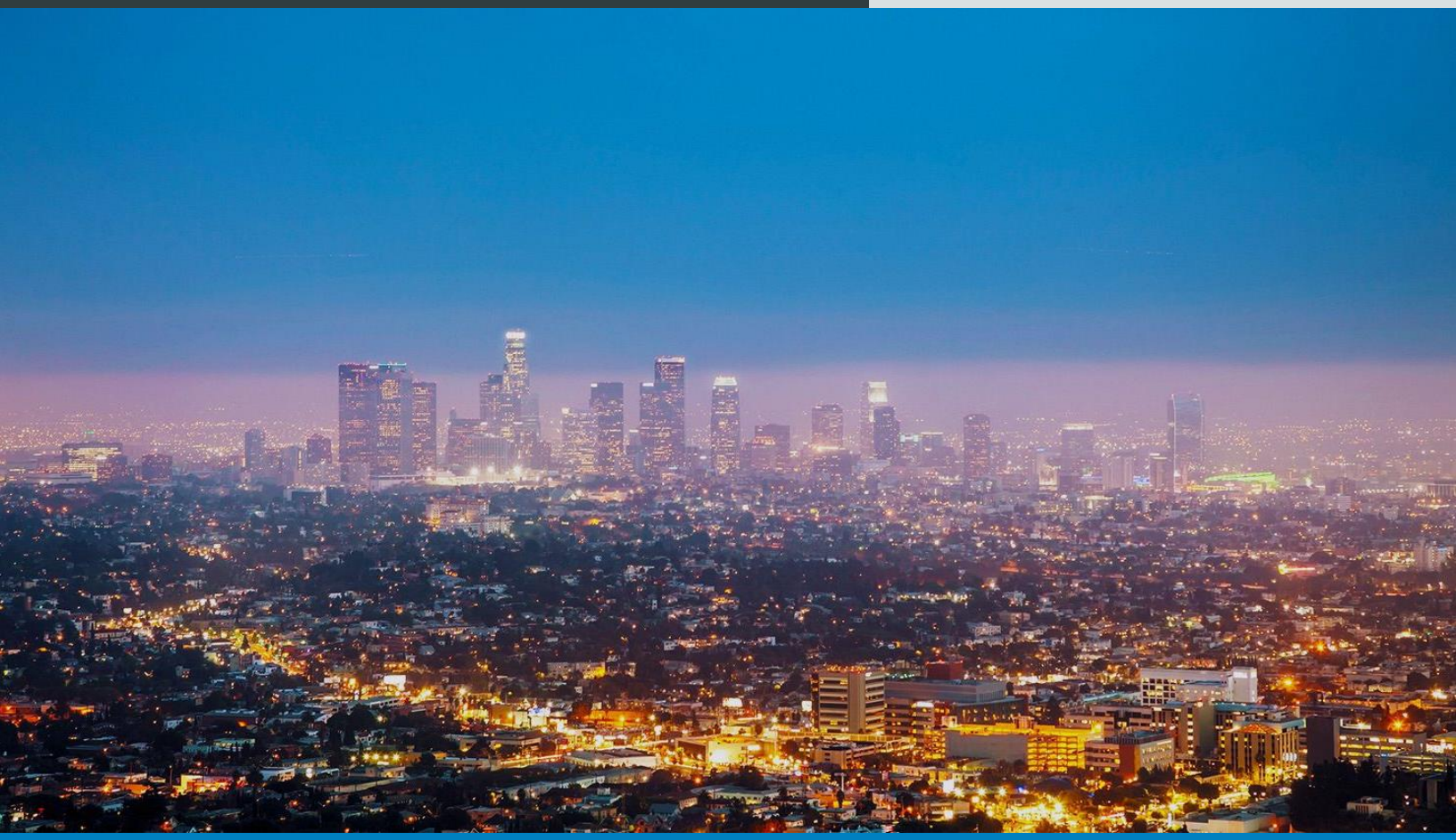
2025

Employee Benefits Booklet
Board of Directors

Metro



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MEDICARE PART D NOTICE
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

The Public Transportation Services Corporation was formed on August 10, 1997. PTSC is a component unit of the Los Angeles County Metropolitan Transportation Authority (Metro). Most former Metro Non-Represented and AFSCME employees are now PTSC employees, a small number of Non-Represented and AFSCME employees remain as Metro employees.

