2025

Employee Benefits Booklet
Contingent Employees

Metro

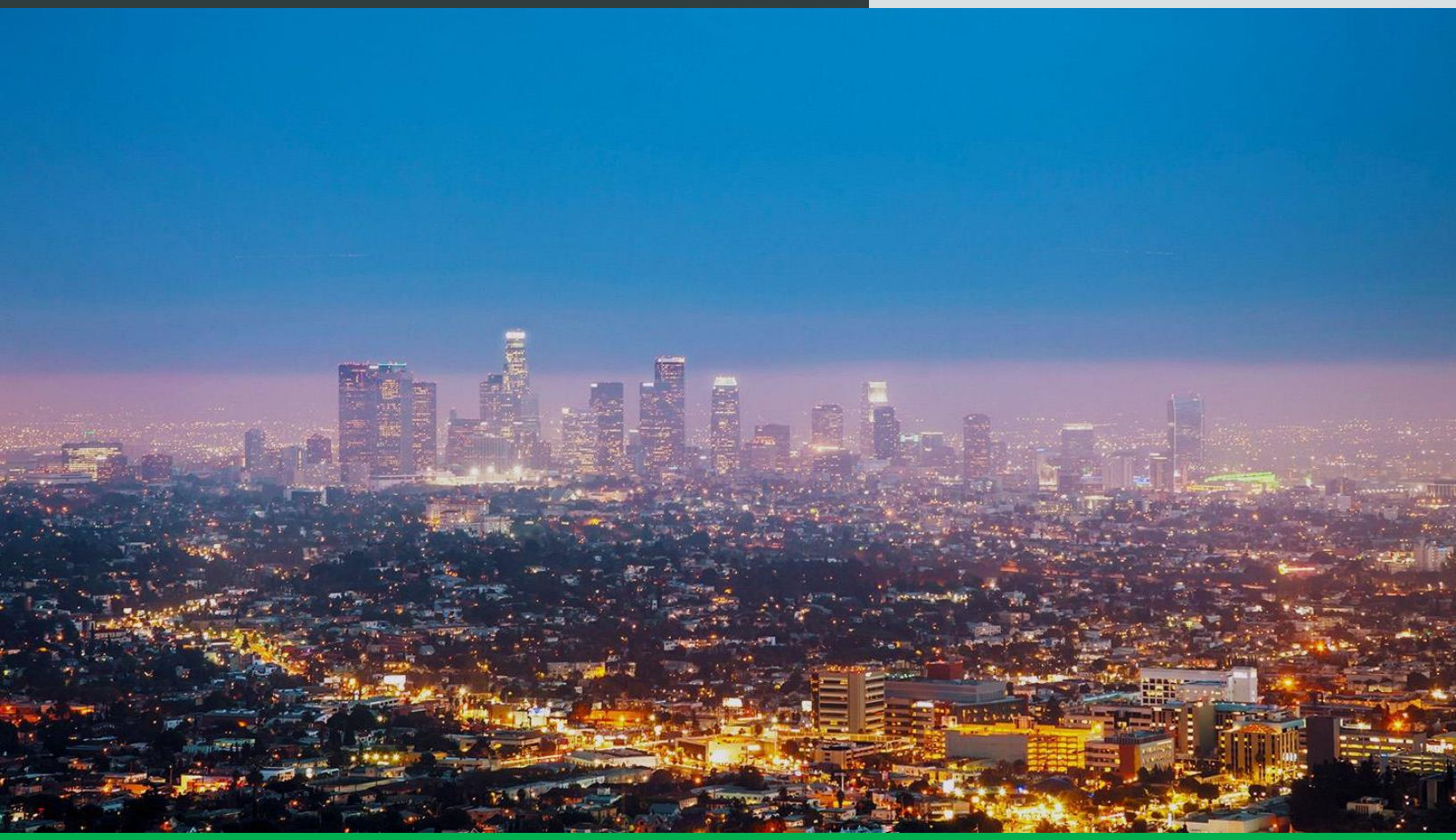


TABLE OF CONTENTS

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 Contingent employee. 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

You are eligible if you are a probationary or regular full-time (working at least 40hrs/week) or part-time Non-Represented or full-time (40 hrs/week) AFSCME employee of the Metro.

Certain individuals who are identified in a contingent worker category may be eligible for medical coverage. Please contact Pension & Benefits Administration at 213.922.5262 or at 213.922.1260 for details.

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.

