County of Los Angeles

Flex
SUMMARY PLAN DESCRIPTION

Effective January 1, 2025

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INTRODUCTION

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

- Medical
- Dental
- Basic Term Life Insurance
- Accidental Death and Dismemberment (AD&D) Insurance
- Optional Group Variable Universal Life (GVUL) Insurance
- Optional Dependent Life Insurance
- Medical Coverage Protection (LTD Health Insurance)
- Spending Accounts
  - Health Care Spending Account
  - Dependent Care Spending Account

Note: For the purposes of this document a Plan Year is the same as a calendar year (January 1 through December 31).

If you have questions not answered in this Summary Plan Description (SPD), contact the insurance carrier directly (see **Contact Information** on page 53) or the County's Benefits Hotline at **213-388-9982** from 8:00 a.m. to 4:00 p.m., Monday through Friday.

GENERAL INFORMATION

Eligibility

Employee Eligibility

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

Dependent Eligibility for County-Sponsored Plans

If you are eligible to participate in County-sponsored medical, dental, Optional Group Variable Universal Life (GVUL), and Accidental Death and Dismemberment (AD&D) insurance plans, so are your eligible dependents. Your *eligible dependents*[1] generally include:

- Your spouse/domestic partner (see page 3 for special rules concerning domestic partner eligibility).
- Your children through age 25 (through age 17 for legal guardianship).

Coverage for a Disabled Child

Coverage for a disabled child may continue past age 25. You must contact your health plan at least six months before your child reaches age 26 to apply for disabled status for your dependent. Your dependent will be eligible for coverage only if your health plan approves and determines that your child became disabled before the limiting age (check with your health plan to determine the limiting age). After your application has been approved by the health plan, proof of your child's disability may be required from time to time. Your disabled child's coverage ends when the plan no longer considers your child to be disabled, your child marries or no longer depends on you for support, you stop coverage for any reason, or at age 26 if you applied for disabled status late or your application has not been approved. If you apply for disabled status after your child's 26th birthday and the health plan later approves your application, you will not be able to add your child to your health plan until the next annual benefits enrollment.

Children

For eligibility purposes, "children" includes children born to you, children legally adopted by you, children awaiting finalization of their adoption by you, stepchildren, children of whom you are the legal guardian (through age 17), children you support because of a valid court order, and children of your domestic partner.

Ineligible Dependents

Your ex-spouse/ex-domestic partner, ex-domestic partner's children, ex-stepchildren, parents, parents-in-law, other relatives, and non-disabled children age 26 or over are not eligible for coverage under your medical and dental plans.[1]

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

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[1] *The Accidental Death and Dismemberment and Optional Dependent Life insurance plans have different age dependent eligibility requirements. See pages 22 and 25 for details. Different dependent requirements also apply to the spending accounts. See pages 30 and 35 for details.*

Rules Governing Domestic Partners

If you are in a domestic partnership and you and your partner both meet **all** of the criteria listed below, you may enroll your domestic partner and their dependent children in your *Flex* medical, dental, and Accidental Death and Dismemberment insurance plans. If you enroll in the Group Variable Universal Life (GVUL) plan, you may also purchase a limited amount of life insurance for your domestic partner and their legally dependent children.

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

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

Cost of Medical/Dental Benefits

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

Taxation of Medical/Dental Coverage for Domestic Partners

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

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

If you want to take advantage of the state tax exemption applicable to domestic partners, you must submit a copy of your **registered** State of California *Declaration of Domestic Partnership form* or California Certificate of Registered Domestic Partnership (or valid proof of a similar legal union from another state) to the Benefits Plan Administrator (see the **Required Proof of Dependent Eligibility** section on page 5 and **Submitting Proof of Dependent Status** on page 6).

To register your domestic partnership with the State, obtain a State of California *Declaration of Domestic Partnership form* from the Secretary of State. You may write to the Secretary of State, Domestic Partners Registry, P.O. Box 942870, Sacramento, CA 94277-2870, or call 916-653-3984. You can also visit their website at **sos.ca.gov/registries/domestic-partners-registry for more information and eligibility rules.**

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

Enrolling a Domestic Partner

When enrolling a domestic partner for the first time, you must send a completed County of Los Angeles *Declaration of Domestic Partnership form* and proof of same principal residence, or submit a copy of your **registered** *State of California Declaration of Domestic Partnership* form or California Certificate of Registered

Domestic Partnership (or valid proof of a similar legal union from another state) to the Benefits Plan Administrator (see the **Required Proof of Dependent Eligibility** section on page 5 and **Submitting Proof of Dependent Status** on page 6). Coverage for your domestic partner and your domestic partner's eligible dependents will not be effective until the Benefits Plan Administrator receives your completed and signed form and approves your enrollment.

You can download and print the County of Los Angeles *Declaration of Domestic Partnership form* from the web enrollment system at **mylacountybenefits.com.**

Adding Domestic Partners During the Year
You may add a domestic partner and your domestic partner's children to your medical and/or dental coverage during the year under the rules described in the section **Enrollment Changes During the Plan Year: Changes in Status** (see pages 13-16).

When Coverage for a Domestic Partner Begins
If you are enrolling your domestic partner during annual benefits enrollment, coverage will become effective January 1 of the following year, provided the Benefits Plan Administrator approves your form. If you are enrolling a domestic partner during the year under the plan's changes in status rules, refer to the section **When Changes Become Effective** on page 16.

STOPPING COVERAGE FOR A DOMESTIC PARTNER DURING THE YEAR
You can stop coverage for your domestic partner and their children on the web enrollment system due to a qualified life event. See the rules described in the section **Enrollment Changes During the Plan Year: Changes in Status** (see pages 13-16).

If you want to terminate your domestic partnership, go to the web enrollment system and indicate that you have a termination of domestic partnership. If you enrolled a domestic partner using the *County of Los Angeles Declaration of Domestic Partnership form*, to terminate the domestic partnership, you must submit your completed *County of Los Angeles Termination of Domestic Partnership form* to the Benefits Plan Administrator and must wait **12 months** to enroll a domestic partner to coverage. If you enrolled a domestic partner using the registered State of California document, you must submit the State of California *Notice of Termination of Domestic Partnership form* (or proof of similar **valid** documents from another state) to the Benefits Plan Administrator and must wait **six months** (from the filing date) to enroll a domestic partner to coverage. See the **Submitting Proof of Dependent Status** on page 6 for more information.

Once you terminate a domestic partnership, your former domestic partner and their children will be removed from any and all insurance plans (e.g., medical, dental, life, etc.), and a COBRA notice will be mailed to them at your mailing address (**see COBRA Continuation of Health Coverage** on page 46).

You must remove you domestic partner and their children from your enrollment record and/or coverage if you are no longer in a domestic partnership. Log on to **mylacountybenefits.com**, click "Life Event" at the top of the homepage, and indicate that you have a termination of domestic partnership**.** Download and print the *County of Los Angeles Termination of Domestic Partnership form*.

Note: There are different rules for adding dependents due to a qualified change in status. See pages 13-16.

*Required Proof of Dependent Eligibility**

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

Dependent	Required Documents	Note*
Spouse	Photocopy of your church, county, or state, or foreign (which also requires **notarized** translation) marriage certificate.	Marriage certificates must include: ▪ Names of parties, ▪ Signature of solemnizing official, and ▪ Marriage date **Marriage licenses will NOT be accepted.**
Child	Photocopy of the hospital, state, county, or foreign (which also requires **notarized** translation) birth certificate, court-appointed guardianship documents, legal adoption documents, or adoptive placement agreements. Children are eligible to be covered through age 25. Or, through age 17 for legal guardianship.	Birth certificates must indicate: ▪ Name of parent(s) ▪ Child's name and date of birth Hospital verification letter must indicate: ▪ Name of parent(s) ▪ Child's name and date of birth ▪ Hospital name ▪ Signature of hospital personnel
Disabled child age 26 or older	Proof of disability requirements may differ by plan and may include certification of the disability from a licensed doctor or the Social Security Administration.	See page 2 for eligibility information and contact your health plan for proof documents. See page 22 for AD&D life insurance eligibility information.
Domestic Partner	County of Los Angeles *Declaration of Domestic Partnership form* and proof of same principal residence document. ***OR*** A copy of your **registered** State of California *Declaration of Domestic Partnership form* or California Certificate of Registered Domestic Partnership (or valid proof of a similar legal union from another state).	Proof of a recent same principal residence document, which includes your domestic partner's name with your address (e.g., CA Driver's License, CA Identification Card, utility bill or financial document such as a bank statement, etc.).
Domestic Partner's Child(ren)	Same documents required to add a Domestic Partner AND photocopy of the child's hospital, state, county, or foreign (which also requires **notarized** translation) birth certificate, court-appointed guardianship documents, legal adoption documents, or adoptive placement agreements.	Birth certificates must indicate: ▪ Domestic Partner's name ▪ Child's name and date of birth Hospital verification letter must indicate: ▪ Domestic Partner's name ▪ Child's name and date of birth ▪ Hospital name ▪ Signature of hospital personnel