GETTING STARTED

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, The Los Angeles County Metropolitan Transportation Authority and the Public Transportation Services Corporation supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This Benefits Guide provides a summary of benefits you have as a member of the Metro Board of Directors. The plans described in this guide are subject to specific terms and provisions of the plans, as established in the plan documents, are the sole source for interpretation and administration of the plans and programs.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

Your 2025 Benefits will be effective from:
January 1, 2025, through December 31, 2025.

WHO'S ELIGIBLE FOR BENEFITS?

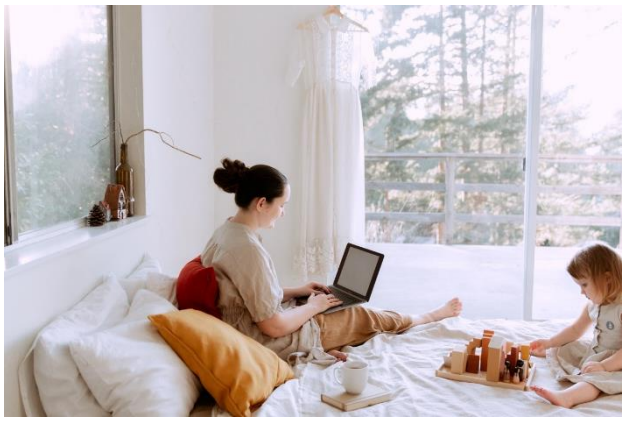
Employees

Members of the Board of Directors.

Eligible dependents

- Your spouse to whom you are legally married
- Same sex spouses will also qualify for health plan coverage on a pretax 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.
- 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, 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 have experienced 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 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 your benefit plans, please request the Domestic Partnership Enrollment Guide from the Benefits Administration Department.

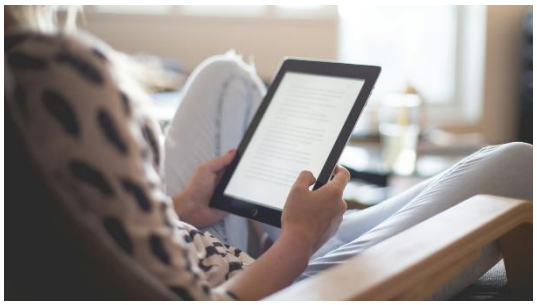
Who is not eligible

Members who are not eligible for coverage include (but are not limited to): Parents, grandparents, and siblings.

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. For Board Members, coverage becomes effective on the first of the month following appointment. If your appointment is on the first day of the month, coverage is immediate. You must enroll within 30 days of becoming eligible.
If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

OPEN ENROLLMENT



Open Enrollment is a once-a-year opportunity to review your benefit choices, change plans, add or drop dependents. After Open Enrollment ends, you cannot change your benefit elections until the next Open Enrollment in 2025, unless you experience an eligible life event,

Open Enrollment begins November 4, 2024, through November 17, 2024.

Any changes made during OE will be effective on January 1, 2025.

Do I need to enroll?

If you do not have any changes to make to your 2025 benefits, then **no action is required.**

If you need to make any changes to your benefits or are enrolling for the first time, you must complete and send all forms to the Pension & Benefits Administration no later than November 29, 2024.

If you require assistance, please contact Jan Olsen, Deputy Executive Officer, Pension & Benefits Administration at 213.922.7151.

What's new or changing

Our current benefit programs will continue into 2025 with no changes. While your benefits aren't changing, you may have had some major life changes, and it is important to review your plans and ensure they continue to meet your needs and the needs of your family. You may also want to take this opportunity to review your beneficiary designation to ensure it is up to date.

Review this Benefits Guide to understand your coverage options. Include your spouse or partner in the review if they have input into your family's benefits decisions.

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 30 days of the date the event occurs.
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare and/or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 30 days after the event.

Dependent Verification

Making changes to dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You will be required to provide proof of one or more of the following within 30 days of their eligibility:

- Marriage Certification or License
- Domestic Partners Affidavit
- Birth Certificate
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)

If you do not supply the proper documentation to make changes to dependents within the 30-day period, you will not be able to add the dependent(s) until the next open enrollment period.

THE EASY WAY TO GET BENEFITS INFO WITH MYBENEFITS.LIFE

MyBenefits.Life® gives you all your benefits information in one place

You can bank online, book a vacation online, and read the news online. Why should your benefits information be any different? MyBenefits.Life® is both a website and a mobile app that gives you access to the benefits information you need, when you need it.

