



2024 BENEFITS GUIDE NON-REPRESENTED & AFSCME



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.

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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 Non-Represented and AFSCME 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 2024 Benefits will be effective from:
January 1, 2024 through December 31, 2024.**

WHO'S ELIGIBLE FOR BENEFITS?

Employees

You are eligible if you are a probationary or regular full-time (working at least 40 hrs/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



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 Flexible Benefits Program.
- “Qualifying Children over age 26”*. Qualifying children are your children by birth, adoption, stepchildren, or foster children who are permanently and totally disabled regardless of age, and:
 - Are not married.
 - Do not provide over one-half of their own support.
 - Have the same principal place of residence as you for more than six months of the year (temporary absences, such as for school, are treated as time at the same principal place of residence).

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

Important: Coverage for individuals who do not meet the criteria for tax-favored health benefits under the IRC will result in imputed income to you, and employee contributions made on their behalf must be paid on an after-tax basis. See IRS Publication 502 at 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.*

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 2024, unless you experience an eligible life event,

Open Enrollment begins November 6, 2023, through November 19, 2023.

Any changes made during OE will be effective on January 1, 2024.

Do I Need to Enroll?

If you do not have any changes to make to your 2024 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 by calling 213.922.5262 or 213.922.1260.

New Hires

New Non-Represented and AFSCME 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.

What's New or Changing for 2024

Our current benefit programs will continue into 2024 with no changes. While your benefits aren't changing, you may have had some major life changes. Do your current choices still meet your needs? 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

Click to play video



GET MYBENEFITS.LIFE®
On the web:
lacmta.mybenefits.life

On your smartphone



Download from the App Store or Google Play.

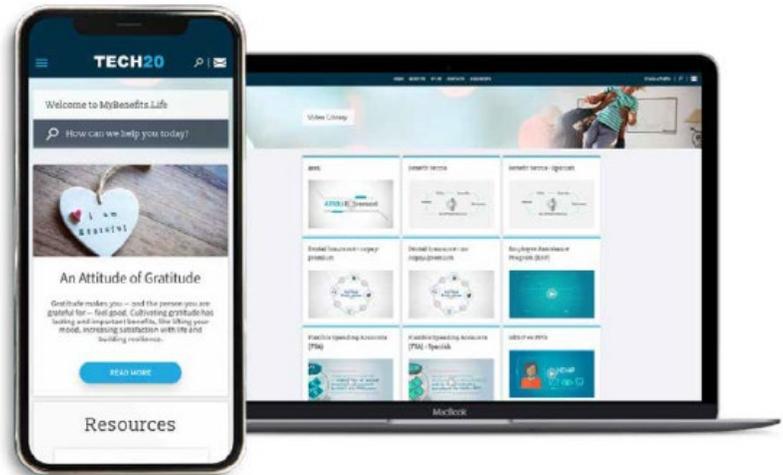
Login With Employer Key
PTSCACTIVES

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, such as healthcare, life insurance, and more
Search	Can't find it? Just search the site
Articles & Video Library	Have 2 minutes? Increase your benefits IQ with short explainer articles and videos
Glossary	HMO? EOB? Coinsurance? Get the definitions in plain English
Inbox	Get messages from your HR team
Documents	Important benefit plan notices ("the fine print")
Contacts	Find HR, benefits, and carrier contacts
Get Help	Need help? Reach helpful resources





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.

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 2024. 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 be 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 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

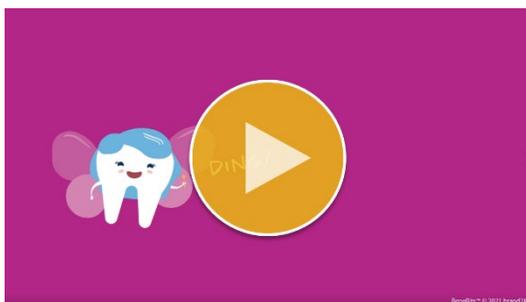
OUR PLANS

Delta Dental Plan (DPPO)

DeltaCare (DHMO)

Dental Health Services (DHMO)

Click to play video



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.

Waiver of Dental

You may voluntarily elect not to be covered under a dental plan. If you elect to waive coverage, you will receive a credit of \$40/month during calendar year 2024. This payment is recorded as taxable cash in your paycheck.

