2026

Retiree Benefits

Amalgamated Transit Union
Local 1277

Caring for you, so LA keeps moving.

Metro

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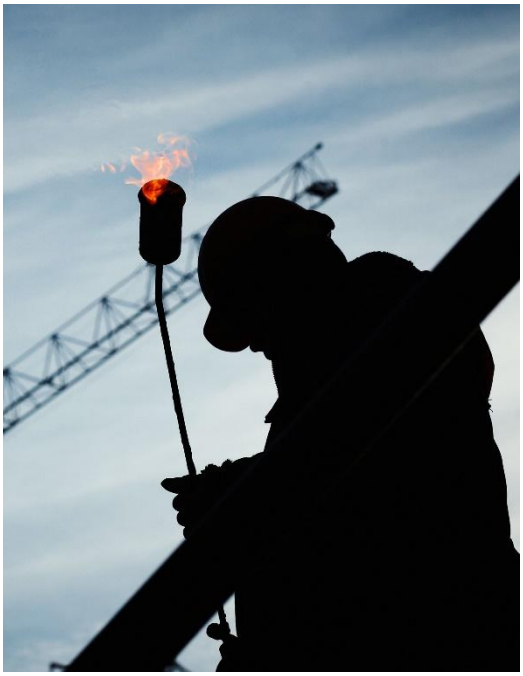


MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

GETTING STARTED

If you're enrolling in retiree benefits for the first time, nearing retirement, or somewhere in between, The Los Angeles County Metropolitan Transportation Authority (LA Metro) and Amalgamated Transit Union Local 1277 (ATU) supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This Benefits Guide provides a summary of benefits you have as a retiree of ATU Local 1277. The plans described in this guide are subject to specific terms and provisions of the plans, as established in the plan documents, are the sole source for interpretation and administration of the plans and programs.

Review the coverage and tools available to you to make the most of your benefits package.

2025-2026 Benefits Coverage

Coverage Period: October 1, 2025 – September 30, 2026

Open Enrollment September 2 - September 23, 2025.

WHAT'S CHANGING THIS OPEN ENROLLMENT

Open Enrollment is a once-a-year opportunity to review your benefit choices, change plans, add or drop dependents. After Open Enrollment ends, you cannot change your benefit elections until the next Open Enrollment in 2026, unless you experience an eligible life event,

Open Enrollment begins September 2, 2025, through September 30, 2025.

Any changes made during OE will be effective on **October 1, 2025.**

What's new or changing?

Our current benefit program will continue into 2025/2026 with only minor changes. While your benefits aren't changing, you may have had some major life changes. Do your current choices still meet your needs? Review this benefits guide to understand your coverage options. Include your spouse or partner in the review if they have input into your family's benefits decisions.

These changes will be effective on October 1, 2025.

Vision:

NEW Enhancements for your vision benefit:, Now these enhancements are included at no additional cost:

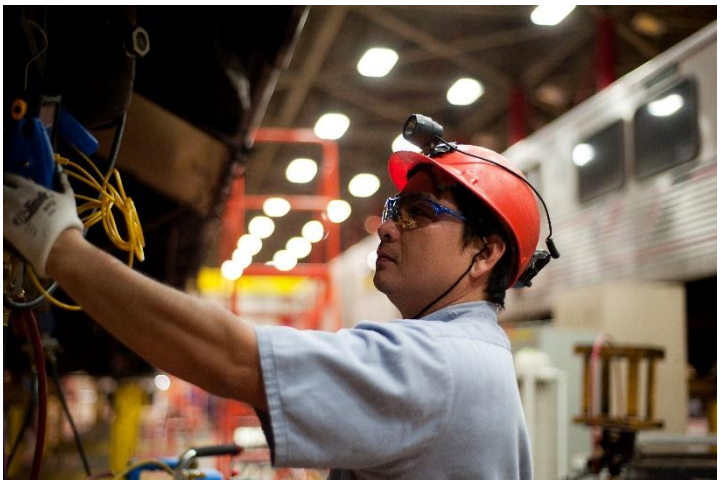
- Progressive lenses Anti-glare coating
- Tints
- Light-reactive lenses
- Impact-resistant lenses
- Scratch-resistant coating
- UV protection
- Blue light filter
- Polarized lenses
- Aspheric lenses

Do I need to enroll?

