the amount of the claim. Reimbursements are processed weekly on Wednesdays.

6. How often may I submit a claim?

You can submit claims as often as you want.

7. Can I submit a claim online?

Yes. Through a WageWorks Enterprise platform at wageworks.com, you can submit claims and upload receipts online – with reimbursements processed in one to two days (you can still use a paper claim form if you prefer). WageWorks also offers EZ Receipts Mobile application. Download the mobile application directly from WageWorks and have your dependent care provider sign your phone for a quick claim submittal.

8. Can I receive my reimbursement via Direct Deposit?

Yes. You can authorize direct deposit to your checking account online. Simply log in to your account and go to "Personal Information".

9. Can I get a debit (payment) card for my Dependent Care Reimbursement Account?

Debit cards are not available for the Dependent Care Reimbursement Account.

10. If I submit a claim for reimbursement and do not have enough money in my Dependent Care Reimbursement Account, what happens?

You can only be reimbursed for the amount that you have in your account. The amount above this will be in pending status until more money is deposited in your account from payroll deductions.

11. How can I check my account balance?

You are able to check your balance through the automated telephone system by calling 877-924-3967 or by logging into your account at wageworks.com. You can also set up monthly balance reminders via e-mail. The balance reminders are also sent following any account activity. For participants who do not provide an e-mail address, the administrator sends quarterly account statements to the address on file.

12. Can I receive an e-mail if my account balance falls below a certain amount?

WageWorks will send out an end of the year communication to you automatically if you still have a balance of at least $20 left in your Healthcare and Dependent Care account.

13. Can I transfer money from my Dependent Care Reimbursement Account to my Healthcare Flexible Spending Account or vice versa?

No. The accounts work separately. Based on IRS rules, you cannot transfer money between the accounts.

14. What happens to my Dependent Care Reimbursement Account if I leave employment with the City mid-year?

No further contributions will go into your account, but you may continue to submit claims for expenses you had while you were employed. **All claims must be submitted by April 30 of the following year.**

15. Are there any restrictions on who can provide day care that is reimbursed through the Dependent Care Reimbursement Account?

Yes. Care must be provided by an eligible caregiver for which you can provide a Social Security number or taxpayer identification number. The caregiver cannot be a parent of the child. Also, your children or stepchildren under age 19 and anyone you or your spouse claims as a dependent on your tax return are not eligible caregivers. If day care is provided in a person's home, that facility must be licensed unless fewer than seven children are being cared for.

16. Can I take the dependent care tax credit on my income tax and also use the Dependent Care Reimbursement Account?

Maybe. You cannot, however, claim the same expenses for both. You could, for instance, pay for $2,000 of dependent day care from your reimbursement account and claim any excess up to your allowable maximum – $3,000 for one child, $6,000 for two or more – as a tax credit. How the tax credit could work for you depends on your level of earnings and how much you would owe in taxes.

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

17. Are day care expenses reimbursable on days I do not work?

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

18. Can I arrange to have my reimbursement account pay my babysitter or day care facility directly?

Yes. You can set up a "Pay My Provider" order online at wageworks.com and have WageWorks send a payment to your provider up to the available funds in your dependent care account.

19. Does summer camp count as dependent care?

Day camp: Yes. The part of summer day camp expenses for care of the child qualifies as dependent care, even if the camp specializes in a certain activity like soccer or computers. This does not include the cost of clothing, entertainment, equipment, activity fees, food or schooling.

Overnight camp: No. An IRS ruling eliminated reimbursement for overnight camp.

20. Can I use a Dependent Care Reimbursement Account to pay for a babysitter while my spouse is attending school?

Yes, if it is full-time. Attending school full-time is considered the same as working, provided your spouse is a full-time student during five months of the calendar year. The maximum you can set aside in this case, however, is $250 a month for one child or $500 for two or more, subject to the annual maximum of $4,992 for the Dependent Care Reimbursement Account.

21. If my day care costs more during the summer than during the school year, can I change my contribution amount?

Yes. If you experience a change in cost or change day care providers, you may change the amount of your per pay period contribution by calling the Benefits Service Center at 1-800-778-2133 within 30 calendar days of the change in cost or provider.

Commuter Spending Accounts

How Transit Spending Accounts Work

1. What is a Transit Spending Account?

A Transit Spending Account (TSA) allows you to set aside up to $130 pre-tax per month from your paycheck to pay for public transit (e.g. bus, light rail, train and subway) expenses you incur when commuting to work.

2. What does saving "pre-tax" mean, and how is it a benefit to me?

Saving pre-tax means that the amounts you save are not treated as taxable income. As an example, if you contributed $130 from your paycheck into a TSA, that amount would not be included in your taxable income for that year. The benefit is that you get to keep the amount of tax you would otherwise have owed on that $130 of income.

3. How would I purchase my public transportation tickets or passes using a TSA?

You have two options: (1) purchase them directly through the program administrator, WageWorks, and have them mailed to your home; or (2) purchase them on your own.

4. How quickly after I sign up for my TSA will the funds become available to me?

You should see your account with WageWorks credited with your payroll contribution on or slightly after payday. Once you see the funds credited online they are available for your use.