IMPORTANT RULES FOR TAX-FAVORED HEALTH BENEFITS

See IRS Publication 502 at irs.gov/publications/p502 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*

Individuals who are otherwise eligible for coverage under the Flexible Benefit Program must also satisfy the following federal criteria 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 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:

- 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)

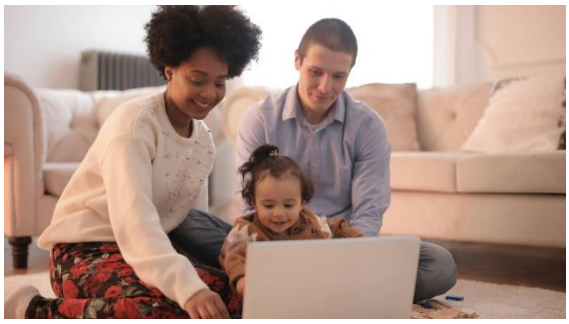
- **"Qualifying Relatives". Qualifying Relatives are:**

- 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.*

OPEN ENROLLMENT



Open Enrollment is a once-a-year opportunity to review your benefit choices, change plans, add or drop dependents, enroll into a Flexible Spending Account, Non-Smoker Life Insurance, or waive your benefits.

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, 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 - except for Health Care and Dependent Care Flexible Spending Accounts, Non-Smoker, and Waive Medical. These benefits will not roll over.**

If you need to make any changes to your benefits or are enrolling for the first time, you must log in to the Online Benefits Enrollment System at **benefits.metro.net**.

Access is available through the Metro's Intranet and remotely from your home computer.

If you require assistance, please contact a staff member in the Pension & Benefits Administration office or call 213.922.5262 or 213.922.1260.

Open Enrollment Confirmation Statement

Once you complete your Online Open Enrollment Form, you should print a copy of the Confirmation Statement which details the benefit options you have selected for 2025. Check this statement carefully to be certain all 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 213.922.5262 or 213.922.1260.

New Hires

New Contingent employees must attend onboarding. A portion of your onboarding 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 HIPAA special enrollment event or qualified status change.

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.

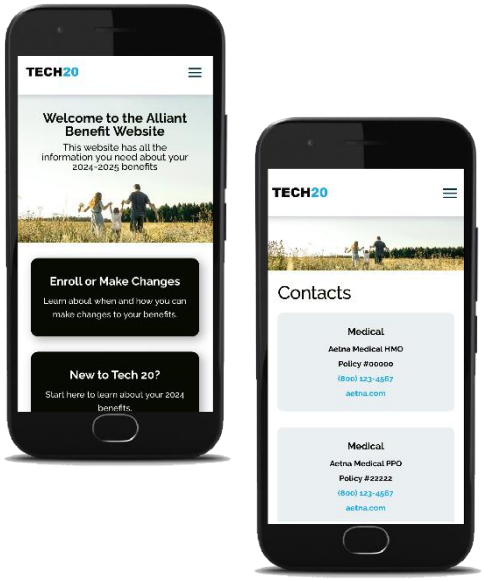
Here's what you'll find on MyBenefits.Life®

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

Kaiser Permanente Plan

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.

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 $277/month during calendar year 2025. 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 not remain in effect unless updated during each Open Enrollment period. Evidence of other coverage required each year.
3. No retroactive payment of opt out credits will made for late submission of coverage verification documents. Credits will begin on the first available payroll period following submission of the documents.
4. 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 7).

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

Medical HMO Plans

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.

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

Kaiser Vision Benefits (Included with the Kaiser HMO Plan)	
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)

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.

EMPLOYEE LIFE INSURANCE

Beneficiary Designation

When completing the Beneficiary Designation form, consider your choices very carefully. You may change your beneficiary designation at any time 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.

On the form 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.

FLEXIBLE SPENDING ACCOUNTS

We partner 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 enrollwithtag.wealthcareportal.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.

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.

The Health Care FSA allows you to contribute up **$3,300** 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 doctor's 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 childcare 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 is provided on enrollwithtag.wealthcareportal.com.

Important! Use-It-Or-Lose-It!

Note the deadline for submitting 2024 claims. You have until March 15, 2025, to use your 2024 funds and until March 31, 2025, to submit claims. You may continue to use your debit card for purchases during this period.

Please remember the “Use-It-Or-Lose-It” rule – you must use all the money you set aside in your flex spending accounts, or you will lose it!

Cards Expiring In 2024

The Advantage Group Flex Benefit Cards that expire December 2024, will have access via their debit card through December 31, 2024. New preloaded cards will be issued by January 2025 with your 2025 healthcare elected funds. If using remaining funds before March 15, 2024, claims will have to be reimbursed through The Advantage Group's claim process.

For claim assistance and claim forms contact the Advantage Group at 877.506.1660 or visit their website at, enrollwithtag.wealthcareportal.com.

If your card does not expire this year, new cards will not be issued unless you request a new card on The Advantage Group website. Healthcare elected funds for 2025 will be preloaded to your current card effective January 1, 2025.

More information can be found on benefits.metro.net under Guidebooks.

How to Enroll for 2025

If you are enrolling in the FSAs for 2025, you will need to follow these steps:

Enroll via the Benefits Online Enrollment System during the Annual Open Enrollment period November 4 - 17, 2024.

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. As a special security feature, activate your card by using the last four digits of your Employee Badge Number, NOT your Social Security Number as indicated in the general notice included with your new debit card or on the TAG website. For example: if your Badge Number is 88888, you would enter it in the SSN field as 000-08-8888.