If you do not have any changes to make to your 2024/2025 benefits, then **no action is required.**

If you need to make any changes to your benefits, you must complete and send all forms to the Benefits Team no later than September 23, 2025:

- Email: benefitsa@metro.net
- by mail to: **LACMTA**
  One Gateway Plaza 99-PL-9,
  Los Angeles, CA 90012
- by FAX: **213-922-7190**



IMPORTANT: *If you miss the enrollment deadline, you'll need to wait until the next Open Enrollment (the one time each year that you can make changes to your benefits for any reason), unless you experience a qualifying life event. If you do, you must enroll within 30 days of becoming eligible.*

CHANGING YOUR BENEFITS

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 30 days of the date the event occurs.
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

Click to play video

Outside of Open Enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare and/or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 30 days after the event.

Dependent Verification

Making changes to dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You will be required to provide proof of one or more of the following within 30 days of their eligibility:

- Marriage Certification or License
- Domestic Partners Affidavit
- Birth Certificate
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)

If you do not supply the proper documentation to make changes to dependents within the 30-day period, you will not be able to add the dependent(s) until the next Open Enrollment period.

THE EASY WAY TO GET BENEFITS INFO WITH MY BENEFITS LIFE

MyBenefits.Life® gives you all your benefits information in one place

You can bank online, book a vacation online, and read the news online. Why should your benefits information be any different? MyBenefits.Life® is a website and a mobile optimized platform that gives you access to the benefits information you need, when you need it.

Here's what you'll find on MyBenefits.Life®

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

To access My Benefits Life, click here: ATU MyBenefits Life

MEDICAL

Early Retiree Plans:

Anthem Fee For Service.

UnitedHealthcare Signature Value.

UnitedHealthcare Harmony.

Kaiser HMO.

Medicare Retirees Plans:

Anthem Medicare Advantage Plan

Kaiser Senior Advantage Plan

All About Medical Plans

Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

Do you prefer specific doctors or hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

Consider the bottom line

Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

Medical Early Retiree PPO Plan

Here is an overview of the Anthem Fee for Service PPO plan for Retirees.

	Anthem Fee For Service	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $0 $0	 $0 $0
Calendar Year Out-of-Pocket Maximum Individual Family	 Unlimited Unlimited	 Unlimited Unlimited
Office Visit Primary Care Specialist	 20% coinsurance 20% coinsurance	 20% coinsurance 20% coinsurance
Online Visit*	20% coinsurance	20% coinsurance
Preventive Services	20% coinsurance	20% coinsurance
Chiropractic (Up to 24 visits/per benefit period)	 20% coinsurance	 20% coinsurance
Lab and X-ray	20% coinsurance	20% coinsurance
Urgent Care	20% coinsurance	20% coinsurance
Emergency Room	20% coinsurance	20% coinsurance
Inpatient Hospitalization	20% coinsurance	20% coinsurance
Outpatient Surgery	20% coinsurance	20% coinsurance
PRESCRIPTION DRUGS		
Calendar Year Deductible	N/A	N/A
Out-of-Pocket Maximum	N/A	N/A
Retail- 100 Day Supply Tier 1 Tier 2 Tier 3 Specialty -30 day only	 $10 copay $15 copay $15 copay $15 copay	 $10 + 50% coinsurance $15 + 50% coinsurance $15 + 50% coinsurance Not
Mail Order- 100 Day Supply Tier 1 Tier 2 Tier 3 Specialty -30 day only	 $10 copay $15 copay $15 copay $15 copay	 Not Covered Not Covered Not Covered Not Covered

*Online visits are only available if their provider also provides services in person. Urgent/acute medical and mental health and substance abuse disorder, and specialist care via Livehealth Online are not covered.