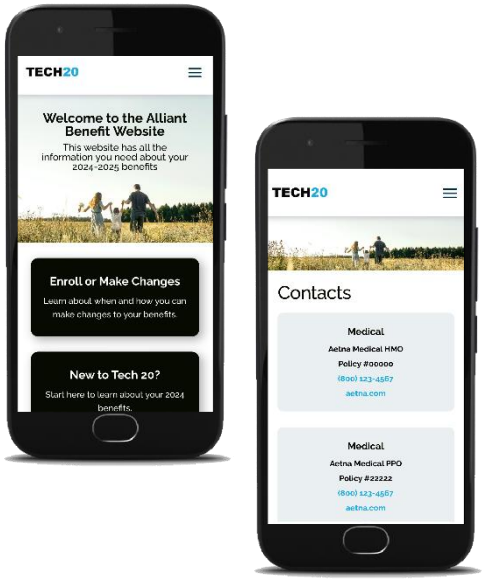
Here's what you'll find on MyBenefits.Life®

Benefits	See benefit details and costs for all plans you're eligible for.
Documents	Read important benefit plan notices ("the fine print").
Contacts	Find HR, benefits, and carrier contacts.

GET MYBENEFITS.LIFE®

On the web: Coming Soon

Mobile URL: Coming Soon



MEDICAL

OUR PLANS

Anthem Blue Cross PPO Plan

Anthem Blue Cross HMO Plan

Kaiser Permanente Plan

All About Medical Plans

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.

Medical PPO Plans

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 online at *anthem.com/ca.*

	Anthem Blue Cross PPO Group Plan #1156SA	
	In-Network	Out-of-Network
Calendar Year Deductible Individual Family	 $150 $450	 $150 $450
Calendar Year Out-of-Pocket Maximum Individual Family	 $1,000 $2,000	 $2,000 $5,000
Office Visit Primary Care Specialist	 $15 copay $15 copay	 30% coinsurance after deductible is met 30% coinsurance after deductible is met
Virtual Visit*	$15 copay (deductible does not apply)	30% coinsurance after deductible is met
Preventive Services	No Charge (deductible does not apply)	30% coinsurance after deductible is met
Lab and X-ray	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Urgent Care	$15 copay (deductible does not apply)	30% coinsurance after deductible is met
Emergency Room $25 emergency room services deductible (waived if admitted directly from ER).	10% coinsurance after deductible is met	10% coinsurance after deductible is met
Inpatient Hospitalization**	No Charge	30% coinsurance after deductible is met
Outpatient Surgery	10% coinsurance after deductible is met	30% coinsurance after deductible is met
PRESCRIPTION DRUGS		
Calendar Year Deductible	N/A	N/A
Out-of-Pocket Maximum	N/A	N/A
Retail Tier 1 (generic) Tier 2 (preferred brand) Tier 3 (non-preferred/specialty drugs)	 $10 copay $15 copay $15 copay	 $10 copay + 50% coinsurance $15 copay + 50% coinsurance $15 copay + 50% coinsurance
Mail Order Tier 1 (generic) Tier 2 (preferred brand) Tier 3 (non-preferred/specialty drugs)	 $10 copay $15 copay $15 copay	 Not Covered Not Covered Not Covered

*Virtual/Telemedicine visits are only available if their provider also provides services in person. Livehealth Online is not covered.
**Member is responsible for a $600 deductible for non-network providers. Member is responsible for an additional $250 deductible if prior authorization is not obtained from Anthem for non-emergency Inpatient admissions to non-network providers.

Medical HMO Plans

The Anthem Blue Cross HMO is a Health Maintenance Organization (HMO) which provides convenient access to medical care when you need it. You choose your personal Primary Care Physician associated with a Medical Group or 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 is an HMO, in which all services are provided through one of Kaiser's facilities. When you join Kaiser, you may use any of the Kaiser medical offices and hospitals in the Southern California region. You are never limited to just one doctor or office.

