Los Angeles County Metropolitan Transportation Authority

Benefits Enrollment Guide 2016

Exposition Metro Line Construction Authority

Expo

METRO PROVIDES EXCELLENCE IN SERVICE AND SUPPORT.

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EXPO is a component unit of the Los Angeles County Metropolitan Transportation Authority. Effective October 12, 2005, the Board of Directors of the Exposition Metro Line Construction Authority approved a benefits plan for EXPO employees which utilizes plans provided by LACMTA/PTSC.

If you (and/or your dependants) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please refer to pages 16–17 for details.

INTRODUCTION

Information in this guide highlights the Flexible Benefits Program for EXPO employees. The plans described in the guide are subject to the specific terms and provisions of the legal documents governing the plans. Provisions of the plans, as established in the legal documents, are the sole source for interpretation and administration of the plans and programs.

It is important to retain this guide for future reference.

Price Tags

With the Flexible Benefit Program, you have many different benefit choices. You decide whether you'd like to "buy up" to increase your level of benefit coverage, or to "buy down" to reduce the benefits you currently have because you don't need them.

All price tags for the available options are reflected on your personalized Enrollment Form if you are a newly hired employee. During each Annual Open Enrollment period, this information will be made available and EXPO employees will be able to make changes to their plans if desired. In most cases, your contributions for the benefit plans are made on a pre-tax basis – as a salary reduction. This means the money you contribute to pay your share of the cost of the benefits program is tax-free. Since these dollars are taken from your gross salary before taxes are calculated, you receive valuable savings of federal and state income taxes.

Price tags are calculated based upon 24 equal installments during a calendar year. This means that two paychecks each month will have benefit deductions reflected. For the months in which you receive three paychecks, the last paycheck of the month will not have any benefit deductions reflected.

HEALTHCARE REFORM SPECIAL NOTICES

Grandfathered Health Plan Status

The Los Angeles County Metropolitan Transportation Authority and the Public Transportation Services Corporation believe the medical plans under the Flexible Benefits Program are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your medical plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to:

> Benefits Administration, One Gateway Plaza, 99-21-7, Los Angeles, CA 90012

> U.S. Dept of Health and Human Services at *www.healthreform.gov*

ELIBIGILITY

You are eligible to participate in the Flexible Benefit Program if you are a probationary or regular full-time employee of EXPO. Your dependents are eligible under the Flexible Benefit Program concurrently.

In addition, you may also enroll your domestic partner and your domestic partner's dependent children in the medical, dental, and vision plans in the same manner afforded spouses and dependent children of other Metro Non-Represented employees, but not on a pre-tax basis unless the domestic partner and dependent(s) are IRS tax dependents.

Eligible Dependents

For Medical, Dental, Vision and Life Insurance coverages, your eligible dependents include:

> Your spouse to whom you are legally married

> Same sex spouses will also qualify for health plan coverage on a pre-tax basis if their marriage is recognized by federal and state governments based on the Supreme Court's ruling on Defense of Marriage Act (DOMA)

> Your domestic partner

- with whom you are registered as domestic partners with the State of California or with whom you have established a substantially similar same-sex union (other than marriage) in another jurisdiction that is recognized under California law as a registered domestic partnership
- if you have submitted a completed Declaration of Domestic Partnership to Benefits Administration[1]

> Dependent children can be covered through the end of the month in which they turn age 26 regardless of whether tax dependent, student, married or residing with the employee

> Unmarried children over the age of 26 if they are incapable of self-support due to a physical or mental handicap and are chiefly dependent on you for financial support

You must enroll your newly eligible dependents (due to birth, marriage, Declaration of Domestic Partnership or adoption or placement for adoption) ***within 30 days to ensure coverage*** as dependents on your insurance plans. ***If more than 30 days have elapsed, you must wait until the next open enrollment period, unless you experience a HIPAA special enrollment event or qualified status change.***

If you are enrolling eligible dependents for the first time, you must provide proof of dependency, such as a marriage certificate, Declaration of Domestic Partnership, or birth certificate. If your marriage or domestic partnership ends, your former spouse or partner is NOT an eligible dependent. You must notify Benefits Administration within 30 days.

To enroll your domestic partner and his/her children in coverages, please request the Domestic Partnership Enrollment Guide from the Benefits Administration office.

HIPAA Notice of Special Enrollment Rights

If you have declined enrollment for yourself or your dependents (including spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, please contact Benefits Administration.

1. Life Insurance is not available to domestic partners who do not meet the State of California's definition of domestic partner.

ELIGIBILITY

Important Rules for Tax-Favored Health Benefits

Individuals who are otherwise eligible for coverage under the Flexible Benefit Program must also satisfy the following federal criteria in order to receive tax-favored health benefits within the meaning of the Internal Revenue Code (IRC):

> "Qualifying Children to age 26"*. Qualifying Children are your children by birth, adoption, stepchildren, or foster children who are otherwise eligible for enrollment in the Metro/PTSC Flexible Benefits Program.

> "Qualifying Children over age 26"*. Qualifying Children are your children by birth, adoption, stepchildren, or foster children who are permanently and totally disabled regardless of age, and the following:

- Are not married
- Do not provide over one-half of their own support
- Have the same principal place of residence as you for more than six months of the year (temporary absences, such as for school, are treated as time at the same principal place of residence)

> "Qualifying Relatives". Qualifying Relatives are:

- Your unmarried children (by birth, adoption, stepchildren or foster children) of any age who receive over half of their support from you and who can't be claimed as anyone else's IRC Qualifying Child* (above); or
- Individuals who:
  (1) Are unmarried
  (2) Who receive over half of their support from you
  (3) Have the same principal place of residence as you for the full tax year (temporary absences, such as for school, are treated as time at the same principal place of residence)
  (4) Who can't be claimed as anyone else's IRC Qualifying Child*
  (5) Are citizens, national, or legal residents of the United States or residents of Canada or Mexico (this requirement doesn't apply to children being adopted by a US citizen or national)

Important: Coverage for individuals who do not meet the criteria for tax-favored health benefits under the IRC will result in imputed income to you, and employee contributions made on their behalf must be paid on an after-tax basis.

See IRS Publication 502 at *www.irs.gov/publications/p502/index.html* for a discussion of the definition of a tax dependent. Please contact Benefits Administration if you have any questions regarding dependent eligibility.

* An employee can treat another person's Qualifying Child as eligible for tax-favored benefits if the child satisfies the other requirements above and if the other person isn't required to file a tax return, and either doesn't file a return or files one only to get a refund of withheld income taxes. For example, this could allow tax-free health coverage for the children of an employee's non-working domestic partner.

Newborns and Mother's Health Protection Act

Federal law protects the benefit rights of mothers and newborns related to any hospital stay in connection with childbirth. In general, group health plans and health insurance issuers may not:

> Restrict benefits for the length of hospital stay for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

> Require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay of up to 48 hours (or 96 hours).

For details on any state maternity laws that may apply to your medical plan, please refer to the plan material for the medical plan in which you are enrolled.