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

Submitting Proof of Dependent Status
Submit all required documentation to the Benefits Plan Administrator. Write your name, employee number, and your dependent's Social Security number on each document or certificate. You may submit your documents by: ▪ **Document upload:** Click the "Doc Upload" button in the "Easily Submit Documents" tile on the homepage on **mylacountybenefits.com** ▪ **Email:** Attach scanned documents to an email and send to documents@mylacountybenefits.com ▪ **Fax:** 310-788-8775 ▪ **Mail:** County of Los Angeles Benefits Plan Administrator, P.O. Box 9005, Norfolk, VA 23501-9005

***The County reserves its right to audit ongoing dependent eligibility from time to time and may require forms of proof in addition to those required at the time of initial enrollment.**

Flex Annual Benefits Enrollment

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

- Enroll or re-enroll in the Health Care and Dependent Care Spending Accounts.
- Enroll in or change medical and dental plans.
- Waive medical coverage if you meet the criteria (see the **Waiving Medical Coverage** section below for details) or waive dental.
- Select, change, or cancel Accidental Death and Dismemberment (AD&D) Insurance or Medical Coverage Protection (LTD Health Insurance).
- Certify that you meet the requirements to avoid the Tobacco User Premium. See below for details.
- Add or drop coverage for dependents. If you add dependents, you must provide the required documents before coverage for your newly added dependent begins (see the **Required Proof of Dependent Eligibility section** on page 5 and **Submitting Proof of Dependent Status** on page 6).
- Do nothing and your current coverage will continue, except for the Health Care and Dependent Care Spending Accounts, which will be canceled.
- Select, change, or cancel Optional Group Variable Universal Life (GVUL) or Optional Dependent Life (click on the MetLife link on the web enrollment system, or contact MetLife at 800-846-0124).

Monthly Benefits Allowance

As a *Flex* participant, you receive a monthly benefits allowance which you can use to pay for your coverage. Your monthly benefits allowance is equal to 10% of your monthly salary or $859, whichever is greater.

Tobacco User Premium

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

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

Waiving Medical Coverage

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

1) You are the primary subscriber (and not a dependent) in another employer's group plan, retirement medical plan, or Medicare (Parts A and Part B).
2) You are enrolled in the other plan when you waive coverage under *Flex*, and you stay enrolled in that other plan for the duration of the year.
3) You provide satisfactory proof of other coverage as requested.

Note: You cannot waive medical coverage if you are an In-Home Supportive Service (IHSS) provider enrolled in a medical plan under the IHSS program.

When you elect to waive medical coverage, you must complete a waiver certification. You must enter your information online.

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

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

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

You are not required to have other dental coverage to waive dental.

Cash in Lieu of Benefits

Except as provided below, any portion of the monthly benefits allowance that you don't spend on benefits is received as additional taxable cash. As explained below, however, there is an exception for certain individuals hired before January 1, 1995.

The Taxable Cash Limit and Pensionable Flex

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

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

Pensionable Amount

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

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

Example of Loss (Forfeiture) of County Allowance

If your Pensionable Amount is $442 and you are eligible for a pension of 50% of your salary, an additional $221 (50% of $442) will be added to your monthly pension. The maximum amount of cash you can receive from your unspent *Flex* allowance is limited to the same amount as your pensionable amount ($442). *You lose any allowance dollars you do not spend on benefits that are over your $442 taxable cash limit.* For example, if your monthly benefits allowance is $859 and you spend $300 on benefits, $559 remains unspent. Since your taxable cash limit is $442, you will lose $117 per month ($559 - $442 = $117).

To avoid forfeiting any of your monthly benefits allowance, you may sign a waiver to remove the taxable cash limit. To remove your taxable cash limit, you must sign the *Waiver of Pensionability* form. The *Waiver of Pensionability* form is included in annual benefits enrollment packets for pensionable *Flex* participants with taxable cash limits. Or you can print the form directly from the enrollment website. By signing the waiver, you:

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

For example, if your monthly benefits allowance is $859, you spend $300 on benefits, and your pensionable limit is $442, then:

1) The remaining unspent allowance of $559 ($859 - $300) will be added to your paycheck as taxable cash.
2) However, at the time of your retirement, $442 will be added to your final compensation before your pension is calculated.
3) The taxable cash you receive that is more than $442 ($117) is **not** pensionable.

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

After You Enroll

Verifying Payroll Deductions for the Benefits You Elected

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

Your paycheck stub will show the amount of your monthly benefits allowance (RF005 FLEX CONTRIB) and the cost of the specific benefits you elected. Payroll deduction codes for all benefits are listed below. Below is a sample paycheck stub.

Cafeteria Benefits Information												
Cafeteria Category			Cafeteria %		County Contribution		Salary Reduction		Contributed Benefits		Taxable Cash	Taxable Cash Limit
RF005 FLEX CONTRIB			10.00%		859.00		0.00		289.95		569.05	0.00
Benefit Category	Benefit Type	Benefit Plan	Benefit Plan Description	Deduction %	Current Base	County Contributed	County Contributed YTD	Salary Reduction	Salary Reduction YTD	Benefits Applied	Benefits Applied YTD	Available Balance YTD
EF124	EF124	C1	KAISER NR 1PTY		0.00	276.00	3,036.00	0.00	0.00	276.00	3,036.00	0.00
EF410	EF410	250E+	AD&D 250K-EE+FM		0.00	5.95	65.45	0.00	0.00	5.95	65.45	0.00
EF046	EF046	EF046	LTD-H FL		0.00	3.00	33.00	0.00	0.00	3.00	33.00	0.00
EF006	EF006	F1W	FLEX ADM FEE		0.00	5.00	55.00	0.00	0.00	5.00	55.00	0.00
Total Cafeteria Benefits						$289.95	$3,189.45	$0.00	$0.00	$289.95	$3,189.45	$0.00

Administrative Fee

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

Payroll Deduction Codes

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

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

Spending Accounts
EF500 Health Care Spending Account
EF502 Dependent Care Spending Account (employee contribution)
RS506 Dependent Care Spending Account (County subsidy)

Dental Insurance
EF308-310 Delta Dental PPO
EF316-318 DeltaCare HMO
EF324-326 MetLife (SafeGuard) HMO

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

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

Miscellaneous
EF047 100% LTD Health Insurance
EF061 Tobacco user premium
EF006 *Flex* administrative fee

MetLife Investment Fund
EL209 MetLife side-fund

When Coverage Ends

For Yourself

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

If this event occurs…	Then your coverage ends…
Your employment ends	At the end of the month following the month in which your employment ends, as long as you are in a paid status for at least eight hours during the month your employment ends
Your employment status changes to temporary or part-time	At the end of the month following the month in which your permanent status ends, as long as you receive at least eight hours of pay under permanent status during the month your status changes
You are billed for insurance premiums under the County's self-pay program (see page 17) and you do not pay by the deadline	On the first day of the billed coverage month
You are offered and you elect to pay for coverage under COBRA	When you stop paying your monthly premiums or at the end of the continuation coverage period (see pages 46-52)
You become eligible for a new benefit plan, such as *Choices* or *Options*	On the date your benefits under the new plan begin

For Your Dependents

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

If this event occurs…	Then coverage for your child ends…
Your child reaches age 26	At the end of the month in which your child reaches age 26* (or age 18 in the case of a child for whom you are the legal guardian)
A dependent otherwise ceases to be an eligible dependent under the terms of the applicable benefit plan	On the last day of the month your dependent no longer qualifies as an eligible dependent. For Spending Accounts coverage ends on the day your dependent no longer qualifies as an eligible dependent (e.g., divorce, or termination of domestic partnership)
Your child is 26 or older and your health plan requests proof of disability, but you do not comply or do not meet the criteria for disability	On the last day of the month your child no longer qualifies as an eligible dependent. For Spending Accounts, coverage ends on the day your child no longer qualifies as an eligible dependent

You and your dependents may continue coverage under certain circumstances when coverage otherwise would end, as described in General Plan Administration: COBRA Continuation of Health Coverage on pages 46. Your former spouse and stepchildren or domestic partner and domestic partner's children are no longer eligible for benefits upon divorce or termination of domestic partnership, and you must remove them from you medical and/or dental coverage in accordance with the Change in Status rules on pages 13-16.

* *For the Health Care Spending Account, coverage ends on the first of the year your child reaches 27 years of age.*

IMPORTANT NOTE REGARDING CONSEQUENCES OF MISREPRESENTING ELIGIBILITY: When you enroll for coverage under the Plan, you certify that you and anyone you cover under *Flex* meet all applicable eligibility requirements for the entire period of enrollment. You must notify the Benefits Plan Administrator by completing a "Change of Status" event (or "Life Event") via the web enrollment system and provide documentation when you or any dependent loses eligibility within 90 days of such event. In addition, the County reserves the right to request information or proof of eligibility that may be different than the proof requested upon initial enrollment, for you and your dependents at any time. If you enroll someone who is ineligible or fail to remove an ineligible dependent from coverage within the time provided, your actions may be considered an intentional misrepresentation and/or fraud.

