2012 EMPLOYEE BENEFITS BROCHURE

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Dear Valued Employee:

Orange County Transportation Authority is known throughout the industry for the quality of service and care we provide to our customers; you help to create this reputation of excellence through the work that you do everyday.

Orange County Transportation Authority is also known for the comprehensive benefit program that we offer to all eligible employees. It is our goal to provide you and your family with a "best-in-class" benefits program at an affordable price. That's why Orange County Transportation Authority pays a majority of your Health care costs for you and your covered dependents.

2012 Plan Offerings

- *Anthem Blue Cross HMO*
- *Anthem Blue Cross PPO*
- *Anthem Blue Cross Lumenos CDHP w/HSA*
- Kaiser Permanente
- *Delta Dental PPO*
- *DeltaCare USA DHMO*
- *Vision Service Plan Choice*
- *Basic Life and AD&D*
- *Supplemental Life*
- *Short Term Disability*
- *Long Term Disability*
- *Voluntary Plans (AFLAC)*
- *Flexible Spending Accounts*
- *Employee Assistance Program (EAP)*
- *Retirement*

Introduction / Benefit Plan Update

Benefit Plan Update for 2012

- OCTA will be moving to Anthem Blue Cross, which will replace the Aetna HMO and OAMC Plan options.
- A Consumer Driven Health Plan, with a Health Savings Account (HSA), which will be fully funded by OCTA @ either $1,250 for an individual or $2,500 for two-party or family. This new plan has a lower premium cost, offers many tax advantages and utilizes the CDHP Lumenos PPO network.
- OCTA will also continue to offer the Kaiser Permanente plan with no benefit plan changes.
- Delta Dental PPO replaces MetLife PPO. DeltaCare USA DHMO replaces SmileSaver
- Vision will now be offered utilizing the VSP Choice Network
- Flexible Spending Account (FSA) will move from WageWorks to Discovery Benefits. In addition to the Health Care and Dependent Care Accounts, there will also be a Limited Purpose Account (covers Dental and Vision) if you are enrolled in a Health Savings Account.

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 pages 25 and 26 for more details.

DISCLAIMER
The information in this brochure is a general outline of the benefits offered under the Orange County Transportation Authority benefits program. This brochure may not include all relevant limitations and conditions. Specific details and limitations are provided in the plan documents, which may include a Summary Plan Description (SPD), Evidence of Coverage (EOC), and/or insurance policies. The plan documents contain the relevant plan provisions. If the information in this brochure differs from the plan documents, the plan documents will prevail.

Open Enrollment

Open Enrollment

Human Resources would like to take this opportunity to give you important information about the benefits being offered by OCTA for the 2012 calendar year. Educational meetings have been scheduled and are listed in the table below. Carrier representatives will be available for individual questions.

What can I do at this year's Open Enrollment?

- Change or waive your Health Plan(s)
- Add or delete dependents
- Enroll or re-enroll in the Flexible Spending Accounts
- Enroll or cancel AFLAC

Please consider your options carefully because you may only make changes to your benefit elections during open enrollment, or if you experience a mid-year "qualified status change" (see page 6). All benefit changes will be effective January 1, 2012.

- If you choose not to participate in the Open Enrollment process, your health benefits will default to
    - Anthem Blue Cross HMO
    - DeltaCare USA DHMO and
    - Vision Service Plan Choice

Open Enrollment Dates:

The open enrollment period is from November 1st - November 17th, and all changes must be received through the Lawson Employee Self Service (ESS) online enrollment by 5:00 p.m. on November 17th. Please plan on attending one of the Open Enrollment meetings which will be held according to the following schedule:

Open Enrollment Meeting Schedule		
October 12th - OE Workshops	10:00 am - 12:00 pm	Orange, CR103/104
October 25th - OE Workshops	2:00 am - 4:00 pm	Orange, CR103/104
November 1st - Carrier Meetings	10:00 am - 2:00 pm	Orange, CR103/104
November 8th - Health Fair	10:00 am - 1:30 pm	Orange Location

Eligibility for Benefits

New Hire Eligibility

You are eligible for our benefit program if you are a regular full-time employee, working a minimum of 20 hours per week, as well as Board of Directors, are eligible for benefits following completion of the required continuous service requirement. Full-time employees are responsible for paying the employee health premium contribution, as set forth in the contribution schedules (see pages 14-15). Part-time employees are responsible for paying 50% of the total health premium plan costs (see pages 14-15). An employee must be actively at work on his/her effective date of coverage to be enrolled in the plan. Failure to meet this requirement will defer the employee's effective date, and that of their enrolled dependents, at least until he/she returns to active full-time work. Extra-Help employees are not eligible for benefits.

When Coverage Begins

As a new employee, your benefits become effective one month after your first day of employment.

Please Note: It is the responsibility of the employee to enroll in the plan prior to completion of the eligibility period. Any employee who declines coverage as a new hire will not have the option to enroll again until open enrollment held annually within the month of November, unless he or she experiences a mid-year "qualified status change" or qualify for a "special enrollment" (see page 6)

Dependent Eligibility

- Your spouse: unless legally separated or divorced
- Your registered domestic partner (with the State of California)
    - Both persons have a common residence, are at least 18 years of age, neither person is married or a member of another domestic partnership, the two persons are not related by blood
- You or your domestic partner's natural children, stepchildren, adopted children and/or children of which the employee or domestic partner is in the legal guardian up to age 26 on the Medical, Dental and Vision Plans
- You or you physically or mentally handicapped children who meet the plan eligibility guidelines and depend on you for support, regardless of age

Eligibility for Benefits

Enrollment Period

New Employees

You must complete and return to the Human Resources Department the necessary benefits enrollment forms within one month of employment. *****IMPORTANT*** Enrollment is never automatic**. Benefit coverage begins one month after employment in an eligible Administrative or TCU position. Benefits coverage begins the 1st of the month following the effective date of transfer for represented employees transferring into an Administrative or TCU position.