Medical HMO Plans

UnitedHealthcare®

	UnitedHealthcare Signature Value HMO	UnitedHealthcare Signature Value Harmony HMO
	In-Network	Out-of-Network
Calendar Year Deductible Individual Family	None None	None None
Calendar Year Out-of-Pocket Maximum Individual Family	$2,000 $6,000	$2,000 $6,000
Office Visit Primary Care Specialist	$10 $10	$10 $10
Preventive Services	$10	$10
Chiropractic	$10 visit (20 visits/year)	$10 visit (20 visits/year)
Lab and X-ray	No Charge	No Charge
Urgent Care	$10 inside geographic area $50 outside geographic area	$10 inside geographic area $50 outside geographic area
Emergency Room	$50 (waived if admitted)	$50 (waived if admitted)
Inpatient Hospitalization	No Charge	No Charge
Outpatient Surgery	No Charge	No Charge
PRESCRIPTION DRUGS		
Calendar Year Deductible	None	None
Out-of-Pocket Maximum	Combined with medical	Combined with medical
Retail- 30 Day Supply Tier 1 Tier 2 Tier 3 Specialty	$5 $15 $25 N/A	$5 $15 $25 N/A
Mail Order- 90 Day Supply Tier 1 Tier 2 Tier 3 Specialty	$10 $30 $50 Not covered	$10 $30 $50 Not covered

Early Retiree Medical HMO Plan

KAISER PERMANENTE®

	Kaiser Traditional HMO
	In-Network
Calendar Year Deductible Individual Family	 None None
Calendar Year Out-of-Pocket Maximum Individual Family	 $1,500 $3,000
Office Visit Primary Care Specialist	 $10 $10
Preventive Services	No Charge
Chiropractic	$10 (40 visits/year)
Lab and X-ray	No Charge
Urgent Care	$10 per visit
Emergency Room	$25 per visit
Inpatient Hospitalization	No Charge
Outpatient Surgery	$10 per procedure
PRESCRIPTION DRUGS	
Calendar Year Deductible	
Out-of-Pocket Maximum	
Retail- 30 Day Supply Tier 1 Tier 2 Tier 3 Specialty	 $10 $10 $10 $10
Mail Order- 90 Day Supply Tier 1 Tier 2 Tier 3 Specialty	 $10 $10 $10 $10

Medical 65+ MAPD Plan

Here is an overview of the Anthem Medicare Advantage plan for 65+ members with Medicare parts A & B.

	Anthem Medicare Advantage Plan	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $0 $0	 $0 $0
Calendar Year Out-of-Pocket Maximum Individual /Family	 $1500	 $1500
Office Visit Primary Care Specialist	 $0 copay $0 copay	 $0 copay $0 copay
Online Visit*	$0	$0
Preventive Services	$0	$0
Chiropractic	$0 copay	$0 copay
Acupuncture	$0 copay (up to 12 visits in 90 days & additional 8 if showing improvement).	$0 copay (up to 12 visits in 90 days & additional 8 if showing improvement).
Lab and X-ray (simple diagnostics) Complex diagnostic tests and or radiology	$0 copay $50 copay	$0 copay $50 copay
Urgent Care	$0 copay	$0 copay
Emergency Room	$75 copay (waived if admitted)	$75 copay (waived if admitted)
Inpatient Hospitalization (Requires pre-authorization to be covered)	$0 copay per admission	$0 copay per admission
Outpatient Surgery	$0 copay	$0 copay
PRESCRIPTION DRUGS		
Calendar Year Deductible	$0	$0
Out-of-Pocket Maximum	N/A	N/A
Retail- 100 Day Supply **(Specialty is limited to 30 days)** Select Generics Generics Preferred Brands Non-Preferred Drugs , Specialty and Non-Formulary Diabetic Supplies	 $0 copay $10 copay $15 copay $15 copay $10 copay	 $0 copay $10 copay $15 copay $15 copay $10 copay
Mail Order- 100 Day Supply **(Specialty is limited to 30 days)** Select Generics Generics Preferred Brands Non-Preferred Drugs , Specialty and Non-Formulary Diabetic Supplies	 $0 copay $10 copay $15 copay $15 copay $10 copay	 $0 copay $10 copay $15 copay $15 copay $10 copay
Part D Catastrophic Coverage Your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of $4,550.		
Select Generics Generics Brand-Name Drugs	$0 5% coinsurance with a minimum of $2.50 and a maximum of $10 5% coinsurance with a minimum of $6.30 and a maximum of $15	

Kaiser Senior Advantage

Here is an overview of the Kaiser Senior Advantage plan for 65+ members.