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

Enrollment Changes During the Plan Year: Changes in Status (Life Events)

If you do not make changes during annual benefits enrollment, you will not be allowed to enroll or make changes later UNLESS:

- You qualify for certain special health plan enrollment periods under HIPAA.[2]
- You have a qualified change in status.
- There are certain cost or coverage changes.
- You experience other special circumstances (see page 15 for details).

Special Enrollment Periods for Medical Plans

Special Medical Plan Enrollment Rights for New Dependents
If you have a new dependent due to a life event, such as marriage, birth, adoption, or placement for adoption, then you, your new dependent, and your spouse or domestic partner (even if they are not the new dependent) may enroll under any *Flex* medical plan option. (See **Consistency Rules** page 14 for more details).

HIPAA special enrollment rules allow you to switch medical plans. However, you must enroll your new dependent into your medical plan. If you switch medical plans, be mindful that services (e.g., doctor visits, pharmacy, and prescriptions) sought under your current plan may not be covered under your new plan. Be sure to check with the new plan before the date of your special enrollment to ensure it will pay any costs incurred because you will be subject to the new plan's continuity/transition-of-care rules. If you have questions, contact the Benefits Hotline at 213-388-9982.

When you request a change in medical plan coverage due to birth, adoption, or placement for adoption, coverage will be effective on the date that the birth, adoption, or placement for adoption took place.

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

Changes in Status (Life Events)

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

Financial hardship is not considered a qualified life event or change in status by the federal government. You may not use financial hardship as a reason to make changes during the year.

Qualified changes in status include:
- You get married or establish a domestic partnership.
- You get divorced or legally separated, your marriage is annulled, or you terminate your domestic partnership.
- A child is born to you, placed with you for adoption, or you obtain legal guardianship (through age 17).
- Your spouse/domestic partner or dependent dies.
- Your spouse/domestic partner or dependent begins or ends employment.
- You, your spouse/domestic partner, or your dependent has a change in employment status that affects employment hours, and you lose or gain eligibility (this includes changes in hours due to strikes and lockouts).

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

- Your eligible dependent child loses eligibility status due to age.
- Your dependent gains eligibility for other employer-sponsored coverage.
- You or your spouse/domestic partner begins or ends an unpaid leave of absence.
- You, your spouse/domestic partner, or your dependent changes where that individual lives or works and this change affects eligibility for benefits under *Flex*.

Consistency Rules

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

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

Cost or Coverage Changes

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

Spending Account Cost or Coverage Changes

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

Elections on how much you put in your Dependent Care Account can be adjusted in the middle of the year if your day care expenses change. Dependent Care Spending Account changes are only allowed if the dependent care provider is not your relative. For these purposes, a relative includes any of the following: (1) your spouse; (2) your child (including an adopted child, stepchild, or foster child) or grandchild; (3) your sibling, half-sibling, or stepsibling; (4) your parent (or ancestor thereof) or stepparent; (5) your uncle, aunt, niece, and nephew; (6) your in-laws; or (7) an individual who lives with you as a member of your household. Also, a dependent care election may be changed during the year to reflect a change in your dependent care provider or a change in the number of hours or days you utilize the provider.

Other Special Circumstances

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

Judgment, Decree, or Court Order

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

Medicare or Medicaid Entitlement

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

Change in Coverage Under Another Employer-Sponsored Plan

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

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

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

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

If you have any questions related to this section, contact the County's Benefits Hotline at 213-388-9982.

Taxation of Medical/Dental Coverage for Domestic Partners

Remember, if you purchase medical and/or dental coverage for your domestic partner, the cost of that coverage is treated as taxable and is reported on your monthly paycheck as "imputed income." However, if you provide the Benefits Plan Administrator with a copy of your marriage certificate or **registered** State of California *Declaration of Domestic Partnership form* or California Certificate of Registered Domestic Partnership (or valid proof of a similar legal union from another state, your cost for such coverage will be deducted before California state taxes are taken out of your pay. Note, your County of Los Angeles registration alone does not qualify you for this tax break.

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

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

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

1) **Go** to the web enrollment system at **mylacountybenefits.com**, click on "Life Events" at the top of the homepage**.** Follow the instructions. If you are adding new dependents to your health coverage, you must provide Social Security numbers. (Social Security numbers for newborns must be provided within 90 days from the date of birth).
2) **Confirm** your elections and submit your request on the system.
3) **Photocopy** any appropriate "proof" documents, such as a marriage certificate, birth certificate, or divorce decree (see the list on pages 5-6). In the case of an election change that involves obtaining coverage under another employer's plan, you will be asked to certify that such coverage was or will be obtained.
4) **Write** your employee number on each certificate and document.
5) **Submit** your proof documents within 90 days of the date of your life event. See the **Required Proof of Dependent Eligibility** section on page 5 and **Submitting Proof of Dependent Status** on page 6. Any request for a qualified change in status is not finalized until the Benefits Plan Administrator receives and approves all necessary proof documents and processes your request. **Proof documents received after 90 days will not be processed!**

Important Life Event Notes

- The 90-day time period for an election change due to a life event is intended to give the participant a reasonable time to make **one** election that is consistent with their change in status. It does not give the participant the right to make multiple election changes.
- If you have a life event between October 1 and December 31, you must complete one life event enrollment for the current Plan Year, and another for the next Plan Year. If you add dependents in November and December through the marriage or birth/adoption life event, but do not complete the second life event enrollment, only the medical and dental coverage you elect for your new dependent automatically carries over to the following Plan Year.

Getting Changes Approved

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

When Changes Become Effective

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

Coverage While Not Receiving Pay

If for any reason, you receive no pay for any month, you will not receive the *Flex* monthly benefits allowance the following month.[3] For example, if you are on an unpaid leave for the entire month of January, you will not receive pay or the benefits allowance in February. When you do not receive a *Flex* monthly benefits allowance, your insurance premiums cannot be withheld from your paycheck. Thus, to continue your insurance coverage while you are in a "no-pay" status, you must pay the entire monthly insurance premiums for your coverage. **Note: Different rules may apply in regard to your coverage if you are on leave covered by the Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). See pages 44-45 for details.**

If you are enrolled in one or more of the following *Flex* Plan benefits, you will be billed monthly for your coverage under the County's self-pay program:

- Kaiser or Anthem Blue Cross medical
- DeltaCare, Delta Dental, or MetLife (SafeGuard) dental
- Accidental Death and Dismemberment Insurance (for a maximum of three years)
- Medical Coverage Protection (LTD Health Insurance)
- Health Care Spending Account (HCSA)
- Optional Group Variable Universal Life (GVUL) Insurance
- Optional Dependent Life Insurance

IMPORTANT: If you are in the process of filing a claim for Long-Term Disability (LTD) benefits or waiting for approval, you must continue to pay for your medical premiums until your claim is approved. If you stop paying the medical premiums, your medical coverage is not continuous, and you will not be eligible for LTD Health Insurance when your LTD benefits begin. See **Medical Coverage Protection (LTD Health Insurance)** on pages 26-27 for more details.

Your insurance coverage continues as long as you are employed with the County and you pay your monthly insurance premiums by the given deadlines. You will continue to receive a billing notice each month while you are in a "no-pay" status.

Nonpayment of Premiums Under the County's Self-Pay Program

If you do not pay the monthly bill for your insurance plans under the County's self-pay program:

- You will no longer receive a billing notice and your coverage will end.
- You may be eligible for continuation of coverage under a federal law known as COBRA.
- You will not be an active participant in the Health Care Spending Account and will be ineligible for claim reimbursement for expenses incurred during the month you did not pay. See pages 32-33 for Important Rules on a Health Care Spending Account.

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

Special Rules Impacting Continued Coverage While Disabled

- If you are enrolled in Optional Group Variable Universal Life (GVUL) insurance and you become completely disabled, you may be eligible for a waiver of premium. Contact MetLife directly at 800-846-0124.
- If you do not pay your insurance coverage, MetLife will bill you directly for the full premium. If you do not pay, you will be ineligible for coverage. You must contact MetLife within 90 days of returning to work to re-enroll for GVUL coverage.

If you leave County service, you will be offered the opportunity to elect and pay for continued health coverage for up to 18 months (29 months if you are disabled) under a federal law known as COBRA. When federal COBRA coverage ends, you may be entitled to extend coverage further under California law. In addition, under federal COBRA, your dependents may be entitled to elect and pay for continued coverage for up to a total of 36 months if certain "qualifying events" occur during the 18-month period. When you first become covered under a County-sponsored health plan, you should receive a notice that explains your rights and obligations under COBRA as well as a notice explaining your rights and obligations under California law. Contact the County's Benefits Hotline at 213-388-9982 if you did not receive your notices or need new copies. Also, see pages 46-52 for more information about COBRA and Cal-COBRA.

Optional Group Variable Universal Life is fully portable. You can keep this coverage, at the same group rates, as long as you pay the full premiums after you end employment with the County.

