Los Angeles County Metropolitan Transportation Authority

Benefits Enrollment Guide

Board of Directors

Metro®

2012

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INTRODUCTION

The information contained in this Flexible Benefit Enrollment Guide (Guide) is intended to provide a basic explanation of the benefit options available to members of the Board of Directors under the Metro Benefits Program.

For Board Members, coverage becomes effective on the first of the month following appointment. If your appointment is on the first day of the month, coverage is immediate. Enrollment forms must be completed within 30 days of appointment, otherwise enrollment may be delayed until the next Open Enrollment period.

The annual Open Enrollment period is from November 7 through November 20, 2011, and the changes to your benefit plans become effective January 1, 2012. If you wish to make any changes to your benefit plans, or wish to enroll for the first time, you must return the completed enrollment forms and supporting documentation by November 20, 2011.

Plans described in the Guide are subject to the specific terms and provisions of the legal documents governing the plans. Provisions of the plans, as established in the plan documents, are the sole source for interpretation and administration of the plans and programs.

You must complete, sign, date and return your Open Enrollment Form indicating changes by November 20, 2011. Return your Open Enrollment information to:

Los Angeles County
Metropolitan Transportation Authority
c/o Michele Jackson, Board Secretary
One Gateway Plaza
Los Angeles, CA 90012

If you have any questions relating to your benefit plans, please feel free to call Jan Olsen, Pension and Benefits Supervisor at 213.922.7151.

If you are enrolled for medical and/or dental benefits through another group insurance plan, it is not necessary to enroll if you do not wish to participate in the Metro Plans.

It is important that you retain this Guide for future reference.

HEALTHCARE REFORM SPECIAL NOTICES

Grandfathered Health Plan Status

The Los Angeles County Metropolitan Transportation Authority and the Public Transportation Services Corporation believe the medical plans under the Flexible Benefits Program are "grandfathered health plans" 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 medical 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 Benefits Administration, One Gateway Plaza, 99-21-7, Los Angeles, CA 90012.

Pre-Existing Condition Exclusions

Effective January 1, 2011, pre-existing condition exclusions can't be imposed for children under age 19 based on Health Care Reform requirements. Please note that MTA/PTSC has removed pre-existing condition exclusions from the Anthem Blue Cross PPO plan for all eligible members.

ENROLLMENT

New Board Members

Included with this Guide is your Metro personalized Enrollment Form. Please make all elections directly on the form.

If you wish to enroll for the first time, you must also complete individual enrollment forms for each elected benefit plan.

Annual Open Enrollment

During the annual Open Enrollment period, there is no need to return your enrollment form if you are not making changes. If you change your medical plan or dental plan, you must also complete an enrollment form for that specific plan.

After you have read this Guide and studied your choices, you will be ready to complete your Metro Enrollment Form, and any other required documents.

ELIGIBILITY

Eligible Dependents

Eligible dependents include:

- Your spouse to whom you are legally married
- 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 a 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 experience a HIPAA special enrollment event or qualified.

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 brochure from the Benefits Administration Department.

ELIGIBILITY

HIPAA Notice of Special Enrollment Rights

If you have declined enrollment for yourself or your dependents (including spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, please contact Benefits Administration.

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 in order 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 MTA/PTSC Flexible Benefits Program.
- "Qualifying Children to age 26"*. Qualifying Children are your children by birth, adoption, stepchildren, or foster children who are permanently and totally disabled regardless of age:
  - Are not married;
  - Do not provide over one-half of their own support; and
  - 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*; and
    (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 www.irs.gov 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.

Newborns and Mother's Health Protection Act

Federal law protects the benefit rights of mothers and newborns related to any hospital stay in connection with childbirth. In general, group health plans and health insurance issuers may not:

Restrict benefits for the length of hospital stay for the mother or newborn child to less than 48 hours

ELIGIBILITY

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).

Require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay of up to 48 hours (or 96 hours).

For details on any state maternity laws that may apply to your medical plan, please refer to the plan material for the medical plan in which you are enrolled.

MEDICAL PLANS

Metro offers you three medical plan options:

1. Anthem Blue Cross PPO Medical Plan
2. Anthem Blue Cross HMO Medical Plan
3. Kaiser Permanente Medical Plan

Anthem Blue Cross PPO Medical Plan

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, or online at *www.anthem.com*.

Anthem Blue Cross HMO Medical Plan

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 Medical Plan

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 more than 90 medical offices and 10 medical centers in the Southern California region. You are never limited to just one doctor or office.