5. What are the rules for making my purchase through WageWorks?

Once you have a balance in your TSA, you can place an order for a transit pass through the WageWorks website, at wageworks.com. **Your order is due by the 10th of each month in order to receive your pass before the 1st of the following month.**

6. What are the rules for making purchases on my own?

If you purchase fares individually (e.g. daily train rail tickets) you can still use the TSA. However, **you must inform WageWorks by the 10th of the month what you plan to spend in the *following* month**. Submit a claim form with receipts up to six months after your purchase(s) to receive reimbursement from your TSA.

7. If I order through WageWorks how likely is it that I'll receive my pass?

WageWorks has a 99.7% successful delivery rate for mailing its passes. In addition, you are required to verify your address at time of purchase, to prevent errors due to incorrect address information. In the event you did not receive your pass, you would contact WageWorks for further guidance.

8. What if I want to load a Transit Access Pass (TAP) card?

You can load your TAP card through the WageWorks website. Just place your order by the 10th of each month in order to have the funds credited as of the 1st of the subsequent month.

9. When can I enroll and cancel my contributions?

You are eligible to enroll, increase or decrease contributions, or cancel participation, at any time.

10. How do I enroll in a TSA?

To enroll in a TSA, go to myflexla.com.

Once you have your first deduction taken, you can go to wageworks.com to manage your account, make purchases, learn more about the program, etc.

11. How do I modify or cancel my contributions to a TSA?

You can modify or cancel your contributions to your TSA by returning to myflexla.com.

12. If I decide to cancel my contributions can I receive a refund of amounts I've already placed into my account?

No. Once you make a contribution into a TSA the funds may only be used for the purpose of purchasing public transportation for your work commute.

13. What if I don't use up my account balance by the end of a given month or year?

Any unused amounts automatically roll forward and are available for use. You can do this indefinitely. However, once you terminate employment (or transfer to the Department of Water and Power), you will have 90 days to use any accumulated funds. If you do not use your accumulated funds within those 90 days, any remaining balance will be forfeited to the City.

Transit Reimbursement

14. What is transit reimbursement?

Transit reimbursement is a benefit provided by the City to qualified employees (excluding Harbor, Airports and DWP employees) to reimburse them up to $50 per month for transit expenses for commuting to work.

15. If I participate in a TSA can I still receive transit reimbursement from the City?

Yes, but it will operate differently. If you have a TSA, you are eligible to be reimbursed up to $50 **for the month that funds are deducted from your paycheck and go into your TSA.** Although, you are still required to comply with all the rules and requirements of the transit reimbursement program, you do not need to submit a claim to the City in order to receive your reimbursement, nor is your reimbursement dependent upon the purchase and use of transit tickets/passes in any particular month.

16. When will I receive my transit reimbursement?

Your reimbursement will be received two months following the month that the contribution to your TSA is made. For example, if you have $130 deducted from your paycheck into a TSA in January, you will receive your $50 reimbursement in March.

17. If I don't want to open up a TSA can I still receive transit reimbursement?

Yes. The existing process of applying for transit reimbursement will not change for those employees who do not open up TSAs. If you do not have a TSA and would like to apply for transit reimbursement please complete and submit a Transit Reimbursement Request form. The Transit Reimbursement Request form is available through the Personnel Department Intranet site at http://per.lacity.org/commuter.htm. You may also contact Commute Options and Parking Section at 213-978-1634, or visit the office at City Hall, 200 N. Spring Street, Room 867, to obtain forms or request additional information.

How Parking Spending Accounts Work

18. What is a Parking Spending Account?

A Parking Spending Account (PSA) allows you to set aside up to $250 pre-tax per month from your paycheck to pay for parking expenses you incur when commuting to work.

19. What does saving "pre-tax" mean, and how is this a benefit to me?

Saving pre-tax means that the amounts you save are not treated as taxable income. As an example, if you contributed $250 from your paycheck into a PSA, that amount would not be included in your taxable income for that year. The benefit is that you get to keep the amount of tax you would otherwise have owed on that $250 of income.

20. How would I purchase my parking pass using a PSA?

You have two options: (1) purchase it directly through the program administrator, WageWorks, which then contacts the parking garage/lot administrator on your behalf; or (2) purchase them on your own.

21. How quickly after I sign up for my PSA will the funds become available to me?

You should see your account with WageWorks credited with your payroll contribution on or slightly after payday. Once you see the funds credited online they are available for your use.

22. What are the rules for making my purchase through WageWorks?

Once you have a balance in your PSA, you can place an order for a parking pass through the WageWorks website, at wageworks.com. **Your order is due by the 10th of each month in order to have the garage/lot administrator notified before the 1st of the following month.**

23. How can I be sure WageWorks has a relationship with the garage/lot I use to park?

Many public parking lots are owned by a relatively small number of firms. WageWorks has relationships with most of these firms and has developed processes to notify them when passes for their lots are purchased through the WageWorks system. They have an extensive online list of parking lots and garages. If your lot is not on their list, you can provide them with information about the lot and they can add it to their list.