	Kaiser Senior Advantage Plan
	In-Network Only
Calendar Year Deductible	None
Calendar Year Out-of-Pocket Maximum Individual Family	 $1,000 $3,000
Office Visit Primary Care Specialist	 $10 copay $10 copay
Online Visit*	No Charge
Preventive Services	No Charge
Chiropractic Care (40 visits per year)	$10 copay
Lab and X-ray	No Charge
Urgent Care	$10 copay
Emergency Room	$25 copay
Inpatient Hospitalization	No charge
Outpatient Surgery	$10 per procedure
PRESCRIPTION DRUGS	
Calendar Year Deductible	$0
Out-of-Pocket Maximum	N/A
Retail- 100 Day Supply **(Specialty is limited to 30 days)**	$10
Mail Order- 100 Day Supply **(Specialty is limited to 30 days)**	$10

PHARMACY

ANTHEM PDP

For members over 65 enrolled in the Anthem FFS plan, you can enroll in this Prescription Drug Plan.

All About Prescription Drugs

Retail- 100 Day Supply **(Specialty is limited to 30 days)** Select Generics Generics Preferred Brands Non-Preferred Drugs , Specialty and Non-Formulary Diabetic Supplies	 $0 copay $10 copay $15 copay $15 copay $10 copay	 $0 copay $10 copay $15 copay $15 copay $10 copay
Mail Order- 100 Day Supply **(Specialty is limited to 30 days)** Select Generics Generics Preferred Brands Non-Preferred Drugs , Specialty and Non-Formulary Diabetic Supplies	 $0 copay $10 copay $15 copay $15 copay $10 copay	 $0 copay $10 copay $15 copay $15 copay $10 copay
Part D Catastrophic Coverage Your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of $4,550.		
Select Generics Generics Brand-Name Drugs	$0 5% coinsurance with a minimum of $2.50 and a maximum of $10 5% coinsurance with a minimum of $6.30 and a maximum of $15	

PRESCRIPTIONS BREAKING YOUR BUDGET?

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Click to play video

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

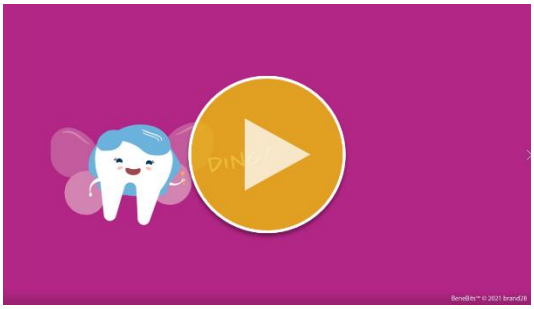
To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

DENTAL

OUR PLANS

Delta Dental PPO Plan

Click to play video



DELTA DENTAL®

KEEP SMILING WITH DELTA DENTAL

Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

Delta Dental Plan

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease. See below for an overview of the Delta Dental PPO available to retirees.

	Delta Dental PPO Plan	
	In-Network	**Out-of-Network**
Annual Deductible Individual/Family	None	$25/person
Annual Plan Maximum	$3,500 per person	$3,500 per person
Waiting Period	None	None
Diagnostic & Preventive	No Charge	No Charge
Basic Services Fillings Root Canals Periodontics	10% coinsurance	20% coinsurance
Major Services	10% coinsurance	20% coinsurance
Orthodontia Adults Children (up to age 26)	25% coinsurance	50% coinsurance
Ortho Lifetime Max	$2,500	$2,500

More details about these plans:

Get Lasik & hearing aid discounts!

Delta Dental members have access to QualSight and Amplifon Hearing Health Care[5], you can save as much as 50% on LASIK procedures and more than 60% on hearing aids. To take advantage of these discounts, call QualSight at 855-248-2020 and Amplifon at 888-779-1429.

Where can I get more details?

Sign up for an online account, find a dentist near you, or print your ID cards by visiting deltadentalins.com.

VISION

OUR PLANS

VSP Vision Signature Plan

NEW options for: Retinal Imaging, Aspheric Lenses, near variable focus and blue light filtering at **$0 copay**.

Click to play video

BE HEALTHY & LIVE HAPPIER WITH HELP FROM VSP

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual WellVision eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol and more.