Layoff Health Benefits

An employee who is placed on layoff may be granted paid health insurance in accordance with the following schedule.

Years of Service	Length of Coverage
Less than 3	1 month
3 but less than 5	2 months
5 but less than 10	3 months
10 or more	4 months

If an employee is re-called within 6 months, health insurance coverage will take effect 30 days from the re-hire date. However, if the granted paid health insurance is still in effect, then effective the first of the month from the date the employee returns to work, the employee will be responsible for the difference between the total plan premium and the OCTA contribution rates approved by the Board of Directors.

Rules for Benefit Changes During the Year

Other than during the annual open enrollment, you may only make changes to your benefit elections if you experience a qualified status change or qualify for a "special enrollment". If you qualify for a mid-year benefit change, you may be required to submit proof of the change or evidence of prior coverage.

Qualified Status Changes include:

- **Change in legal marital status**, including marriage, divorce, legal separation, annulment, and death of a spouse
- **Change in number of dependents**, including birth, adoption, placement for adoption, or death of a dependent child
- **Change in employment status that affects benefit eligibility**, including the start or termination of employment by you, your spouse, or your dependent child
- **Change in work schedule**, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits
- **Change in a child's dependent status**, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- **Change in place of residence or worksite**, including a change that affects the accessibility of network providers
- **Change in your health coverage or your spouse's coverage** attributable to your spouse's employment
- **Change in an individual's eligibility for Medicare or Medicaid**
- **A court order** resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child
- **An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA)** including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- **An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act.** Under provisions of the Act, employees have 60 days after the following events to request enrollment:
  - Employee or dependent loses eligibility for Medicaid (known as Medi-Cal in CA) or CHIP (known as Healthy Families in CA).
  - Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP

Two rules apply to making changes to your benefits during the year:

- **Any changes you make must be consistent with the change in status, AND**
- **You must make the changes within 30 days of the date the *event* (marriage, birth, etc.) occurs (unless otherwise noted above).**

How You Can Help Control Healthcare Costs

OCTA employees, service providers and insurance groups must work together to help manage health care costs. Employees can start by becoming better informed benefits consumers and by shopping for value when it comes to health care. Here are suggestions on steps you can take to save money for yourself and the plan:

- Stay healthy. Experts say the first line of defense against rising health care costs is to take preventive measures; that means eat healthy, exercise, don't smoke, and get regular check-ups. If you need medicine, take it as prescribed by your doctor to avoid health complications and lengthy hospital stays.
- Use network providers for primary care and referrals. The Plan has negotiated special rates with network providers to help keep costs affordable without sacrificing quality.
- Always request generic drugs. Generic drugs can cost up to 95% less than their brand-name counterparts, yet they are equally effective.
- Comparison shop and consider reasonable options. For example, the co-payment for your prescription cough medicine may cost more than an over-the-counter product that may be equally effective. Do not spend more than you have to.
- Use Mail-Order pharmacy. The Mail-Order pharmacy allows you to buy larger quantities at less cost. The "volume discount" adds up to savings for you and the Plan.
- Take advantage of the Plan's well-baby and maternity care programs. These programs have been proven to reduce Plan costs by helping patients identify and avoid risks to a pregnancy.
- Save the emergency room for emergencies. An urgent care center can be a good option for non-emergencies at night and on weekends when your doctor may not be in the office. You can usually get x-rays, stitches, and care for minor injuries that aren't life threatening yet require medical attention the same day.
- Request a detailed hospital bill and review it carefully. Studies show that 90% of all hospital bills have billing errors. By reviewing your bill, you can prevent yourself and the Plan from paying for services you did not receive.
- Use the Health Care Flexible Spending Account and increase your spending power for out-of-pocket health care expenses.
- Always follow pre-certification procedures for hospitalizations and surgeries. Pre-certification ensures that recommended treatment is appropriate and provided in the most cost-effective setting.
- Ask questions and read your printed materials. Talk to your doctor about reasonable treatment alternatives that may be more cost effective. Visit your plan's website for information on how to use your benefits efficiently.
- **Call the 24/7 Nurseline for Anthem (800) 977-0027 or Kaiser (800) 576-6225** and speak to an experienced registered nurse 24/7 to discuss symptoms you're experiencing and get help making informed decisions.

Note: These are ways to control costs, if you have any questions about your health care needs please contact your personal physician.

Health Savings Account (HSA)

A Health Savings Account (HSA) is available to employees who participate in the Anthem Blue Cross Consumer Driven Health Plan (CDHP).

How a HSA Works

- A Health Savings Account is a bank account that works in conjunction with a Consumer Driven Health Plan. A HSA is an employee owned bank account that can be used to help pay for qualified medical expenses such as office visits, hospital stay, prescription drugs, etc.
- If your spouse or domestic partner has other coverage, they are not eligible to participate in the Consumer Driven Health Plan.
- The HSA moves with you, if you ever change employers, and funds in the HSA roll-over year-to-year. A HSA is **not** a 'use-it-or-lose-it' plan.
- You elect how much you want to contribute to your HSA each pay period, up to the IRS maximum before taxes are withheld.
- You can elect to change your HSA payroll deduction at anytime throughout the year, as long as your annual contribution remains under the IRS limits.
- If you and your spouse are both enrolled in a CDHP and contribute into a HSA, your combined HSA contribution cannot be more than the 2012 IRS maximum, even if your spouse does not work for Orange County Transportation Authority.
- When you have an eligible expense, simply use your HSA debit card to pay for the expense. Your HSA account balance must be greater than or equal to the total expense amount, otherwise your transaction will be denied.
- Funds in your HSA can be used to pay for qualified medical expenses of **IRS tax dependents**, even if the dependent is not enrolled in your CDHP.
- You are not eligible to elect a HSA if you are covered by another health plan, such as a health plan sponsored by your spouse's employer, Medicare or Tricare or if an employee is claimed as a dependent on another's tax return.