24. What are the rules for making purchases on my own?

If you purchase parking passes on your own you can still use the PSA. However, **you must inform WageWorks by the 10th of the month what you plan to spend in the *following* month**. Submit a claim form with receipts issued by the garage/lot administrator up to six months after your purchase(s) to receive reimbursement from your TSA. If your lot does not issue a receipt, you may still submit a claim and inform WageWorks that no receipt was provided by the lot administrator.

25. Can I use my PSA to pay for my City parking?

If you have a payroll deduction for parking provided by the City to its employees at a City-owned or leased lot, you cannot use your PSA to pay or be reimbursed for that expense. This is because the parking fees that are being payroll deducted for your City permit are already being paid on a pre-tax basis. The exception to this would be employees who are paying by check for certain limited passes (e.g. night permits), since those payments are being provided after-tax.

26. When can I enroll and cancel my contributions?

You are eligible to enroll, increase or decrease contributions, or cancel participation, at any time.

27. How do I enroll in a PSA?

To enroll in a PSA, go to myflexla.com.

This site will allow you to establish your payroll deduction into the program. Once you have your first deduction taken, you can go to wageworks.com to manage your account, make purchases, learn more about the program, etc.

28. How do I modify or cancel my contributions to a PSA?

You can modify or cancel your contributions to your PSA by returning to myflexla.com.

29. If I decide to cancel my contributions, can I receive a refund of amounts I've already placed into my account?

No. Once you make a contribution into a PSA the funds may only be used for the purpose of purchasing parking for your work commute.

30. What if I don't use up my account balance by the end of a given month or year?

Any unused amounts automatically roll forward and are available for use. You can do this indefinitely. However, once you terminate employment (or transfer to the Department of Water and Power), any remaining balance in your account would be forfeited to the City.

Life Insurance

1. If I do not select supplemental or dependent life insurance, what will my coverage be?

If you do not select supplemental or dependent life insurance, your coverage will depend on your eligible status:

- You will have $10,000 in basic life insurance coverage, provided at no cost to you, if you are a full-time employee (regardless of representation by an employee representation unit); a regular half-time employee hired on or before July 24, 1989 (regardless of representation by an employee representation unit); an elected official; or a member of the Board of Public Works.
- You will have $5,000 in basic life insurance coverage if you are a regular half-time employee hired after July 24, 1989, not represented by an employee representation unit.
- You have one times your annual earnings, to a maximum of $750,000 in basic life insurance coverage if you are an employee represented by an employee representation (collective bargaining) unit for which an Employer-sponsored term life insurance plan has been negotiated in Memorandum of Understanding (MOU), General Manager (employees hired prior to 7/1/2014), or non-represented Assistant General Manager.

Also, if you are age 65 or older, your life insurance coverage is reduced. See the 2016 Flex Benefits Booklet for more information.

2. Are life insurance amounts reduced based on age?

Yes, your life insurance amounts (basic and supplemental) are reduced once you reach age 65. For your spouse or domestic partner, dependent life insurance amounts are reduced once he or she reaches age 65. From age 65 to 69, coverage amounts are reduced to 65%. At age 70, coverage amounts are reduced to 35%. See the 2016 Flex Benefits Booklet for more information.

3. Is the portability feature automatic or do I have to enroll in it?

No, portability is not automatic. To continue coverage through portability, you must obtain a portability form from the Employee Benefits Division and return the completed form to the insurance company within 60 days of the date Flex coverage ends.

4. With portability, will my life insurance coverage be the same as the coverage I have now under Flex if I leave employment or lose coverage?

You can continue the same amount of coverage you have under Flex after your employment ends – up to a maximum combined amount of $1 million.

You will pay group rates for portable coverage. These group rates are not the same as the City's employee coverage cost but are generally lower than the cost of an individual term or whole life policy.

5. What do I need to do if I am leaving the City, but I want to port my employee coverage?

You must complete your portion of the portability form and send it to the Employee Benefits Division so that the employer's portion can be completed. Send the form to the Employee Benefits Division at least 14 days before the filing deadline, which is within 60 days of the day your employment ends. The form is available at http://per.lacity.org/bens/docforms.htm or from the Employee Benefits Division.

On the date your employment terminates, you must have been continuously insured for at least 12 consecutive months, not be disabled and be a member or spouse under age 80. A dependent child under age 26 or a spouse may port only if the member ports their coverage.

6. How do I pay for portable coverage?

If you select portable coverage after your City employment ends, the insurance company will bill you for the cost of coverage and you will send payments directly to the insurance company.

7. Can I convert my life insurance to another policy if I leave the City or otherwise lose my coverage?

Yes, if your coverage ends or is reduced with the City for any reason except failure to make a required premium contribution or payment of an Accelerated Benefit, you can convert your life insurance to an individual whole life policy. Because group rates will no longer apply, this individual conversion policy will cost more than coverage you have as an active City employee through Flex.

Conversion is the only option available to you if you are disabled, have been covered less than 12 months, are over age 80 or have less than $10,000 in life insurance coverage when your coverage with the City ends or reduces. In these situations, you may convert coverage but you cannot select portable coverage.