VALUE AND SAVINGS YOU LOVE.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

Like shopping online? Go to eyeconic.com and use your vision benefits to shop over 50 brands of contacts, eyeglasses, and sunglasses.

VSP Vision Plan

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	VSP Signature	
	In-Network	**Out-of-Network**
Exams		
Regular Exam & Glasses	$10 copay	Up to $45 copay
Contact Lens Examination	Up to $60 copay	Up to $60 copay
Frequency	Once every 12 months	Once every 12 months
Eyeglass Lenses		
Single Vision Lens	$0	Up to $45
Bifocal Lens	$0	Up to $65
Trifocal Lens	$0	Up to $85
Frequency	Once every 12 months	Once every 12 months
Frames		
Benefit	$300 allowance	Up to $47 allowance
Costco	$165 allowance	N/A
Frequency	Once every 12 months	Once every 12 months
Contacts (in lieu of glasses)		
Benefit	$300 allowance	Up to $105 allowance
Frequency	Once every 12 months	Once every 12 months

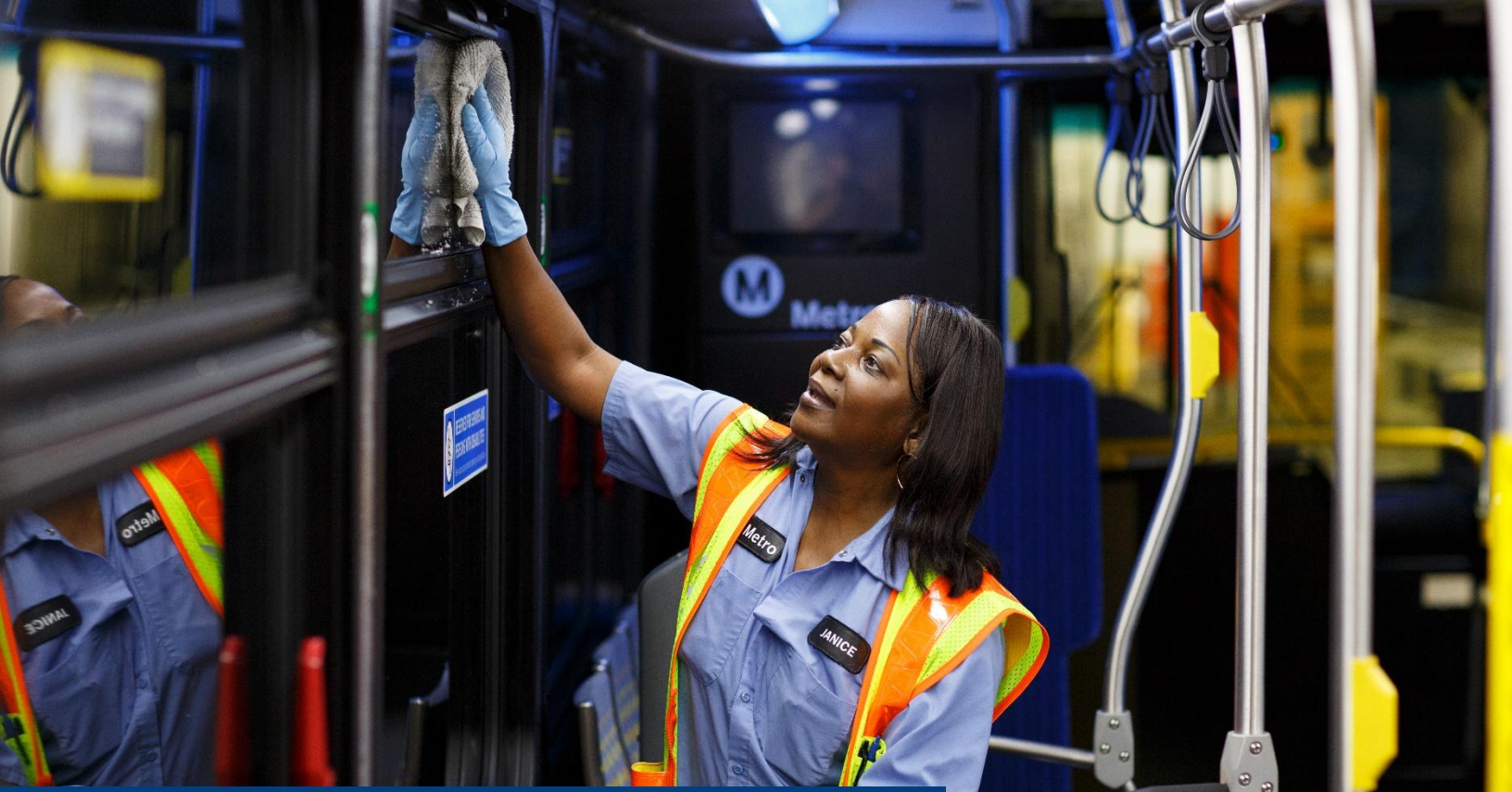
NEW Options for: Retinal Imaging, Aspheric Lenses, near variable focus and blue light filtering at **$0 copay.**