Return to Work

If you return to work from a leave of absence, your coverage will resume on the first of the following month. Your monthly benefits allowance resumes and your insurance premiums are deducted from your mid-month paycheck.

YOUR MEDICAL PLAN OPTIONS

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

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

Special Notices Regarding Your Rights Under the Health Plans

Statement of Newborns' and Mothers' Rights

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

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

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

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

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

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

Precertification Requirements

The medical plan administrators have the sole and exclusive power to exercise discretion as to claims for coverage for any other items not specifically listed in the *Medical and Dental Plans Comparison Chart* (included in your enrollment packet). You should contact the providers before obtaining a service or treatment if you have a question about whether the Plan covers the service or treatment. See page 53 for a complete list of the insurance carriers and their contact information.

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

Exclusions and Limitations for HMO, POS, and PPO Medical Plans

The medical plan options limit or exclude some medical treatments, services, and supplies. See the insurance carrier for information about items that are not eligible for reimbursement. See page 53 for **Contact Information**.

Other Benefits and Programs

Each medical plan carrier has special programs and benefits for members. They may include healthy lifestyle, smoking cessation, and stress management programs, discounts, etc. Visit each plan's website, or contact the member services department, for details. See page 53 for a complete list of the insurance carriers and their contact information.

YOUR DENTAL PLAN OPTIONS

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

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

How to Obtain Dental Benefits

HMO Dental Plans

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

PPO Dental Plans

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

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

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

If You Lose Coverage During Treatment

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

Exclusions and Limitations for HMO and PPO Dental Plans

The dental plan options limit or exclude some dental treatments, services, and supplies. Contact your insurance carrier for information about items that are not eligible for reimbursement. See page 53 for **Contact Information**.

Need More Information?

If you have questions about the medical and dental plan options, or need more information about what's covered, contact the insurance carrier directly. See page 53 for a complete list of the insurance carriers and their contact information.

LIFE INSURANCE BENEFITS

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

Basic Term Life Insurance

The County gives you Basic Term Life insurance at no cost to you.

- General Members of Retirement Plan A, B, C, or D: You are insured for $5,000.
- Members of Retirement Plan E: You are insured for $13,000.

Accidental Death and Dismemberment Insurance

You can buy Accidental Death and Dismemberment (AD&D) insurance at low monthly group rates. If you die in an accident, become paralyzed, or lose a limb, eyesight, speech, or hearing because of an accident, your AD&D insurance pays benefits. AD&D coverage amounts are shown in the table below. During annual benefits enrollment refer to the *Personalized Enrollment Worksheet* in your enrollment packet. It will show the pre-tax monthly premium rates for AD&D insurance.

Beneficiary Designation

When you designate a specific beneficiary (such as a child) and your personal circumstances change (such as marriage), your beneficiary remains the same as you originally designated unless you request a change. To designate a beneficiary, mail a completed *Beneficiary Designation Form* to New York Life Group Benefits Solutions (New York Life). If you do not have a named beneficiary on file, the plan will pay out your life insurance benefit in the following order:

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

AD&D Coverage for Dependents

When you enroll yourself for AD&D coverage under *Flex*, you may also buy coverage for your **spouse/domestic partner under age 70 and unmarried dependent children through age 20 (or through age 25 if full-time students) and primarily supported by you**. **Coverage for a child may continue past age 26 if your disabled child is primarily supported by you and incapable of self-sustaining employment.** Contact New York Life at 800-842-6635 for more information. The amount of coverage you have for yourself determines the amount of coverage your family members may have. The amounts are shown in the following table.

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

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

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

AD&D Coverage for Domestic Partners
To purchase AD&D insurance for your domestic partner, you must have a County of Los Angeles Declaration of Domestic Partnership form or registered State of California *Declaration of Domestic Partnership form* or California Certificate of Registered Domestic Partnership (or valid proof of a similar legal union from another state) on file with the Benefits Plan Administrator. **Remember, if you end a domestic partner relationship and complete the termination of a domestic partnership life event, your former domestic partner is no longer eligible for the AD&D coverage. See Stopping Coverage for a Domestic Partner on page 4.**

Note: If you are enrolled in AD&D under *Flex,* you cannot also be insured as a spouse/domestic partner or dependent on another employee's AD&D coverage. In addition, dependent children may only be insured under one County employee's AD&D coverage.

OPTIONAL LIFE INSURANCE

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

Optional Group Variable Universal Life (GVUL) Insurance

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

The MetLife GVUL program offers:

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

Enrolling for Coverage

During Annual Benefits Enrollment

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

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

Calculating Your Monthly Premium

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

You can calculate your monthly premium using the rates shown in the table on page 25. **All premiums are paid on an after-tax basis.** See pages 24-25 for information about how your monthly premium is calculated.

Beneficiary Designation

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

How the Plan Pays Benefits

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

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

Increasing Your Coverage During the Year

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

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

Total Disability and Terminal Illness Provisions

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

How Your Monthly Premium Is Calculated

The monthly cost (premium) of your GVUL insurance is determined by following the steps shown in the example below. You can calculate your monthly premium using the rates shown in the table on page 25.

Kelly is 45 years old and earns $47,800 per year. She chooses two times her annual salary in GVUL coverage.	**Step 1** Round her salary up to the next highest $1,000 if it is not an even multiple of $1,000 **Step 2** $48,000 x 2 = $96,000 **Step 3** $96,000 ÷ $1,000 = $96 **Step 4** $96 x $.090 = $8.46 **The Monthly cost of insurance = $8.64**

Optional Group Variable Universal Life Monthly Premium Rates

Employee Age	Cost Per $1,000 of Insurance*	Employee Age	Cost Per $1,000 of Insurance*	Employee Age	Cost Per $1,000 of Insurance*
20-24	0.037	57	0.268	77*	2.203
25-29	0.045	58	0.301	78*	2.262
30-34	0.054	59	0.337	79*	2.548
35-39	0.055	60	0.386	80*	3.290
40	0.063	61	0.436	81*	3.797
41-42	0.064	62	0.481	82*	4.141
43	0.071	63	0.517	83*	4.515
44	0.081	64	0.573	84*	4.919
45	0.090	65	0.595	85*	5.368
46	0.099	66	0.669	86*	5.837
47	0.106	67	0.711	87*	6.350
48	0.125	68	0.792	88*	6.901
49	0.133	69	0.880	89*	7.468
50	0.142	70	0.969	90*	8.046
51	0.160	71	1.071	91*	8.655
52	0.168	72	1.190	92*	9.280
53	0.185	73	1.306	93*	9.926
54	0.203	74	1.445	94*	10.581
55	0.230	75	1.593		
56	0.248	76*	1.769		

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

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

Optional Dependent Life Insurance

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

Amount of Optional Dependent Life Coverage*	Monthly Cost for Dependent Life Coverage
$5,000	$1.03
$10,000	$2.06
$15,000	$3.09
$20,000	$4.12

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

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

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

Important Note: If your spouse/domestic partner is also enrolled in *Flex* benefits, you cannot enroll each other under MetLife Dependent Life insurance. In addition, dependent children may only be insured under one County employee's MetLife Dependent Life insurance.

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

Prospectuses for Group Variable Universal Life insurance and its underlying portfolios can be obtained by calling 800-846-0124. You should carefully consider the information in the prospectuses about the contract's features, risks, charges and expenses, and the investment objectives, risks and policies of the underlying portfolios, as well as other information about the underlying funding choices. Read the prospectuses and consider this information carefully before investing. Product availability and features may vary by state. All product guarantees are subject to the financial strength and claims-paying ability of Metropolitan Life Insurance Company.

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

Optional Dependent Life Insurance Coverage for Domestic Partners

To purchase Optional Dependent Life insurance for your domestic partner, you must have a registered County of Los Angeles *Declaration of Domestic Partnership form* or registered *State of California Declaration of Domestic Partnership form* or California Certificate of Registered Domestic Partnership (or valid proof of a similar legal union from another state) on file with the Benefits Plan Administrator.

MEDICAL COVERAGE PROTECTION (LTD HEALTH INSURANCE)

You must be enrolled in a County-sponsored Anthem Blue Cross or Kaiser medical plan to participate in the LTD Health Insurance plan. Refer to the Long-Term Disability booklet for a more detailed explanation of the LTD plan provisions. You can get a copy of the booklet by going to the Department of Human Resources website at **employee.hr.lacounty.gov/benefits-2** and clicking on "Return to Work" on the left side menu.

The LTD Health Insurance plan is designed to help you continue your medical insurance coverage if you are eligible for LTD and become totally and permanently disabled. If you meet the eligibility requirements listed below and become totally disabled, the LTD Health Insurance plan continues your County medical insurance coverage while you are receiving County LTD benefits.

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

- You are a General (not safety) Member of Retirement Plan A, B, C, D, or E of the Los Angeles County Employees Retirement Association (LACERA).
- You are enrolled in a County-sponsored medical plan.