IRS HSA Contribution Limits for 2012 tax year

	OCTA 2012 Contribution	Maximum Voluntary Employee Contribution	HSA Contribution Limit for 2012*
Annual Single Contribution Maximum	$1,250	$1,850	$3,100
Annual Family Contribution Maximum	$2,500	$3,750	$6,250

* Annual Catch-Up Contribution Maximum (for HSA participants that are 55 years or older) is $1,000

Kaiser Permanente and Anthem Blue Cross
HMO Medical Plans

MEDICAL PLAN BENEFITS	Kaiser Permanente	Anthem Blue Cross
Benefit Plan Limits		
Calendar Year Deductible *(Individual / Family)*	None	None
Calendar Year Out-of-Pocket Maximum (*Individual / Family)*	$1,500/$3,000	$1,500/$3,000
Lifetime Benefit Maximum	Unlimited	Unlimited
Outpatient Professional Services	**Your Copay**	**Your Copay**
Office Visit	$20	$20
Specialist Visit	$20	$20
Preventive Health Services		
• Routine Physical Examination	No Charge	No Charge
• Routine Laboratory Services	No Charge	No Charge
Outpatient Diagnostic Lab & X-ray	No Charge	No Charge*
Chiropractic	Not Covered	$15 (20 Visits/Year)
Hospital Services	**Your Copay**	**Your Copay**
Inpatient Hospital	$500/Admission	No Charge
Outpatient Surgery	$20 per Procedure	No Charge
Emergency Room Copay *(waived if admitted)*	$100	$100
Mental Health / Substance Abuse	**Your Copay**	**Your Copay**
Inpatient Hospital	$500/Admission	No Charge
Outpatient Services	$20	$20
Prescription Drug Benefits	**Your Copay**	**Your Copay****
Calendar Year Deductible *(Individual / Family)*	None	None
Retail Pharmacy (30-Day Supply)	(100 Day Supply)	
Generic	$10	$10
Brand Name Formulary	$20	$20
Brand Name Non-Formulary		$40
Mail Order Pharmacy (90-Day Supply)		
Generic		$10
Brand Name Formulary		$40
Brand Name Non-Formulary		$80

* Complex Radiology (MR/CAT, CT, PET) is $100/Test)

**Mandatory Generic Substitution applies: If a member requests a brand-name drug when a generic EQUIVALENT drug substitution exists, then the member pays the generic drug copay plus the difference in cost between the negotiated rate for the generic drug and the brand-name drug, but not more than 50 percent of Anthem's cost of the prescription drug. Mandatory generic substitution does not apply when the member's physician has specified "dispense as written" (DAW) or a brand-name drug has been determined to be "medically necessary" for the member. In such case, the applicable copay for the dispensed drug will apply.

Anthem Blue Cross
PPO Medical Plan

MEDICAL PLAN BENEFITS		
Benefit Plan Limits	**In-Network**	**Out-of-Network**
Calendar Year Deductible *(Individual / Family)*	$250/$750	
Calendar Year Out-of-Pocket Maximum (*Individual / Family)*	$1,500/$3,000	$3,000/$6,000
Lifetime Benefit Maximum	Unlimited	
Outpatient Professional Services	**Your Copay / Coinsurance**	
Office Visit	$15	40%
Specialist Visit	$15	40%
Preventive Health Services		
• Routine Physical Examination	No Charge	40%
• Routine Laboratory Services	No Charge	40%
Outpatient Diagnostic Lab & X-ray	No Charge	40%
Chiropractic - 24 Visits	20%	40% to $25 (24 Visits/Year)
Hospital Services	**Your Copay / Coinsurance**	
Inpatient Hospital	20%	40%
Outpatient Surgery	20%	40%
Emergency Room Copay *(waived if admitted)*	$100	
Mental Health / Substance Abuse	**Your Copay / Coinsurance**	
Inpatient Hospital	20%	40%
Outpatient Services	$15	40%
Prescription Drug Benefits	**Your Copay / Coinsurance***	
Calendar Year Deductible *(Individual / Family)*	None	
Retail Pharmacy (30-Day Supply)		
Generic	$10	
Brand Name Formulary	$20	
Brand Name Non-Formulary	$35	
Mail Order Pharmacy (90-Day Supply)		
Generic	$10	
Brand Name Formulary	$40	
Brand Name Non-Formulary	$70	