ENROLLMENT

New Hires

New EXPO employees attend a New Employee Orientation provided by MTA/PTSC Benefits Administration staff.

Your Orientation session is dedicated specifically to your enrollment in the health and welfare benefit plans offered by the company. Benefit coverage becomes effective on the first day of the month following your hire date. If your hire date is on the first day of the month, coverage is effective immediately.

If you fail to complete the enrollment forms within 30 days of employment, you are not eligible to participate until the next Open Enrollment period, unless you experience a HIPAA special enrollment event or qualified status change.

Annual Open Enrollment

The 2016 Annual Open Enrollment period is November 9 through November 22, 2015. Any changes to your benefit plans become effective January 1, 2016.

During the annual enrollment, you may:

> Continue your 2015 insurance benefits for calendar year 2016

> Choose different medical and/or dental plans

> Waive medical insurance if you are covered by another group medical plan, retirement medical plan or Medicare (proof of coverage required)

> Waive dental insurance

> Increase or decrease Employee Life Insurance coverage

> Add eligible family members to your medical and dental insurance plans, or drop them from the coverage

> Elect to participate in a Health Care and/or Dependent Care Flexible Spending Account for 2016

> Certify whether or not you used tobacco or tobacco products in the last 12 months in order to qualify for the $5,000 Non-Tobacco Users Life Insurance (free to the employee)

> Change Long-Term Disability Insurance option

Changes you make during this annual enrollment period will take effect on January 1, 2016.

If you do not complete your enrollment/changes by the established deadline, your benefits as of December 31, 2015 will continue through 2016 – except for Health Care or Dependent Care Flexible Spending Accounts, and the Non-Tobacco Users Life Insurance which will be canceled.

During the Open Enrollment Period, you will be able to select your benefit options, research benefit plans, print all enrollment forms and print a Confirmation Statement from the online benefits enrollment system. Access is available through Metro's Intranet and from remote access, *i.e.* your home computer.

> *http://benefits.metro.net*

If you require assistance, please contact a staff member in the Benefits Administration office.

The Open Enrollment System contains the following information:

> Your current 2015 benefit elections

> 2016 benefit options and price tags

> Insurance carrier enrollment forms for benefit plans

> Benefit Guide booklets

> Links to insurance carrier websites

(Please note that these websites provide a great deal of general information related to each insurance carrier in addition to physician directories. For information specific to MTA/PTSC plans, contact Benefits Administration for brochures/enrollment kits.)

> Beneficiary and dependent designations

> Your confirmation statement

If you have questions or require assistance in making your benefit plan selections for 2016, please contact a staff member in the Benefits Administration office.

ENROLLMENT

Open Enrollment – Confirmation Statement

Once you complete Online Open Enrollment, you should print a copy of the Confirmation Statement which details the benefit options you have selected for 2016. Check this statement carefully to be certain all of the information is correct and retain a copy for your records. This copy will be required in the event an enrollment discrepancy arises. If you have any questions you may call 213.922.7186.

Changing Your Benefit Coverage

You may not change your coverage elections during calendar year 2016 unless you experience a qualified change in status.

Qualified status changes include:

> Marriage, divorce or legal separation

> Establishment or temination of a domestic partnership

> Adding or losing an eligible dependent due to birth, adoption, placement for adoption or death

> A child who loses eligibility for dependent coverage

> Experiencing a significant change in your health care coverage, or cost of your spouse's health care coverage due to your spouse's employment

> The beginning or ending of your spouse's or domestic partner's employment

> You, your spouse, or domestic partner switching from full-time to part-time employment, or vice versa

> You, your spouse, or domestic partner taking an unpaid leave of absence

You may also change your health care coverage (or FSA contribution) if you experience a HIPAA (Health Insurance Portability and Accountability Act) Special Enrollment Event:

> Gaining a dependent by marriage, birth, adoption, or placement for adoption

> Losing other health care coverage if you waived enrollment due to that other coverage.

Some changes in coverage may be subject to insurance company approval. Contact Benefits Administration to verify that a change in your personal circumstances qualifies you to make a change in your benefit selections. Changes must be made within 30 days of the qualifying event.

Open Enrollment website:

http://benefits.metro.net

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you and any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1.877.KIDS NOW or go to *insurekidsnow.gov* to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "Special Enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

California – Medicaid
Website: *www.dhcs.ca.gov/services*

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov.ebsa
1.866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
1.877.267.2323, Ext. 61565

MEDICAL PLANS

You may select from four medical plan options:

1. Anthem Blue Cross PPO Medical Plan
2. Anthem Blue Cross HMO Medical Plan
3. Kaiser Permanente Medical Plan
4. Waiver of Medical Coverage

Anthem Blue Cross PPO Medical Plan

Anthem Blue Cross has a Preferred Provider Network. If you choose to utilize a network provider, your out-of-pocket costs can be significantly reduced. To find out if your doctor or hospital is in the PPO network, refer to the Anthem Blue Cross PPO directory for your area, or online at *www.anthem.com/ca*.

Anthem Blue Cross HMO Medical Plan

Anthem Blue Cross HMO is a Health Maintenance Organization (HMO). You choose your personal Primary Care Physician associated with a Medical Group or an Independent Practice Association (IPA). You and each of your covered family members may select a different Medical Group or IPA. Your Medical Group/IPA physician will provide routine medical care and will refer you to a specialist, should you need specialized treatment.

Kaiser Permanente Medical Plan

Kaiser Permanente is an HMO, in which all services are provided through one of Kaiser's facilities. When you join the Kaiser Plan, you may use any of the more than 90 medical offices and 10 medical centers in the Southern California region. You are never limited to just one doctor or office.

The tables on the following pages briefly outline some of the plan provisions.

Table 1 highlights the Anthem Blue Cross PPO Medical Plan benefits; Table 2 highlights the Anthem Blue Cross HMO and Kaiser benefits.

Special Notice – The Women's Health and Cancer Rights Act (WHCRA)

WHCRA requires coverage for certain types of reconstructive surgery following a mastectomy. When a person is receiving benefits under one of our medical plans in connection with a mastectomy and elects breast reconstruction, coverage will be provided for treatment of mastectomy complications, including lymphedemas, and the following treatments if agreed to by the patient and attending physician:

> All stages of reconstruction of the breast on which the mastectomy was performed

> Surgery and reconstruction on the other breast to produce a symmetrical appearance

> Prostheses and Treatment of physical complications of all stages of the mastectomy, including lymphedemas

Coverage for these services will be provided subject to the same deductibles, coinsurance, and co-pay provisions as other benefits under the plan. (Please refer to the Evidence of Coverage for your medical plan to obtain specific details relating to plan deductibles, co-pays, etc.)