If you meet the eligibility requirements, and you experience a disability on or after the later of January 1, 2007, or the date your medical coverage begins, the LTD Health Insurance plan pays 75 percent of your monthly medical premium while you are disabled and receiving LTD benefits. You must pay the other 25 percent of the monthly medical premium. For disabilities occurring after January 1, 2007, this coverage is provided automatically at no cost to you.

For disabilities occurring on or after January 1, 2007, eligible employees can elect the 100 percent LTD Health Insurance "buy-up" at a cost of $4.75 per month. Under this optional coverage, the LTD Health Insurance plan will pay 100 percent of the monthly medical plan premium while you receive LTD benefits. **If you do not elect to purchase (or you cancel) the optional 100 percent coverage for a Plan Year, you cannot elect this coverage for the next Plan Year. You must wait two Plan Years before you again have the option to elect this coverage.**

When Coverage Begins

If you meet the LTD Health Insurance eligibility requirements described on page 26, your medical coverage protection under the LTD Health Insurance plan begins after you satisfy the Long-Term Disability plan's eligibility waiting period (five years of continuous County service **OR** total disability as a result of a work-related injury or illness). **When you are in the process of filing a claim or have filed a claim for Long-Term Disability benefits, you must continue to pay for your medical premiums (maintain continuous coverage) until you are approved for LTD Health Insurance. LTD Health Insurance benefits begin when you start receiving LTD benefits. Failure to maintain continuous coverage will end your eligibility for LTD Health Insurance.**

Increasing Your Coverage During Annual Benefits Enrollment

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

When Benefits Begin and End

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

Survivor Coverage

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

For more information on Long-Term disability benefits, visit **employee.hr.lacounty.gov/benefits-2** and click on “Return to Work” on the left side menu.

HEALTH CARE AND DEPENDENT CARE SPENDING ACCOUNTS

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

The Spending Account Tax Advantage

When you elect to participate in a spending account, you set aside part of your salary on a pre-tax basis to pay certain eligible expenses. In addition, the County will make contributions to a Dependent Care Spending Account on your behalf if you elect to participate. (See page 36 for information on the County contribution). You would normally pay these expenses out of your own pocket with after-tax dollars. But when you make contributions to a spending account, you pay no taxes on the money you contribute. This means you lower your taxable income and pay less in taxes.

How Spending Accounts Work

- First, you need to estimate your eligible out-of-pocket health care and dependent care expenses for the coming Plan Year. These are the expenses not covered by your health plans, such as deductibles, co-payments, prescribed and over-the-counter medication expenses, day care costs, etc. Use the handy worksheets on pages 34 and 40 of this SPD to help you estimate expenses.
- When you have an eligible health care or dependent care expense, pay the bill as usual and then submit your claim for reimbursement. You may also submit unpaid bills for eligible expenses. See pages 41-42 of this SPD for information on submitting a claim for eligible spending account expenses.
- You are reimbursed from your spending account with tax-free dollars:
  - Anytime during the year, you may file a health care claim and be reimbursed for the maximum annual amount that you elected to be deposited into your Health Care Spending Account, even if the total amount has not yet been deposited into your account.
  - Dependent care expenses are reimbursed up to the amount in your account at the time the claim is filed.
- Remember, these are separate accounts. You may not use money from your Health Care Spending Account to pay dependent care expenses, and you may not use money from your Dependent Care Spending Account to pay health care expenses.

Careful planning is the key to saving taxes through spending accounts. You should contribute money only for eligible expenses you expect to have during the Plan Year. Due to certain forfeiture requirements imposed by the IRS, you may not want to deposit money for unanticipated expenses. You will forfeit any money in your Dependent Care Spending Account that is not used to reimburse you for eligible day care costs incurred during the Plan Year. You also will forfeit any unused amount in your Health Care Spending Account in excess of the applicable “carryover amount” amount (See **Important Rules on a Health Care Spending Account** on pages 32-33). Be sure to estimate your expenses carefully AND submit your claims on time. You have until June 30 of the following year to file a claim for reimbursement of eligible expenses that you incurred as a spending account participant in the Plan Year in which the money was deposited in your account.

Eligibility

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

Enrolling in a Spending Account

If you would like to participate in a spending account, you may elect to participate in one or both accounts during annual benefits enrollment by using the web enrollment system. You must re-enroll each year if you wish to participate in the Dependent Care Spending Account or contribute to a Health Care Spending Account. . If you enroll during annual benefits enrollment, you will begin participating in your spending accounts — and contributing to your spending accounts — in January.

Health Care Spending Account

The Health Care Spending Account (HCSA) helps you save tax dollars on eligible out-of-pocket medical, dental, vision, and hearing expenses. You may submit claims for yourself, your spouse, your eligible federal tax dependents, and any of your natural, adopted, step, or foster children who will not reach age 27 during the Plan Year (even if they are not tax dependents).

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

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

Under applicable federal tax rules, a domestic partner and his or her dependents who do not qualify as your federal tax dependents may not participate in your Health Care Spending Account.[4] More details on who qualifies as a dependent eligible to receive tax-favored benefits under a Health Care Spending Account are found in IRS Code Sections 105 and 152 and Notice 2010-38.

Eligible expenses *include the following items if they are not covered by your insurance. See the worksheet on page 34 for additional eligible expenses:*

- Medical and dental deductibles and co-payments
- Menstrual products — including pads, lines, and similar products
- CDC-approved masks
- Orthodontia treatment not covered by your dental insurance
- Vision care — including prescription eyeglasses, contact lenses and solution, laser eye surgery, and nonprescription reading glasses
- Nicotine patches and nicotine gum (with a doctor's prescription)
- Smoking cessation programs
- Hearing aids and tests
- Special equipment prescribed by a doctor for family members with mental or physical disabilities
- Over-the-counter medications and drugs, such as pain relievers, antacids, allergy, and cold medicines
- Insulin

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

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

- Cosmetic surgery and procedures if not medically necessary, including teeth whitening
- Insurance premiums, including long term care insurance premiums, and Medicare premiums
- Expenses reimbursed by any other health care plan including Medicare or Medicaid
- Diaper service (unless medically required)
- Funeral expenses
- Long-term care services
- Herbal remedies
- Weight loss medications or weight control programs not prescribed to treat a specific condition or disease
- Cotton balls, bandages, rubbing alcohol, Vaseline, toothpaste, and cosmetics
- Health club dues (unless prescribed by a doctor for a medical condition)
- Nonprescription dietary supplements or vitamins
- Dependent care expenses
- Health foods
- Electrolysis

Refer to Internal Revenue Service (IRS) Publication 502 for the types of expenses that qualify for a tax deduction under Internal Revenue Code Section 213. Call your local IRS office to obtain a copy of Publication 502 or access the list through the IRS website at **irs.gov/forms-pubs/about-publication-502**

An Example of How You Can Save Money Using Your Health Care Spending Account
Suppose you paid $350 for new prescription sunglasses, which are not considered a covered expense under your medical plan. You wrote a check for $350 and gave it to your optometrist. If you paid 25 percent in federal income taxes when you earned this $350, **your actual cost for the prescription sunglasses was $437.50** ($350.00 + $87.50 federal income taxes = $437.50).

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

Contributing to Your Health Care Spending Account

You may put from $10 to $266 each month (up to $3,192[5] each Plan Year) into your Health Care Spending Account. To calculate your monthly contribution amount, estimate your eligible out-of-pocket health care expenses for the Plan Year (or the remainder of that year if you are enrolling mid-year) and divide that number by the number of months in that year that you have left to contribute. Your contributions must be stated in whole dollars.

Example: Let's assume you estimate that your annual eligible out-of-pocket health care expenses will come to $900. In October, during annual benefits enrollment, you want to enroll in a Health Care Spending Account and begin contributing in January. To determine your monthly contribution amount, divide $900 by 12 (the number of months you will be contributing for the next Plan Year). In this example, you would be contributing $75 a month to your Health Care Spending Account.

You might also have "carryover" amounts. As explained on page 32, unused amounts up to $640 may be carried over for those employees who are participants (including COBRA participants) at the end of the Plan Year. Any carryover amount is in addition to the up to $3,192 that you may elect to contribute. See the **"Use-It-or-Lose-It" Rule and the $640 Carryover Rule on page 32.**

Remember, the money in your spending account is yours to use for eligible health care expenses you incur while you are an active participant. **TIP:** To help you estimate your health care expenses, use the worksheet on page 34. You should also review the important rules on pages 32-33.