Table 1 highlights the Anthem Blue Cross PPO Medical Plan benefits; Table 2 highlights Anthem Blue Cross HMO and Kaiser benefits.

Special Notice – The Women's Health and Cancer Rights Act (WHCRA)

WHCRA requires coverage for certain types of reconstructive surgery following a mastectomy. When a person is receiving benefits under one of our medical plans in connection with a mastectomy and elects breast reconstruction, coverage will be provided for treatment of mastectomy complications, including lymphedemas, and the following treatments if agreed to by the patient and attending physician:

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

Coverage for these services will be provided subject to the same deductibles, coinsurance, and co-pay provisions as other benefits under the plan. (Please refer to the Evidence of Coverage for your medical plan to obtain specific details relating to plan deductibles, co-pays, etc.)

Table 1

Anthem Blue Cross PPO Medical Plan

Plan Provision	PPO	Non-PPO
Deductible – Individual	$150	$150
Deductible – Family	$450	$450
Deductible Waived:		
Inpatient Hospitalization	Yes	No
Mammogram	Yes	No
Cervical Cancer Screening	Yes	No
Well Baby Care	Yes	No
Co-Pay/Coinsurance:		
Inpatient Hospitalization	0%	$600/30%
Outpatient	10%	30%
Office Visit	$15	30%
Surgery (Outpatient)	10%	30%
Routine Wellness Checkup and Exams:		
Child 0-6	0%	30%, limited to $20/exam
Age 7 to Adult	0%	Not covered
Prescription Drugs: (up to 30 day supply)	$10 Generic/$15 Brand	See Below*
Prescription Mail Order: (up to 60 day supply)	$10 Generic/$15 Brand	N/A
Out-of-Pocket Maximum (after deductible):		
Individual	$1,000	$2,000
Family	$2,000	$5,000
Lifetime Maximum	Unlimited	Unlimited

** You pay the copayment plus the difference between the cost of prescription at a non-network pharmacy and 50% of the cost of the prescription at a network pharmacy.*

Vision *Covered by the Vision Service Plan (VSP)*

Mental Health and Substance Abuse

Deductible:	No separate deductible	
Co-Pay/Coinsurance:		
Inpatient	0%	30%
Outpatient (pre-service review required after the 12th visit)	$15	30%

Table 2

Anthem Blue Cross HMO and Kaiser Comparison

Hospital Services, Skilled Nursing Facility Care, Ambulatory Surgical Centers, Hospice and Home Health Care

Plan Service	Anthem Blue Cross HMO	Kaiser
Inpatient Care:		
Semi-private room	No charge	No charge
Operating room	No charge	No charge
Nursing Care	No charge	No charge
Drugs, Medications & Oxygen	No charge	No charge
Blood & Blood Products	No charge	No charge
All necessary and ancillary services	No charge	No charge
Outpatient Care (Hospital Only)	No charge	$5 per visit
Skilled Nursing Facility (limited to 100 days*)	No charge	No charge
Ambulatory Surgical Center	No charge	$5 per visit
Hospice	No charge	No charge
Home Health Care Visits (limited to 100 visits/year)	$5 per visit	No charge
Physician Services: Physician visits including primary care, specialty care, and consultation		
Office Visits	$5 per visit	$5 per visit
Specialists/Consultants	$5 per visit	$5 per visit
Rehabilitative Care	$5 per visit/limited to 60 days per illness or injury	$5 per visit
Hospital visits (inpatient)	No charge	No charge
Skilled Nursing Facility visits	No charge	No charge
Diagnostic studies and laboratory procedures	No charge	$5
Surgeon, surgical assistants and anesthesia	No charge	No charge
Prescription Drug	$5 Generic/$10 Brand	$5 Generic/$10 Brand
Health Maintenance and Wellness Services Preventive Care		
Routine check-ups and examinations	$0 per exam	$5 per visit
Well Baby Care	$0 per exam	$5 per visit
Hearing examinations	$0 per exam	$5 per visit
Immunizations	No charge	No charge
Allergy testing and treatments	$5 per visit	$5 per visit
Health Education and Wellness Programs	No charge	Varies

* Anthem Blue Cross HMO: The 100 day limit does not apply for Skilled Nursing Facility for mental health and substance abuse, but will apply for other conditions.

