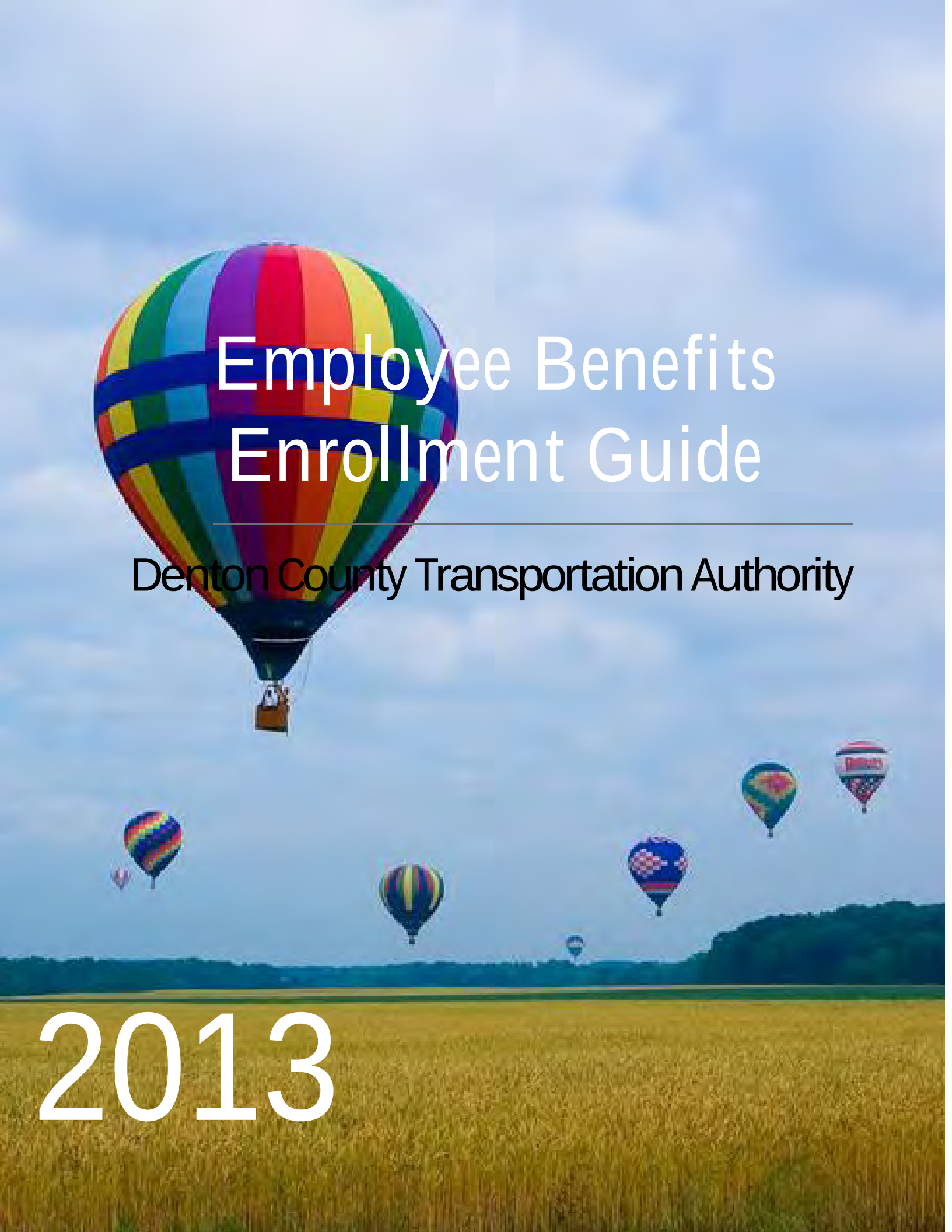


Employee Benefits Enrollment Guide

Denton County Transportation Authority

2013

This guide highlights the main features of many of the benefit plans sponsored by Denton County Transportation Authority. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. Denton County Transportation Authority reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Eligibility for any benefit plan is determined by applicable plan documents and policies. You should be aware that any and all elements of the Denton County Transportation Authority Employee Benefits Plan may be modified in the future to meet Internal Revenue Service rules or otherwise as determined by Denton County Transportation Authority.

Table of Contents

Benefits Overview

DCTA Our Benefits Program Has You Covered

Most days, we all count on our simple routines to get us through like getting the kids to school, beating the traffic to work and finishing dinner in time to enjoy a favorite hobby. But sometimes things don't always go as planned. Like when your head cold turns into the flu and you have to be out of work. Or your son's football game ends with a broken leg. Or even when your spouse learns he needs an extensive root canal. That's when Denton County Transportation Authority (DCTA)'s benefits are there to help you.

Below is an overview of our benefits program, which gives you the coverage you need for all types of things life brings your way. DCTA's plans allow you to choose the plans that work best for your own needs—and your pocketbook. The key to getting the most from our benefits program is to take an active role in understanding and using the plans so that you are getting the best value for the money you spend.

TML Intergovernmental Employee Benefits Pool

TEXAS COUNTY & DISTRICT RETIREMENT SYSTEM

ICMA-RC

Lincoln Financial Group

Discovery Benefits simplify.

EyeMed VISION CARE

HOLMES MURPHY

AIG VALIC

Employee Benefit Rates

Effective January 1, 2013 - December 31, 2013
24 pay periods

TML Medical PPO Plan (75-25-A Plan)

Tier	Monthly Rate	DCTA Portion	Employee Portion	Per Pay Period
Employee Only	$601.15	$601.15	$0.00	$0.00
Emp + Spouse	$1,359.36	$1,209.36	$150.00	$75.00
Emp + Child(ren)	$1,008.80	$858.80	$150.00	$75.00
Emp + Family	$1,558.81	$1,258.81	$300.00	$150.00

Lincoln Financial Benefits DPPO Plan

Tier	Monthly Rate	DCTA Portion	Employee Portion	Per Pay Period
Emp Only	$42.82	$42.82	$0.00	$0.00
Emp + Spouse	$84.38	$54.14	$30.24	$15.12
Emp + Child(ren)	$86.80	$53.76	$33.04	$16.52
Emp + Family	$139.34	$66.80	$72.54	$36.27

EyeMed Vision Plan (Select Network)

Tier	Monthly Rate	DCTA Portion	Employee Portion	Per Pay Period
Emp Only	$11.04	$0.00	$11.04	$5.52
Emp + Spouse	$20.97	$0.00	$20.97	$10.49
Emp + Child(ren)	$22.08	$0.00	$22.08	$11.04
Emp + Family	$32.45	$0.00	$32.45	$16.23

Lincoln Financial Basic and Voluntary Life/AD&D Insurance

DCTA pays 100% of Basic Life/AD&D employee coverage. Employees pay 100% of Voluntary Life/AD&D coverage.