[5] Based on 2024 IRS limits

Important Rules on a Health Care Spending Account

- **Plan carefully** — the IRS says that your election to put a specific amount of money each month into a Health Care Spending Account is an "irrevocable" decision. This means that once you make your election for the year, you may not change your mind unless you experience a qualified change in status and your change is consistent with the change in status. The change-in-status rules are explained in this SPD. Note, the beginning or end of an unpaid leave of absence is not treated as a qualified change in status for purposes of your Health Care Spending Account. If you take an unpaid leave of absence, you will be billed directly for your monthly contribution to your Health Care Spending Account while you are on leave and, upon your return, your contribution amounts will resume at the level in effect before your leave. Unless you have a qualified change in status, you may not change your election even if you do not incur an estimated expense or an expense turns out to be ineligible for reimbursement. See page 44 for special rules when you take FMLA leave.
- **Deadline for reimbursement claims** — HCSA claims for reimbursement may be made at any time during the current Plan Year but must be received by June 30 of the following year (the end of the "run out period").
- **"Use-It-or-Lose-It" Rule** — do not put more money into your account than you think you'll need. Why? Any amount over the allowed "carryover amount" (see **$640 Carryover Rule** below) that remains in your account at the end of the run-out period will be forfeited (lost) to the County.
- **$640 Carryover Rule —** if you are a participant (including a COBRA participant) on the last day of the Plan Year, any unused amount in your account up to $640 is carried over to the next Plan Year (the "carryover amount"). This carryover amount is in addition to any elective contributions (up to $3,192) that you make for the current Plan Year. The HCSA pays all claims for expenses incurred during the current Plan Year first from coverage elected for the current Plan Year before using the carryover amount.
  Example: During annual benefits enrollment in October 2024, Jane elects a Health Care Spending Account salary reduction amount of $3,192 for 2025. By December 31, 2024, Jane's unused amount from the 2024 Plan Year is $800. On February 1, 2025 – during the run-out period for 2024 — Jane submits claims and is reimbursed with respect to $350 of expenses incurred during the 2024 Plan Year. That leaves a carryover on June 30, 2025 (the end of the run-out period) of $450 of unused Health Care Spending Account funds from 2024. The unused amount of $450 is not forfeited. Instead, it is carried over to 2025 and available to pay claims incurred in that year so that $3,642 (that is, $3,192 + $450) is available to pay claims incurred in 2025. Jane incurs and submits claims for expenses of $2,700 during the month of July 2025 and does not submit any other claims during 2025. Jane is reimbursed with respect to the $2,700 claim, leaving $942 as a potential unused amount from 2025. After the run-out period, Jane will only be able to carry over $640 to 2025 and will forfeit $302.
- **Expenses are "incurred" at the point of service** — an expense is "incurred" when a service is provided or a product is received, not when a bill is sent or paid. A Health Care Spending Account typically cannot make advance reimbursements of future or projected expenses.
- **Expenses must not be reimbursed or reimbursable from other sources** — any eligible expenses for which you are not otherwise reimbursed may be paid from your account.
- **You must be an active participant (or have a carryover amount) to have eligible claims** — with respect to your current year's elected coverage, you may submit claims for expenses incurred only for those months in the Plan Year in which you are an "active participant" in the HCSA. You are considered an active participant during any month that you contribute to the account and the month before your first contribution. In addition, you are an active participant to the extent of any "carryover amount" from a prior Plan Year that is not yet exhausted, even if you did not elect to make contributions for a Plan Year. You may not submit claims for reimbursement of expenses that are incurred before the date you become a participant in an account, after December 31 (except with regard to any "carryover amount"), or after the month in which you terminate employment (or otherwise become an ineligible employee) unless you elect COBRA.
- **COBRA participation is available** — if you take a leave of absence or leave County service while you are a participant, you may continue participation in a Health Care Spending Account for the rest of the year by making your monthly payments through COBRA. Also, see the rules on page 44 regarding the special rules that apply while you are on FMLA leave.
- **Accounts must be kept separate** — dollars you put into your Health Care Spending Account may not be transferred to a Dependent Care Spending Account, or vice versa. These accounts must be kept separate. In addition, dependent care expenses may not be reimbursed from your Health Care Spending Account.
- **No double tax shelter** — you may not take a tax deduction on your income tax return for expenses paid through your Health Care Spending Account. Also, you cannot deduct any unclaimed account money from

your federal income taxes.

- **You must enroll every year in order to contribute to an HCSA** — you must re-enroll in the Health Care Spending Account every year if you wish to make elective contributions to it. However, if you have a carryover amount from the prior year, an account will automatically be established on your behalf to hold that carryover amount. If you wish to make elective contributions in addition to any carryover amount, you must make an election during annual benefits enrollment.
- **Termination of participation during a Plan Year** — your active participation in the Health Care Spending Account terminates during a Plan Year when you terminate employment, otherwise cease to be an eligible employee, or go on a leave of absence and do not elect COBRA and make any necessary premium payments, or do not otherwise continue to make any required elective contributions to your account (e.g., while on FMLA leave). Expenses incurred while you are not an active participant are not eligible for reimbursement. If you return to County service in the same year in which your employment terminated and within 30 days of your termination, you must make the same election that was in effect at the time of your termination unless you experience a qualified change in status during your unemployment. If you return to County service 30 or more days after your termination, you can make a new election for coverage under the account. See page 44 for rules governing certain leaves of absence.

Health Care Spending Account Worksheet

Your health care flexible spending account may reimburse only those expenses that are medical expenses as defined in Code Section 213(d). Note, some expenses (such as insurance premiums) that are deductible for purposes of Code Section 213 are not eligible for reimbursement from your Health Care Spending Account. In addition, while expenses are reimbursable from your Health Care Spending Account based on the year in which they are *incurred* – that is, when the services or products are provided — expenses are deductible in the year paid. The following is a partial list of expenses eligible for reimbursement.

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

Type of Expense	Expense Amount
Smoking cessation programs; and nicotine patches, and nicotine gum (with doctor's prescriptions)	_____
Special equipment and treatment for a mentally or physically disabled eligible dependent	_____
Sterilization	_____
Substance abuse and alcohol treatment programs	_____
Surgery	_____
Therapy	_____
Transplants	_____
Weight loss programs as prescribed by a physician to treat a specific medical condition	_____
Wheelchairs	_____
X-ray fees	_____
A. Total annual eligible health care expenses:	A. $_____
B. Decide how much of the total annual amount in Line A you want to put into your individual account for the year:	B. $_____
C. Divide the annual amount in Line B above by the number of months during the year that you can put money into your Health Care Spending Account. This will give you your monthly contribution amount (must be between $10 and $266):	C. $_____

Dependent Care Spending Account

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

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

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

Eligible expenses include, but are not limited to:

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

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

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

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

Contributing to Your Dependent Care Spending Account

Your Dependent Care Spending Account (DCSA) may be funded on a tax-free basis with County contributions. To receive the County contribution, you must contribute at least $10 each month. Your contribution and the County's contribution cannot exceed $400 per month. If you elect to participate in the DCSA, the County will make a non-taxable monthly contribution of up to the following amount (subject to an annual cap[1]) to your DCSA based on your annual base pay:

Your Annual Base Pay	**County's Monthly Contribution** (subject to the annual cap on contribution[1])
Less than $34,999	$375
$35,000 - $39,999	$300
$40,000 - $44,999	$275
$45,000 - $49,999	$200
$50,000 - $54,999	$125
$55,000 or more	$100

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

If the County contribution is reduced and/or stopped because of the cap, you may have the opportunity to increase the contribution amount deducted from your pay in order to keep the same total contribution level for the remainder of the Plan Year. In addition, you may be allowed to make other changes that are consistent with a qualified change in status, cost, or coverage (for example, revoking your election if your dependent care provider quits or terminates its contract with you). (See pages 13-16) for a discussion of the changes in status and cost and coverage rules).

The County will contribute to your DCSA if you are paid for a minimum of eight hours of earnings per month or received a minimum of eight hours of leave benefits. If you become ineligible to participate in *Flex* (e.g., because you terminate employment), your County contribution will end (See **When Coverage Ends** on page 11). If you change flexible benefits program eligibility in the middle of a Plan Year (e.g., from *Flex* to *Options*) due to a change in employment status, you can make changes that are on account of and consistent with your eligibility change. However, if you do not complete your enrollment on time, you will be defaulted into a Dependent Care Spending Account under the new flexible benefits program as of the first day of the second month after the enrollment period ends. You then will be subject to the County contribution cap that applies under the new plan.

Limits on Total Contributions to Your Dependent Care Spending Account

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

Single or Married Filing a Joint Federal Tax Return?

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

Married Filing Separate Federal Tax Returns?

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

For any month that your spouse is a full-time student or incapable of self-care, your spouse is deemed to be gainfully employed with an earned income of $250 (or $500 if you have more than one qualifying individual as described on page 35).

Calculating Your Monthly Contribution Amount

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

Example: Assume that you make $47,000 per year and your estimated out-of-pocket dependent care expenses for the Plan Year come to $3,600. To determine how much you should contribute to the Dependent Care Spending Account, divide $3,600 by 12, or $300. Because this amount exceeds the County contribution ($200 for someone making $47,000), subtract the monthly County contribution to determine the monthly amount you should have deducted from your pay ($300 - $200 = $100). This means you would elect to contribute $100 per month, which will be deducted from your pay and deposited into your Dependent Care Spending Account. The County will contribute $200 each month, for a total of $300 per month.

Note: Use the worksheet on page 40 to determine your monthly contribution amount.

How Does a Dependent Care Spending Account Save You Money?