What you need to know about this plan

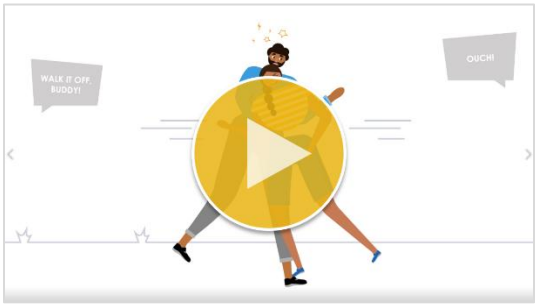
Features: As a VSP member, you get personalized care from a VSP network doctor at low out-of-pocket costs.

Extra savings! The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and even hearing aids.

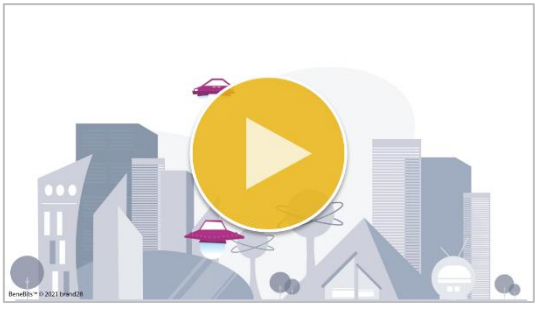
Where can I get more details? Visit www.vsp.com or call 800.877.7195



ENGAGE WITH YOUR BENEFITS!



Urgent Care vs ER



Virtual Healthcare

Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Understanding preventive care benefits
- Saving money on prescription drugs

Health Enhancing Programs

In addition to medical coverage, we provide these programs and services to help you access care when and how you need it and address special health concerns:

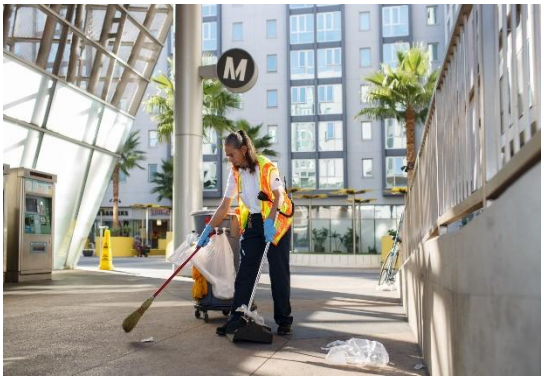
- **Mystrength (Kaiser)**
- **Calm (Kaiser)**
- **LiveHealth Online Virtual Care (Anthem)**
- **Lark Diabetes Prevention Program (Anthem)**
- **Browning Therapy Group Mental Health & Substance Abuse Benefit**
- **Epic Hearing**
- **And more!**

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	**$0**
Online visit 	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	**$**
Office visit 	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room 	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	**$$$$$**

MENTAL HEALTH & SUBSTANCE ABUSE BENEFIT BY BROWNING THERAPY



For more information or to set up an appointment call:

(800) 4-YOU-NOW

(562) 596-2141

(714) 662-1212

Website

www.BrowningTherapy.com

Email

info@BrowningTherapy.com

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. Your Union provides a Mental Health & Substance Abuse benefit available to you and your immediate family members through Browning Therapy.

This benefit can help you handle a wide variety of personal issue such as emotional health and substance abuse; marriage and family struggles; addictions; and even workplace issues and stress.