8. What do I need to do if I am leaving the City or lose coverage, but I want to convert coverage?

You must complete your portion of the conversion form and send it to the Employee Benefits Division so that the employer's portion can be completed. Send the form to the Employee Benefits Division at least 14 days before the filing deadline, which is within 60 days of the day your coverage ends or reduces. The form is available at http://per.lacity.org/bens/docforms.htm or from the Employee Benefits Division.

9. What is supplemental life insurance and what are my options?

Supplemental life insurance pays a benefit to your beneficiary if you die, in addition to your basic life insurance benefit. You can choose coverage of one, two, three, four or five times annual base pay – up to a maximum of $1 million.

10. How is my annual base pay determined for life insurance?

For 2016 coverage, your pay is your annual base pay as of September 1, 2015, and does not include overtime or bonuses. If your pay changes during the year, your life insurance amount will not change unless you have a change in job class or pay grade.

11. Can I purchase dependent life insurance for a newborn child?

Yes. You can enroll a newborn child in dependent life insurance as long as you go to myflexla.com or call the Benefits Service Center at 1-800-778-2133 within 30 days of the child's live birth. The child will have $5,000 in coverage. The cost to cover dependent children is a flat rate, regardless of the number of children covered under your Flex benefits.

12. Why do I have to select supplemental life insurance before I can select spouse or child life insurance?

Because the Flex program is designed to benefit City employees, the insurance company providing supplemental life requires that you must enroll in supplemental life insurance to enroll in dependent life insurance.

13. Are there any restrictions on enrolling in dependent life insurance?

Life insurance coverage for your spouse/domestic partner may not exceed 100% of your total life insurance coverage amount – basic plus supplemental.

14. Why do I have to purchase dependent life insurance with after-tax dollars?

IRS rules do not allow the purchase of dependent life insurance with pre-tax dollars.

15. Does supplemental and dependent life insurance create extra taxable income for me?

It might. Since you purchase supplemental life insurance with pre-tax dollars, extra taxable income, called "imputed income," applies to combined basic and supplemental life insurance amounts over $50,000 under IRS rules. Imputed income does not apply to your first $50,000 of basic and supplemental life. If you have over $50,000 in coverage, the imputed income will be based on amounts greater than $50,000. Imputed income may also apply to life insurance you purchase for your spouse/domestic partner and/or children.

16. If this coverage creates imputed income, why would I choose it?

Even though your supplemental life choice may create imputed income, you may still come out ahead because you purchase the coverage with pre-tax dollars from your pay – creating tax savings for you. Imputed income reduces the advantage of pre-tax dollars somewhat. Because imputed income applies only to supplemental life insurance amounts above $50,000, you get the full pre-tax advantage for coverage amounts below that.

For dependent life insurance, imputed income will generally apply only if you cover a spouse/domestic partner over age 55 or more than one child.

Most people make a life insurance choice based on their personal situation – with imputed income as only one factor in that decision.

17. What is proof of good health?

Proof of good health – also called evidence of insurability or EOI – includes a questionnaire on your health status and sometimes a physical. Depending on the answers to the questionnaire and the results of any physical, life insurance coverage will be approved or denied.

18. Since the City requires an annual physical exam for my job, why do I have to satisfy the proof of good health requirement?

Proof of good health is required by the insurance company – not the City. The insurance company may require it before providing coverage or increasing your coverage amount.

19. When is proof of good health required for supplemental life insurance?

During open enrollment, proof of good health is required if you are a current employee:

- For basic life coverage in excess of $500,000 for employees represented by an employee representation (collective bargaining) unit for which an Employer-sponsored term life insurance plan has been negotiated in a Memorandum of Understanding (MOU), General Manager (employees hired prior to 7/1/2014), or non-represented Assistant General Manager.
- Enrolling in supplemental life insurance for the first time if you are applying more than 60 days after you became eligible.
- Increasing your coverage by more than one level – for instance, from one to three times annual base pay – or to a level more than three times annual pay or an amount above $750,000.

If you are a new hire, proof of good health is required for supplemental life of four or five times annual pay or for any amount above $750,000.

If you have a change in family status, you have 30 calendar days to change your life insurance choice. Proof of good health is required for increases of more than one coverage level, increases to four or five times annual base pay or amounts above $750,000.

If you have a change in job class or pay grade with a pay increase, you will have to provide proof of good health if your coverage amount increases to more than $750,000, regardless of your coverage level.

20. When is proof of good health required for dependent life insurance?

If you are currently enrolled in Flex, you will have to provide proof of good health for your spouse or domestic partner to purchase spouse or domestic partner life insurance for the first time or increase coverage during open enrollment if you are applying more than 60 days after you became eligible. If you are a new hire, proof of good health is not required if you apply within 60 days after you become eligible. For coverage choice changes during the year because of a change in family status, proof of good health is required for spouse/domestic partner insurance – unless you are adding a spouse/domestic partner within 30 calendar days of marriage or beginning a domestic partner relationship.

Proof of good health is never required for life insurance for your dependent children.

21. When is my child no longer eligible for life insurance?

Children are eligible for life insurance coverage up to the last day of the month in which they reach age 26. In case of disability, your child will have to meet eligibility requirements for disability as determined by the life insurance carrier. You must provide proof on the life insurance carrier's forms within 30 days after the date on which insurance would otherwise end because of the child's age.