If you need assistance with your account setup, please contact the Customer Support Center at enrollwithtag.wealthcareportal.com or call toll free at 877.506.1660.

You can contact TAG at 877.506.1660 on January 2nd for any questions regarding your account set-up or your 2024 and 2025 funds or debit card.

- FSA Mastercard 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 FLEXIBLE SPENDING 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 your eligible expenses! To calculate your potential savings, go to enrollwithtag.wealthcareportal.com.

Am I eligible to participate in a Dependent Care FSA?

You are eligible for this benefit if you have a dependent under age 13 (whose expenses are eligible) who requires care to enable you to work. This includes before and after school care. 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 childcare 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 enrollwithtag.wealthcareportal.com.

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 enrollwithtag.wealthcareportal.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: enrollwithtag.wealthcareportal.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 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.

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, contact:

- **TAG Participant Support Phone:** 877.506.1660
- **Website:** enrollwithtag.wealthcareportal.com

Frequently Asked Questions about the Debit Card

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

Why do participants appreciate the Flex Benefits Mastercard 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. 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 Flex Benefits Mastercard 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 Flex Benefits Mastercard Debit Card accepted?

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

These IRS-imposed limitations help ensure 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.

How do we verify that the Flex Benefits Mastercard 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 Flex Benefits Mastercard 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 flex benefits card receipts*).

What happens if the Flex Benefits Mastercard 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 Flex Benefits Mastercard 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 Mastercard cards.

What if the Flex Benefits Mastercard 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).

401(K) THRIFT PLAN AND 457 DEFERRED COMPENSATION PLAN

The 2025 individual contribution limits to the 457 Deferred Compensation plan and the 401(k) Thrift Plan are based on indexing determined by the IRS.

457 Deferred Compensation Plan

For calendar year 2025, you may contribute up to $23,000 in pretax dollars to your 457 Plan. If age 50 or older, your annual limit is $30,500.

401(k) Thrift Plan

For calendar year 2025, you may contribute up to $23,000 in pretax dollars to your 401(k) Plan. If age 50 or older, your annual limit is $30,500.

Maximum – Both Plans

During calendar year 2025, you may defer up to $45,000 ($60,000 if age 50 or older) in pre-tax dollars by simultaneously contributing the maximum amount to each plan.

Roth IRA

An after-tax contribution, which upon meeting eligibility requirements, allows you the opportunity to build retirement assets without ever owing taxes on the earnings. The maximum contribution for 2024 is $6,500 ($7,500 for age 50 or older). Your modified adjusted gross income must be within the allowable guidelines in order to participate.

Catch-up rule (457 Plan)

If you have not previously participated in “catch-up,” you can contribute $45,000 to the 457 Plan in calendar year 2024, plus $22,500 ($30,000 for age 50 or older) in the 401(k) plan for a total of $67,500 ($75,000 for age 50 or older) in pre-tax dollars.

Rollover

Effective January 1, 2003, combining or “rolling over” your retirement assets became more flexible than ever. You can combine previous employer plan assets (401(k), 457, 403b or IRAs) into either the Metro’s 401(k) or 457 plan, or a combination of both plans.

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 Mission Square Representative or other expert for guidance prior to making any major decisions.

Loans

The 401(k) and 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 401(k) Plan, any distribution from the plan prior to age 59 1/2 is taxable as ordinary income PLUS a 10% tax penalty as a premature distribution of pension assets. 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 Pension & Benefits Office and from the Mission Square representatives.

COSTS OF COVERAGE

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

MEDICAL

Plan Name	Coverage Option	Total Monthly Cost	Employee Monthly Contribution
Kaiser HMO	Single	$837.07	$83.00
	Two-Party	$1,674.14	$167.00
	Family	$2,368.91	$236.00

FOR BENEFITS ASSISTANCE

Nicole Patino **213.922.5262** **Email:** patinoni@metro.net
Leocricia Olmedo **213.922.1260** **Email:** olmedol@metro.net

Plan Type	Provider	Phone Number	Website
Medical	Kaiser Member Services	800.464.4000	http://www.kp.org
Employee Assistance Program	Guidance Resource	877.335.5327	www.guidanceresources.com
Membership Information	CalPERS	888.CalPERS	calpers.ca.gov
Flexible Spending Accounts	The Advantage Group	877.506.1660	enrollwithtag.wealthcareportal.com
401(k), 457 plans	MissionSquare Retirement *Onsite Rep: Crystal Durazo* *Onsite Rep: Jessica Sequeira*	800.669.7400 866.266.7312 866.339.8795	icmarc.org cdurazo@icmarc.org jsequeira@icma.org
Open Enrollment Website			benefits.metro.net

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.

OMB Control Number 1210-0137 (expires 1/31/2025)

Employee Benefits Booklet designed and developed by

in conjunction with the Los Angeles County
Metropolitan Transportation Authority and
Public Transportation Services Corporation