	Anthem Blue Cross HMO Plan Group Plan #59V40A	Kaiser Traditional HMO Group Plan #101912
	In-Network	In-Network
Calendar Year Deductible Individual Family	 $0 $0	 $0 $0
Calendar Year Out-of-Pocket Maximum Individual Two-Party Family	 $1,000 $2,000 $3,000	 $1,500 $1,500 $3,000
Office Visit Primary Care Specialist	 $5 copay $5 copay	 $5 copay $5 copay
Preventive Services	No Charge	No Charge
Lab and X-ray	No Charge	No Charge
Urgent Care	$5 copay	$5 copay
Emergency Room	$50 copay (copay waived if admitted)	$50 copay
Inpatient Hospitalization	No Charge	No Charge
Outpatient Surgery	No Charge	$5 per procedure
PRESCRIPTION DRUGS		
Calendar Year Deductible	N/A	None
Out-of-Pocket Maximum	N/A	Combined with medical
Retail Tier 1 (generic) Tier 2 (preferred brand) Tier 3 (non-preferred/specialty drugs)	 $5 (up to 30-day supply) $10 (up to 30-day supply) $10 (up to 30-day supply)	 $5 (up to 100-day supply) $10 (up to 100-day supply) $10 (up to 30-day supply)
Mail Order Tier 1 (generic) Tier 2 (preferred brand) Tier 3 (non-preferred/specialty drugs)	 $5 (up to 90-day supply) $10 (up to 90-day supply) $10 (up to 90-day supply)	 $5 (up to 100-day supply) $10 (up to 100-day supply) $10 (up to 30-day supply)

DENTAL

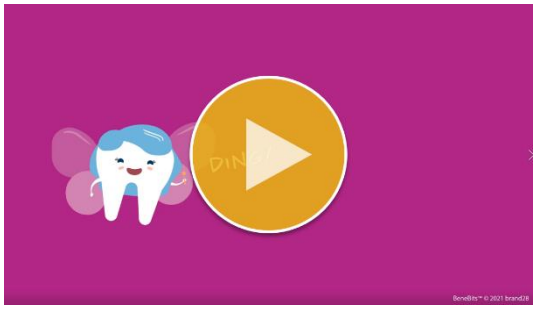
OUR PLANS

Delta Dental Plan (DPPO)

DeltaCare (DHMO)

Dental Health Services (DHMO)

Click to play video



DELTA DENTAL®

Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance can cover four types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

Dental Health Services

Dental DPPO Plans

A dental DPPO plan 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. If you receive services from one of Delta's Preferred Option (DPO) dentists, your out-of-pocket costs will usually be lower. Please refer to the individual dental plan brochure's schedule of benefits for complete listings of covered services, charges and co-payments.

	Delta Dental PPO Plan Group Plan #0361-5555	
	In-Network	**Out-of-Network (Includes Delta Dental Premier Dentists)**
Annual Deductible (waived for preventive) Individual Family	 $0 $0	 $50 $150
Annual Plan Maximum	$2,500	$1,500
Diagnostic & Preventive Oral Exams X-Rays Teeth Cleaning Fluoride Treatment	No Charge	No Charge
Basic Services Fillings Root Canals Periodontics	10% coinsurance	20% coinsurance
Major Services Single Crowns Inlays, Onlays Dental Implants Bridges & Dentures	40% coinsurance	50% coinsurance
Orthodontia Adult Child Lifetime Max	 50% coinsurance 50% coinsurance $2,000	 50% coinsurance 50% coinsurance $2,000

More details about this plan:

Get Lasik & hearing aid discounts!	Delta Dental members have access to QualSight and Amplifon Hearing Health Care, you can save as much as 50% on LASIK procedures and more than 60% on hearing aids. To take advantage of these discounts, call QualSight at 855.248.2020 and Amplifon at 888.779.1429.
Where can I get more details?	Sign up for an online account, find a dentist near you, or print your ID cards by visiting deltadentalins.com.
Note About Delta Dental Premier Dentists	Delta Dental Premier is a network of providers that provides members protection from balance billing out of network. Premier dentists however will still offer moderate savings for visits outside the regular PPO network. For more information visit deltadentalins.com or call member services at 888.335.8227.

Dental DHMO Plans

The DeltaCare USA and Dental Health Services plan are prepaid plan options that have similar plan provisions. There are no deductibles, and no charge for preventive services. However, copayments are required for certain services and orthodontia. Please refer to the individual dental plan brochure's schedule of benefits for complete listings of covered services, charges and co-payments.

	DeltaCare USA Dental DHMO Plan Group Plan #02112-0001	Dental Health Services DHMO plan Group Plan #1862-01
	In-Network Only	In-Network
Annual Deductible (waived for preventive) Individual Family	N/A	N/A
Annual Plan Maximum	N/A	N/A
Diagnostic & Preventive Office Visit Teeth Cleaning X-Rays Sealants-per tooth	 $0 $0 $0 $5	 $0 $0 $0 $0
Periodontics Scaling and Root Planning Gingivectomy Osseus Surgery	 $0 $80 $175	 $0 $25 $325
Endodontics Pulp Cap Root Canal Therapy –anterior Root Canal therapy – molar	 $0 $45 $205	 $0 $0 $0
Prosthodontics Immediate – Upper or Lower Complete – Upper or Lower Partial Denture – Upper or Lower	 $120 $100 $120	 $65 $65 $75
Crown & Bridge Inlay/Onlay Crown	 $0 $70 - $195	 $40 $55 - 135
Oral Surgery Extractions	$25 - $70	$30 - $40
Orthodontia Adults Children (up to age 26)	 $1,900 $1,700	 $1,000 $1,000