MEDICAL PLANS

Table 1

Anthem Blue Cross PPO Medical Plan

Plan Provision	PPO	Non-PPO
Deductible – Individual	$150	$150
Deductible – Family	$450	$450
Deductible Waived:		
Inpatient Hospitalization	Yes	No
Mammogram	Yes	No
Cervical Cancer Screening	Yes	No
Well Baby Care	Yes	No
Co-Pay/Coinsurance:		
Inpatient Hospitalization	0%	$600/30%*
Outpatient	10%	30%
Office Visit	$15	30%
Surgery (Outpatient)	10%	30%
Routine Wellness Checkup and Exams:		
Child 0-6	0%	30%, limited to $20/exam
Age 7 to Adult	0%	Not covered
Prescription Drugs: (up to 30-day supply)	$10 Generic/$15 Brand	See Below*
Prescription Mail Order: (up to 60-day supply)	$10 Generic/$15 Brand	N/A
Out-of-Pocket Maximum (after deductible):		
Individual	$1,000	$2,000
Family	$2,000	$5,000
Lifetime Maximum	Unlimited	Unlimited

** You pay the co-payment plus the difference between the cost of the prescription at a non-network pharmacy and 50% of the cost of the prescription at a network pharmacy.*

Mental Health and Substance Abuse		
Deductible:	**No separate deductible**	
Co-Pay/Coinsurance:		
Inpatient	0%	30%*
Outpatient (pre-service review required after the 12th visit)	$15	30%

** A $600 co-pay/admission plus an additional $250/admission if utilization review is not obtained for out-of-network inpatient hospitalization and for inpatient mental health and substance abuse.*

Table 2

Anthem Blue Cross HMO and Kaiser Comparison

Hospital Services, Skilled Nursing Facility Care, Ambulatory Surgical Centers, Hospice and Home Health Care

Plan Service	Anthem Blue Cross HMO	Kaiser
Inpatient Care		
Semi-private room	No charge	No charge
Operating room	No charge	No charge
Nursing Care	No charge	No charge
Drugs, Medications & Oxygen	No charge	No charge
Blood & Blood Products	No charge	No charge
All necessary and ancillary services	No charge	No charge
Outpatient Care (Hospital Only)	No charge	$5 per visit
Skilled Nursing Facility (limited to 100 days*)	No charge	No charge
Ambulatory Surgical Center	No charge	$5 per visit
Hospice	No charge	No charge
Home Health Care Visits (limited to 100 visits/year)	$5 per visit	No charge
Physician Services: Physician visits including primary care, specialty care, and consultation		
Office Visits	$5 per visit	$5 per visit
Specialists/Consultants	$5 per visit	$5 per visit
Rehabilitative Care	$5 per visit/limited to 60 days per illness or injury	$5 per visit
Hospital visits (inpatient)	No charge	No charge
Skilled Nursing Facility visits	No charge	No charge
Diagnostic studies and laboratory procedures	No charge	$5
Surgeon, surgical assistants and anesthesia	No charge	$5
Prescription Drug	$5 Generic/$10 Brand	$5 Generic/$10 Brand
Health Maintenance and Wellness Services Preventive Care		
Routine check-ups and examinations	$0 per exam	$0 per visit
Well Baby Care	$0 per exam	$0 per visit
Hearing examinations	$0 per exam	$0 per visit
Immunizations	No charge	No charge
Allergy testing and treatments	$5 per visit	$5 per visit
Health Education and Wellness Programs	No charge	Varies

* Anthem Blue Cross HMO: The 100-day limit does not apply for Skilled Nursing Facility for mental health and substance abuse, but will apply for other conditions.

MEDICAL PLANS

Plan Service	Anthem Blue Cross HMO	Kaiser
Pregnancy and Maternity Care		
Prenatal and Postnatal Care (Office Visit)	$5 per visit	$5 per visit
Normal Delivery, Cesarean, Complications of Pregnancy		
Physician services (inpatient)	No charge	No charge
Hospital and ancillary services	No charge	No charge
Genetic testing	No charge	No charge
Physician services (outpatient)	$5 per visit	$5 per visit
Emergency Care – In Area		
Physician and Medical Services	No charge	No charge at Kaiser
Outpatient Hospital Services	$50*	$50 at Kaiser*
Inpatient Hospital Services	No charge	No charge at Kaiser
Emergency Care – Out of Area		
Physician and Medical Services	No charge	No charge
Outpatient Hospital Services	$50	$50
Inpatient Hospital Services	No charge	No charge
Mental Health		
Outpatient (pre-service review required after 12th visit)	$5/visit co-payment	$5/individual visit $2 group visit
Inpatient (pre-authorization required)	$0/copay	No charge
Vision		
	Covered by Vision Service Plan (VSP)	Covered under Kaiser Medical Plan

* Waived if admitted to hospital

MEDICAL PLANS

Waiver of Coverage

You may voluntarily elect not to be covered under a medical plan provided, you have alternative coverage through your spouse's employer or an individual policy.

If you elect to waive coverage, you will receive a credit of $125/month during calendar year 2016. This payment is recorded as taxable cash in your paycheck.

The following requirements apply to the waiver option:

1. You must be covered under another health plan. Documentation is required showing alternative coverage at the time of election.
2. Waiver of coverage election will remain in effect unless changed during an Open Enrollment period.
3. This option cannot be revoked, changed or modified during the plan year unless you experience a qualified status change or HIPAA Special Enrollment Event (see page 6).
4. In the event your alternative coverage is terminated due to a qualified status change, you may be allowed to enroll in a sponsored medical plan. This would be subject to insurance carrier restrictions; may be contingent upon evidence of good health; and insurance carrier underwriting approval, unless you provide a HIPAA certificate of coverage.
5. If you waive medical coverage, you automatically waive vision coverage.

Price Tags

Medical plan price tags are on a pre-tax basis, (except for domestic partner coverage unless the person is your IRS tax dependent) providing valuable tax savings.

Special Note – If you plan to enroll in any of the medical plans, you may want to consider participating in a Health Care Flexible Spending Account. You may be eligible for reimbursement for out-of-pocket medical expenses which you incur or expenses not covered by the healthcare plans.

California Mental Health Parity and Addiction of 2008 Act

California Law requires California HMOs and insured medical plans to provide certain mental health benefits.

MTA/PTSC's medical plans are in compliance with this legislation.

As of January 1, 2010, mental health services will be treated the same as any other health service under MTA/PTSC's medical plans. For both the PPO and HMO Plans, this means that some of the annual behavioral health benefits limits are being eliminated, and co-pays will be the same as for any other specialist visit.

Effective January 1, 2011, the same financial requirements or treatment limits will apply to mental health and substance abuse as predominant financial requirements or treatment limits that apply to medical/surgical benefits. The behavioral health co-pays will be the same as for any other PCP (Primary Care Physician) visit.

HEALTH REFORM INDIVIDUAL HEALTH PLAN COVERAGE MANDATE

Under the Affordable Care Act (ACA), beginning in 2014, the "individual mandate" requires almost everyone in the U.S. to have medical coverage or pay a penalty on their federal income tax return.

If you're enrolled in an MTA/PTSC medical plan as of January 1, 2014, and remain enrolled in a plan, you will fulfill the individual mandate, and you won't have to pay a penalty.