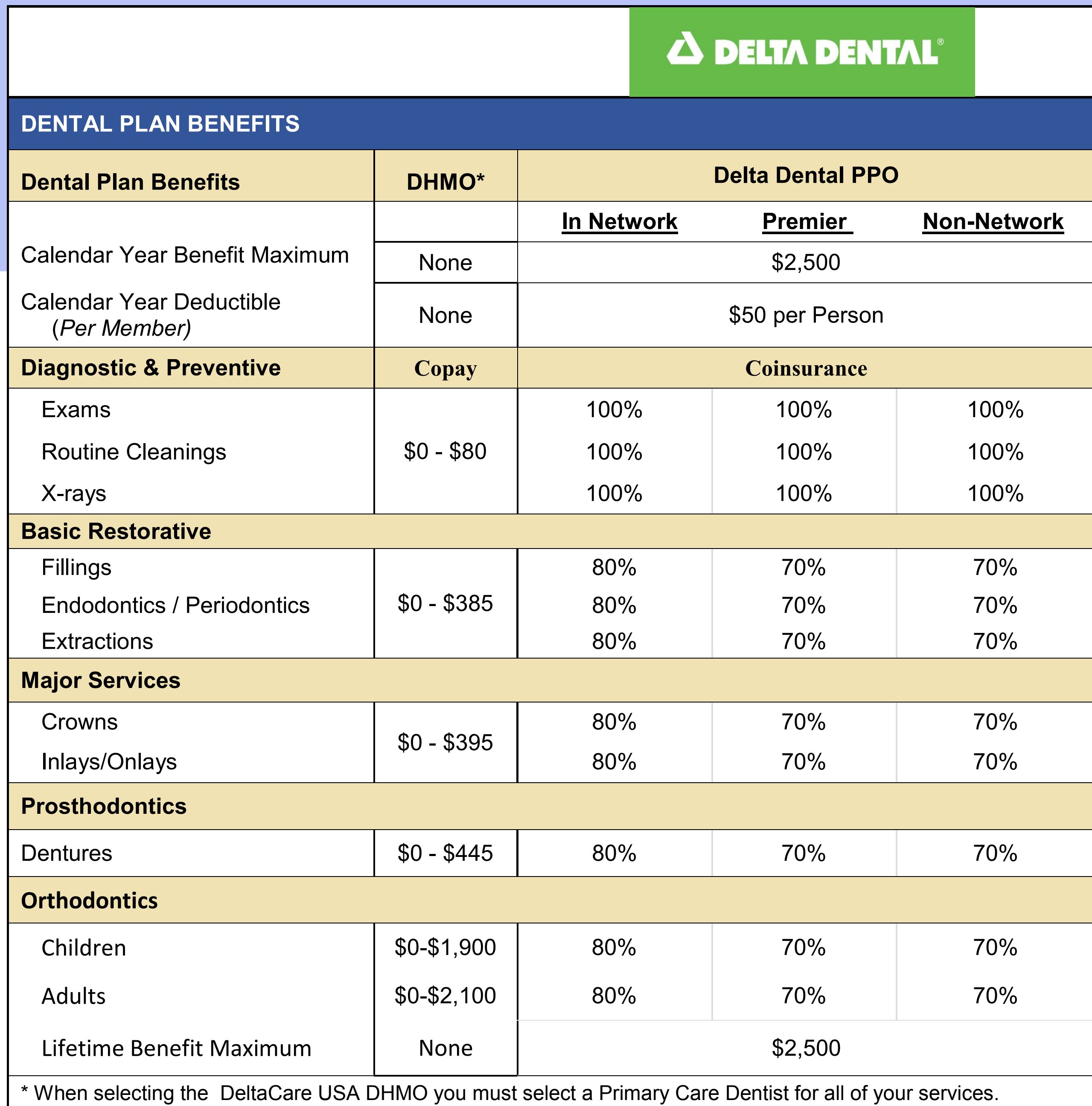
*Mandatory Generic Substitution applies: If a member requests a brand-name drug when a generic EQUIVALENT drug substitution exists, then the member pays the generic drug copay plus the difference in cost between the negotiated rate for the generic drug and the brand-name drug, but not more than 50 percent of Anthem's cost of the prescription drug. Mandatory generic substitution does not apply when the member's physician has specified "dispense as written" (DAW) or a brand-name drug has been determined to be "medically necessary" for the member. In such case, the applicable copay for the dispensed drug will apply.

Anthem Blue Cross
CDHP Medical Plan

MEDICAL PLAN BENEFITS		
Benefit Plan Limits	**In-Network**	**Out-of-Network**
Calendar Year Deductible *(Individual / Family)*	$1,250/$2,500	
Health Savings Account—OCTA Funded (Individual/Family)	$1,250/$2,500	
Calendar Year Out-of-Pocket Maximum (*Individual / Family)*	$2,500/$5,000	$5,000/$10,000
Lifetime Benefit Maximum	Unlimited	
Outpatient Professional Services	**Your Copay / Coinsurance**	
Office Visit	10%	30%
Specialist Visit	10%	30%
Preventive Health Services		
• Routine Physical Examination	No Charge	30%
• Routine Laboratory Services	No Charge	30%
Outpatient Diagnostic Lab & X-ray	10%	30%
Chiropractic	10%	30% to $25 (24 Visits/Year)
Hospital Services	**Your Copay / Coinsurance**	
Inpatient Hospital	10%	30%
Outpatient Surgery	10%	30%
Emergency Room Copay *(waived if admitted)*	10%	
Mental Health / Substance Abuse	**Your Copay / Coinsurance**	
Inpatient Hospital	10%	30%
Outpatient Services	10%	30%
Prescription Drug Benefits	**Your Copay / Coinsurance***	
Calendar Year Deductible *(Individual / Family)*	Must satisfy Medical Deductible prior to Pharmacy Copays	
Retail Pharmacy (30-Day Supply)		
Generic	$10	
Brand Name Formulary	$30	
Brand Name Non-Formulary	$50	
Mail Order Pharmacy (90-Day Supply)		
Generic	$10	
Brand Name Formulary	$60	
Brand Name Non-Formulary	$100	

*Mandatory Generic Substitution applies: If a member requests a brand-name drug when a generic EQUIVALENT drug substitution exists, then the member pays the generic drug copay plus the difference in cost between the negotiated rate for the generic drug and the brand-name drug, but not more than 50 percent of Anthem's cost of the prescription drug. Mandatory generic substitution does not apply when the member's physician has specified "dispense as written" (DAW) or a brand-name drug has been determined to be "medically necessary" for the member. In such case, the applicable copay for the dispensed drug will apply.