Lincoln Financial Short Term Disability Insurance

DCTA pays 100% of employee coverage.

Lincoln Financial Long Term Disability Insurance

DCTA pays 100% of employee coverage.

Who Is Eligible

You are eligible to enroll in DCTA's benefit plans if you are a regular, full-time employee scheduled to work at least 36 hours per week. As a regular, full-time employee, you are eligible for benefits on the first day of the month following 30-days of continuous service.

Dependent Eligibility

You may also cover your eligible dependents, including:

- Your legal spouse.
- Your eligible children up to age 26 for medical coverage; your unmarried, eligible children up to age 25 for dental and vision coverage.
  - "Children" are defined as your natural children, stepchildren, legally-adopted children and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

If your child becomes ineligible for coverage (i.e., turning age 26 under the medical plan), you must notify DCTA Human Resources at 972-316-6097.

When Coverage Begins

Initial Enrollment

When you first join DCTA, you have 30 days to enroll yourself and your dependents for benefits. If you enroll on time, coverage begins the first of the month following 30 days of employment. If you do not enroll within 30 days of becoming eligible, you will automatically be enrolled in company-sponsored benefits, such as medical, dental, basic life and accidental death insurance and the employee assistance program (EAP), but you will have to wait until the next annual Open Enrollment to enroll for other benefits and make changes to coverage.

Annual Enrollment

During annual Open Enrollment, coverage takes effect on January 1 of the following year.

No Cost Benefits:
Basic Life Insurance
Basic AD&D Insurance

Pre-Tax Benefits:
Medical/Prescription
Dental
TCDRS Retirement
Flexible Spending Accounts
457b Contributions
Voluntary Vision

Post-Tax Benefit:
Voluntary Life Insurance
ROTH IRA Retirement

Making Changes to Coverage

Once you make your benefit elections, these choices remain in effect until the next annual Open Enrollment unless you have a qualified status change or you or your eligible dependents become eligible for coverage through special enrollment rules.

If you have a qualified status change or you have another allowable event, you can make certain changes during the plan year. However, you must make your enrollment change within 30 days of the event by completing a Benefit Changes/Enrollment form and returning it to Human Resources. If you do not return your form within 30 days, you will have to wait until the next Open Enrollment to make new elections.

Qualified status changes include, but are not limited to:

- Change in number of eligible dependents due to birth, adoption, placement for adoption or death
- Gain or loss of dependent status (i.e., your child reaches the age limit for eligibility)
- Change in legal marital status, including marriage, divorce, or death of a spouse
- Change in residence or workplace that changes your or your dependent's eligibility for coverage
- Change in employment status, such as starting or ending employment, for you, your spouse or your children
- End of the maximum period for COBRA coverage

For a more complete list of qualified status changes, refer to the Summary Plan Description.

Special Enrollment Rules

If you choose not to enroll yourself or your dependents (including your spouse) because you have other coverage, you may be able to enroll yourself and your dependents at a later date if:

- You or your dependents lose Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage, or
- If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must enroll within 60 days of the qualified events shown in the "Special Enrollment Rules" above.

If your dependent also had other health coverage and lost that coverage in the above situations, they may be added to your coverage. However, you will not be able to add yourself or your dependents to this coverage if the other coverage was terminated "for cause" (including failure to pay the required premiums on time).

In addition to the changes described above, you may enroll yourself and your spouse (with or without the new dependent) in a DCTA health plan following marriage or the adoption, placement for adoption, or birth of a child, as long as you request enrollment within 30 days of the event.

You must be enrolled to cover your dependents. If you have a special enrollment event and want to enroll for health coverage, call DCTA Human Resources at 972-221-4600.

Medical Plan

Medical insurance represents one of the largest components of the Denton County Transportation Authority (DCTA) Employee Benefits Plan. It is for this reason that we offer eligible employees a comprehensive Preferred Provider Organizations (PPO) Plan through the Texas Municipal League– Intergovernmental *Employee Benefit Pool (*TMLIEBP*) which is designed to provide you and your family with access to quality, affordable health care. DCTA's medical plan option provides coverage for the same types of expenses, such as doctor's office visits, preventive care, prescription drugs and hospitalization.*

Medical Option

When it comes to medical plan coverage you have the following choice:

- TMLIEBP Medical PPO Plan (75-25-A)

Preferred Provider Organizations (PPO)

The PPO plans offer in-network and out-of-network benefits. When you need care, you decide whether to go to a TML Intergovernmental Employee Benefits Pool (TMLIEBP) in-network doctor or to an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than if you use out-of-network providers and facilities because the TMLIEBP network providers discount their fees.

If you choose to receive care from an out-of-network provider, the medical plan pays a lower benefit and you must file a claim to receive reimbursement for covered expenses.

Network:
An insurance company's group or list of approved or contracted providers from which you can obtain service at a higher benefit level than other non-participating providers.

Copay:
A per occurrence payment that is due at the time of service. An example would be an office visit copay when visiting a doctor's office.

Deductible:
The amount you pay toward medical expenses each year before the plan begins sharing costs with you for certain services. Not all services are subject to a deductible.

Is Your Doctor In the TMLIEBP Network?

All of the providers in the PPO network change frequently. To find out if your doctor participates in the network, go to **www.tmliebp.org** for access to MyTMLIEBP .

Take Charge of Your Health Care

Useful recommendations to control your health

By taking a proactive role in your health care, you can make better decisions about your medical care and ultimately reduce your health care costs. Gain control over your care with the following recommendations.

Surround yourself with professionals – at the very least, a primary care physician and a pharmacist. Make sure each professional you work with understands what you want out of your medical and pharmacy care.

Be honest with your doctor. Give all your medical information to your doctors so you can receive the appropriate care. Make a list of concerns to discuss with your doctor. Be honest before and during the examination – if your doctor doesn't know about a problem, he or she will not be able to give you the help you need.

When you are confused or unsure about something your doctor tells you, ask questions. Visit the Agency for Healthcare Research and Quality (AHRQ) at **www.ahrq.gov/questionsaretheanswer** to build a list of questions for your doctor.

Find out about the best treatment available. Visit the National Guideline Clearinghouse at **www.guideline.gov** to review the guidelines for a variety of medical conditions. These guidelines list the most successful and widely accepted care options that provide proven results. Whether you visit this website or not, make sure you review your options with your doctor – not all treatments are best for everyone.