If you are not eligible for an MTA/PTSC medical plan, or if you are eligible but don't enroll, you can get medical coverage through a number of other sources, including:

> Your spouse/domestic partner or your parent, if coverage is available

> A private insurance plan

> Medicare/Medicaid or Veterans Affairs (VA), if you qualify

> One of the public health insurance marketplaces

The health insurance marketplace – also called an "exchange" – is an online public shopping site where individuals, families, and small business owners can shop for plans. Each state will sponsor a marketplace that will offer affordable, quality medical insurance options. Some exchanges will be run by the states, other by the federal government.

Marketplaces will have annual open enrollments and special enrollment events, much like many employer plans.

Almost everyone will be able to buy coverage through the health insurance marketplace. For people who have coverage through their employer, the marketplace may not be the most cost effective. MTA/PTSC coverage is expected to be more cost effective as MTA/PTSC pays 90% of the cost for your coverage.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Under the Affordable Care Act, employers are required to provide this notice containing basic information about the new Health Insurance Marketplace.

MTA/PTSC and EXPO are committed to providing a comprehensive package of health resources to employees and their dependents. Employees covered under our plans will not need to access the Health Insurance Exchange.

What is the Health Insurance Marketplace?

The Marketplace is designed to help individuals find health insurance and offers one-stop shopping to find and compare private health insurance options. Enrollment opportunities begin November 15, 2015, for coverage effective January 1, 2016.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premiums, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings one might be eligible for depends on your household income.

EXPO employees are covered under the MTA/PTSC health plans which meet or exceed the required standards.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. Since MTA/PTSC plans meet or exceed the standards, you will not be eligible for a tax credit through the Marketplace. If you purchase a health plan through the marketplace instead of accepting coverage offered by MTA/PTSC, the employer's contribution will not apply to coverage you purchase through the Exchange. Also payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage provided through the MTA/PTSC plans, please contact Jodi Stewart at 213-922-7186 or Jan Olsen at 213-922-7151.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Information About Health Coverage Offered By Your Employer

This section contains information about the health coverage offered through the MTA/PTSC plans. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name Exposition Metro Line Construction Authority	4. Employer Identification Number (EIN) 41-2185643	
5. Employer Address 707 Wilshire Blvd., 34th Floor	6. Employer Phone Number 213.922.7080	
7. City Los Angeles	8. State CA	9. Zip Code 90017
10. Who can we contact about employee coverage at this job? Jodi Stewart , Pension & Benefits Department, 21st Floor		
11. Phone number (if different from above) 213.922.7186	12. Email Address stewartj@*metro.net*	

Here is some basic information about health coverage offered by MTA/PTSC:

> As your employer, we offer a health plan to:

☐ All employees

☒ Some Employees. Eligible Employees are:

- Full-time employees
- Part-time employees (working less than 30 hours)

> With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

- Your spouse to whom you are legally married
- Your domestic partner (Declaration of Domestic Partnership Form required)
- Dependent children, to age 26
- Unmarried children over the age of 26 if they are incapable of self-support due to a physical or mental handicap and are chiefly dependent upon you for financial support

☐ We do not offer coverage

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages. You may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, *coveredca.com* and *HealthCare.gov* can help guide you through the process.

IMPORTANT NOTICE FROM LACMTA/PTSC ABOUT YOUR PRESCRIPTION DRUG COVERAGE & MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Anthem Blue Cross or Kaiser Permanente and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **LACMTA/PTSC has determined that the prescription drug coverage offered by Anthem Blue Cross and Kaiser Permanente is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.**

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th. This may mean that you have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a 60-day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan.

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you are an active employee or family member of an active employee, and if you decide to enroll in a Medicare prescription drug plan, you may continue your LACMTA/PTSC-sponsored coverage. In this case, the LACMTA/PTSC-sponsored coverage will continue to be primary or secondary, as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop LACMTA/PTSC-sponsored coverage, Medicare will be your only payer. You can reenroll in the LACMTA/PTSC-sponsored coverage at annual enrollment or if you have a special enrollment event as defined in your benefit plan material for the LACMTA/PTSC-sponsored coverage.

For retired employees and their dependents, if you enroll in a Medicare prescription drug plan, you and your dependents will no longer be eligible for LACMTA/PTSC-sponsored medical or prescription drug coverage and you will not be able to have that coverage reinstated if you later disenroll from the Medicare prescription drug plan. Before you decide to enroll in a Medicare prescription drug plan, you should compare your LACMTA/PTSC-sponsored medical plan options – including which drugs are covered – with the coverage and cost of the plans offering Medicare medical and prescription drug coverage in your area.

IMPORTANT NOTICE FROM LACMTA/PTSC ABOUT YOUR PRESCRIPTION DRUG COVERAGE & MEDICARE

***Remember*: Retired employees and their dependents that enroll in a Medicare prescription drug plan and drop their LACMTA/PTSC-sponsored prescription drug coverage will NOT be able to get this coverage back.**

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with Anthem Blue Cross or Kaiser Permanente and don't enroll in a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For more information about this notice or your current prescription drug coverage:

Contact Jodi Stewart, Benefits Administration, at 213.922.7186.

NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through LACMTA/PTSC changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage:

You will find more detailed information about Medicare plans that offer prescription drug coverage in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit *www.medicare.gov*
- Call your State Health Insurance Assistance Program (see your copy of the *Medicare & You* handbook for their telephone number) for personalized help
- Call 1.800.MEDICARE (800.633.4227); TTY users should call 877.486.2048

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at *www.socialsecurity.gov*, or you may call them at 800.772.1213 (800.325.0778).

***Remember*: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium (a penalty).**

Date:	October 15, 2015
Name of Entity/Sender:	LACMTA/PTSC
Contact–Position/Office:	Jodi Stewart, Benefits Administration, 21st Floor
Address:	One Gateway Plaza, Los Angeles, CA 90012-2952
Phone Number:	213.922.7186

VISION PLANS

For Employees enrolled in the Anthem Blue Cross PPO or Anthem Blue Cross HMO medical plans may enroll for vision benefits provided through Vision Service Plan (VSP).

To receive the maximum benefit available under the VSP plan, you should utilize the VSP provider network. VSP Member Provider benefits are shown in Table 3.

Table 3

VISION SERVICE PLAN – Benefit Schedule for employees enrolled in Anthem Blue Cross PPO and Anthem Blue Cross HMO Only

Plan Services	In Network(1)	Out of Network(2)
Vision Exam every 12 months	$10 Co-Pay	Limited to $50
Corrective Lenses every 12 months	$20 Co-Pay	Limited to: Single Vision $50 Bi-Focal $75 Tri-Focal $100 Lenticular $125
Eyeglass Frame every 24 months	$20 Co-pay/ $120 Retail allowance	Limited to $70
Contact Lenses	$120 Allowance in lieu of other Plan Benefits	$105 Allowance in lieu of other Plan Benefits
Medically Necessary Contact Lenses(3)	$20 Co-pay	Limited to $210 Allowance
Computer Glasses	See Table 4	Not Covered

(1) Refer to the VSP brochure for detailed information on how to utilize VSP and its network.

(2) Services obtained from out-of-network providers are subject to the same co-payments and limitations as services obtained through VSP doctors.