Dental
DeltaCare USA DHMO and Delta PPO Plan



DENTAL PLAN BENEFITS

Dental Plan Benefits	DHMO*	Delta Dental PPO		
		In Network	Premier	Non-Network
Calendar Year Benefit Maximum	None	$2,500		
Calendar Year Deductible (*Per Member)*	None	$50 per Person		
Diagnostic & Preventive	**Copay**	**Coinsurance**		
Exams	$0 - $80	100%	100%	100%
Routine Cleanings		100%	100%	100%
X-rays		100%	100%	100%
Basic Restorative				
Fillings	$0 - $385	80%	70%	70%
Endodontics / Periodontics		80%	70%	70%
Extractions		80%	70%	70%
Major Services				
Crowns	$0 - $395	80%	70%	70%
Inlays/Onlays		80%	70%	70%
Prosthodontics				
Dentures	$0 - $445	80%	70%	70%
Orthodontics				
Children	$0-$1,900	80%	70%	70%
Adults	$0-$2,100	80%	70%	70%
Lifetime Benefit Maximum	None	$2,500		

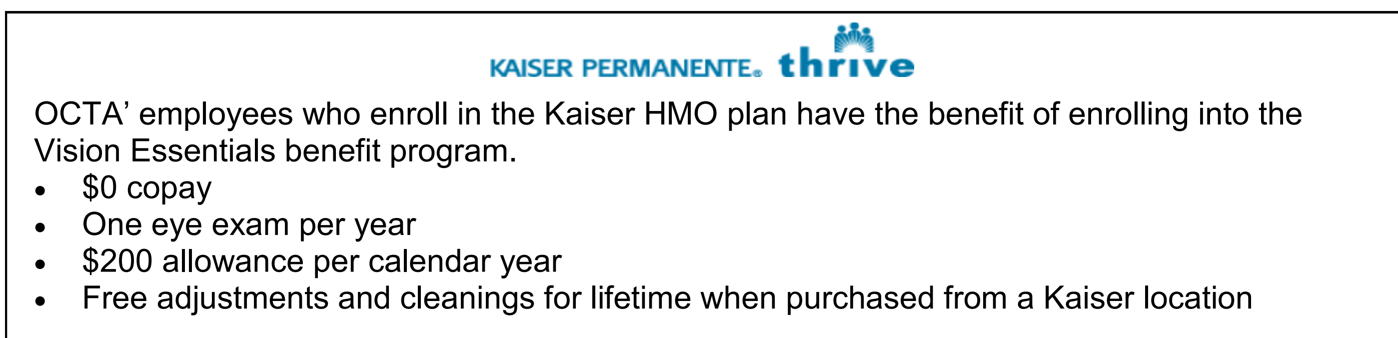
* When selecting the DeltaCare USA DHMO you must select a Primary Care Dentist for all of your services.

Which PPO dental network is right for you?

In-Network	Non-Network	
Delta Dental Preferred Providers	**Delta Dental Premier Network**	**Out-of-Network Providers**
You will receive the highest level of benefits because these dentists have agreed to charge lower rates. Plus, you will pay a lower percentage of these lower, negotiated rates.	You will be required to pay the higher, non-network percentage of Reasonable & Customary charges instead of the lower, negotiated rates charged by in-Network providers. However, you will not be required to pay more than Reasonable & Customary (no balance billing).	When you see a non-network provider you will pay the deductible, the applicable coinsurance, plus any amount above the Reasonable & Customary charges.

VSP and Kaiser Permanente
Vision Service Plan Choice and Vision Essentials

	Schedule of Benefits	
Plan Benefits	**In-Network**	**Out-Of-Network**
FREQUENCY		
Examination	Every 12 Months	
Lenses	Every 12 Months	
Contact Lenses (in lieu of lenses)	Every 12 Months	
Frames	Every 24 Months	
COPAY	$25 copay	Not Applicable
EXAM *(Dilation Included)*	100%	$45 Allowance
STANDARD LENSES		
Single Vision	100%	$30 Allowance
Bifocal	100%	$50 Allowance
Trifocal	100%	$65 Allowance
FRAMES	Up to $120 frame allowance plus 20% discount on any frame overage	$70 Allowance
CONTACT LENSES		
Elective	Up to $105 Allowance	$105 Allowance
Medically Necessary	No Charge if medically necessary, otherwise $50 fee. Every 12 months if needed.	$250 Allowance


KAISER PERMANENTE. thrive

OCTA' employees who enroll in the Kaiser HMO plan have the benefit of enrolling into the Vision Essentials benefit program.

- $0 copay
- One eye exam per year
- $200 allowance per calendar year
- Free adjustments and cleanings for lifetime when purchased from a Kaiser location

Employees that have selected Anthem may elect vision coverage through VSP (Employees who have selected Kaiser, the vision coverage is included in the Kaiser medical plan).

Employee Contributions-Less Than 10 Yrs. Service

Plans	Monthly Premium	Employee Cost Per Month	Employee Cost Per Pay Period
Kaiser			
Employee Only	$505.80	$50.58	$23.34
Two-Party	$1,011.61	$151.74	$70.03
Family	$1,431.43	$214.71	$99.10
Anthem HMO			
Employee Only	$456.89	$45.69	$21.09
Two-Party	$959.45	$143.92	$66.42
Family	$1,370.65	205.60	$94.89
Anthem PPO			
Employee Only	$660.48	99.07	$45.73
Two-Party	$1,387.01	277.40	$128.03
Family	$1,981.44	$396.29	$182.90
Anthem CDHP			
Employee Only	$494.58	$49.46	$22.83
Two-Party	$1,038.61	$155.79	$71.90
Family	$1,483.73	$222.56	$102.72
Delta Dental DHMO			
Employee	$11.19	$1.12	$0.52
Two-Party	$17.30	$2.60	$1.20
Family	$22.94	$3.44	$1.59
Delta Dental DPPO			
Employee	$77.46	$7.75	$3.58
Two-Party	$163.58	$24.54	$11.32
Family	$218.99	$32.85	$15.16
Vision Service Plan (VSP)			
Employee	$11.79	$1.18	$0.54
Two-Party	$22.61	$3.39	$1.57
Family	$32.34	$4.85	$2.24