VISION

OUR PLANS

VSP Vision Plan (Available to Anthem PPO & HMO members only)

Kaiser Vision Plan (Available to Kaiser members only)

Click to play video

BE HEALTHY & LIVE HAPPIER WITH HELP FROM VSP

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual WellVision eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol and more.

VALUE AND SAVINGS YOU LOVE.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

Like shopping online? Go to eyeconic.com and use your vision benefits to shop over 50 brands of contacts, eyeglasses, and sunglasses.

Vision Plans

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	VSP Vision Plan	
	In-Network	**Out-of-Network**
Exams Frequency	$10 copay Once every 12 months	Up to $50 copay Once every 12 months
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	 $20 $20 $20 Once every 12 months	 Up to $50 Up to $75 Up to $100 Once every 12 months
Frames Benefit Frequency	 $150 allowance Once every 12 months	 Up to $70 allowance Once every 12 months
Contacts (in lieu of glasses) Benefit Frequency	 $120 allowance Once every 12 months	 Up to $105 allowance Once every 12 months

What you need to know about this plan

Features:

As a VSP member, you get personalized care from a VSP network doctor at low out-of-pocket costs.

Extra savings!

The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and even hearing aids.

Where can I get more details?

Visit www.vsp.com or call 800.877.7195

	Kaiser Vision Benefits (Included with the Kaiser HMO Plan)
	In-Network
Exams Frequency	No Charge
Eyewear	$300 allowance Every 24 months
Contacts	Fitting and Training fees may apply (fee may be applies towards the $300 allowance every 24 months)

ENGAGE WITH YOUR BENEFITS!

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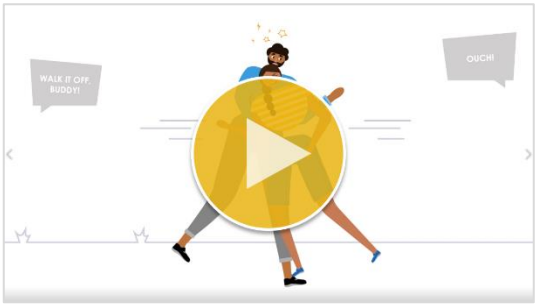
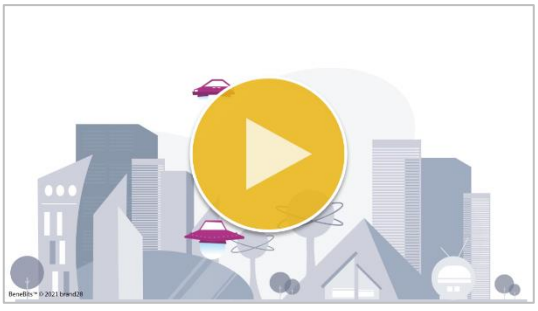


Urgent Care vs ER



Virtual Healthcare

Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Understanding preventive care benefits
- Saving money on prescription drugs

Health Enhancing Programs

In addition to medical coverage, we provide these programs and services to help you access care when and how you need it and address special health concerns:

- **Mystrength (Kaiser)**
- **Calm (Kaiser)**
- **LiveHealth Online Virtual Care (Anthem)**
- **Lark Diabetes Prevention Program (Anthem)**
- **And more!**

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	$0
Online visit 	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	$
Office visit 	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	$$
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	$$$
Emergency room 	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	$$$$$

PREVENTIVE CARE SCREENING BENEFITS

TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit cdc.gov/prevention for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

KAISER RESOURCES

Everyone needs support for total health – mind, body, and spirit. Digital tools can help you navigate life's challenges, make small changes that improve sleep, mood, and more, or simply support an overall sense of well-being.

KAISER PERMANENTE TELEMEDICINE

Kaiser Permanente members have access to remote healthcare. For primary care, specialty care, and mental health services, KP members can connect with their care team from the comfort and safety of their homes.

Kaiser members can assess telehealth by signing in to **kp.org**.

KAISER CALM MEDITATION AND MINDFULNESS APP

Kaiser Permanente Members have **free access** to the highly acclaimed Calm meditation and mindfulness smart phone application.