22. How do I file a claim?

The beneficiary must file a claim with the Employee Benefits Division by calling 213-978-1655. A copy of the death certificate must be included with the claim form. The Employee Benefits Division will forward the claim to the life insurance claim administrator for payment.

23. Can I name any beneficiary for life insurance coverage?

You can name anyone as the beneficiary of your basic and supplemental life insurance. You are automatically the beneficiary for any dependent life insurance you choose.

24. How do I change my beneficiary and how often can I make changes?

Go to myflexla.com or call the Benefits Service Center at 1-800-778-2133 between 8 a.m. to 5 p.m. from Monday to Friday if you need to make a change. Your change will take effect immediately once you submit your beneficiary information. You can change your beneficiary for basic and supplemental life insurance any time.

AD&D Insurance

1. What is AD&D?

AD&D, or accidental death and dismemberment insurance, provides benefits for covered loss of life, limb, hearing or sight as a result of an accident. Dependents may also be insured. Generally, the plan pays the full coverage amount selected for loss of life. For other covered losses, the plan may pay the full coverage amount or a percentage of the coverage amount depending on the type of loss. See your Certificate of Coverage for a detailed list of covered losses, benefit amounts and additional features. The Certificate of Coverage is available at http://per.lacity.org/bens/docforms.htm or by calling the Employee Benefits Division at 213-978-1655.

2. What are my AD&D options?

You can choose coverage for yourself in any amount from $50,000 to $500,000, in multiples of $50,000. (Note: An additional $3,000 will be payable if the accidental injury sustained by you or your insured dependent results in loss of life). From age 65-69, the principal sum is reduced to 65% and at age 70, the principal sum is reduced to 35%.

If you choose to cover your family, coverage will extend to **all** Flex-eligible persons in the family (children and spouse/domestic partner), not just dependents covered under your benefits. See the Flex Benefits Booklet for a complete definition of eligible dependents.

3. If I enroll in family coverage, what is the AD&D benefit for my family members?

Benefits for your family members depend on your family makeup and the amount of coverage you choose for yourself. If you choose family coverage, your AD&D benefit will extend to **all** Flex-eligible persons in the family (children and spouse/domestic partner), not just dependents covered under your benefits.

- If your family consists of spouse/domestic partner only, and that person was to suffer an accidental death and/or dismemberment, you would receive up to 60% of your employee coverage amount.
- If your family consists of children only, and a child was to suffer an accidental death or dismemberment, you would receive up to 20% of your employee coverage amount for each injured child.
- If your family consists of a spouse/domestic partner and children, and the spouse/domestic partner was to suffer an accidental death or dismemberment, you would receive up to 50% of your employee coverage amount. If a child was to suffer an accidental death or dismemberment, you would receive up to 10% of your employee coverage amount for each child.

Another thing to note is that benefits are always paid to you because you are the one with the policy. If you die, the beneficiary succession would be the same as with life insurance.

4. If I have a spouse/domestic partner and children in my family, can I enroll only my children, but not my spouse/domestic partner (or vice versa) for AD&D coverage?

No. If you choose family coverage, your AD&D benefit will extend to **all** Flex-eligible persons in the family (children and spouse/domestic partner), not just dependents covered under your benefits. Please see question 3 for more information.

5. If I have automobile insurance, will AD&D cover losses as the result of accidents involving my car?

You and any eligible dependents you cover will have AD&D coverage for losses resulting from an automobile accident – even if you already have automobile insurance. If you are wearing a seatbelt at the time of an automobile accident, the plan may pay additional benefits.

6. What types of exclusions does the AD&D Plan have?

AD&D benefits will not be paid for a loss resulting from injuries or accidents contributed to by sickness or disease; medical treatment for sickness or disease; war or any act of war, whether declared or not; intentionally self-inflicted injury, suicide or suicide attempt, whether sane or insane; drugs not prescribed or administered by a doctor; traveling in an aircraft for the purpose of parachuting or otherwise exiting from the aircraft while in flight, except for self-preservation; and travel in test or experimental aircraft, aircraft by or for any military authority or travel beyond the earth's atmosphere; sustained while riding on any aircraft as a pilot crewmember, or student pilot, as a flight instructor or examiner or if it is owned, operated, leased by or on behalf of the policyholder, or any employer or organization whose eligible persons are covered under the policy; sustained while committing or attempting to commit a felony and accidents caused by your intoxication while operating a motor vehicle, including alcohol in combination with any drug; also voluntary intake or use of poison, gas or fumes. See your Certificate of Coverage at http://per.lacity.org/bens/docforms.htm for a detailed list of exclusions.

7. Can I name any beneficiary for my AD&D coverage?

Your beneficiary for AD&D will automatically be the same as your life insurance beneficiary. If you change your life insurance beneficiary, that change applies to AD&D as well. Like life insurance, you are automatically the beneficiary of any family AD&D coverage you select.

8. How do I file a claim?

You must provide the Employee Benefits Division with a completed claim form. They will forward this information to the AD&D insurance claim administrator for payment. To obtain a form, go to http://per.lacity.org/bens/docforms.htm. If you have any questions, please call the Life Insurance Coordinator at 213-978-1655.