Employee Contributions-More Than 10 Yrs. Service*

Plans	Monthly Premium	Employee Cost Per Month	Employee Cost Per Pay Period
Kaiser			
Employee Only	$505.80	$0	$0.00
Two-Party	$1,011.61	$50.58	$23.34
Family	$1,431.43	$71.57	$33.03
Anthem HMO			
Employee Only	$456.89	$0.00	$0.00
Two-Party	$959.45	$47.97	$22.14
Family	$1,370.65	$68.53	$31.63
Anthem PPO			
Employee Only	$660.48	$49.54	$22.86
Two-Party	$1,387.01	$138.70	$64.02
Family	$1,981.44	$198.14	$91.45
Anthem CDHP			
Employee Only	$494.58	$24.73	$11.41
Two-Party	$1,038.61	$77.90	$35.95
Family	$1,483.73	$111.28	$51.36
Delta Dental DHMO			
Employee	$11.19	$1.12	$0.52
Two-Party	$17.30	$2.60	$1.20
Family	$22.94	$3.44	$1.59
Delta Dental DPPO			
Employee	$77.46	$7.75	$3.58
Two-Party	$163.58	$24.54	$11.32
Family	$218.99	$32.85	$15.16
Vision Service Plan (VSP)			
Employee	$11.79	$1.18	$0.54
Two-Party	$22.61	$3.39	$1.57
Family	$32.34	$4.85	$2.24

Opt-out-Credit

Employees who elect to waive all OCTA health plans—medical, dental and vision, are eligible to receive as taxable income an opt-out-credit of $200 per month. Documentation which verifies proof of other medical plan coverage is required in order to receive the opt-out-credit. An employee who is a spouse, child, or any other eligible dependent of another OCTA Administrative/TCU employee, is not eligible for the opt-out-credit if he/she is covered under an OCTA health plan.

* Employees hired prior to 06/27/04 will be grandfathered into the ten-year tenured benefit.

Life and Disability Insurance

Life Insurance and AD&D Plan Features				
Benefit Type	**Provider Name**	**Amount of Benefit**	**Minimum/ Maximum Benefit Amount**	**Eligibility**
Life and AD&D Insurance	Lincoln Financial Group	2X Annual Salary rounded to the next thousand. Board Members $50,000	Minimum-$10,000 Maximum-$500,000	All full-time & part-time Administrative/TCU Employees/Board of Directors
Supplemental Life Insurance	Lincoln Financial Group	Varies	Increments of $10,000 to a Maximum of $250,000 (not to exceed five times your annual earnings)	All full-time & part-time Administrative/TCU Employees/Board of Directors

Short-Term Disability (STD)

When a non-work related illness or injury makes it impossible for you to work for a short period of time, your income may be continued under OCTA's Short-Term Disability Plan. This plan includes:

- Income protection of 67% of your basic weekly salary less any income from other sources,
- A maximum benefit of $1,400 per week,
- Non-occupational illness covered the first day of disability due to accident injury or the day sick leave is exhausted (whichever is longer); and the 8th consecutive day of Disability due to sickness or the day sick leave is exhausted (whichever is longer),
- Eligibility for full-time and part-time Administrative employees only under this plan, and
- 100% of premium paid for full-time employees; 50% of premium is paid for part-time employees if this benefit is elected.

Long-Term Disability (LTD)

When an illness or injury makes it impossible for you to work for an extended period of time, your income may be continued under OCTA's Long-Term Disability Plan. Under this plan, if you are disabled for more than 13 weeks, you are eligible to receive benefits. This plan includes:

- Income protection of 67% of your monthly base earnings less any income from other sources,
- A maximum benefit of $8,000 per month,
- Eligibility for full-time and part-time Administrative and TCU employees only under this plan, and
- 100% of premium paid for full-time employees; 50% of premium is paid for part-time employees if this benefit is elected.

Voluntary Benefits & Employee Assistance Program (EAP)

AFLAC

OCTA employees can purchase supplemental insurance through AFLAC. If you get hurt or sick, AFLAC pays you a cash benefit. Unlike traditional health insurance, AFLAC does not pay the doctor or the hospital, unless you tell them to. AFLAC works autonomously from any other insurance plan, and includes the following:

- Personal Accident Indemnity
- Cancer Indemnity
- Specified Health Event with Intensive Care
- Hospital Protection
- Dental and Vision

Resources For Living

OCTA's Employee Assistance Program (EAP), administered by Resources for Living (RFL), is a **CONFIDENTIAL** service designed to help you and members of your household resolve personal and workplace challenges, such as:

- Substance Abuse Recovery
- Legal Assistance
- Money Management
- Work Issues
- Parenting and Child Care

Access your EAP, RFL, 24-hours a day, 7 days a week.
Contact number: (866) 370-4838 or www.rfl.com

Flexible Spending Account (FSA)

Flexible Spending Accounts (FSAs) are made possible by Section 125 of the Internal Revenue Code. FSAs enable employees to set aside money on a pre-tax basis to cover eligible health care and dependent care expenses. To be eligible for participation under the FSA, you must be a regular full-time or part-time employee who works at least 20 hours each week.

If you elect the Health Care, Limited Purpose and/or Dependent Care Account options, an annual pre-tax amount is taken in increments each pay period, determined by you, from your gross pay. This money goes directly into the flexible spending accounts you have specified. After you incur eligible health or dependent care expenses, simply submit a Flexible Spending Account claim form to be reimbursed from the appropriate account.

Discovery Benefits is the FSA plan administrator, and provides many great online resources for you. Your account information is viewable anytime by accessing www.discoverybenefits.com.

A debit card is available for you and your dependents for eligible health care expenses at any qualified merchants. The debit card will hold your 2012 account election amount.