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	\$0	\$50
Family	\$0	\$150
Annual Plan Maximum	\$2,500	\$1,500
Diagnostic & Preventive		
Oral Exams	No Charge	No Charge
X-Rays		
Teeth Cleaning		
Fluoride Treatment		
Basic Services		
Fillings	10% coinsurance	20% coinsurance
Root Canals		
Periodontics		
Major Services		
Single Crowns	40% coinsurance	50% coinsurance
Inlays, Onlays		
Dental Implants		
Bridges & Dentures		
Orthodontia		
Adult	50% coinsurance	50% coinsurance
Child	50% coinsurance	50% coinsurance
Lifetime Max	\$2,000	\$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.



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?

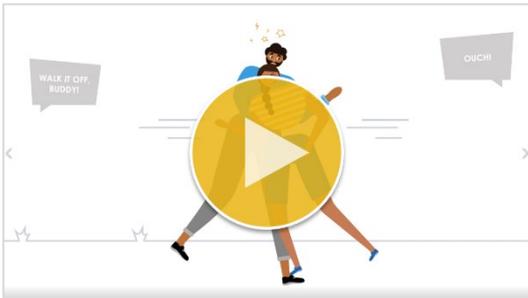
Visit www.vsp.com or call 800.877.7195

	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)	

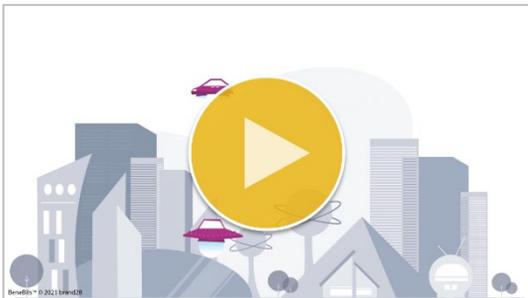


ENGAGE WITH YOUR BENEFITS!

Click to play video



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	<ul style="list-style-type: none"> Identifying symptoms Decide if immediate care is needed Home treatment options and advice 	24/7	\$0
Online visit 	Many non-emergency health conditions	<ul style="list-style-type: none"> Cold, flu, allergies Headache, migraine Skin conditions, rashes Minor injuries Mental health concerns 	24/7	\$
Office visit 	Routine medical care and overall health management	<ul style="list-style-type: none"> Preventive care Illnesses, injuries Managing existing conditions 	Office Hours	\$\$
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	<ul style="list-style-type: none"> Stitches Sprains Animal bites Ear-nose-throat infections 	Office Hours, or up to 24/7	\$\$\$
Emergency room 	Life-threatening conditions requiring immediate medical expertise	<ul style="list-style-type: none"> 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](https://www.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.

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).

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 Daily 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.

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 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](https://www.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](https://www.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](https://www.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](https://www.MyAdvocatehelps.com). It doesn't cost you anything extra to sign up and you'll have support for up to 12 weeks after birth.

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](https://www.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](https://www.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](https://www.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.



EMPLOYEE LIFE INSURANCE

Life Insurance represents an important part of a complete benefit protection package. Metro provides the core Life Insurance plan (1x annual salary) through The Standard to all eligible full-time employees, with a minimum benefit amount of \$30,000, at no cost to you. In addition, you may purchase higher levels of insurance coverage or Supplemental Life Insurance with underwriting approval by The Standard.

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

Coverage Option	Amount
Basic Life insurance (no extra cost)	1x salary (Min \$30,000)
Supplemental Life Insurance (extra cost)	
Buy-up	1x salary
Buy-up	2x salary
Buy-up	3x salary
Buy-up	4x salary

Buy- up Maximums: Maximum for basic Life Insurance is \$400,000 and maximum supplemental is \$750,000. The total amount of Basic and Supplemental Life will not be over \$1,000,000.

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

COST OF COVERAGE FOR SUPPLEMENTAL LIFE BUY-UP

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

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

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

Employee’s Age (As of January 1, 2024)	Bi-Weekly Rate per \$1,000 Insurance
Under age 20	\$0.060
Age 20-24	\$0.060
Age 25-29	\$0.060
Age 30-34	\$0.090
Age 35-39	\$0.090
Age 40-44	\$0.100
Age 45-49	\$0.150
Age 50-54	\$0.230
Age 55-59	\$0.430
Age 60-64	\$0.660
Age 65-69	\$1.270
Age 70-74	\$2.060
Age 75+	\$2.060

Important Note: If your spouse or domestic partner is also employed by the Metro as a Non-Represented or AFSCME employee, or as a Security Guard, and is eligible to participate in the life insurance plan as an employee, you may **NOT** be enrolled as a dependent on each other’s benefits.