(3) Medically necessary contact lenses must be prescribed for certain conditions that prevent you from wearing eyeglasses and must be pre-approved by VSP.

VISION PLANS

Table 4

VISION SERVICE PLAN – CVC (Computer Vision Care) Benefit Schedule. The CVC benefit is designed to meet the significant needs of employees who need "computer glasses."

> Services for this benefit must be obtained from a VSP participating doctor

> Available for employees only; dependents and out-of-network services are not eligible

> The CVC Eye Exam is provided at the same time as your regular eye exam

> Subject to a $20 co-payment and available at the same frequency as the standard program (exam and lenses every 12 months, frame every 24 months). Frame allowance $120, basic lenses covered for VSP–CVC plan.

> Includes any materials and professional services connected with ordering, fitting and adjusting CVC lenses

> Covers a wide selection of frames; if selected frame exceeds the limit, you will pay the difference

> Contact Lenses are not covered under the CVC program

> Provides up to $200 allowance for therapy for certain diagnosed muscular conditions associated with CVC use (requires pre-approval from VSP)

Table 5

Kaiser Permanente – Vision Benefit Schedule
For employees enrolled in the Kaiser Medical Plan.

Plan Services	Benefits Paid
Eye Exams for refraction/contact lenses	No Charge
Eyewear purchased at Plan Medical Offices or plan optical sales offices every 24 months	One time $300 allowance every 24 months
Contact lenses	Fitting and Training fees may apply for change in fit or type or new contact lenses. (This fee may be applied towards the $300 allowance every 24 months.)

DENTAL PLANS

You may select from four different options for dental coverage including:

1. Delta Dental Plan
2. DeltaCare (DHMO)
3. Dental Health Services (DHMO)
4. Waiver of Dental Coverage

Delta Dental Plan

This option allows you to see the dentist of your choice. This plan pays a percentage of the cost of the services you receive based on usual, customary and reasonable charges. You pay a $50 annual deductible and any required copayments. Preventative services are not subject to deductible.

If you receive services from a Delta Preferred Option (DPO) dentist, your out-of-pocket costs will usually be lower.

The Delta Dental Plan does not provide orthodontia benefits.

DeltaCare and Dental Health Services

Both of these Dental HMOs (DHMO) have similar plan provisions. Offering a choice of two separate prepaid plans gives employees greater choice in selecting a dentist from the plans' panels of dental providers. There are no deductibles, and no charges for preventive services. However, co-payments are required for major work and orthodontia.

DENTAL PLANS

This table compares your dental options.

Table 6

Dental Plan Comparison Chart

Plan Provision	Delta Dental	DHS	DeltaCare
Deductible	$50 per person/$150 per family(3)	None	None
Annual Maximum	$1500 per person(4)	None	None
Cleaning(2)	100% UCR(1) (2 in 12 months)	No charge	No charge
Exam(2)	100% UCR(1) (2 in 12 months)	No charge	No charge
Bitewing X-Rays(2)	100% UCR(1) (2 in 12 months for children to age 18 or 1 in 12 months for adults ages 18 and over)	No charge	No charge
Panoramic X-Rays	Once in 5 years	No charge	No charge
Extractions	80% UCR(1)	No charge	No charge
Emergency Treatment	Covered as regular treatment	No charge	No charge
Fillings	80% UCR(1)	No charge	No charge
Dentures, Crowns, Cast Restorations	50% UCR(1)	Covered	Covered
Orthodontia	Not covered	Covered	Covered

(1) Usual, customary and reasonable charges for service provided.
(2) Deductible does not apply.
(3) Paid by employee.
(4) $2,000 if DPO dentists are used.

Please refer to the individual dental plan brochures Schedule of Benefits for complete listings of covered services, charges, and co-payments.

EMPLOYEE LIFE INSURANCE

Our employee life insurance benefit will be provided through ReliaStar Life Insurance (a Voya Financial Company). Life insurance represents an important part of a complete benefit protection package. The core life insurance plan (1x annual salary) is provided to all eligible full-time employees, with a minimum benefit amount of $30,000, at no cost to you. In addition, under the Flexible Benefit Plan, you may purchase higher levels of insurance coverage with underwriting approval by ReliaStar Life Insurance.

During the Open Enrollment period, you will be allowed to keep your current level of coverage, reduce your coverage, or apply for an increase in coverage. To apply for an increase in coverage you must submit a completed and signed Evidence of Insurability Form. The requested increase will become effective only upon the written approval of the insurance company.

All core life insurance (1x annual salary) in excess of $50,000 is subject to imputed income tax pursuant to Internal Revenue Code Section 79.

Coverage Options

Table 7

Full-time Employee Life Insurance

Basic	1x salary ($30,000 minimum)

Supplemental Employee Life Insurance

Buy up	1x salary
Buy up	2x salary
Buy up	3x salary
Buy up	4x salary

Maximum for basic life insurance is $400,000 and maximum supplemental is $750,000; total not to exceed $1 million.

Price Tags

If you decide to "buy up," you contribute dollars toward the cost of your coverage. The actual price tags for this benefit are shown on your personalized enrollment form. The premiums for life insurance are taken on an after-tax basis.

Adjustments to the amount of your life insurance will occur on January 1 of each year, based upon your salary in effect as of the previous November 1st, and will remain frozen until the next Open Enrollment Period.

Adjustments to your premium payments will be based on your attained age as of January 1 of each year. Attained age is defined as your actual age in whole years. For example, if you were 28 years and 11 months on January 1, your attained age is 28.

EMPLOYEE LIFE INSURANCE

Employee life insurance premiums are based on your age, within the age grouping shown below. You can determine how much your bi-weekly premium payments will be based on the following:

Table 8

Your Age (as of January 1, 2016)	Bi-Weekly Rate per $1000 insurance
Under age 30	$.030
30-39	.045
40-44	.050
45-49	.075
50-54	.115
55-59	.215
60-64	.330
65-69	.635
70-74	1.030
75 and older	1.030

Example 1

You are age 28 on January 1, 2016, with an annual salary of $42,300. You have $43,000 (1x) life insurance at no cost. You wish to purchase an additional 2x life insurance, or $86,000. (Total life insurance = $129,000, or 3x), 86 x .030 = $2.58, That is, you pay $2.58 per bi-weekly pay period for this insurance.

Example 2

You are age 45 on January 1, 2016, with an annual salary of $52,900. You have $53,000 (1x) life insurance at no cost. You wish to purchase an additional 3x life insurance, or $159,000 (Total life insurance = $212,000, or 4x), 159 x .075 = $11.93. That is, you pay $11.93 per biweekly pay period for this insurance.

Note: If your spouse or domestic partner is also employed by MTA/PTSC as a Non Represented or AFSCME employee, or as a Security Guard, and is eligible to participate in the life insurance plan as an employee, you may not be enrolled as a dependent on each others benefits.

DESIGNATION OF BENEFICIARY

You may change your beneficiary designation at anytime during the year.

If you wish to make a change in beneficiary designation, you must complete a new "Beneficiary Designation" form and forward to Benefits Administration.