Health Care Account

The maximum contribution to the Health Care Flexible Spending Account is $3,500/year.
A Health Care Spending Account is used to pay for eligible health care expenses not covered by any insurance plan (for example: medical, dental, or vision). Specific covered items include:

- Expenses for certain commonly used over-the-counter (OTC) medicines such as Claritin, Advil, and Robitussin cough syrup, are eligible for reimbursement with a doctor's written directive or Letter of Medical Necessity. Please visit www.discoverybenefits.com for additional information on eligible expenses
- Out-of-pocket (with prescription) Medical, Dental, Vision, and
- Deductibles/Co-pays

Changes to Your Health Care Account

- You may also make changes to your Health Care Spending Account for life changing events, with one exception: You may not make changes to your Health Care Spending Account because of a significant change in coverage or cost.

Flexible Spending Account (FSA)

Dependent Care Account

Covers expenses incurred for the care of a qualifying dependent.

The maximum contribution to the Dependent Care Flexible Spending Account is $5,000/ year.

Changes to Your Dependent Care Account

You may also make changes to your **Dependent Care Spending Account** if you experience one of the events listed below. You may even make changes if you experience significant changes in coverage or cost, such as:

- You change day care providers,
- Your cost for dependent care increases or decreases more than 10% (as long as the caregiver is not a relative), or
- Your child reaches age 13 and expenses for his or her care are no longer eligible expenses under the account, or
- “Special Enrollment Events” may allow you to change your pre-tax contributions to the medical, dental, vision, or Health Care Spending Account, but not your Dependent Care Spending Account.

Limited Purpose Health Care Account

A Limited Flexible Spending Account (LFSA) allows you to purchase eligible out-of-pocket dental, vision and/or preventive care expenses with pre-tax dollars. You save money because you don't pay taxes on the money you set aside. It’s a great perk from your employer and it will save you money. Specific covered items include:

- Dental - Dental visits/treatment, dental copays/deductible, cleaning, filings, crowns and orthodontics
- Vision - Lasik surgery, eye exams, contact lenses, eyeglasses, refractions and vision correction procedures
- Preventive - Tobacco Cessation Programs, Obesity Weight Loss Programs, Prescriptions taken to prevent the onset of a condition for which a person has developed risk factors, Cholesterol-lowering Drugs, Screening Services, Immunizations and Health Exams which includes annual check-ups
- Ineligible Expenses - Medical office visits, medical deductible expenses, prescription co-insurance, cosmetic dental services, medical expenses, mental health expenses, medical copays, chiropractic, cosmetic optional services, most over the counter drugs and prescriptions drugs/copays
- Please visit www.discoverybenefits.com for additional information on eligible and ineligible expenses

Please note **important points regarding the Flexible Spending Account:**

- You must enroll each plan year to participate in FSA.
- There is a two and a half month grace period that allows you to be reimbursed from the prior plan year balance, if any, for expenses incurred during the grace period.
- IRS regulations state that any unused funds which remain in a Flexible Spending Account after a plan year ends and all reimbursement requests have been submitted and processed within the grace period cannot be returned to you. “Use it or Lose It”.

Retirement

Orange County Employees Retirement System (OCERS)

Employees of OCTA are exempt from contributing to the Social Security System for retirement purposes, with the exception of 1.45% of gross income, which is paid into the Medicare portion of Social Security. Instead, contributions are made to the Orange County Employees Retirement System (OCERS) each pay period for full-time and part-time employees of regular status. The contribution amount is based on the employee's age when enrolled into the system. For Administrative employees, OCTA pays both the employee's portion as well as the employer's portion of the contributions.

The earliest date of retirement is age 50 or over with 10 or more years of service credit. Part-time employees age 55 or older with 5 years of service credit and at least 10 years of active employment are eligible to receive retirement benefits.

OCTA's Plan Type (Tier II) is "1.6667 @ 57.5." The monthly value of this benefit at age 65 with 10 years of service is equal to 2.4% of your final average salary (three consecutive years).

Employees who became members prior to September 21, 1979, participate in a different Plan Type (Tier I). For further information, please contact Lorraine Mills in Human Resources at (714) 560-5825.

Additional Retiree Benefit Account (ARBA) Plan

An employee who retires from OCTA after January 1, 1995, may be eligible for a supplemental retirement benefit under the Additional Retiree Benefit Account (ARBA) Plan. The benefit is $10.00 per month for each year of service performed for OCTA covered by OCERS, not to exceed a monthly supplement of $150.00.

The retiring employee is eligible if the following conditions are met:

- Employees must be members of the Orange County Employee's Retirement System, and
- Service retirement must occur within 30 days of separation from OCTA, and
- Employees must meet the OCERS eligibility criteria of a minimum age 50 and have at least 10 years of OCERS service.

OCTA reserves the right to modify or terminate this plan at any time by action of the Board of Directors. Administration of the ARBA Plan will be in accordance with the plan document.

Retirement

457(b) Deferred Compensation Plan and 401(a) Defined Contribution Plan

The 457(b) Deferred Compensation Plan provides you with the opportunity to invest a portion of your salary on a pre-tax basis and/or roll funds from other qualified plans into your 457(b) retirement plan. The minimum payroll deferral is $25 each pay period.

The process for enrolling in the Deferred Compensation plan is as follows:

- Complete an enrollment form stating the portion of your wages you would like transferred through payroll deductions into your personal Deferred Compensation account.
- Return the completed enrollment form to Human Resources. Please see the Health and Welfare Contact List at the back of this booklet for more information.
- The amount you have specified for deferral will be allocated directly into your personal Deferred Compensation account each pay period on a pre-tax basis.
- You may start or stop 457(b) payroll contributions or change your contribution rate throughout the year.
    - Increases to your contribution rate are effective the first of the following month from when your change form is received in Human Resources.
    - Decreases to your contribution rate are effective the next available pay period, unless otherwise specified

2012 Maximum Annual Contributions to the 457(b) Plan

(Established by the Internal Revenue Service)

For Employees Under Age 50: **$17,000**

For Employees Age 50 and Above: **$22,500**

For Pre-Retirement Catch-Up Provision: **$31,000**

Please note that deferral limits are subject to change. Visit the IRS website at www.irs.gov for more information. To help maximize your retirement savings, OCTA offers a 401(a) Plan to eligible employees, which compliments your Deferred Compensation savings. Your personal contributions are allocated to your 457(b) Plan. Employer-paid contributions are allocated to your 401(a) Plan. Contributions to the 401(a) Plan do not reduce the amount you may contribute to your 457(b) Plan.