Seek a second opinion. You may want to get a second opinion if any of the following applies:

- You have a serious medical condition
- You are prescribed a treatment that comes with significant risks
- You are told surgery is a treatment option
- You have no improvement in a treated medical condition
- You have visited a doctor who could not diagnose your problem

Don't try to handle everything alone. If you are hospitalized, bring a friend or relative with you to help you understand medical information and assist in making health care decisions. Talking to others can also provide you with a solid support system, so you won't have to worry about taking care of everything all by yourself.

Start a health care journal. This will allow you to monitor your health, become more informed on potential treatment options and learn how to manage your conditions more effectively.

Plan Highlights

PPO 75-25-A

Administered by TML Intergovernmental Employee Benefits Pool

Plan Provision	In-Network Coverage	Out-of-Network Coverage
Annual Deductible	$750 individual $1,500 family	$1,000 individual $2,000 family
Annual Out-of-Pocket Maximum	$2,500 individual $5,000 family	No maximum No maximum
Preventive Care		
Adult physical examinations, including diagnostic tests and immunizations	100%, no deductible	55% after the deductible
Well-woman exams by PCP or OB/GYN, including mammogram and Pap test	100%, no deductible	55% after the deductible
Routine pediatric care, including diagnostic tests and immunizations	100%, no deductible	55% after the deductible
Outpatient Care		
PCP office visit	100% after $30 copay	55% after the deductible
Specialist office visit	100% after $30 copay	55% after the deductible
Emergency Room	85% after $100 copay	85% after $100 copay
Urgent Care	100% after $55 copay	55% after the deductible
Outpatient surgery	85% after the deductible	55% after the deductible
X-ray and lab tests Preferred Other	 100% after the deductible 85% after the deductible	 55% after the deductible 55% after the deductible
Inpatient Hospital Care		
Surgical services	85% after the deductible	55% after the deductible
Semi-private room and board	85% after the deductible	55% after the deductible

The Importance of Preventive Health Care

Remember the old saying that "an ounce of prevention is worth a pound of cure." This can be especially true when it comes to preventive health care. And, better health may lower your health care costs. Maintaining or improving your health is important; and a focus on regular preventive care, along with following the advice of your doctor, can help you stay healthy. Routine checkups and screenings can help you avoid serious health problems, allowing you and your doctor to work as a team to manage your overall health.

What is preventive care?

Preventive care focuses on maintaining your health, and establishing your baseline health status. During your preventive visit your doctor will determine what tests or screenings are appropriate for you based on many factors such as your age, gender, overall health status, personal health history and your current symptoms or chronic health concerns. Even if you're in the best shape of your life, a serious condition with no signs or symptoms may put your health at risk. Through a preventive exam and other routine health screenings, your doctor can detect the early warning signs of more serious issues to provide early treatment.

How can I determine what will be covered as a preventive care service?

Certain services can be done for preventive or non-preventive (diagnostic) reasons. Generally when a service is performed during your annual preventive care visit, specifically for preventive screening, and there are no known symptoms, illnesses or history, the services will be considered as preventive care.

Preventive services can include many types of exams, subject to age and gender guidelines, including:

Physician office services:

- Routine physical examinations
- Well baby and well child care
- Immunizations
- Prostate cancer screening

Lab, X-ray or other preventive screening tests:

- Screening mammography
- Screening colonoscopy
- Cervical cancer screening

Prescription Drug Coverage

If you enroll in one of the DCTA medical plans, you will automatically receive prescription drug coverage. For the PPO plans, prescriptions are provided through ReStat. When you need prescriptions, you can purchase them through a local retail pharmacy or, for medications you take on an ongoing basis, through the mail order program.

Taking an active role in your treatment

Taking an active role in your prescription treatment plan doesn't mean just swallowing a pill.

Understand Your Medicines

Take part in your treatment decisions. Do not be afraid to ask your doctor questions or talk about your concerns. When prescribed a new medication, discuss:

- The risks and benefits
- The name of the medication and side effects it could have
- Possible interactions with other medicines you take
- The cost
- Any medication allergies
- If you are or might become pregnant or are breast-feeding
- Any conditions being treated by another doctor

Other Talking Points

Here are some other topics you should discuss with your doctor or a pharmacist to make sure you are receiving the full benefits of your medication:

- If your medication has a generic version
- The medication's ingredients
- Help in setting up a system or routine for taking your medication properly
- If the medication should be taken with food
- When you can expect the medicine to start working

A train

The Align Network

Effective January 1, 2013, DCTA employees and their covered dependents will receive opportunities to save on generic medications at specific pharmacy locations as part of Restat's Align Program. Restat's Align Program is specifically designed to maintain our commitment to offering affordable benefits while managing the benefit costs as a whole.

How can you take advantage of Align program savings?

If you currently purchase your prescriptions at one of the Align pharmacies listed:	If you currently do not use an Align pharmacy:
Simply present your new Restat prescription benefit ID card on or after January 1, 2013. You will automatically be charged the lower generic copay as of January 1, 2013.	Switch to an Align pharmacy. Call the pharmacy or bring your current prescription to the Align pharmacy of your choice.

Sample of Participating Pharmacies

There are numerous pharmacies that participate in the Align network. You can do a search of align pharmacies online.

Align Pharmacies
KROGER
TOM THUMB
SAM'S
SAVON
TARGET
UNITED MARKET STREET

If you have any questions regarding your prescription drug plan, please feel free to contact Restat's Customer Service Center TOLL FREE at (855) 224-4653.

Retail Prescription Drug Program

The retail prescription drug program uses a network of participating pharmacies. To receive the highest level of benefits, you should use an Align network participating pharmacy. Prescriptions you fill at a Broad network participating pharmacies are covered at a higher copay. If you fill your prescriptions at a non-participating pharmacy, there may not be any coverage.

Retail (34-day supply)	Amount You Pay at an Align Participating Pharmacy
Align Network Pharmacy	
Generic:	$0 copay
Preferred Brand:	$38 copay
Non-Preferred Brand:	$60 copay
Retail (34-day supply)	**Amount You Pay at Broad Network Pharmacy**
Broad Network Pharmacy	
Generic:	$10 copay
Preferred Brand:	$38 copay
Non-Preferred Brand:	$60 copay
Retail (34-day supply)	**Amount You Pay at a Non-Participating Pharmacy**
PPO Options	
Generic:	Not covered
Preferred Brand:	Not covered
Non-Preferred Brand:	Not covered

Mail Order Program

The mail order program offers a convenient and cost-effective way to fill prescriptions for medications that you take on a regular basis (maintenance medications).

Your medications are mailed directly to your home. To order prescriptions through the mail order program, you must fill out and return a mail order form and return it with a 90-day prescription from your doctor and your payment.