Disability Insurance

1. Who administers the disability insurance benefit programs?

The City of Los Angeles' Short Term Disability (STD) and Long Term Disability (LTD) benefit programs are administered by Standard Insurance Company (The Standard). These FAQs are in no way a complete review of the benefit policies, nor are they meant to replace the Certificate of Coverage outlining your benefits. If you do not have a Certificate of Coverage please contact your Employee Benefits Member Services Representative by dialing 213-978-1655.

2. How much will I get paid if I am disabled?

The City of Los Angeles has a STD plan and a LTD plan, each with two payment options: Plan 1 (Basic) for STD and LTD benefits is a core plan provided by the City to all eligible employees; Plan 2 (Supplemental) for STD and LTD benefits, is paid for by the employee. Plan 1 pays 50% of the amount you were earning when you became disabled (predisability earnings) up to a maximum of $3,129 per month in 2016. Plan 2 pays 66 2/3% of your predisability earnings up to a maximum of $12,000 per month.

3. When do my benefits become payable?

The benefit waiting period (period of time you must be disabled before benefits become payable) for the STD policy is the end of the period for which you are eligible for 100% and 75% sick leave. The benefit waiting period for LTD is the end of the period for which you are eligible for 100% and 75% sick leave plus 180 days. If you do not have sick leave that you can use there is a zero day waiting period for STD and a 180-day waiting period for LTD.

4. What if I receive a new bank of sick leave at the beginning of the year?

If you receive sick leave at the beginning of the year and you are still serving the benefit waiting period, the additional days you receive will extend the benefit waiting period. If you are receiving benefits at the time a new bank of sick leave is received, the amount of sick leave you are able to use will be deducted from your STD or LTD benefits.

5. How often will I receive checks?

STD benefits are paid on a weekly basis. Benefit checks are mailed on Wednesdays covering payment for the previous Monday through Sunday. LTD benefits are paid on a monthly basis, at the end of the benefit month. Your disability date and benefit waiting period will determine your benefit month. For LTD benefits, you also have the option of having your benefit payments directly deposited into your bank account via electronic funds transfer (EFT) or transferred to a SecureCard (similar to a debit card) provided by The Standard and U.S. Bank. Please contact the benefits analyst administering your claim for details on these options.

6. How will Workers' Compensation affect my disability claim?

Workers' Compensation benefits are deductible from LTD benefits. **(Note: you are not eligible for STD benefits if you are receiving or eligible to receive Workers' Compensation benefits)**. All Workers' Compensation benefits are deductible except permanent benefits. The City of Los Angeles Workers' Compensation pays three types of benefits that will be deducted from your disability benefit if you receive or are eligible to receive them. Deductible Workers' Compensation benefits include IOD, State Rate and Vocational Rehab Maintenance Allowance.

7. Do I have to apply for Los Angeles City Employee's Retirement System (LACERS) benefits?

The group policy requires that you apply for LACERS Disability benefits if you are eligible for those benefits. You are not required to apply for Service Retirement benefits. Currently, the City requires that employees apply for LACERS Disability benefits within 12 months from their last date on payroll. If you do not apply for these benefits during the designated period of time, you will have missed your chance to apply. LACERS Disability benefits are deductible if you are receiving them or *are eligible to receive* them. Therefore, if you do not file your claim with LACERS in a timely manner and miss the opportunity to receive these benefits, The Standard may still be obligated, per the City of Los Angeles group policy, to reduce your monthly LTD benefit by the amount you would have been eligible to receive. Note that these benefits are not deductible from your STD benefits.

8. I have disability benefits through another policy, how will these benefits affect my disability benefits through The Standard?

We understand that you may be eligible for additional disability benefits through another program such as LACEA or PORAC. Benefits you receive through another group insurance plan will be deductible. If your other benefit plan deducts the benefits you receive from The Standard, we will coordinate benefits with them so that you receive the amount of benefits payable under the greater plan, with payment from both entities. For example, if you are to receive 50% of your predisability earnings (up to the designated maximum) from The Standard and 60% of your predisability earnings from the other plan, you will receive a total of 60% between both plans. Please note that Individual Disability benefits, such as those you would receive through AFLAC, would not be deductible from your City of Los Angeles group disability benefits.

9. What if I choose not to apply for deductible income?

The City of Los Angeles group disability policy requires that you apply for deductible income you may be eligible to receive. If you do not apply for other income you are eligible to receive, The Standard has the right to deduct the amount we estimate you would be eligible to receive upon proper pursuit of the deductible income.

10. What if I receive benefits for a retroactive period of time?

You may receive payment of other income for an earlier period of time (retroactive or past benefits) than the approval date. If the award includes past benefits, or if you receive other income before notifying The Standard, there will be an overpayment on your claim. This is because you received benefits from The Standard AND income from another source for the same period of time. You will be asked to immediately repay The Standard for any overpayment occurring on your claim. You will not receive any additional benefits until The Standard has been repaid in full.