Taking the facts from the example above, assume that you pay 25 percent in federal income taxes. This means that, without the Dependent Care Spending Account, your real cost for dependent care would be $4,500 ($3,600 + $900 in federal taxes). However, if you elect to participate in a County Dependent Care Spending Account, your dependent care will only cost you $1,200 for the year ($100 x 12 = $1.200) because you receive a County subsidy and you do not pay federal income taxes on amounts contributed to and distributed from your account.

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

TIP: To help you determine the amount you should contribute to a Dependent Care Spending Account to cover your estimated dependent care expenses, use the worksheet on page 40. You should also review the important rules in the next section.

Important Rules on a Dependent Care Spending Account

- **Plan carefully** — the IRS says that your election to put a specific amount of money each month into a Dependent Care Spending Account is an "irrevocable" decision. This means that once you make your election for the year, you cannot change or cancel your monthly contribution amount unless you experience a qualified change in status or certain cost or coverage changes. And you cannot change your monthly contribution amount just because your expenses turn out to be ineligible for reimbursement. The changes in status, cost, and coverage rules that are applicable to you are explained on pages 13-16. Note, to change your contributions to your Dependent Care Spending Account, your change must be consistent with a qualified change in status. Generally, you may be permitted to change your monthly contribution amount if, for example, you:
  - Experience an increase or decrease in day care fees charged by a dependent care provider who is not your relative.
  - Change day care providers and this change causes your day care fees to change.
  - Have a change in your work schedule (e.g., from full-time to part-time or vice versa), which causes a change in the number of hours or days worked by a provider.
  - Your dependent child becomes ineligible because he or she reaches age 13 (and is not mentally or physically incapable of self-care).

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

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

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

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

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

Dependent Care Spending Account Worksheet

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

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

Estimating Your Dependent Care Spending Account Tax Savings

Visit **mylacountybenefits.com**, click on "Health & Insurance" header, click "More", and click "Calculate Spending Account Needs" located under "Tools" to access the Spending Account Calculators. Use the FSA tax savings calculator to help you determine your estimated tax savings.

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

Submitting Your Spending Account Expense Claims

1. When you have a claim under either your **Health Care Spending Account** or **Dependent Care Spending Account,** you have to complete and submit a claim form and include an itemized bill or receipts for each expense. Below is information regarding submitting claims based on your spending account:
    - **Health Care Spending Account Claims.** Complete a *claim form* and submit an itemized bill or receipt. The Spending Account Plan Administrator will not process your claim unless you include itemized bills or receipts from the provider of the service (you may be asked to provide an Explanation of Benefits statement), for each claim you submit. Canceled checks will not be accepted. Your itemized bill or receipt must include all of the following items:
        - Provider's name
        - Patient's name
        - Service date(s)
        - Type of service
        - Out-of-pocket cost
    - **Dependent Care Spending Account Claims**. Complete the *Dependent Care Pay Me Back Claim Form* and submit an itemized bill or receipt. The Spending Account Plan Administrator will not process your claim unless you include itemized bills or receipts as proof of each expense. Canceled checks will not be accepted. If you do not include bills or receipts, you must provide the following information on your claim form:
        - Provider's name
        - Service date(s)
        - Dependent's name and relationship to account holder
        - Type of service
        - Amount billed

2. You can submit your claim by:
    - **Online:** use your smartphone, tablet, or computer to submit your claims anytime 24/7.
        - Log on to **mylacountybenefits.com**
        - Click on the "Spending Account" tile to be navigated to the HealthEquity website
        - Click on "Reimburse Me"
        - Follow the online instructions to submit your claims. Once your claim has been submitted, follow the instructions to upload your itemized receipts.
    - **EZ Receipts App:** use your smartphone to download the EZ Receipts app from the Apple App Store or Google Play. The app registration process will require you to establish a User ID and password. You can also use the EZ Receipts app to check your balance, file claims, take photos of your receipts, and upload documents. With the EZ Receipts app, your DCSA provider can also sign the electronic receipt on your phone or tablet so you don't need to submit a claim form.
    - **Fax:** fax your completed Health Care or Dependent Care Claim Form and documentation (e.g., itemized bill or receipt, or Explanation of Benefits) toll-free to 877-353-9236.
    - **Mail:** mail copies (not the originals) of your completed Health Care or Dependent Care Claim Form and documentation (e.g., itemized bill or receipt, or Explanation of Benefits) to:

        HealthEquity
        P.O. Box 14053
        Lexington, KY 40512

3. Claims are processed within 3-5 business days from the date they are received. You will either receive a check in the mail or (if you prefer) your reimbursement will be deposited directly into your bank account. To initiate direct deposit of your reimbursements:
    - Log on to **mylacountybenefits.com**
    - Click on the "Spending Account" tile to be navigated to the HealthEquity website
    - Click your name in the upper right corner of the screen and click on "Profile"
    - Click on your spending account for the current year (e.g., Health Care Spending Account 2025" or "Dependent Care Spending Account 2025")
    - Click on "Reimbursement Method" and select "Direct Deposit"
    - Enter and save your direct deposit information

Every three months, you will receive a statement to help you monitor your account balance. Review these statements carefully.

You must submit your claims for all eligible expenses incurred while you are a participant during the Plan Year by June 30 of the following year. If you submit a Dependent Care Spending Account claim that is postmarked after this date, the claim will not be paid, and you will forfeit any money left in your spending accounts. If your Health Care Spending Account claim is postmarked after this date, the claim will not be paid and any amount over the allowed “carryover amount” will be forfeited.

If you leave County service during the Plan Year, you may continue to submit claims for eligible expenses incurred during the Plan Year until June 30 of the following year. However, these claims must be for eligible expenses incurred during the Plan Year while you were actively participating in the applicable spending account.

If you have any questions about claims administration of the spending accounts, call the Spending Account Plan Administrator, HealthEquity, at **877-924-3967.** Or, you can check you claims and your balance in your account at any time by going to **mylacountybenefits.com**, and clicking on the “Spending Account” tile.

What Happens to My Spending Accounts if I Leave County Service or Retire?
You still have until June 30 of the next year to submit claims, but only for the months in which you contributed to the account as an active participant. If you leave the County or retire, your contributions stop and participation in the account ends. You cannot submit claims for eligible expenses incurred during the months you did not contribute to the account. See pages 32-33 and 38-39 for **Important Rules** to regarding active participation.

If you were participating in a HCSA, you may continue your participation in the account after leaving County service by electing COBRA coverage and paying the monthly contributions after-tax through the remainder of the Plan Year. If you spend more from your HCSA than you contribute before you leave the County, you should elect COBRA coverage to continue your HCSA for the remainder of the Plan Year.

Health Care Spending Account Visa Card

When you elect to enroll in a Health Care Spending Account, you will automatically be mailed a Health Care Spending Account (HCSA) Visa card. Once you activate your card, you can use your HCSA Visa card instead of cash or credit to instantly pay most health care providers and pharmacies for eligible expenses (when you swipe your card at checkout choose credit). When you use your HCSA Visa card you save time by not having to file a claim for most common expenses (e.g., standard copays for doctor’s office visits and prescriptions). You can request additional HCSA Visa cards for yourself or your eligible dependents through HealthEquity’s website available at **mylacountybenefits.com**.

HealthEquity may ask you for receipts, Explanation of Benefits (EOB) or other documentation for verification, so keep your receipts. Failure to provide the requested information may result in your HCSA Visa card being suspended. If you have lost or cannot produce an EOB or receipt, contact the HealthEquity at 877-924-3967 to find out what your options are. If you lose your HCSA Visa card, or it is stolen, report it to HealthEquity immediately.

Miscellaneous

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

AFFORDABLE CARE ACT (ACA) COMPLIANCE

In January, the County and your medical plan will mail new tax forms, 1095-B and 1095-C.

Form 1095-B

Your medical plan will mail 1095-B to your address because it documents the months you and your dependents had ACA-compliant medical coverage during the Plan Year. Anthem Blue Cross enrollees will not receive Form 1095-B, instead this information will be included in Section III of Form 1095-C, which will be sent by the County.

Form 1095-C

The County is required to mail this form to your address. Form 1095-C documents whether you were treated as a "full-time" employee for ACA purposes and whether you (and your dependents) received an offer of ACA-compliant medical insurance each month during the Plan Year.[6] Full-time employees who were offered coverage, but who waived or declined it for the Plan Year, will still receive the Form 1095-C.

Keep these forms; you may need to file them with your tax returns.

GENERAL PLAN ADMINISTRATION

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

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

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6 For purposes of ACA and reporting on Form 1095-C, an employee is considered to be full-time if he or she is credited with an average of 30 hours of service a week (or 130 hours of service per month). An hour of service is an hour for which you are paid or entitled to pay for performing services or for time away from work due to vacation, sickness/disability, military duty, jury duty, or other leave of absence. If you are initially hired into a position that is expected to be full-time, your full-time status is determined on a month-to-month basis until you have been employed for an entire "measuring period." A measuring period runs from October 1 through September 30. Once you have been employed for a full measuring period, your status is determined by looking back at your employment history for the measuring period ending immediately prior to the Plan Year. If you have any questions about your status for the purposes of ACA and reporting on Form 1095-C, contact the County's Benefits Hotline at 213-388-9982. Be aware that your treatment as "full-time" for the purposes of ACA and reporting on Form 1095-C has no bearing on your employment status for any other purpose.