Mail Order (84 or 90-day supply)	Amount You Pay
PPO Options	
Generic:	$25 copay
Preferred Brand:	$95 copay
Non-Preferred Brand:	$150 copay

Dental Plan

DCTA's Dental Plan is administered through Lincoln Financial and provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays, filling and major services such as dentures.

Dental PPO Plan

The Dental PPO allows you the freedom to visit any dentist, without referrals, for all of your dental care. If you receive care from one of Lincoln Financial's preferred dentists, you'll pay less for your care. If you choose a non-preferred dentist, your share of costs will generally be higher and you may need to file your own claims.

For a list of Lincoln Financial preferred dentists, go to **www.lincoln4benefits.com**.

Dental Plan Highlights

Plan Feature	Dental Plan - PPO
Annual Deductible ■ Individual ■ Family	 $50 $150
Annual Benefit Maximum	$1,500
Preventive Services (Exams, routine cleanings, fluoride treatments, space maintainers)	100% (no deductible)
Basic Services (X-rays, fillings, sealants, denture repairs)	80% after deductible
Major Services (Crowns, bridges, and dentures)	50% after deductible

You will not need a dental ID card to receive dental services. When you visit the dentist, give the provider your Social Security number and DCTA's name. Your dentist's office can verify your eligibility for benefits by calling Lincoln Financial at 1-800-423-2765.

Vision Plan

DCTA's Vision Plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses. The Vision Plan is administered through EyeMed.

Vision Coverage

If you enroll for vision coverage, you can go to any eye care provider you choose for care. However, if you choose providers who are part of the EyeMed network, you will receive a discount on services. To find a network provider, go to **www.eyemedvisioncare.com**.

The Vision Plan is designed to cover eye care needs that are visually necessary. You have to pay extra if you choose certain cosmetic or elective eyewear, so be sure to ask your eye doctor what items are covered by the plan before you purchase materials.

Plan Feature	In-Network	Non-Network (Reimbursement)
Eye Exam	$0 copay	Up to $30
Lenses*		
Single vision	$0	Up to $25
Bifocal	$0	Up to $40
Trifocal	$0	Up to $60
Frames (Every 12 months)	Up to $100 retail allowance	Up to $50 retail
Contact Lenses*	Up to $200 allowance	Up to $160
Lasik Vision Correction Lasik or PRK	15% off retail price -or- 5% off promotional price	Not Covered
Frequency		
Examination	Once every 12 months	Once every 12 months
Frame	Once every 12 months	Once every 12 months
Lenses and Contact Lenses	Once every 12 months	Once every 12 months

Life Insurance

DCTA offers life insurance coverage to provide financial protection in the event you or your dependents die while you are still working. This coverage is administered through Lincoln Financial.

Basic Life Insurance

DCTA automatically provides Basic Life Insurance for all eligible employees at no cost. Basic Life Insurance is equal to 2 times your annual base earnings; up to a maximum benefit of $210,000.The benefit is paid to your beneficiaries in the event of your death. When you or a covered dependent reaches age 65, Basic and Optional Life Insurance benefits are reduced. For more information, refer to your Group Life Insurance booklet.

IRS Rules About Basic Life Coverage

If your Basic Life Insurance coverage is more than $50,000, your income taxes may be affected. IRS regulations require that the value of life insurance benefits over $50,000 be reported as "imputed income," which is non-cash income that you receive from an employer-provided benefit. The value of any coverage that exceeds $50,000 will be reported to the IRS as imputed income on your W-2 form.

Optional Life Insurance

In addition to Basic Life Insurance, you may also purchase Optional Life Insurance for yourself, your spouse and your dependent children. However, you may only elect coverage for your dependents if you enroll for Optional Life coverage for yourself. You pay for the cost of Optional Life Insurance on an after-tax basis through payroll deductions.

Type of Coverage	Coverage
Employee	1 – 5 times annual base earnings, up to a maximum of $500,000 Any amount you elect over $100,000 is subject to Evidence of Insurability If you wish to enroll or increase your coverage after your initial eligibility, any new amount you elect will be subject to Evidence of Insurability
Spouse	$5,000 increments with a maximum of $250,000 Any amount you elect over $10,000 is subject to Evidence of Insurability Evidence of insurability is required for any coverage you elect for your spouse if you enroll him/her after the initial eligibility period as a new hire
Child(ren)	$10, 000 per child (or $250 for ages 14 days to 6 months)

Beneficiary Designation

You must designate a beneficiary for Basic and Optional Life Insurance benefits when you enroll. Your "beneficiary" is the person(s) who will receive the benefits from your life and AD&D coverage in the event of your death. You are always the beneficiary of any dependent life and AD&D insurance you elect. You can change your beneficiaries at any time during the year. If you do not name a beneficiary, or if your beneficiary dies before you, your life and AD&D benefits will be paid to your estate.

AD&D Insurance

DCTA offers accidental death and dismemberment (AD&D) Insurance for you and your family to help with expenses in the event you or a covered dependent dies or becomes injured as a result of an accident. This coverage is administered through Lincoln Financial.

Basic AD&D Insurance

DCTA automatically provides Basic AD&D Insurance for all eligible employees at no cost. Basic AD&D Insurance is equal to 2 times your annual base earnings, up to a maximum benefit of $210,000.

Optional AD&D Insurance

In addition to Basic AD&D Insurance, you may also purchase Optional AD&D Insurance for you and your eligible dependents. You pay for this coverage on a pre-tax basis through payroll deductions.

Type of Coverage	Coverage
Employee	1 – 5 times annual base earnings, up to a maximum of $500,000
Spouse	$5,000 increments with a maximum of $250,000
Child(ren)	$10, 000 per child (or $250 for ages 14 days to 6 months)

Beneficiary Designation

You must designate a beneficiary for Basic and Optional Life Insurance benefits when you enroll. Your "beneficiary" is the person(s) who will receive the benefits from your life and AD&D coverage in the event of your death. You are always the beneficiary of any dependent life and AD&D insurance you elect. You can change your beneficiaries at any time during the year. If you do not name a beneficiary, or if your beneficiary dies before you, your life and AD&D benefits will be paid to your estate.

Disability Coverage

DCTA offers you two disability plans that work together to keep all or part of your paycheck coming if you cannot work because of illness, injury or pregnancy. Short Term and Long-Term Disability benefits are administered through Lincoln Financial.

Short-Term Disability

Short-term disability (STD) benefits are provided by DCTA to all eligible employees at no cost. Your STD benefits will replace 66.67% of your base pay for up to a maximum of $1,000 per week.