MEDICAL PLANS

Plan Service	Anthem Blue Cross HMO	Kaiser
Pregnancy and Maternity Care		
Prenatal and Postnatal Care (Office Visit)	$5 per visit	$5 per visit
Normal Delivery, Cesarean, Complications of Pregnancy:		
Physician services (inpatient)	No charge	No charge
Hospital and ancillary services	No charge	No charge
Genetic testing	No charge	No charge
Physician services (outpatient)	$5 per visit	$5 per visit
Emergency Care – In Area		
Physician and Medical Services	No charge	No charge at Kaiser
Outpatient Hospital Services	$50*	$50 at Kaiser*
Inpatient Hospital Services	No charge	No charge at Kaiser
Emergency Care – Out of Area		
Physician and Medical Services	No charge	No charge
Outpatient Hospital Services	$50	$50
Inpatient Hospital Services	No charge	No charge
Mental Health		
Outpatient (pre-service review required after 12th visit)	$5/visit copayment	$5/individual visit, $2 group visit
Inpatient (pre-authorization required)	$0/copay	No charge
Vision		
	Covered by Vision Service Plan (VSP)	Covered under Kaiser Medical Plan

* Waived if admitted to hospital.

VISION PLAN

To receive the maximum benefit available under the VSP plan, you should utilize the VSP provider network. VSP Member Provider benefits are shown in Table 4 below.

For Board Members enrolled in either the Anthem Blue Cross PPO or the Anthem Blue Cross HMO Medical Plan, you may enroll for vision benefits provided through Vision Service Plan (VSP).

Table 3

VISION SERVICE PLAN – Benefit Schedule For employees enrolled in Anthem Blue Cross PPO and Anthem Blue Cross HMO Only

Plan Services	In Network(1)	Out of Network(2)
Vision Exam every 12 months	$10 Co-Pay	Limited to $50
Corrective Lenses every 12 months	$20 Co-Pay	Limited to: Single Vision $50 Bi-Focal $75 Tri-Focal $100 Lenticular $125
Eyeglass Frame every 24 months	$20 Co-pay/ $120 Retail allowance	Limited to $70
Contact Lenses	$120 Allowance in lieu of other Plan Benefits	$105 Allowance in lieu of other Plan Benefits
Medically Necessary Contact Lenses(3)	$20 Co-pay	Limited to $210 Allowance
Computer Glasses	See Table 5	Not Covered

(1) Refer to the VSP brochure for detailed information on how to utilize VSP and it's network.

(2) Services obtained from out-of-network providers are subject to the same copayments and limitations as services obtained through VSP doctors.

(3) Medically necessary contact lenses must be prescribed for certain conditions that prevent you from wearing eyeglasses and must be pre-approved by VSP.

VISION PLAN

Table 4

VISION SERVICE PLAN

Computer Vision Care (CVC) – Benefit Schedule

- Services for this benefit must be obtained from a Vision Service Plan participating doctor
- Available for employees only; dependents and out-of-network services are not eligible
- The CVC Eye Exam is provided at the same time as your regular eye exam
- Subject to a $20 copayment and available at the same frequency as the standard program (exam and lenses every 12 months, frames every 24 months). Frame allowance $120, basic lenses covered for VSP–CVC plan.
- Includes any materials and professional services connected with ordering, fitting and adjusting CVC lenses
- Covers a wide selection of frames; if selected frame exceeds the limit, you will pay the difference
- Contact Lenses are not covered under the CVC program
- Provides up to $200 allowance for therapy for certain diagnosed muscular conditions associated with CVC use (requires pre-approval from VSP)

Table 5

Kaiser Permanente – Vision Benefit Schedule
For employees enrolled in the Kaiser Medical Plan.

Plan Services	Benefits Paid
Eye exams	$5 per visit
Corrective lenses	$300 Allowance for lenses, frame and
Frames	contact lenses, fitting and dispensing
Contact lenses	every 24 months if obtained at Kaiser

DENTAL PLANS

There are three dental plan options available from which to choose:

1. Delta Dental Plan
2. DeltaCare (DHMO)
3. Dental Health Services (DHMO)

Delta Dental Plan

This option 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. You pay a $50 annual deductible and any required copayments.

The annual maximum benefit is limited to $1,500 per covered person. The deductible does not apply to preventive services. **This plan does not provide orthodontia benefits.**

DeltaCare and Dental Health Services (DHMO'S)

Both of these prepaid plan options have similar plan provisions. Offering a choice of two separate prepaid plans gives employees greater choice in selecting a dentist from the plans' panels of dental providers. There are no deductibles, and no charge for preventive services. However, copayments are required for major work and orthodontia.