Adult members can get the Calm app at no cost. Practice mindfulness with Calm can help you build resilience and support your overall emotional health and wellness. Anyone can benefit from Calm, and the app offers something for everyone:

- ✓ A new 10-minute Daly Calm meditation every day
- ✓ Guided meditations covering anxiety, stress, gratitude, and more
- ✓ Sleep stories (soothing bedtime tales for grown ups)
- ✓ Music or focus, relaxation, and sleep
- ✓ Calm Masterclasses taught by world-renowned experts and celebrities

KP members can get access to Calm at kp.org/selfcareapps.

MYSTRENGTH APP

myStrength® is a personalized program that includes interactive activities, in-the-moment coping tools, inspirational resources, and community support. You can track preferences and goals, current emotional states, and ongoing life events to improve your awareness and change behaviors.

This program can help with depression, anxiety, sleep, stress, substance abuse, and even chronic pain. To get started or to learn more, go to kp.org/selfcareapps/scal to access myStrength.

FOR IN-PERSON MENTAL HEALTH AND SUBSTANCE USE SERVICES

If you need to set up or find a participating therapist and psychiatrist, use the SoCal Kaiser Permanente Location finder at https://healthy.kaiserpermanente.org/southern-california/health-wellness/mental-health or call member services at **833.574.2273** (TTY 711).

All support is confidential.
Our providers will never share your information with your employer.

ANTHEM RESOURCES

Did you know that Anthem offers several programs to help you manage your healthcare? Learn more about them here.

Sydney Health Mobile App

Meet Sydney, Anthem's mobile app. With Sydney, you can find everything you need to know about your personalized Anthem benefits all in one place. Sydney makes it easier to get things done, so you can spend more time to focus on your health.

Livehealth Online – Virtual Care

LiveHealth Online is your telemedicine provider and lets you have a video visit with a board-certified doctor using your smartphone, tablet or computer with a webcam. No appointments, no driving and no waiting at an urgent care center. Doctors are available 24/7 to assess your condition and, if it's needed, they can send a prescription to your local pharmacy. You can access Livehealth Online by logging into the **Sydney app**, go to **Care**, and then select **Virtual Care**.

Costs for a visit are the same as your Anthem plan's in-network office visit copay/coinsurance.

Click to play video

Lark – Digital Diabetes Prevention Coaching

Roughly 88 million Americans are living with prediabetes but 84% aren't even aware they have it. Prediabetes often doesn't cause symptoms, but it does increase the risk of developing type 2 diabetes, heart disease, and stroke. That's why Anthem partnered with Lark to offer a diabetes prevention program that can help determine if you're at risk for prediabetes and if needed, take steps to address it. This program can help you with losing weight, eating healthier, increase activity, sleep better, manage stress.

Participation in this program is at no extra cost as part of your health plan. Track progress, check in with a personalized coach, and learn more about prediabetes right in Lark's free mobile app. This program is flexible, convenient, and follows guidelines from the Centers for Disease Control and Prevention (CDC) to help make small changes that can improve health and decrease risk over time.

To get started, log in to the **Sydney app** and you will find the **Lark DPP** screen under **Programs** in **My Health Dashboard**. Take the one-minute survey and start improving your health and well-being today.

24/7 Nurse Line

Health issues can arise at the most inconvenient times and places for you and your loved ones. Whether it's 3 a.m. at home or 10 a.m. while you're in the office. You have access to a nurse you can talk to any time, day or night, 365 days a year. Just call the number on the back of your ID card.

Anthem

ANTHEM RESOURCES CONTINUED

Emotional Well-Being Resources Administered by Learn to Live

Your emotional health is an important part of your overall health. With Emotional Well-being Resources, administered by Learn to Live, you can receive support to help you live your happiest, healthiest life.

Built on the proven principles of Cognitive Behavioral Therapy (CBT), our digital tools are available anywhere, anytime. They can help you identify thoughts and behavior patterns that affect your emotional well-being – and work through them. You'll learn effective ways to manage stress, depression, anxiety, substance use, and sleep issues.

To access this benefit, log in to anthem.com/ca, go to **My Health Dashboard**, choose **Programs**, and select **Emotional Well-Being Resources.**

Special Offers

As an Anthem member, you qualify for discounts on products and services that help promote better health and well-being. These discounts are available through Special Offers to help you save money while taking care of your health. You can get discounts on hearing aids, glasses and contacts, fitness memberships, pet insurance, weight loss programs and more! To find discounts available to you, log in to anthem.com/ca, choose **Care** and select **Discounts**.