11. What if I return to work to a modified duty or on a part-time basis?

If the medical information provided by your doctor continues to support that you are unable to work full-time in your own occupation, you may be entitled to continued benefits while working. The City of Los Angeles disability plans contain a provision called the Return to Work Incentive. For the first 12 months following the date you return to work, while disabled, you are eligible to receive 100% of your predisability earnings between work earnings and disability benefits combined. For example: If your predisability earnings are $3,000 and your disability benefit is $2,000, you can return to work earning up to $1,000 before The Standard will reduce your disability benefit. If you return to work earning $1,500, you will receive $1,500 from The Standard for a total of $3,000 ($1,500 work earnings + $1,500 disability benefits). After the first 12 months following your initial return to work date, one-half of your work earnings will be used to reduce your disability benefit. For example: If your disability benefit is $2,000, work earnings are $1,000, $500 is deductible income. Your total income equals $2,500 ($1,000 work earnings + $1,500 LTD benefits).

12. Are my disability benefits taxable?

Yes. The percentage of taxable benefits depends on what plan you are covered under (Basic or Supplemental). All benefits under the Basic plan are 100% taxable. Benefits under the Supplemental plan are less than 100% taxable. The explanation of benefits you receive with your disability check will reflect the amount of benefits that are considered taxable.

13. Can I have taxes withheld from my disability benefits?

Yes, you may have State and/or Federal income taxes withheld from your STD and LTD disability benefits. State and Federal tax withholding from your disability benefit is voluntary. You may choose to have taxes withheld from your benefit or wait until you file your tax return to determine the amount of taxes to be paid. You will receive tax withholding forms and notice of the taxable percentage upon approval of your LTD claim. If you would like taxes withheld from your STD benefit please request forms from the Benefits Examiner handling your claim.

14. Will I receive a W-2 form?

You will receive a W-2 form for disability benefits you received from The Standard. You will receive one form per claim paid by The Standard. Therefore, if you have two STD claims and one LTD claim, you will receive three W-2 forms.

15. What is the Definition of Disability?

The **STD policy** defines disability as follows:

Total Disability Definition: You are Totally Disabled from your Own Occupation if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to perform with reasonable continuity the Substantial And Material Acts necessary to pursue your Own Occupation and you are not working in your Own Occupation.

Partial Disability Definition: You are Partially Disabled from your Own Occupation if you are not Totally Disabled and you are actually working in your Own Occupation but, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to earn 80% or more of your Predisability Earnings.

The **LTD policy** defines disability as follows:
During the Benefit Waiting Period and the Own Occupation Period (first 24 months after the Benefit Waiting Period) you are required to be Disabled only from your Own Occupation.

Total Disability Definition: You are Totally Disabled from your Own Occupation if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to perform with reasonable continuity the Substantial And Material Acts necessary to pursue our Own Occupation and you are not working in your Own Occupation.

Partial Disability Definition: You are Partially Disabled from your Own Occupation if you are not Totally Disabled and you are actually working in your Own Occupation but, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to earn 80% or more of your Predisability Earnings.

Own Occupation may be interpreted to mean the employment, business, trade or profession that involves the Substantial And Material Acts of the occupation you are regularly performing for your Employer when Disability begins. Own Occupation is not necessarily limited to the specific job you perform for your Employer.

Substantial And Material Acts means the important tasks, functions and operations generally required by employers from those engaged in your Own Occupation that cannot be reasonably omitted or modified. In determining what Substantial And Material Acts are necessary to pursue your Own Occupation, we will first look at the specific duties required by your job. If you are unable to perform one or more of these duties with reasonable continuity, we will then determine whether those duties are customarily required of other individuals engaged in your Own Occupation. If any specific, material duties required of you by your job differ from the material duties customarily required of other individuals engaged in your Own Occupation, then we will not consider those duties in determining what Substantial And Material Acts are necessary to pursue your Own Occupation. After 24 months of disability, you need to be Totally Disabled from all occupations or Partially Disabled.

Total Disability Definition: You are Totally Disabled from all occupations if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to engage with reasonable continuity in Any Occupation.

Partial Disability Definition: You are Partially Disabled if you are not Totally Disabled and you are actually working in an occupation but as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to engage with reasonable continuity in that occupation or Any Occupation.

16. How long will I receive benefits?

The length of time you receive benefits will depend on the plan you are covered under. No benefits are payable after you are no longer disabled as defined by the policy or reach the maximum benefit period.

- STD: Both Plan 1 (Basic) and Plan 2 (Supplemental) benefits under the STD policy pay for a maximum period of 180 days after sick leave is exhausted.
- LTD: Plan 1 benefits are paid for a maximum period of 18 months after the benefit waiting period. Plan 2 benefits are paid to a maximum of age 65 with a change in the definition of disability after 24 months.

17. Are there any limitations to the policy?

Yes, below are examples of some of the limitations in the STD and LTD group policies. Please refer to your Certificate of Coverage for a complete list of limitations and exclusions.

Short Term Disability

- No STD Benefits will be paid for any period of disability when you are not under the ongoing care of a Physician.
- No STD Benefits will be paid for any period when you are eligible to receive benefits under a Workers' Compensation law or similar law. If your claim for these benefits is accepted, compromised or settled (whether disputed or undisputed), you must repay us for the full amount of any payments we make to you while your claim for occupational benefits is pending.
- No STD Benefits will be paid for any period: (a) when you are working for wage or profit for any employer other than your Employer; or (b) when you are self-employed. This limitation applies whether you are working in your own or another occupation.