Table 6

Dental Plan Comparison Chart

Plan Provision	Delta Dental	DHS	DeltaCare
Deductible	$50 per person/$150 per family(3)	None	None
Annual Maximum	$1500 per person(4)	None	None
Cleaning(2)	100% UCR(1) (2 in 12 months)	No charge	No charge
Exam(2)	100% UCR(1) (2 in 12 months)	No charge	No charge
Bitewing X-Rays(2)	100% UCR(1) (2 in 12 months for children to age 18 or 1 in 12 months adults ages 18 and over)	No charge	No charge
Panoramic X-Rays	Once in 5 years	No charge	No charge
Extractions	80% UCR(1)	No charge	No charge
Emergency Treatment	Covered as regular treatment	No charge	No charge
Fillings	80% UCR(1)	No charge	No charge
Dentures, Crowns, Cast Restorations	50% UCR(1)	Covered	Covered
Orthodontia	Not covered	Covered	Covered

(1) Usual, customary and reasonable charges for service provided.

(2) Deductible does not apply.

(3) Paid by employee.

(4) $2,000 If DPO dentists are used.

Please refer to the individual dental plan brochures Schedule of Benefits for complete listings of covered services, charges and copayments.

OTHER BENEFITS

Designation of Beneficiary

You may change your beneficiary at any time during the year by completing and submitting a new Beneficiary Designation form (PERS-220).

Please review your Metro Open Enrollment form carefully to be sure your current beneficiary is listed. If you wish to make a change in beneficiary designation, you must complete a new "Beneficiary Designation" form (PERS-220) and return it with your enrollment materials.

Other Benefits

For your information, Board Members are also automatically enrolled for the following benefits.

- $250,000 in Accidental Death and Dismemberment Insurance
- $250,000 in Business Travel Accident Insurance
- $100,000 in Letter Bomb Insurance

MEDICAL PLANS — SPECIAL NOTICES

Mental Health Parity & Addiction Act of 2008

Assembly Bill 88 (AB 88) requires HMOs and insured medical plans issued, amended or renewed after July 1, 2000, to provide certain mental health benefits. Metro/PTSC medical plans are in compliance with this legislation.

As of Janaury 1, 2010, mental health services will be treated the same as any other health service under Metro/PTSC'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 copays 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.

Michelle's Law

As of October 9, 2009, your eligible full-time-student dependents can maintain their current benefits if they have to take a medically necessary leave of absence. Under this new law, your eligible full-time-student dependents' coverage can continue for up to a year, unless their eligibility would end earlier under another plan provision, such as termination of a parent's employment or the dependent's age exceeding 24 years of age.

Effective January 1, 2011, dependent children to age 26 can maintain their benefits regardless of whether tax dependent, student, married, or residing with the employee, as long as they are ineligible for other employer health plan coverage except for other parent coverage.

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 and 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 *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.**

California – Medicaid
Website: *www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx*
1.866.298.8443

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov.ebsa
1.866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
1.877.267.2323, Ext. 61565

IMPORTANT NOTICE FROM LACMTA/PTSC ABOUT YOUR PRESCRIPTION DRUG COVERAGE & 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. **LACMTA/PTSC 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 sixty (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 LACMTA/PTSC-sponsored coverage. In this case, the LACMTA/PTSC-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 LACMTA/PTSC-sponsored coverage, Medicare will be your only payer. You can reenroll in the LACMTA/PTSC-sponsored coverage at annual enrollment or if you have a special enrollment event as defined in your benefit plan material for the LACMTA/PTSC-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 LACMTA/PTSC-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 LACMTA/PTSC-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.

IMPORTANT NOTICE FROM LACMTA/PTSC ABOUT YOUR PRESCRIPTION DRUG COVERAGE & MEDICARE

Remember – Retired employees and their dependents that enroll in a Medicare prescription drug plan and drop their LACMTA/PTSC-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 nineteen months (19) 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 November to enroll.

For more information about this notice or your current prescription drug coverage…

Contact Jan Olsen, Benefits Administration, at 213.922.7151.

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 LACMTA/PTSC 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 800.MEDICARE (800.633.4227). TTY users should call 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 800.772.1213 (TTY 800.325.0778).

***Remember*: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium (a penalty).**

Date:	October 15, 2011
Name of Entity/Sender:	LACMTA/PTSC
Contact–Position/Office:	Jan Olsen, Pension and Benefits Administration, 21st Floor
Address:	One Gateway Plaza, Los Angeles, CA 90012-2952
Phone Number:	213.922.7151

NOTES

Los Angeles County
Metropolitan Transportation Authority
One Gateway Plaza
Los Angeles, CA 90012-2952
Phone 213.922.6000
metro.net