- 13 weeks

Your STD benefits begin on the 1st calendar day of your disability for accidents and on the 8th day for illness related disabilities if you are unable to work. The maximum benefit available is 13 weeks per STD claim.

"Base pay" means your annual base salary in effect at the time you become disabled, excluding bonuses, commissions or any other incentive payments.

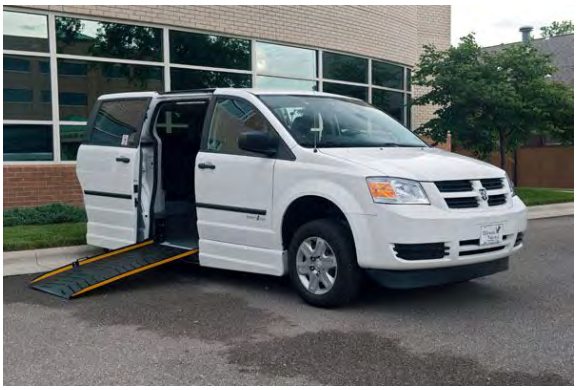
Long-Term Disability

If you remain totally disabled and unable to work for more than 90 days, you may be eligible for Long-Term Disability (LTD) benefits. DCTA automatically provides you LTD benefits that replace up to 60% of your base pay, up to a maximum of $6,000 per month. Your monthly LTD benefit will be reduced by Social Security and any other disability income you are eligible to receive (such as Workers' Compensation).

When Are You Disabled?

To be considered totally disabled and eligible for LTD benefits, you must be approved by the insurance carrier and seeing a doctor regularly for treatment. In addition:

- Your doctor must certify that you are not able to perform each of the main duties of your own occupation



Flexible Spending Accounts

DCTA allows you to contribute to one or both flexible spending accounts, which allow you to save taxes on certain out-of-pocket health care and dependent care expenses. The FSAs are administered by Discovery Benefits.

How the FSAs Work

DCTA offers two types of FSAs:

- Health Care FSA
- Dependent Care FSA

If you elect to contribute to one or both of the FSAs, you choose an annual amount to be taken from each of your paychecks and deposited into your account throughout the year. Your contributions are taken out of your paycheck before you pay taxes, so you save money. Then, when you have eligible health care or dependent care expenses, you can use the account to reimburse yourself, up to the amount you have elected to contribute to your account for the year.

With both accounts, the IRS requires you to use all of the money in your account by the end of the year or you lose it. This is called the "use it or lose it" rule

Health Care FSA

You can use the Health Care FSA to pay for eligible out-of-pocket expenses that are not covered by another health plan. Examples include, but are not limited to:

- Medical or dental deductibles
- Office visit copays
- Coinsurance amounts
- Amounts you pay for prescription drugs
- Amounts you pay for certain over-the-counter items
- Eyeglasses, contacts and other vision-related expenses not covered by the vision plan
- Orthodontia expenses not covered by the dental plan

For a complete list of eligible expenses, visit **www.discoverybenefits.com**.

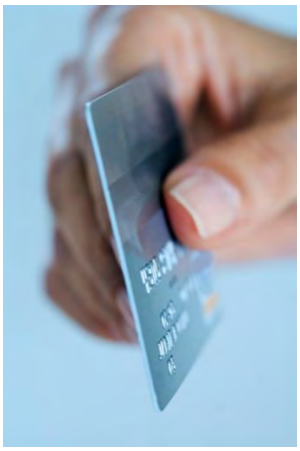
Annual Contribution Amount

You can contribute $100 to $2,500 per year to the Health Care FSA.

A Note About Over-the-Counter Medications

Effective January 1, 2011, you must have a doctor's prescription to use the Health Care FSA to reimburse yourself for certain over-the-counter medications. Examples of medications that require you to submit a doctor's prescription include:

- Acid controllers, digestive aids and stomach remedies
- Allergy and sinus medicines
- Anti-itch and insect bite remedies
- Cold sore remedies
- Cold, cough and flu drugs
- Pain relief medications
- Respiratory treatments
- Sleep aids and sedatives



How the Debit Card Works

If you enroll in the Health Care FSA, you will receive one debit card in the mail. To request additional debit cards for your family members, please contact Discovery Benefits Customer Service 866-451-3399 or apply via participant web-portal.

You can use your debit card at certain places to pay for eligible expenses up-front, such as prescription drugs and office visit copays, without having to pay with cash and wait for a reimbursement. If you use your debit card at a health care provider's office or at a vendor that has the software in place to track eligible FSA expenses, you will not be required to submit a receipt. For a list of vendors that have this software, go to **www.discoverybenefits.com**. **However, for most debit card transactions, you will need to submit your receipts as substantiation of your expense, so it's important to keep them.**

If you choose not to use your debit card, you can always pay for your eligible expense and file a claim for reimbursement.

It's important to keep copies of all your receipts—even if you are not required to submit them as proof of your expense. That way, if the IRS asks for substantiation of your expenses, you will have the receipts.

Dependent Care FSA

The Dependent Care FSA helps you afford day care for your children under age 13 or for a disabled dependent. There are some special rules for participating in this account:

- The day care expenses must be necessary so you can work.
- You can only be reimbursed for expenses incurred during the plan year.
- If you are married, your spouse must be:
  - Employed, or
  - A full-time student at least five months during the plan year, or
  - Mentally or physically disabled and unable to provide care for himself or herself.

Eligible Dependent Care Expenses

Generally, you may use the money in your Dependent Care FSA for care for:

- Your children under age 13 whom you claim as a dependent for tax purposes
- Other dependents of any age who are mentally or physically disabled and whom you claim as a dependent for tax purposes (spouses and dependents age 13 and older must spend at least eight hours a day in your home if you are reimbursing yourself for services provided outside the home).
- Licensed nursery school and day care centers for children
- Licensed day care centers for disabled dependents
- Services from a care provider over the age of 19 (inside or outside the home)
- Day camps
- After-school care

Annual Contribution Amount

You can contribute $100 to $5,000 per year to the Dependent Care FSA. If you are married and you and your spouse file separate tax returns, the maximum you can contribute is $2,500.

For a complete list of eligible expenses, visit **www.discoverybenefits.com**.

In some cases, a federal child-tax credit may save you more money than the Dependent Care FSA. You may want to consult a tax advisor to find which option is better for you.

Important FSA Considerations

- Any money left in your FSAs at the end of the plan year may not be rolled over to pay for future expenses in another plan year. Any unused funds will be forfeited, per IRS rules.
- For the Dependent Care FSA, you may only be reimbursed up to the amount in your account at the time you file a claim. If your eligible expenses are greater than the amount in your account, the unreimbursed amount will carry over and be reimbursed after your next deposit. (For the Health Care FSA, you can be reimbursed up to the full amount you have elected to contribute for the year—even if you have not yet contributed that much to your account.)
- The Health Care FSA and the Dependent Care FSA are separate accounts. You cannot use funds from one account to pay for expenses of the other. You also cannot transfer funds between the two accounts.
- If you use the Dependent Care FSA, you must provide your caregiver's Social Security number or tax ID when you file a claim for reimbursement.