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary receives the benefit. Make sure to review your Metro Open Enrollment form carefully to be sure your current beneficiary is listed.

If you wish to make a change to your beneficiary designation, you must complete a new “Beneficiary Designation” form (PERS-220) and forward it to Benefits Administration.

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

- Name a primary beneficiary(ies) to receive survivor’s benefits from all plans
- Determine how the benefits are divided among your beneficiaries if you name more than one beneficiary, (e.g. 75% to your spouse and 25% to your parents)
- Name contingent beneficiary(ies) in case no primary beneficiary survives you. For example, you may decide to name your spouse as primary beneficiary and your children as contingent beneficiaries, in case your spouse does not survive you

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

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

NON-TOBACCO LIFE INSURANCE

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

- You do not smoke, chew, or otherwise use any form of tobacco
- You have not used tobacco products for at least the last year
- You complete and return to Benefits Administration the “Non-Tobacco Users Certification Form” or certify such on the Online Enrollment System.

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

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

SPOUSE & DOMESTIC PARTNER LIFE INSURANCE



Important:

Evidence of insurability is required and must be submitted for all new or increased life insurance amounts above the \$10,000 increment included in the Special Offer (above). Please complete an Evidence of Insurability Form online or request a copy from Pension & Benefits Administration.

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

Spouse and domestic partner life insurance is provided by The Standard. It gives you the opportunity to buy life insurance coverage for your same or opposite sex spouse.

Coverage is also available to domestic partners who meet the State of California's definition of domestic partner. *(State of California registration required).*

Special Note – This coverage is not available for part-time employees.

Spouse or domestic partner coverage is available up to \$500,000 in increments of \$10,000 only. Your spouse or domestic partner may enroll up to a maximum of 50% of the life insurance amount you elect, rounded down to the next \$10,000 increment.

The premiums for spouse and domestic partner life insurance are deducted on an after-tax basis.

Spouse's Age (As of January 1, 2024)	Bi-Weekly Rate per \$1,000 Insurance
Under age 20	\$0.060
Age 20-24	\$0.060
Age 25-29	\$0.060
Age 30-34	\$0.090
Age 35-39	\$0.090
Age 40-44	\$0.100
Age 45-49	\$0.150
Age 50-54	\$0.230
Age 55-59	\$0.430
Age 60-64	\$0.660
Age 65-69	\$1.270
Age 70-74	\$2.060
Age 75+	\$2.060

CHILD LIFE INSURANCE



Child Life Insurance is provided by The Standard. If enrolled, all your dependent children are covered for \$10,000 if age six months to 26 years. The benefit is \$250 for children aged 14 days to six months.

The price tag for dependent children coverage is \$1.30 per month, regardless of the number of children. The premium is deducted from your paycheck on an after-tax basis. In all cases, you are the designated beneficiary for Child Life Insurance. This coverage is available only to dependent children of full-time Non-Represented and AFSCME employees.

Important: *If your spouse or domestic partner is also employed by MTA/PTSC as a Non-Represented or AFSCME employee, or as a Security Guard and is eligible to participate in the life insurance plan as an employee, only one of you may enroll your dependent children; not both.*

Accidental Death & Dismemberment (AD&D) Insurance

Metro/PTSC also provides you with basic Accidental Death & Dismemberment (AD&D Insurance) in the amount of \$50,000. Accidental Death & Dismemberment is provided by the Federal Insurance Company (one of the Chubb Group of Insurance Companies) and covers you for accidental death or accidental loss of limb, eyesight or hearing, 24 hours a day, either on or off the job. Full benefits are paid for an accidental death and certain dismembering losses; partial benefits are paid for other losses. AD&D premiums are deducted on a pre-tax basis, providing valuable tax savings.

Coverage Options

You may select additional employee AD&D coverage for a minimum of \$50,000 up to a maximum of, not to exceed \$500,000. Evidence of insurability is not required for AD&D coverage. You may enroll your family in the AD&D plan. The premium is reflected on your enrollment form.

If you enroll your family in the AD&D insurance, the amount of benefit payment that will be made to you in the event of a covered loss of a dependent will be determined by the nature of your family status at the time of the loss.

Special AD&D

Full-time Non-Represented and AFSCME employees are also automatically enrolled for the following benefits:

- \$250,000 Business Travel Accident Insurance
- \$100,000 Letter Bomb Insurance

Eligible Dependents

- Same and opposite-sex spouses
- Domestic partners who meet the State of California's definition of domestic partner
- Children of the above

Employee Only:

Covers you for the benefit amount selected.