Retirement

<u>401(a) Plan - Employer-Paid Contribution Schedules</u>
(For Administrative Employees and for Employees Represented by the Transportation Communications International Union)

Employer-Paid Matching Contributions to All Administrative Employees:
OCTA will match contributions to your 401(a) Plan based on years of service as set forth below:

- 1% of base pay for employees with 5 years or more of service
- 2% of base pay for employees with 10 years or more of service
- 3% of base pay for employees with 20 years or more of service

Employer-Paid Matching Contributions to Administrative Employees in Salary Grade V and Above:
In addition to the above schedule, OCTA will match contributions to your 401(a) Plan, up to 2% of your base salary, upon hire or promotion.

Employer-Paid Contributions to All Employees Represented by the Transportation Communications International Union:
OCTA will contribute to your 401(a) Plan based on years of service as set forth below:

- 1% of base pay for employees with 5 years or more of service
- 2% of base pay for employees with 15 years or more of service

To learn more about the Deferred Compensation Plan, please go to the octatoday intranet site. If you are unable to access the Intranet, please check out your location's information board. You can also contact the Deferred Compensation provider, Nationwide Retirement Solutions, or an OCTA Human Resources Representative. Please see the Health and Welfare Contact List at the back of this booklet for more information.

Required Federal Notices

HIPAA Pre-Existing Condition Exclusion Rules

Your medical benefit plan may impose a preexisting condition exclusion upon enrollees age 19 and older. That means that if you are age 19 or older and have a medical condition before coming to our Plan, you might have to wait a certain period of time before the Plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period. Generally, this 6 month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6 month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy.

This exclusion may last up to 12 months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days.

To reduce the exclusion period by your creditable coverage, you should provide the new carrier with a copy of any certificates of creditable coverage (HIPAA Certificates) you have. If you do not have a Certificate, but you do have prior health coverage, you can obtain one from your prior plan or issuer. This does not apply to the Kaiser and Anthem HMO Medical plans.

Notice of Availability of HIPAA Privacy 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 Human Resources Department or by contacting the insurance carriers directly.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires employer groups to notify participants and beneficiaries of the group health plan, of their rights to mastectomy benefits under the plan. Participants and beneficiaries have rights for coverage to be provided in a manner determined in consultation with the attending Physician 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. You can contact your health plan's Member Services for more information.

Required Federal Notices

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

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

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

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

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

If You may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility. This information is current as of January 31, 2011.

CALIFORNIA—MEDICAID
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 866-298-8443

If you live outside of California, please contact 877-KIDS-NOW or visit www.insurekidsnow.gov to find your state's information.

For more information you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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, Ext. 61565

Important Notice from Orange County Transportation Authority 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 Orange County Transportation Authority and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare 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.

Orange County Transportation Authority has determined that the prescription drug coverage offered by Orange County Transportation Authority is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you do decide to join a Medicare drug plan and drop your current Orange County Transportation Authority prescription drug coverage, be aware that you and your dependents will may 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.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Orange County Transportation Authority and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

(continued)

Important Notice from Orange County Transportation Authority About Your Prescription Drug Coverage and Medicare

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may 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 join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Orange County Transportation Authority changes. You also may request a copy of this notice at any time.

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 drug plans.

For more information about Medicare prescription drug coverage: Visit www.medicare.gov.

Call your State Health Insurance Assistance Program (see the inside back cover of 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.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or 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, 2012
Name of Entity:	Orange County Transportation Authority
Contact:	Human Resources
Address:	550 South Main Street
Phone Number:	(714) 560-5825

Notes

Carrier Contact Information

Plan	Carrier	Telephone	
Medical	Kaiser Permanente	(800) 464-4000	www.kp.org
	Anthem Blue Cross HMO	(800) 888-8288	www.anthem.com/ca
	Anthem Blue Cross PPO	(800) 888-8288	www.anthem.com/ca
	Anthem Blue Cross CDHP	(866) 207-9878	www.anthem.com/ca
Dental	Delta Dental PPO	(800) 765-6003	www.deltadentalins. com
	DeltaCare USA DHMO	(800) 765-6003	www.deltadentalins. com
Vision	Vision Service Plan Choice	(800) 877-7195	www.vsp.com/choice
Employee Assistance Program (EAP)	Resources for Living	(866) 370-4838	www.rfl.com
Life	Lincoln Financial Basic Life and AD&D	(714) 560-5812	www.lfg.com
	Lincoln Financial Group Supplemental Life	(714) 560-5812	www.lfg.com
Disability	Lincoln Financial Group STD	(714) 560-5812	www.lfg.com
	Lincoln Financial Group LTD	(714) 560-5812	www.lfg.com
Deferred Compensation	Nationwide Retirement Solutions	(877) 677-3678	www.nrsservicecenter. com
Voluntary	AFLAC	(800) 992-3522	www.aflac.com
FSA	Discovery Benefits	(866) 451-3399	www.discoverybenefits.com
OCERS	Orange County Employees Retirement	(888) 570-6277	www.ocers.org
Credit Union	Orange County Credit Union	(714) 755-5900	www.orangecountyscu.org

Employee Benefits Brochure designed and developed by

in conjunction with Orange County Transportation Authority October 2011