RETIREMENT PLANS

Texas County and District Retirement System (TCDRS)

Who We Are and How the Plan Works

In 1967 the Texas Legislature created TCDRS to provide the state's county and district employees with retirement, disability and death benefits. From modest beginnings, we've grown into a multibillion-dollar plan that includes more than 600 participating counties and districts, providing benefits to more than 220,000 Texans. TCDRS is nationally recognized for integrity, consistent investment performance and outstanding customer service. We are governed by a board of trustees comprised of nine system members or retirees appointed by the governor.

Each county and district in TCDRS has its own individual defined benefit plan. Your employer's governing body decides the level of benefits. (The governing body is a commissioner's court, a board of directors or other authority.) The money that funds your plan comes from employee deposits, employer contributions and earnings from investments. Your participation in TCDRS is mandatory unless you are a temporary employee.

Changes to Benefits

Your employer's governing body chooses your TCDRS benefits. Every year it reviews your employer's retirement plan and makes changes, if needed. It decides:

- What percentage of your paycheck goes into your TCDRS account
- How much your employer will match when you retire
- What you must do to be eligible for retirement

Your Deposits

Every time you get a paycheck, a certain percentage of your money goes into your TCDRS account. Your employer decides how much. Your money currently earns interest at a rate of 7%. (That rate can only be changed by the Texas Legislature.) The money you deposit into your TCDRS account is not taxed until you withdraw it or choose a retirement benefit. (If your employer participates in Social Security, the money you deposit in TCDRS is subject to Social Security withholding.)

How Your Money Grows

Your account earns an annual interest credit of 7%. TCDRS credits this interest to your account each December 31, based on your account balance as of January 1. Over time, the value of your account can increase a great deal because of compounding — that is, paying interest on interest. Every year you'll get a statement from TCDRS that shows all your deposits for the year as well as how much interest you received. You can also view your current balance online at **www.tcdrs.org**. One of the great things about a defined benefit plan like your TCDRS plan is that the ups and downs of the investment market don't affect your account. Whether the market does well or does poorly, your account still gets the 7% interest credit. Your employer assumes the investment risk of providing your retirement benefit. TCDRS pools the money from both employee and employer accounts and invests it to help your employer fund your retirement plan. If you are interested in the current TCDRS portfolio asset allocation, you can learn more at **www.tcdrs.org**

Denton County Transportation Authority Plan Design

- Account Base: 5% (pre-tax) is deducted from each paycheck and builds your account.
- Account growth: You earn 7% compound interest on your account balance every year.
- Employer matching: Your final account balance is matched 150% at retirement.
- Vesting level for your plan (5 years of service).

View your account online at **www.tcdrs.org**

Other Retirement Plans

ICMA-RC

About Us: We Build Retirement Security

Founded in 1972, ICMA-RC is a non-profit independent financial services corporation focused on providing retirement plans and related services for close to a million public sector participant accounts and approximately 9,000 retirement plans. Our mission is to help build retirement security for public employees. We deliver on our mission by focusing on service, quality and value.

All of our retirement programs, administrative services and educational tools have been developed specifically for public sector retirement plan administrators and participants like you. Our retention rate is one of the highest of any public sector retirement plan provider.

Accessing Your Account

Manage Your Account Online with Account Access or via Telephone with Vantage Line

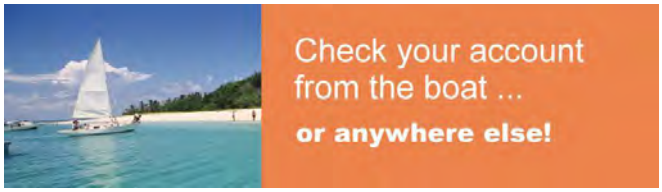
With ICMA-RC you have 24/7 access to your account, either online through Account Access or over the phone via Vantage Line, our automated telephone service available at 800-669-7400.

AIG-VALIC

It pays to have a plan provider with financial strength, strong investment products and reasonable fees. It's equally important to be with a company that offers the services you really need. Helping investors plan, build and protect their financial resources is something VALIC has been doing for more than 50 years.
Benefits for Individuals: VALIC has been helping Americans plan, build and protect their financial resources for over 50 years. VALIC has the experience and the ability to address the planning needs of our clients throughout every stage of the financial lifecycle.

Plan Information & Literature

Welcome to our online source for accessing retirement plan enrollment materials and associated regulatory documents. For more information view your account online visit **https://my.valic.com/Online**.



Employee Assistance Programs (EAP)

Employee Connect Program

What is the EmployeeConnect Program?

The EmployeeConnect program, provided to you through Lincoln Financial, can help provide support for a variety of issues including: stress, anxiety, depression, family and marital issues, problem solving, drug and alcohol issues, dependent and adult care services, workplace concerns, legal issues, and financial questions and issues.

How many sessions will I receive?

When face-to-face sessions are warranted, you may receive up to four. However, in some cases sessions are not warranted, such as simply calling about childcare resources. In other cases, such as severe substance abuse or threats of harm to yourself/others, you may be referred to an inpatient program. In yet other cases, the issue may simply require a discussion with a community counselor. In all cases, employees receive the type of assistance most appropriate to their immediate need.

How do I access the EmployeeConnect program?

Access the program via phone or the Internet. Call the toll-free number (1-877-757-7587) to speak with a consultant 24 hours a day, 7 days a week. Consultants are trained to assist clients over the phone, provide an assessment, and make a referral that may include face-to-face meeting(s) with a local counselor, if appropriate. Online access is available at www.eapadvantage.com. (Password = Connect)

Are EmployeeConnect services confidential? Will my employer know I called?

The EmployeeConnect program holds confidentiality of employee personal information as its highest priority. Your employer will not be informed of your participation without your prior written consent. In order to protect the safety of those involved, information may be released as required by law in instances of child/elder abuse or subpoena, or in a life-threatening situation.

How much will I have to pay for EmployeeConnect services?

The EmployeeConnect program is free to covered individuals. If an issue requires specialized or extended treatment beyond what is covered, a referral will be made for which the employee will be financially responsible. In many cases, this fee may be covered by the employee's health plan.

What services are available on the Web site?