When completing the Beneficiary Designation form, consider your choices very carefully. You may choose to:

> Name a primary beneficiary(ies) to receive survivor's benefits from all plans

> Determine how the benefits are divided among your beneficiaries if you name more than one beneficiary, (*e.g.* 75% to your spouse and 25% to your parents)

> Name contingent beneficiary(ies) in case no primary beneficiary survives you. For example, you may decide to name your spouse as primary beneficiary and your children as contingent beneficiaries, in case your spouse does not survive you

Please note: Under the Community Property Laws of California, your spouse may be automatically entitled to 50% of monies due upon your death. If you name your spouse for less than 50%, or name someone other than your spouse as primary beneficiary, we require your spouse's consent to avoid complications which could delay the distribution of your life insurance benefit and other monies due your beneficiaries.

It is also strongly recommended that you NOT name a minor child as a beneficiary, as payment of the claim could be delayed until the minor becomes 18 years of age. If you choose to name a minor, you may want to consider adding special instructions naming an individual who is the legal trustee or guardian.

NON-TOBACCO USERS LIFE INSURANCE

Active full-time employees only are eligible for an additional $5,000 of life insurance coverage at no cost, if:

> You do not smoke, chew or otherwise use any form of tobacco

> You have not used tobacco products for at least the last year

> You complete and return to Benefits Administration the "Non-Tobacco Users Certification Form" or certify such on the Online Enrollment System

This insurance is in addition to any employer-paid life insurance you may have.

You must re-certify eligibility each year during Open Enrollment.

LONG TERM DISABILITY (LTD)

Full time EXPO employees are provided a Long-Term Disability (LTD) plan with income replacement of 60% of monthly earnings to a maximum monthly benefit of $6,000 after a 180-day waiting period at no cost to you. Benefits are payable to age 65, or longer, if you become disabled after age 62.

In addition, under the Flexible Benefit Plan:

> You can "buy up," that is, purchase more LTD benefit coverage, or

> You can "buy down," that is, elect less LTD benefit coverage and receive additional cash in your paycheck. This payment is recorded as taxable cash.

During each Open Enrollment, you are permitted to keep your current level of coverage, reduce your coverage, or apply for an increased level of coverage. To apply for an increase in coverage complete and submit an Evidence of Insurability form. All approvals/denials of increased coverage are the responsibility of The Standard Insurance Company. However, preexisting limitations will apply to any "step up" in coverage.

You should note that any LTD benefits paid by the insurance carrier, The Standard Insurance Company, will be OFFSET by any payments made to you by EXPO from your sick pay banks, State Disability, Workers' Compensation, Social Security, or retirement plans.

Table 10

Your options are:

Plan Options	Plan Benefit
180-Day/50% Plan:	The LTD benefit will be 50% of earnings to a maximum monthly salary of $10,000, which will result in a maximum monthly benefit of $5,000. The benefit waiting period is 180 days of disability.
180-Day/60% Plan (Basic Plan):	The LTD benefit will be 60% of earnings to a maximum monthly salary of $10,000, which will result in a maximum monthly benefit of $6,000. The benefit waiting period is 180 days of disability.
180-Day/70% Plan:	The LTD benefit will be 70% of earnings to a maximum monthly salary of $10,000, which will result in a maximum monthly benefit of $7,000. The benefit waiting period is 180 days of disability.
90-Day/50% Plan:	The LTD benefit will be 50% of earnings to a maximum monthly salary of $10,000, which will result in a maximum monthly benefit of $5,000. The benefit waiting period is 90 days of disability.
90-Day/60% Plan:	The LTD benefit will be 60% of earnings to a maximum monthly salary of $10,000, which will result in a maximum monthly benefit of $6,000. The benefit waiting period is 90 days of disability.
90-Day/70% Plan:	The LTD benefit will be 70% of earnings to a maximum monthly salary of $10,000, which will result in a maximum monthly benefit of $7,000. The benefit waiting period is 90 days of disability.

LONG TERM DISABILITY (LTD)

Price Tags

The actual price tags for this benefit are shown on your personalized Enrollment Form. For new employees, the price tags for LTD Coverage are based on your salary in effect as of your hire date. For each Open Enrollment period, the price tags are based on your salary in effect on November 1st of each year.

During a plan year, price tags will not change even if ***your benefit amount changes to reflect a salary*** adjustment (increase or decrease).

Long Term Disability Insurance Plan price tags are on a pre-tax basis, providing valuable tax savings. Credits are recorded as taxable cash in your paycheck. Any LTD payments you receive will be taxable.

Many employees may be OVER insured or UNDER insured for LTD benefits. In addition to considering your income needs, you should look carefully at the waiting period you have selected (90 days vs 180 days). You should note that any LTD benefits paid by the insurance carrier will be OFFSET by any payments made to you by EXPO from your TOWP bank. Therefore, you should add up your available TOWP hours and use the following table as a guideline to determine which waiting period (180 days or 90 days) is better for you.

If your total available TOWP hours match or exceed the amount in the chart, (or comes close to this amount), you should receive full pay for the 180-day waiting period. Your available hours are integrated with SDI or Workers' Compensation benefits. If this is true, you may wish to select the 180-day waiting period.

If your total of available paid hours is much less than the amount on the chart, this indicates you may wish to consider enrolling for the 90-day waiting period.

Table 11

Hourly Rate of Pay	Assumed Weekly SDI Rate	Available hours Required for Full Pay for 180 Days/ Integrated with SDI
$14	$309	466
$16	$352	468
$18	$397	468
$20	$440	468
$25	$550	468
$30	$660	468
$35	$770	468
$40	$880	468

FLEXIBLE SPENDING ACCOUNTS

What is a Flexible Spending Account (FSA)?

Flexible Spending Accounts allow employees to set aside money, before taxes, to use on eligible health care and dependent care expenses. You elect how much you want to contribute, and your employer deducts the amount from your paychecks. Since you use pretax dollars you lower your taxable income, and you use pre-tax money to pay for eligible expenses.

There are two kinds of FSAs

The Health Care FSA allows you to contribute up to $2,550 annually to pay for eligible health care services and items not covered by insurance for you and your dependents.

The following are just a few of the many services and items eligible under this account:

> Prescriptions

> Over-the-counter items and medicines (a doctors' prescription is required for over-the counter (OTC) drugs and medicines. Over-the-counter items, such as bandages, do not require a prescription)

> Co-payments

> Dental care, orthodontia

> Vision care, eye surgery

> Therapies

The Dependent Care FSA allows you to contribute up to $5,000 annually to pay for eligible child care expenses, and under certain circumstances, may be used to help pay for the care of elderly dependents or a disabled spouse or dependent. The following are examples of eligible expenses:

> Before- and after-school programs

> Day care and nursery schools

> Preschool

> Dependent adult day care

> Transportation provided by care giver

A complete list of eligible expenses are provided on *www.enrollwithtag.com*.