Future Moms Program

Future Moms with Digital Maternity Support is here to give you the information, tools and resources you need for a healthy pregnancy, delivery and baby. Once you're pregnant and have seen a doctor, you should get an email, text or interactive voice response inviting you to enroll in Future Moms. Make sure you're registered at anthem.com/ca, so we know how to get in touch with you. You can also download the My Advocate Helps app or go to MyAdvocatehelps.com. It doesn't cost you anything extra to sign up and you'll have support for up to 12 weeks after birth.

Anthem

FINDING CARE WITH ANTHEM

Choose with confidence

You can start using **Find Care** by downloading the Sydney Health app to your mobile device or logging in to **anthem.com/ca**. Select **Find Care** and the Find Care tool will guide you through the steps.

We're ready to help you

The Find Care tool empowers you to take control of your healthcare by helping you connect with high quality care options. If you have questions, you can reach us using the interactive chat feature on the Sydney Health app or through the Message Center on **anthem.com/ca**.

The Find Care tool helps you search for doctors/dentists and compare costs

Choosing a provider, you trust is important — and choosing one in your plan's network can help keep your costs down. Finding high-quality, cost-effective care is simple when you use the Find Care tool on the Sydney Health mobile app or **anthem.com/ca**.

How to use Find Care

The Find Care tool brings together details about doctors, hospitals, labs, and healthcare facilities in your plan's network. You can easily compare information such as costs, locations, and office hours. You can:

1. Search for providers and facilities in your plan's network by name, specialty, or procedure.
2. Customize the list of providers you see in your search based on factors that are most important to you, such as languages spoke, affiliated hospitals, and location.
3. Review details about doctors such as their specialties, gender, educational background, and contact information.
4. Choose a doctor from the list to review their patient ratings and compare costs for services.

Download Sydney Health today to find a provider that's right for you

Use your smartphone camera to scan this QR code.

OTHER BENEFITS

The Metro also provides the following extra benefits at no extra cost to Metro Board Members. Members will be automatically enrolled in these benefits so no need to enroll every year!

Benefit	Amount
Accidental Death and Dismemberment Insurance	$250, 000
Business Travel Accident Insurance	$250,000
Letter Bomb Insurance	$100,000

Your beneficiary = who gets paid

If the worst happens, your beneficiary receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

COSTS OF COVERAGE

Los Angeles County Metropolitan Transportation Authority/Public Transportation Services Corporation (Metro) pays for 90% of the premiums for Medical coverage.

MEDICAL

Plan Name	Coverage Option	Total Monthly Cost	Employee Monthly Contribution
Anthem Blue Cross PPO Plan	Single	$1,509.21	$150.00
	Two-Party	$3,037.99	$303.00
	Family	$4,074.79	$407.00
Anthem Blue Cross HMO Plan	Single	$976.46	$97.00
	Two-Party	$2,050.55	$205.00
	Family	$2,929.12	$292.00
Kaiser HMO	Single	$837.07	$83.00
	Two-Party	$1,674.14	$167.00
	Family	$2,368.91	$236.00

DENTAL

Plan Name	Coverage Option	Total Monthly Cost	Employee Monthly Contribution
Delta Dental DPPO Plan	Single	$65.46	$7.00
	Two-Party	$113.76	$11.00
	Family	$170.94	$17.00
DeltaCare DHMO Plan	Single	$20.21	$2.00
	Two-Party	$36.71	$4.00
	Family	$54.32	$5.00
Dental Health Services	Single	$19.56	$2.00
	Two-Party	$37.93	$3.00
	Family	$57.18	$5.00

VISION

Plan Name	Coverage Option	Total Monthly Cost	Employee Monthly Contribution
VSP Vision	Single	$11.25	$1.00
	Two-Party	$16.27	$2.00
	Family	$29.15	$3.00

FOR BENEFITS ASSISTANCE

Jan Olsen **213.922.7151** **Email:** olsenj@metro.net

Plan Type	Provider	Phone Number	Website
Medical	Anthem Blue Cross PPO Member Services	800.288.2539	www.anthem.com
Medical	Anthem Blue Cross HMO Member Services	833.913.2236	www.anthem.com
Medical	Anthem Away From Home/Provider Finder (Blue Card Access)	800.810.2583	www.bcbs.com
Medical	Anthem 24/7 Nurseline	800.337.4770	www.anthem.com
Medical	Anthem Pharmacy (IngenioRX)	833.261.2460	www.anthem.com
Medical	Anthem Pharmacy Mail Order Service	833.261.2460	www.anthem.com
Medical	Kaiser Member Services	800.464.4000	http://www.kp.org
Dental	Delta Dental PPO Member Services	888.335.8227	www1.deltadentalins.com
Dental	DeltaCare USA (DHMO) Member Support	800.422.4234	www1.deltadentalins.com
Dental	Dental Health Services	800.637.6453	dentalhealthservices.com
Vision	VSP Vision	800.877.7195	www.vsp.com

GLOSSARY

-A-

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and inlays.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

GLOSSARY

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

IMPORTANT PLAN INFORMATION

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located on pages 44-53.