Employees can access the comprehensive Web site that allows employees to gather information and conduct their own personalized search for areas of concern. The following is a listof some of the resources available:

- The Childcare Locator
- Parenting and Child Care Articles and Information
- Education and Adoption
- The Elder Care Locator
- Eldercare Articles and Information

TravelConnect

As part of your employee benefits package, your Lincoln Financial Group® life insurance coverage includes our TravelConnect program, which focuses on travel, medical and safety-related services you may need while traveling. Lincoln Financial has partnered with MEDEX Assistance Corporation, a worldwide leader in travel assistance, to make this valuable benefit available.

How much will I have to pay for TravelConnect?

The TravelConnect benefit is provided at no additional cost to you and includes a wealth of services when traveling just 100 miles or more from home. Services are provided for both business and leisure travel. Whether you want the weather forecast for your destination or need emergency medical help halfway around the world, MEDEX has the staff and resources to provide support 24 hours a day, seven days a week.

What services are available?

We also provide these services:

- Destination info – weather, currency and more
- Emergency travel arrangements and funds transfer
- Lost or stolen travel documents assistance
- Language translation services
- Medical and dental referrals
- Assistance with corrective lenses or medical
- Device replacement
- Arrangement for the delivery of medications,
- Vaccines or blood
- Updates to family, employer and/or home physician
- Repatriation of a deceased traveler
- Security and political evacuation assistance

To use TravelConnect services, call MEDEX at 1-800 527-0218 or 1-410 453-6330, and provide them with the MEDEX ID 322541 and Group Name Lincoln Financial Group.

NOTES

Health Coverage Notices

For Your Files

This brochure contains several legal notices that are required to be distributed to participants in group health plans sponsored by Denton County Transportation Authority.

The notices included in this brochure are:

- **Medicare Part D Notice** that provides information about how your current prescription drug coverage under the DCTA health care plans is affected—and your options for coverage—when you become eligible for Medicare.
- **COBRA Rights Notice** that explains when you and your family may be able to temporarily continue coverage under DCTA's health plan if coverage would otherwise end for you.
- **Newborn & Mothers Health Protection Notice** that describes federal laws that govern benefits for hospital stays for mothers following the birth of child.
- **Women's Health and Cancer Rights Act** that summarizes the benefits available under your medical plan if you have had or are going to have a mastectomy.
- **Patient Protection Disclosure** that explains who you and your family can designate as a primary care provider under the health plans and rules around access to obstetrical/gynecological care.
- **Expanded Coverage for Women's Preventive Care** that explains how DCTA covers women's preventive care, including contraceptives, under the **Affordable Care Act**
- **Preexisting Conditions** that explains certain coverage exclusions.
- **Notice of Special Enrollment Rights** that explains when you can enroll in the plan due to special circumstances.
- **60-Day Special Enrollment Period** that describes a special 60-day timeframe to elect or discontinue coverage.

IMPORTANT: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Prescription Drug program gives you more choices about your prescription drug coverage. Please see pages 19 and 20 for more details.

Medicare Prescription Drug Notice

Important Notice from Denton 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 DCTA 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.

DCTA has determined that the prescription drug coverage offered by DCTA plan 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 to 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 decide to join a Medicare drug plan, your current DCTA coverage will be affected. If you do decide to join a Medicare drug plan and drop your current DCTA coverage, be aware that you and your dependents will not be able to get this coverage back.

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 DCTA 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.

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 Shanna O'Gilivie at the phone number shown below for further information. *NOTE:* 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 DCTA. 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 "Medicare & You" handbook for their telephone number) for personalized help

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: December, 2012]

Name of Entity/Sender: Denton County Transportation Authority

Contact/Office: Shanna O'Gilvie

Address: 1660 South Stemmons Freeway #250, Lewisville, TX 75067

Phone Number: (972) 221-4600

COBRA Rights Notice

You are receiving this notice because you have recently become eligible for coverage under the DCTA group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the ABC Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review your Summary Plan Description or contact Human Resources at (972) 316-6097.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for that coverage.

You will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

Your spouse will become a qualified beneficiary if he or she loses coverage under the Plan because any of the following qualifying events happens:

- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- Your death;
- Your entitlement to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- Your death;
- Your entitlement to Medicare benefits (under Part A, Part B or both);
- Your divorce or legal separation; or
- The dependent stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Coverage Available?

DCTA will offer COBRA continuation coverage to qualified beneficiaries only after it has been notified that a qualifying event occurred. For the following qualifying events, DCTA will notify Discovery Benefits, the administrator for COBRA continuation coverage, of the qualifying event:

- Your hours of employment are reduced;
- Your employment ends;
- Your death; or
- Your entitlement to Medicare benefits (under Part A, Part B or both).

You Must Give Notice of Some Qualifying Events

For the following qualifying events, you or a family member must notify the Human Resources at (972) 316-6097 within 60 days after the qualifying event occurs:

- Your divorce or legal separation; or
- Your dependent's loss of eligibility for coverage as a "dependent child."

You must notify DCTA of the qualifying event by calling the Human Resources at (972) 316-6097.

How Is COBRA Coverage Provided?

Once DCTA receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect continuation coverage on behalf of your spouse and dependent children. Your spouse may also elect continuation coverage on behalf of your dependent children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is one of the following events, COBRA continuation coverage lasts for up to a total of 36 months for your spouse and dependent children:

- Your death;
- Your divorce or legal separation; or
- Your dependent stops being eligible for coverage under the plan as a "dependent child."

When the qualifying event is one of the following events, COBRA continuation coverage lasts for up to a total of 18 months for qualified beneficiaries:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

When the qualifying event is your reduction in hours or your termination of employment and you were entitled to Medicare benefits prior to the qualifying event, additional coverage for your spouse and dependents may be available. Your spouse and dependents would be eligible to receive up to 36 months of COBRA continuation coverage from the date of your entitlement to Medicare. For example, if you became entitled to Medicare eight months before the date your employment terminates, COBRA continuation coverage for your spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months prior to the qualifying event).

There are two ways in which an 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

COBRA coverage may be available for you and your family up to a total of 29 months at a higher premium if:

- You, your covered spouse or your covered dependents (including newborn and newly adopted children) are determined to be disabled, as defined by the Social Security Act, prior to the qualifying event or during the first 60 days of COBRA coverage;
- The Social Security Administration's disability determination is received within the disabled individual's 18 months of COBRA coverage;
- The disability lasts at least until the end of the 18-month period of continuation coverage; and
- DCTA is notified of the Social Security Administration's disability determination within 60 days of the disabled individual's receipt of a Social Security Disability award. If the disability determination occurred before COBRA coverage started, you're required to notify Discovery Benefits within the first 60 days of COBRA coverage.

