2026

Employee Benefits Booklet

Teamsters

The Perks Are in Motion

Your Benefits are Going Places, Are You?

Metro®

TABLE OF CONTENTS

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).

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 Teamsters employee. The plans described in this guide are subject to specific terms and provisions of the plans, as established in the plan documents, and 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 2026 Benefits will be effective from:
January 1, 2026, through December 31, 2026

WHO'S ELIGIBLE FOR BENEFITS?

Employees

You are eligible if you are a probationary or regular full-time (working at least 40hrs/week) or part-time Teamsters 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 or Non-Smoker Life Insurance, or waive your benefits.

After Open Enrollment ends, you cannot change your benefit elections until the next Open Enrollment in 2026, unless you experience an eligible life event.

Open Enrollment begins November 3 and runs through November 16, 2025.

Any changes made during OE will be effective on

January 1, 2026.

Do I Need to Enroll?

If you do not wish to make changes to your 2026 benefits, no action is required. However, please note that certain benefits require action during open enrollment and will **not** automatically roll over. Enrolling or re-enrolling in a Flexible Spending Account (FSA) or Dependent Care FSA requires you to act. 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 213.922.2701 or email: pensionbenefits@metro.net

New Hires

New Teamsters 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 a HIPAA special enrollment event or qualified status change.

What's New or Changing for 2026

Our current benefit programs will continue into 2026 with no changes. While your benefits aren't changing, you may have had some major life changes, and it is important to review your plans and ensure they continue to meet your needs and the needs of your family. You may also want to take this opportunity to review your beneficiary designation to ensure it is up to date.

This year, we are excited to introduce our new virtual Benefits Bookshelf, which is a great resource to reference benefits related material not only during Open Enrollment, but year-round. Please visit here: https://eb.alliant.com/ptscbenefitsbookshelf/full-view.html

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

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.

Click to play video

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.).
4. The effective date will be the first of the month following the event date.

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.

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, 2026)	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 Teamsters employee 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.

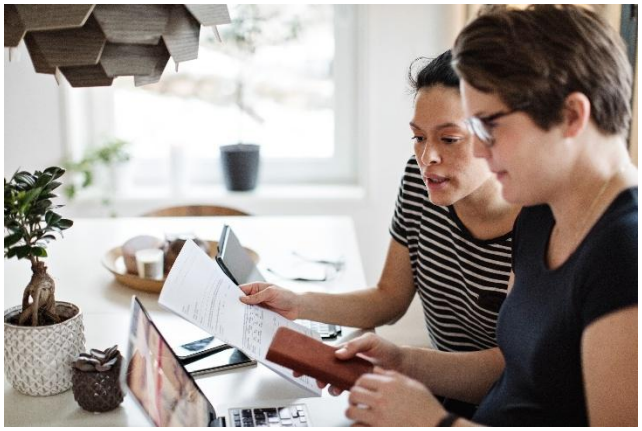
When completing the Beneficiary Designation form, consider your choices very carefully. You may choose to:

- 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.

SPOUSE & DOMESTIC PARTNER LIFE INSURANCE



Important:

Evidence of insurability is required and must be submitted for all new or increased life insurance amounts. Please complete an Evidence of Insurability Form that you can find online at benefits.metro.net or request a copy from Pension & Benefits. Refer to the Special Note on the right to know how much coverage can be applied for.

If your spouse or domestic partner is also employed by MTA/PTSC as a Teamsters employee 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, 2026)	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

OTHER LIFE INSURANCE

Child Life Insurance

Child Life Insurance is provided by The Standard. If enrolled, all your dependent children are covered for $10,000.

The cost for dependent children coverage is $1.27 per month for $10,000 of coverage, 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 under the age of 26 of full-time Teamsters employees.

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 Teamsters employees are also automatically enrolled for the following benefits:

- $250,000 Business Travel Accident Insurance
- $250,000 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.

Important: *If your spouse or domestic partner is also employed by MTA/PTSC as a Teamsters 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.*

LONG-TERM DISABILITY (LTD)

The Metro provides Teamsters 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.

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.

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.

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.

THE ADVANTAGE GROUP

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 pre-tax dollars you lower your taxable income, and you use pre-tax money to pay for eligible expenses.

The Health Care FSA - allows you to contribute up **$3,400** in 2026, 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

Dependent Care FSA - allows you to contribute up to **$7,500** 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: https://www.enrollwithtag.com/services/flex-plans/eligible-expenses/

FLEXIBLE SPENDING ACCOUNTS CONTINUED

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

Note the deadline for submitting 2025 claims. You have until March 15, 2026, to use your 2025 funds and until March 31, 2026, to submit claims. You may continue to use your debit card for purchases during this period.

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

Cards Expiring In 2025

The Advantage Group Flex Benefit Cards that expire December 2025, will remain active through December 31, 2025. New preloaded cards will be issued by January 2026 with your 2026 healthcare elected funds. If using remaining funds before March 15, 2026, 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 2026 will be preloaded to your current card effective January 1, 2026.

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

How to Enroll for 2026

If you are enrolling in the FSAs for 2026, you will need to follow these steps:

Enroll via the Benefits Online Enrollment System during the Annual Open Enrollment period November 3-16, 2025.

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.

- 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
- Employer ID: TAGTHELAMET
- Employee ID: 000-0##### (Badge number preceded by four zeros)

You can contact TAG at 877.506.1660 on January 2nd for any questions regarding your account set-up or your 2025 and 2026 funds or debit card.

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FLEXIBLE SPENDING ACCOUNTS FAQs

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. To claim the Federal Tax Credit, who is a qualifying person? Please consult with your tax professional and or visit the IRS for information on Child and Dependent Care Credit FAQs.

- 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.

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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.

FSA FAQs CONTINUED

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.

THE ADVANTAGE GROUP

FSA FAQs CONTINUED

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 as is the case with card swipes for co-pays or multiple co-pays at qualified locations, such as the doctor's office, and card swipes at Inventory Information Approval System (IIAS) retailers. 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).

FOR BENEFITS ASSISTANCE

Pension and Benefits
Phone: 213.922.2701
Email: pensionbenefits@metro.net

Plan Type	Provider	Phone Number	Website
Flexible Spending Accounts	The Advantage Group	877.506.1660	enrollwithtag.wealthcareportal.com
Life and Disability	The Standard		www.standard.com
Open Enrollment Website			Benefits.metro.net

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