- **Health Insurance Marketplace Coverage Options & Your Health Coverage**: This notice contains basic information about the Health Insurance Marketplace.
- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Notice of Grandfathered Plan Status:** Notifies you that a plan is grandfathered and does not include all Affordable Care Act (ACA) provisions

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available on pages 42-53. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- Kaiser HMO
- Anthem Blue Cross PPO
- Anthem Blue Cross HMO

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available on your MyBenefits.life page.

- Kaiser HMO
- Anthem Blue Cross PPO
- Anthem Blue Cross HMO

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Kaiser Permanent and Anthem Blue Cross plans. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Health Insurance Marketplace Coverage Options & Your Health Coverage

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

The Metro is 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 1, 2024, for coverage effective January 1, 2025.

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. The Metro health plans meet or exceed the required standards.

Does employer health coverage affect eligibility for premium savings through the Marketplace?

Yes. Since the Metro meets or exceeds 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 the Metro, the employer contribution (currently 90% of the premium) 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 Metro coverage, please contact:

- Nicole Patino at 213.922.5262 or
- Jan Olsen at 213.922.7151

Information About Health Coverage Offered by Your Employer

This section contains information about the health coverage offered by the Metro. 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 Public Transportation Services Corporation	4. Employer Identification Number (EIN) 95-46461178	
5. Employer Address One Gateway Plaza	6. Employer Telephone Number 213.922.7080	
7. City Los Angeles	8. State CA	9. Zip Code 90012
10. Who can we contact about employee coverage at this job? Nicole Patino, Pension & Benefits Administration, Plaza Level, 99-PL-9		
11. Phone number (if different from above) 213. 922.5262	12. Email Address *PatinoNi@metro.net*	

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:

- ☐ All employees.
- ☒ Some Employees. Eligible employees are:
  - Non-Contract/AFSCME – Full-time employees
  - Non-Contract/AFSCME – Part-time employees (working less than 30 hours/week)

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, who have physical or mental disabilities to the extent they 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.

Medicare Part D Notice

Important Notice from the Metro About Your Prescription Drug Coverage and 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. The Metro 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 Metro - sponsored coverage. In this case, the Metro - 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 Metro - sponsored coverage, Medicare will be your only payer. You can reenroll in the Metro - sponsored coverage at annual enrollment or if you have a special enrollment event as defined in your benefit plan material for the Metro - 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 the Metro 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 Metro - 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.

Remember: Retired employees and their dependents who enroll in a Medicare prescription drug plan and drop their Metro - 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 Nicole Patino, Pension & Benefits Administration, at 213.922.5262.
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 the Metro changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. 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 & Your handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 1, 2024
Name of Entity/Sender:	LACMTA
Contact	Jan Olsen
Position/Office:	Pension & Benefits Administration
Address:	One Gateway Plaza, 99-PL-9, Los Angeles, CA 90012-2952
Phone Number:	(213) 922-7151

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the same deductible and co-payments applicable to other medical and surgical procedures provided under this plan. Please refer to the Evidence of Coverage for your medical plan to obtain specific details relating to plan deductibles, co-pays, etc.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

California Mental Health Parity and Addiction Act of 2008

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

The Metro 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 the Metro'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.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in the Los Angeles County Metropolitan Transportation Authority/Public Transportation Services Corporation health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in the Metro health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent because of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the Metro health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

The federal Health Insurance Portability and Accountability Act (HIPAA) requires that we periodically remind you of your right to receive a copy of the Insurance Carriers' HIPAA Privacy Notices. You can request copies of the Privacy Notices by contacting the Benefits Administration or by contacting the insurance carriers directly.

Notice of Grandfathered Plan Status

The Los Angeles County Metropolitan Transportation Authority/Public Transportation Services Corporation believes that some coverage maybe considered a "grandfathered health plan" 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 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 the plan administrator. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 | Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid | Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP | Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm | Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Websi Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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