Administration

We're excited to announce our partnership with The Advantage Group (TAG) as our health care and dependent care Flexible Spending Account (FSA) administrator. TAG offers:

> A debit card you can use to pay for qualified expenses such as a doctor's office visit or the cost to fill your prescriptions, and dependent care providers. The funds are automatically deducted from your account so you don't have to file a paper claim*.

> Access to your spending account 24/7 at *www.myflexonline.com* so you can monitor your spending.

> Mobile App to monitor your accounts and/or submit claims in the event you do not use the debit card.

> Remember, you lose any funds left in your account at the end of the two and one-half month FSA grace period (March 15 of the following year).

* With TAG you still have an option to either use the debit card or file a claim. Using the card will eliminate the need to file paper claims.

FLEXIBLE SPENDING ACCOUNTS

Are you currently participating?

If you're currently participating in an FSA for 2015, you'll need to follow these steps:

> Submit all claims for 2015 expenses to the Benefits Department 99-21-7 according to the posted reimbursement schedule (see page 33)

> Questions relating to 2015 claims must be directed to Jodi Stewart in the Benefits Administration office at 213.922.7186

> You have until March 15, 2016, to use your 2015 funds and until April 15, 2016, to submit claims to the Benefits Department for reimbursement

> You **cannot** use the new debit card for services, rendered through the grace period (March 15, 2016), that are applied to your 2015 account balance

Please remember the "Use-It-or-Lose-It" rule – you must use all the money you set aside in your 2015 flex spending accounts, or you will lose it.

Are you enrolling for 2016?

If you are enrolling in the FSAs for 2016, you will need to follow these steps:

> Enroll via the Benefits Online Enrollment System during the Annual Open Enrollment period November 9–22, 2015 (TCU members must complete an enrollment form and submit directly to Jodi Stewart, Benefits Administration, 99-21-7, by November 30, 2015)

> Your new FSA debit cards will be sent to your home address and should arrive prior to January 1.

Note: your debit card(s) will arrive in an ordinary plain white envelope from a Charleston, Texas address

> If you use this card, it will automatically deduct from your FSA 2016 funds *(not 2015 grace period funds)*

> You can contact TAG at 877.506.1660 on January 2nd for any questions regarding your 2016 funds or debit card

  > FSA VISA Debit Card

  > Reimbursement Request – file a claim online, by fax or mail for reimbursement

  > Mobile App – view your account information and submit claims

Frequently asked questions about FSA accounts

Why should I enroll in an FSA?
With an FSA, your out-of-pocket health and/or dependent care expenses are paid with tax-free dollars. You can save an average of 30 percent on all of your eligible expenses! To calculate your potential savings, go to *www.enrollwithtag.com*.

Am I eligible to participate in a Dependent Care FSA?

You are eligible for this benefit if you have a dependent (whose expenses are eligible) who requires care to enable you to work. In addition, you must meet one of the following eligibility criteria:

> You are unmarried

> Your spouse works, is a full-time student, is actively seeking work, or is disabled (incapable of self-care)

> You are divorced or legally separated and have custody of your child even though your former spouse may claim the child for income tax purposes

Your Dependent Care FSA can be used to pay for child care services provided during the period the child resides with you. For a complete list of expenses that are eligible for reimbursement through a Dependent Care FSA, please go to *www.enrollwithtag.com*.

FLEXIBLE SPENDING ACCOUNTS

What expenses are eligible for reimbursement?

Health Care FSA
Health care plan deductibles, co-payments, prescription glasses, orthodontia and certain over-the-counter medicines and supplies are eligible if incurred while you are a participant in the Plan. For a comprehensive list, please go to *www.enrollwithtag.com*.

Important Notes:

> Expenses are treated as having been incurred at the time the medical care was provided, not when you are formally billed, charged, or pay for the medical expenses

> You cannot receive reimbursement for future or projected expenses

> All submitted expenses are reviewed for eligibility according to Internal Revenue Code Section 125 guidelines

Dependent Care FSA
Eligible dependent care expenses may include services inside or outside your home by anyone other than your spouse or a person you list as a dependent for income tax purposes or one of your children under the age of 19. Services may be provided at a child or adult care center, nursery, preschool, after-school or summer day camp.

Important Notes:

> Dependent care for a child over 13, overnight camp, baby-sitting that is not work related, schooling in kindergarten and higher grades, and long-term care services are not eligible expenses

> All submitted expenses are reviewed for eligibility according to Internal Revenue Code Sections 125 and 129 guidelines

How do I get started?

> Review and estimate your expenses to help determine the amount you should elect. Reviewing your checkbook, credit card statements and insurance statements from the past year and calculating your health and/or dependent care costs is a good way to start. You can also use TAG's online calculator by going to the following website: *www.enrollwithtag.com*.

> Sign up for the FSA account(s) along with your other benefits during the Annual Benefits Open Enrollment period or during the new hire benefit orientation session.

What happens if I do not use all of the money in my account by the end of the plan year?

Federal law governing flexible spending accounts specifies that any money remaining in your account at the end of the plan year will be forfeited. This is more commonly known as the "Use-It-or-Lose-It" rule. However, your plan has a "grace period," until March 15th of the following year, that allows additional time to use money from your FSA.

Can I change my election amount during the plan year?

Your decision to participate in an FSA is binding for the entire plan year, and you may change your election only as permitted by IRS regulations.

Generally, to make an FSA election change, you must experience a significant life event such as marriage, divorce, birth or death in your immediate family. For a Dependent Care FSA only, you may also make election changes that simply correspond with changes in your cost of the care. You may not reduce your election amount to an amount less than either your then-current FSA balance or your year-to-date FSA contributions. A change to your FSA election constitutes the end of your prior election and the beginning of a new election period. Expenses incurred during the period prior to the election change are subject to the initial election amount; expenses incurred during the period after the election change are subject to the new election amount.

FLEXIBLE SPENDING ACCOUNTS

What happens to my FSA if I terminate employment?

Participation in the FSA ends if you terminate employment. This means only expenses incurred prior to the date your participation in the plan ends are eligible for reimbursement. Claims for expenses incurred prior to the plan termination date must be submitted within the "runout" period.

What is the "runout" period?

The runout is a specified period of time after the end of the plan year, or following your termination in the plan, in which you may continue to submit claims incurred during your period of coverage. This is not a period when you are able to continue to incur new expenses, but rather it allows you time to gather and submit expenses before forfeitures are applied.

For plan assistance please contact:
TAG Participant Support
Phone: 877.506.1660
Email: *support@enrollwithtag.com*

Frequently Asked Questions about the Debit Card

Now, you've got a brand new way to pay for qualified plan expenses and you won't have to pay with your personal funds and then wait for reimbursement from the plan.

Some cards are worth holding on to and your **take care Flex Benefits Visa® Debit Card** is definitely one of them! Your card is good for three years, so even if you've exhausted your current plan year account balance, your current take care card is valid for the next plan year when you enroll in the plan.

Why do participants appreciate the "take care Flex Benefits Visa® Debit Card"?

Participants who use the debit card won't have to pay qualified expenses out of their personal funds and then wait for a reimbursement, and there's less paperwork.