CONTINUING COVERAGE UNDER CERTAIN CIRCUMSTANCES

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

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

- If you are in pay status for at least eight hours in any month, the County will pay your full *Flex* contribution.
- If you are not in pay status during the month FMLA/CFRA leave is taken, the County will continue to pay the portion of the County contribution allocated to the County-sponsored medical plan, the County-sponsored dental plan, and the Health Care Spending Account.
- If you paid any portion of the premium for your medical, dental and Health Care Spending Account coverage prior to the FMLA/CFRA leave, you will be billed for the same amount while on leave.
- If you choose not to continue your coverage by paying your premium, or otherwise fail to timely pay your share of the premium, your coverage will be suspended as of the first day of the month following the last month for which the premium was paid. You will not be entitled to payment or reimbursement of expenses incurred during any period your coverage is suspended.
- Under FMLA and CFRA, the County is entitled to recover any premium payments made on your behalf if you fail to return to work from FMLA/CFRA leave after the leave entitlement has been exhausted or the leave expires, unless:
  - You are unable to return to work because of the continuation, recurrence, or onset of a serious health condition which would entitle you to continue FMLA/CFRA leave.
  - You are unable to return to work due to unexpected circumstance(s) beyond your control.
- Likewise, under the PDL law, the County is entitled to recover any premium payments made on your behalf if you fail to return to work from PDL after the leave entitlement has been exhausted or the leave expires, unless:
  - You are unable to return to work because you are taking CFRA leave,
  - You are unable to return to work because of the continuation, recurrence or onset of a health condition which would entitle you to continue PDL,
  - You are unable to return to work due to non-pregnancy related medical conditions requiring further leave,
  - You are unable to return to work due to unexpected circumstance(s) beyond your control.

You also may continue your Life Insurance, Accidental Death & Dismemberment (AD&D), and Long-Term Disability (LTD) Health Insurance, at your own cost. You will be billed monthly for the cost of these benefits, under the County's self-pay program. If you do not pay for the cost of one or more of these benefits, the benefit(s) will be canceled. See page 17 for more information regarding the self-pay program.

Reinstatement of Benefits Upon a Return From Leave of Absence
Benefits that are terminated during a leave of absence will be reinstated on the first of the month following the month you return to work. When you are reinstated in your Health Care Spending Account and your Dependent Care Spending Account, you will resume premium payments at the level in effect before the leave with a corresponding reduction in the total level of coverage for the remainder of the Plan Year. Alternatively, with regard to the reinstatement of your Health Care Spending Account only, you may elect to resume coverage for the remainder of the Plan Year at the level in effect before your leave with a corresponding increase in your premium payments. Any other change in your pre-tax premiums may only be made in accordance with the Change in Status rules described on pages 13-16.

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

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

Continuation of Coverage During Active Military Service

If you are ordered to active military duty, you are entitled to receive benefits for a period not to exceed 720 days. On August 15, 2017, the Board of Supervisors approved the 720-day limit on County-provided paid military benefits. The County will comply with any obligation to continue benefits in accordance with the federal law known as USERRA.

While on active military duty, you may continue participation in the Flex Plan and may participate in annual benefits enrollment. Any benefit changes you make during annual benefits enrollment will be effective on January 1 of the following year. If you make no changes, your benefits will continue except for Health Care and Dependent Care Spending Accounts, which will be canceled. **If you are away from home during the annual benefits enrollment period, you may designate someone to enroll for you.** If you use a designee, ensure that person completes your enrollment by the deadline.

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

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

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

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

Health Care and Dependent Care Spending Accounts — Provided you continue to make contributions to your spending accounts; you may continue to participate in these accounts while on active duty. Remember, claims for reimbursement for services used during the year in which you are a participant must be claimed by June 30 of the following year. See **Submitting Your Spending Account Expense Claims** on pages 41-42.

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

COBRA Continuation of Health Coverage

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

What is COBRA Continuation Coverage?

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

Qualifying Events

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

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

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

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

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

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

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

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

For the other qualifying events (*annulment*, *divorce* or *legal separation* of the employee and spouse, or a *dependent child's losing eligibility for coverage* as a dependent child), **you (or the qualified beneficiary) must notify the Plan Administrator in writing within 60 days after the later of (1) the qualifying event, or (2) the date coverage will end as a result of the event.** ***The procedure for notifying the Plan Administrator of a qualifying event is explained on page 49.***

How is COBRA Coverage Provided?

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

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

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

How Long Will COBRA Coverage Be Provided?

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

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

Disability Extension of 18-month Continuation Coverage Period

If any qualified beneficiary is determined by the Social Security Administration (SSA) to have been disabled at any time before the 60th day of continuation coverage (or, for a newborn or adopted child, within 60 days of the birth or adoption), the 18-month continuation coverage period may be extended to 29 months for each qualified beneficiary, if the disability lasts at least until the end of the 18-month period of continuation coverage. **However, in order for the extended coverage to apply, you must notify the Plan Administrator about the disability determination before the end of the 18-month continuation coverage period and within 60 days after the latest of (1) the date of the SSA determination; (2) the date of the qualifying event; or (3) the date on which the qualified disabled beneficiary loses (or will lose) coverage as a result of the qualifying event.** The procedure for notifying the Plan Administrator of a disability determination is explained on page 49.

If the SSA later determines that the qualified disabled beneficiary is no longer disabled, you must notify the Plan Administrator of that fact within 30 days of the SSA's determination following the procedure on page 49. The plan may end the extended continuation coverage for all qualified beneficiaries as of the first month that begins more than 30 days after the SSA's final determination.

Second Qualifying Event Extension of 18-month Continuation Coverage Period

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

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

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

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

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

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

Can COBRA Coverage Be Cut Short?

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

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

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

Special Rules for the Health Care Spending Account

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

Electing and Paying for COBRA Continuation Coverage

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

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

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

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

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

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

After COBRA Continuation Coverage Ends

During the 180-day period immediately before the expiration of your 18-month, 29-month, or 36-month continuation coverage period, you have the option of enrolling in the conversion health plan otherwise generally available under the medical and/or dental plan under which you are covered. For detailed information on your conversion rights, contact the Plan Administrator listed page 51.

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

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

COUNTY OF LOS ANGELES
Department of Human Resources
Employee Benefits Division – COBRA Unit
510 S. Vermont Avenue, 12th Floor
Los Angeles, CA 90020
213-388-9982

Extended Medical Coverage Under California Law After Exhaustion of Federal COBRA

Eligibility Period and Extended Coverage

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

The extended medical coverage ends automatically on the earlier of:

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

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

Electing and Paying for Extended Coverage

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

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

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

Conversion Option After Extended Coverage Ends

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

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

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

KEEP THE COUNTY INFORMED OF ADDRESS CHANGES

To protect your and your family's rights, you should keep your Departmental Personnel Office informed of any change in your home address. Or, if you have access to a County computer, you can update your address and phone number at **mylacounty.gov** – choose the Employee Self Service option.

Contact Information

Contact	Group Number	Phone Number	Website	APP
County of Los Angeles Department of Human Resources				
Benefits Hotline	N/A	213-388-9982	**employee.hr.lacounty.gov**	N/A
Benefit System				
Web enrollment	N/A	N/A	**mylacountybenefits.com**	N/A
Fax	N/A	310-788-8775	N/A	N/A
Medical				
Kaiser Permanente HMO Vision: Contact Kaiser	101000-3	800-464-4000	**choose.kp.org/county-of-la**	Kaiser Permanente
Anthem Blue Cross Vision coverage for HMO, POS, & PPO plans only; VSP, 800-877-7195 or vsp.com	HMO: 56089A POS: 56061A PPO: 1284EH CAT: 1313GD	844-730-1931	**anthem.com/ca/countyoflosangeles**	Sydney Health
Dental				
MetLife (SafeGuard) HMO	70334	800-880-1800	**metlife.com/safeguard**	MetLife US App
DeltaCare HMO	70831-00003	800-422-4234	**deltadentalins.com**	Delta Dental Mobile App
Delta Dental PPO	4915-10002	888-335-8227	**deltadentalins.com**	Delta Dental Mobile App
Health Care and Dependent Care Spending Account Administrator				
HealthEquity	N/A	877-924-3967	**mylacountybenefits.com** Click on "Spending Accounts"	EZ Receipts
Fax	N/A	877-353-9236	N/A	N/A
Life Insurance				
MetLife	N/A	800-846-0124	**mylacountybenefits.com** Click on the "MetLife" link	MetLife US App
Life and AD&D Insurance				
New York Life	Life: FLI52070 AD&D: OK819451	800-842-6635 818-477-1494 (Fax)	**bsc4lac.com**	N/A

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

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

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

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