You, your covered spouse or your covered dependents must notify DCTA within 60 days of receipt of the disability determination and prior to the end of the initial 18-month continuation period in order to receive the coverage extension. To notify DCTA of the disability determination, call Human Resources at (972) 316-6097.

You, your covered spouse or your covered dependents must notify DCTA within 30 days of the date the disability ends by calling Human Resources at (972) 316-6097.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. Additional continuation coverage is available only if the event would have caused your spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. These events include:

- Your death;
- Your entitlement to Medicare (under Part A, Part B or both);
- Your divorce or legal separation; or
- Your dependent stops being eligible for coverage under the plan as a "dependent child."

You, your covered spouse or your covered dependents must notify DCTA within 60 days after the event occurs in order to receive this additional coverage. To notify DCTA of the qualifying event, call Human Resources at (972) 316-6097.

Events That May Change Continued Coverage

Once your COBRA coverage begins, you may be able to change your COBRA coverage elections based on plan rules if you experience a qualified change in status. You, your covered spouse or your covered dependents must notify DCTA by calling Human Resources at (972) 316-6097 within 60 days of the qualified change in status to change your COBRA coverage. See your Summary Plan Description for detailed information on allowable changes in status. Adding family members to COBRA coverage may result in a higher premium for this additional coverage.

You may also change COBRA coverage if a child is born to the covered employee or placed for adoption with the covered employee during the 18-, 29- or 36-month continuation period. In such case, you must notify DCTA by calling Human Resources at (972) 316-6097 within 60 days of the birth or placement to cover the new dependent as a qualified beneficiary under COBRA. There may be a higher premium for this additional coverage.

Events That End Continued Coverage

COBRA coverage will end automatically upon the expiration of the 18-, 29- or 36-month continuation periods described on the previous pages. In addition, COBRA coverage will end automatically if any of the following situations occur:

- DCTA stops providing group health benefits;
- Premiums are not paid within 30 days of the due date (with the exception of the initial premium which is due within 45 days of your election date); or
- A person eligible for continued benefits becomes covered under any other group health plan (unless the health plan has an enforceable pre-existing condition clause) or becomes entitled to Medicare.

If your coverage ends because of expiration of the 18-, 29- or 36-month limit, you may be able to convert coverage to an individual policy if this right currently exists in the Plan.

Address Information

Be sure to keep your current address information up to date with DCTA. Doing so is the only way to ensure that important benefit information will reach you.

Your Rights Under ERISA

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

For More Information

If you have any questions about COBRA continuation coverage, call Human Resources at (972) 316-6097.

Other Notices

Newborn & Mothers Health Protection Notice

For maternity hospital stays, in accordance with federal law, the Plan does not restrict benefits, for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultations with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact Human Resources at (972) 316-6097. or your medical plan administrator.

Patient Protection Disclosure

DCTA generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources at (972) 316-6097.

For children, you may designate a pediatrician as the primary care provider.

Expanded Coverage for Women's Preventive Care

Under the Affordable Care Act, DCTA provides female plan participants with expanded access to recommended in-network preventive services, including contraceptives, without cost sharing.

Additional women's preventive services that will be covered without cost sharing requirements include:

- Well-woman visits
- Gestational diabetes screening
- HPV DNA testing
- STI counseling, and HIV screening and counseling
- Contraception and contraceptive counseling
- Breastfeeding support, supplies, and counseling
- Domestic violence screening

For a description of what these items include, visit
http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html.

Preexisting Conditions

DCTA's medical plan(s) impose a preexisting condition exclusion to persons age 19 and older. This means that if you 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 90-day period before enrollment. Generally, this 90-day period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 90-day period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption. 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 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

If you are under age 19, the preexisting conditions exclusion does not apply to you because of a change in the law effective January 1, 2011. All questions about the preexisting condition exclusion and creditable coverage should be directed to Human Resources at (972) 316-6097.

Notice of Special Enrollment Rights

If you decline enrollment in medical coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in DCTA's medical coverage if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no more than 31 days after your or your dependent's other coverage ends (or after the employer stops contributing to the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll yourself and your dependents in DCTA's medical coverage as long as you request enrollment by contacting the DCTA no more than 31 days after the marriage, birth, adoption or placement for adoption. For more information, contact Human Resources at (972) 316-6097.

60-Day Special Enrollment Period

In addition to the qualifying events listed in the enrollment guide and this document, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

Important Contacts

Who to Contact	Phone/Web Address	For Information On:
Medical and Prescription TMLIEBP	(800) 282-5385 www.tmliebp.org	Find a provider, ID cards, eligibility, claim status, prescription drugs, covered services; pre-certification of a hospital stay or surgery
Dental PPO Lincoln Financial	(800) 423-2765 http://www.lfg.com	Benefits, eligibility, claim status, find a provider
Vision EyeMed Vision Care	(866) 939-3633 www.eyemedvisioncare.com	Benefits, eligibility, claim status, provider directory
Life and AD&D Coverage Lincoln Financial	(800) 423-2765 http://www.lfg.com	Basic Life and AD&D , Voluntary Life and AD&D and Dependent Life
Disability Coverage Lincoln Financial	(800) 423-2765 http://www.lfg.com	File a claim, inquire about claim status
Flexible Spending Account Discovery Benefits	(866) 451-3399 http://www.discoverybenefits.com	Account balance, file a claim, inquire about claim status, reimbursement forms
Texas County and Districts Retirement System (TCDRS)	(800) 823-7782 http://www.tcdrs.org Email: memberservices@tcdrs.org	How the plan works, retirement benefits; retirement estimates; account balance; service history
ICMA-Retirement Corporation	(800) 669-7400 http://www.icmarc.org	Retirement benefits; retirement estimates; account balance; service history
AIG-Valic Retirement Planning	(800) 448-2542 http://www.valic.com	Retirement benefits; retirement estimates; account balance; service history
Employee Assistance Plan EmployeeConnect	(877) 757-7587 http://www.eapadvantage.com Password: Connect	To discuss personal, work, legal, or financial issues
Employee Assistance Plan Travel Assistance	(800) 527-0218 MEDEX ID: 322541 Group Name: Lincoln Financial Group	Travel needs, safety-related services, weather forecast and more.
Employee Benefits **Help Line**	(866) 252-8671 mybenefits@holmesmurphy.com	Benefits, eligibility, enrollment, claim issues, provider directory
DCTA **Human Resources**	Benefits Administrator Shanna O'Gilvie (972)221-4600 (972) 316-6097 sogilvie@dcta.net	Employee benefits including retirement plan; qualifying events such as change in family status; ID cards; beneficiary designations and changes; forms; claim issues; prescription drugs; Employee Self-Service