For example, when the card is swiped for a co-pay at the doctor, pharmacy, or at IIAS (Inventory Information Approval System) retailers, no additional paperwork is required.

The **take care Flex Benefits Visa® Debit Card** meets IRS requirements. The card can only be used by the participant (or their dependent(s) or spouse) at IRS-qualified providers to pay qualified expenses from their flex account.

Where is the take care Flex Benefits Visa® Debit Card accepted?

The card can be used only at qualified locations, but not necessarily at all merchants that accept Visa. For example, it works at providers like pharmacies, doctors' offices, vision care centers, hospitals, IIAS retailers, etc.

These IRS-imposed limitations help to insure that the card is used only when paying qualified expenses. When the card is swiped at a qualified location and there is a sufficient balance available in the participant's account, the card swipe is approved.

An informative insert with "Important Tips for Using the Card" will be mailed along with the participant's **take care Flex Benefits Visa® Debit Card**.

How do we verify that the take care Flex Benefits Visa® Debit Card is used ONLY for qualified expenses?

The IRS requires that TAG, as your plan service provider, verify all card swipes. Most swipes are automatically verified.

Card swipes for co-pays or multiple co-pays at qualified locations such as the doctor's office.

Card swipes at IIAS retailers. (Inventory Information Approval System). This is because IIAS retailers allow only qualified plan expenses to be paid with the **take care Flex Benefits Visa® Debit Card**. Therefore, when the cardholder's shopping basket contains both qualified healthcare items and other merchandise, the transactions will be automatically split and the cardholder will be asked for another form of payment to complete the purchase.

When a card swipe is automatically verified, we will not request a receipt be provided to us *(The IRS requires the participant to retain all itemized merchant receipts as well as the take care card receipts)*.

What happens if the take care Flex Benefits Visa® Debit Card is used to pay for services that are NOT IRS qualified?

If any portion of a card swipe is considered questionable, the participant will be notified and asked to turn in receipts. If it is determined that a portion of a card transaction is not qualified, or the participant does not respond, they will be asked to repay the amount. The amount they owe may be repaid by logging into the website. It may also be repaid by deducting it from the participant's future claim.

If the participant does not respond by the deadline, their card may be suspended until the amount they owe is repaid. At the employer's option, the card may be reinstated.

Can participants file claims when the take care Flex Benefits Visa® Debit Card is not used?

Yes. Participants may also pay expenses from their personal funds and then file a claim for reimbursement. This will be necessary if a merchant does not accept Visa cards.

What if the take care Flex Benefits Visa® Debit Card is lost, stolen or was not received by a participant?

To report a lost or stolen card, or if a participant did not receive their card in the mail at their home address on record, call 877.506.1660, weekdays, 8am to 5pm (PST).

FLEXIBLE SPENDING REIMBURSEMENT CLAIM SCHEDULE FOR 2015 ONLY

2015 Claims: Reimbursement request(s) received by the Benefits Department by 4pm on the following dates will be reimbursed on the first payroll of the following month.

Wednesday, January 27, 2016

Wednesday, February 24, 2016

Wednesday, March 23, 2016

Friday, April 15, 2016

***Deadline for submitting reimbursement claims for 2015 FSA Accounts (expenses incurred between January 1, 2015 and March 15, 2016).

Flexible Spending Claim Forms are located on *MyMetro.net* website; go to Departments, Pension & Benefits, Links, Forms and Flex-Spending Schedules and Benefit Guides, see Flexible Spending Reimbursement Request form.

457 DEFERRED COMPENSATION PLAN

The 2016 individual contribution limits to the 457 Deferred Compensation plan is based on indexing determined by the IRS.

Effective January 1, 2016, your individual contribution limits to the 457 Deferred Compensation Plan:

457 Deferred Compensation Plan

For calendar year 2016, you may contribute up to $18,000 in pretax dollars to your 457 Plan. If age 50 or older, your annual limit is $24,000.

Catch-up rule (457 Plan)

If you have not previously participated in "catch-up," you can contribute $36,000 to the 457 Plan in calendar year 2016.

Rollover

Effective January 1, 2003, combining or "rolling over" your retirement assets became more flexible than ever. You are able to combine previous employer plan assets (401(k), 457, 403b, or IRAs) into your EXPO 457 Plan.

Upon separation of employment, you have the option to combine retirement assets, 401(k), 457, and IRAs. Combining these assets can have an impact on your withdrawal options.

These changes can have significant positive and/or negative impacts on your taxes. The rules are complicated! Therefore, we urge you to check with your ICMA Representative or other expert for guidance prior to making any major decisions.

Loans

The 457 Plans permit loans of up to 50% of your account value (maximum loan amount is $50,000; minimum loan amount is $1,000). Only one loan outstanding at a time.

Distributions

Under the 457 Plan, any distribution from the plan is taxable only as ordinary income; there is NO premature distribution tax penalty.

Prior to January 1, 2002, once a payment method was established by an employee/retiree for their 457 Plan, it was cast in stone and could not be changed. Effective January 1, 2002, 457 distributions have the same flexibility as 401(k) plans.

Further details are available in the Benefits Office and from the ICMA-RC representatives.

Note

IRS has not yet released contribution limits for 2016.

IMPORTANT CONTACTS

Contacts		Phone No.	Websites
Anthem Blue Cross (PPO)	Customer Service Express Scripts 24/7 NurseLine	800.288.2539 800.700.2541 800.977.0027	*www.anthem.com/ca*
Anthem Blue Cross (HMO)	Customer Service Express Scripts 24/7 NurseLine	800.227.3771 800.700.2541 800.977.0027	*www.anthem.com/ca*
Kaiser Permanente	Member Services	800.464.4000	*www.kaiserpermanente.org*
Vision Service Plan (Anthem Blue Cross PPO/Anthem Blue Cross HMO members)	Customer Service	800.877.7195	*www.vsp.com*
Delta Dental Plan of CA	Customer Service	800.765.6003	*www.deltadentalins.com*
DeltaCare	Customer Service	800.422.4234	*www.deltadentalins.com*
Dental Health Services	Customer Service	800.637.6453	*www.dentalhealthservices.com*
Employee Assistance Program	Guidance Resources	877.335.5327	*www.guidanceresources.com*
ICMA Retirement Corp. 401(k), 457 Plans	Investor Services Onsite Representatives: Orlando Delgado Jessica Sequeira Certified Financial Planner: Chris Vega	800.669.7400 866.266.7312 866.339.8795 866.620.6063	*www.icmarc.org* *odelgado@icmarc.org* *jsequeira@icmarc.org* *cvega@icmarc.org*
CalPERS	Membership Information	888.CalPERS	*www.calpers.ca.gov*
Social Security Admin.	General Questions	800.772.1213	*www.ssa.gov*
Flexible Spending Accounts	Jodi Stewart	213.922.7186	*www.irs.gov/publications/p502/index.html* and *www.irs.gov/publications/p503/index.html*
Open Enrollment Website	Jodi Stewart	213.922.7186	*http://benefits.metro.net*

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One Gateway Plaza
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Expo