Long Term Disability

- No LTD Benefits will be paid for any period of Disability when you are not under the ongoing care of a Physician in the appropriate specialty as determined by The Standard.
- Payment of LTD Benefits is limited to 18 months during your entire lifetime for a Disability caused or contributed to by a Mental Disorder, or your use of alcohol, alcoholism, use of any drug, including hallucinogens, or drug addiction.

- If you apply for disability benefits within the first year that you become insured for those benefits, The Standard will be required to conduct a pre-existing condition investigation. If The Standard finds that you received medical treatment or services, or took prescribed drugs or medication for conditions causing or contributing to your disability, during the 90-day period just prior to your insurance effective date your claim may be excluded from payment. The policy also states that if you have been continuously insured for the entire Treatment-Free Period (6 consecutive months after your insurance becomes effective) and have not consulted a physician, received medical treatment or services or taken prescribed drugs or medication for conditions causing or contributing to your disability, you are eligible for benefits even if you were seen during the pre-existing condition time period. If you were seen during both the pre-existing condition period (90-days) and the Treatment-Free Period (6 months) your claim would be excluded from payment for the conditions for which you were treated during the pre-existing condition period.

18. Who should I contact if I have questions about my disability policy?

If you have questions regarding your disability policy, please contact The Standard. Carla Mohr 1-800-368-2859 x3398 or Tanya Bradford x6718 for an STD claim, or Susan Kranitz 1-800-368-2859 x6120 for an LTD claim. They will be happy to answer your questions regarding the provisions of the policy.

19. Who should I contact if I have questions about my disability claim?

If you have questions regarding a disability claim that you have submitted, please contact your benefits representative. If you do not know the name of your benefits representative, contact The Standard's customer service team at 1-800-368-2859 and they will be happy to assist you.

20. Who do I contact if I need to submit a claim?

If you need to submit a claim please contact your Member Services Representative with the City of Los Angeles Employee Benefits Division at 213-978-1655.

Buying Benefits and Flex Dollars

1. What's the difference between the Flex Plan, the Flex-Pay Plan 1 and the Flex-Pay Plan 2?

For 2016, there are three categories for health coverage costs:

- **The Flex Plan,** which applies to most City employees who are eligible for Flex.
- **The Flex-Pay Plan 1** – You have Flex-Pay coverage costs if you are in MOU 29 or 31.
- **The Flex-Pay Plan 2** – You have Flex-Pay coverage costs if you are in MOU 00, 01, 19, 20, 21, 26, 27, 28, 32, 38, 39, 40 or 61.

If you have questions regarding the health plan contribution change, please refer to your applicable MOU or LAAC section 4.307 for non-represented employees.

2. How many Flex dollars do I receive?

If you are a regular full-time employee…

If you take Cash-in-Lieu for health coverage, you will receive an additional $50 in Flex dollars per pay period. If you select the Preventive Only dental plan at the employee only coverage level, you will receive an additional $2.50 in Flex dollars per pay period.

If you are a regular half-time employee…

If you take Cash-in-Lieu for health coverage, you will receive an additional $25 in Flex dollars a pay period – and $1.25 a pay period in Flex dollars if you choose employee only dental coverage under the Preventive Only option. See your MOU's Benefits Section for information on your coverage amount.

3. If I receive Flex dollars for enrolling in Cash-in-Lieu or the Preventive Only dental plan, how can I use them?

You can use your Flex dollars toward the cost of the pre-tax benefits you choose. If the cost of your pre-tax benefits is more than your Flex dollars, you pay the additional cost with pre-tax dollars taken from your pay each pay period. If the cost of your pre-tax benefits is less than your Flex dollars, you will receive the remaining Flex dollars as additional taxable pay in each paycheck.

4. If I do not receive my Flex dollars in my paycheck, who should I call?

Contact the Employee Benefits Division at 213-978-1655 and be sure to provide a copy of your pay stub to show that Flex dollars are not included.

5. I just got a paycheck that did not include my Cash-in-Lieu. Why is that?

Flex dollars – including Cash-in-Lieu – are added to your paychecks 24 pay periods a year. The other two paychecks are "no-deduction" paychecks where you have no deductions for Flex benefit costs and no additions for Flex dollars.

You must be eligible for Flex to receive Cash-in-Lieu. See the General section of these FAQs, question 2, for more on Flex eligibility.

6. I am a new employee and just enrolled in Flex. When will my Flex dollars show up in my paycheck?

After you enroll in Flex, it takes at least two pay periods until Flex dollars and any deductions show up in your paycheck. If it has been three pay periods since you enrolled, contact the Employee Benefits Division at 213-978-1655.

7. What is the City subsidy?

Through the City subsidy, the City pays a major portion of the Flex benefit costs. The amount of the premium you are responsible for depends on your employment status (full-time or half-time), the MOU that applies to you, the number of dependents (if any) covered, and the specific plan you choose.

For more about the City subsidy, see page 43 of the 2016 Flex Benefits Booklet. Also, see the 2016 Flex Benefits Booklet for health plan and dental plan per pay period cost for both you and the City.