Family:

Covers you for the benefit amount selected. Your spouse or domestic partner for 60% of your benefit amount if there are no dependent children, or 50% of your benefit amount if there are dependent children. Each of your dependent children for 20% of your benefit amount if there is no spouse or domestic partner, or 15% of your benefit amount if there is a spouse or domestic partner. The maximum benefit amount for each dependent child is \$50,000.

LONG-TERM DISABILITY (LTD)

The Metro provides full time Non-Represented and AFSCME employees with a Long-Term Disability (LTD) plan with income replacement of 60% of monthly earnings to a maximum monthly benefit of \$6,000 after a 180-day waiting period at no cost to you. Benefits are payable to age 65, or longer, if you become disabled after age 62. In addition, under your Benefit Plan, you can either:

- “Buy up,” that is, purchase more LTD benefit coverage
- “Buy down,” that is, elect less LTD benefit coverage and receive additional cash in your paycheck. This payment is recorded as taxable cash.

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

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

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

Cost of coverage for this benefit are shown on your personalized Enrollment Form. For new employees, the price tags for LTD Coverage are based on your salary in effect as of your hire date. For each Open Enrollment period, the price tags are based on your salary in effect on November 1st of each year. During a plan year, price tags will not change even if your benefit amount changes to reflect a salary adjustment (increase or decrease). Long Term Disability Insurance Plan price tags are on a pre-tax basis, providing valuable tax savings. Credits are recorded as taxable cash in your paycheck. Any LTD payments you receive will be taxable.

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

Your available hours are integrated with SDI or Workers’ Compensation benefits. You will need approximately 470 hours of TOWP to reach the 180-day waiting period. If your total available paid hours are much less than 470 hours, you may wish to consider enrolling for the 90-day waiting period.

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 to **\$3,050** 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 2023 claims. You have until March 15, 2024, to use your 2023 funds and until March 31, 2024, 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 2023 flex spending accounts, or you will lose it!

Cards Expiring In 2023

The Advantage Group Flex Benefit Cards that expire December 2023, will have access via their debit card through December 31, 2023. New preloaded cards will be issued by January 2024 with your 2024 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 2024 will be preloaded to your current card effective January 1, 2024.

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

How to Enroll for 2024

If you are enrolling in the FSAs for 2024, you will need to follow these steps:

Enroll via the Benefits Online Enrollment System during the Annual Open Enrollment period November 6-19, 2023.

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 2023 and 2024 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 2024 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 2024, you may contribute up to \$22,500 in pretax dollars to your 457 Plan. If age 50 or older, your annual limit is \$30,000.

401(k) Thrift Plan

For calendar year 2024, you may contribute up to \$22,500 in pretax dollars to your 401(k) Plan. If age 50 or older, your annual limit is \$30,000.

Maximum – Both Plans

During calendar year 2024, 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

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	\$1,384.59	\$138.00
	Two-Party	\$2,787.15	\$279.00
	Family	\$3,738.34	\$374.00
Anthem Blue Cross HMO Plan	Single	\$1,052.79	\$105.00
	Two-Party	\$2,210.83	\$221.00
	Family	\$3,158.08	\$316.00
Kaiser HMO	Single	\$767.84	\$77.00
	Two-Party	\$1,535.67	\$154.00
	Family	\$2,172.97	\$217.00

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	\$4.00
	Family	\$57.18	\$6.00

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



Nicole Patino
Leocricia Olmedo

213.922.5262
213.922.1260

Email: patinoni@metro.net
Email: olmedol@metro.net

			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
Flexible Spending Accounts	The Advantage Group	877.506.1660	enrollwithtag.wealthcareportal.com
401(k), 457, Roth IRA plans	MissionSquare Retirement <i>Onsite Rep: Crystal Durazo</i> <i>Onsite Rep: Jessica Sequeira</i>	800.669.7400 866.266.7312 866.339.8795	icmarc.org cdurazo@icmarc.org jsequeira@icma.org

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 particular 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 onlays.

-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 situation, 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 6, 2023, for coverage effective January 1, 2024.

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 <u>PatinoNi@metro.net</u>	

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 & You 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:	January 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 as a result 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 may be 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](tel: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 \(3272\)](tel:1-866-444-EBSA).

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.medicicaid.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/ofa/applications-forms>

Phone: 1-800-442-6003 | TTY: Maine relay 711

Private Health Insurance Premium Webpage: <https://www.maine.gov/dhhs/ofa/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 Rlte 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
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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