Best of all, contacting Browning Therapy is completely confidential. Everything that takes place between you and your counselor at Browning Therapy can never become a part of your permanent employee records. This information will not be shared with any outside person, governmental agency, insurance company, or your employer.

Professional Mental Health Services

You'll get solution-focused professional counseling to help you overcome problems like these:

Mental & Emotional Issues

- Anxiety & fear
- Mood swings
- Depression
- Anger, guilt & shame
- Self-hate
- Grief & loss
- Pain from past trauma & abuse
- Feelings of betrayal & abandonment
- Spiritual struggles
- Suicidal thoughts

Marriage & Family Struggles

- Conflicts with spouse or partner
- Divorce prevention or adjustment
- Adultery & infidelity
- Separation
- Parenting conflicts
- Blended family issues
- Domestic violence
- Disability adjustment

Addiction

- Alcohol or drug addiction
- Out-of-control gambling
- Sexual addiction
- Eating disorders
- Obsessive compulsive habits
- Addictions to electronics devices
- Habitual lying or stealing

Problems On The Job

- Chronic absence or tardiness
- Problems with coworkers or supervisors
- Lack of concentration
- Self-destructive workplace behaviors
- Drug or alcohol related problems
- Family or medical problems impacting work performance
- Harassment, or sexual harassment, by coworkers or supervisors

MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS

PLAN FAQ

Who is Covered Under This Plan?
This benefit and its services are available to eligible active retire members of ATU and their immediate families.

EAP Vs. Your Union Plan – What's the Difference?
Services you receive with the Employee Assistance Program (EAP) are provided by MTA management to help resolve employee problems that impact work performance. With the EAP program, privacy and confidentiality of your counseling is limited and cannot be guaranteed, since the outcome may be shared with your employer, or become part of your permanent employee records.
On the other hand, under your Union Plan you receive care from a professional and highly skilled therapists with the assurance of total confidentiality. Everything that takes place between you and your counselor at Browning Therapy Group can never become part of your permanent employee records. This information will not be shared with any outside person, governmental agency, insurance company, EAP group, or your employer.
In addition, the comprehensive Mental Health and Substance Abuse services provided to you and your family under your Union Plan are not available through EAP services, nor any other typical healthcare insurance plan.

Do I Need a Doctor's Referral to Make an Appointment?
No referral is needed. Just have your badge numbers and call the number on the back cover. Browning Therapy Group's staff is here to help you and answer any questions that you may have. After they verify your eligibility, you will receive a call back to schedule an appointment and provide any pertinent information for your first visit.

If Marriage-Partner or Family Counseling Needed?
Most healthcare plans will not cover marriage-partner or family related therapy unless a
mental disorder" of some kind exists. This benefit provides comprehensive and solution-focused professional therapy for marriage-partner relationship, and parenting challenges.

When are Mental Health Services Needed?
If you or a loved one find that you are becoming increasingly nervous, irritable, angry, withdrawn, discouraged, depressed, or are experiencing disturbances in sleep or appetite – seeking therapy may be the wisest choice you can make. If workplace, family or emotional problems are affecting our physical health in the form of high blood pressure, ulcers, eating disorders or panic attacks – seeking professional help early can reduce your changes of long-term physical damage.

Is Substance Abuse Treatment Right For You or a Loved One?
Those who are suffering from addictions, or a affected by a loved one's addiction, can find the help they need. Browning Therapy Group's staff provides one-on-one and family therapy for the addict and his or her family for destructive behaviors such as: problem drinking, drug dependence (including prescription drugs), sexual and porn addiction, eating disorders, compulsive stealing, out-of-control gambling, and other forms of obsessive-compulsive disorders. Addiction counseling typically requires involvement in an ongoing recovery program, such as a 12-step group or other form of rehab while seeing a Browning Therapy Group staff member. This benefit does not provide in-patient rehabilitation or medication management for the addict; but they do provide referrals for those in need of more intensive care. Browning Therapy Group will coordinate and provide outpatient therapy upon discharge from an in-patient program for a seamless transition of care.

When is Workplace Counseling Needed?
If you are having emotional or relationship struggles in your personal life, many times they can cause major difficulties on the job as well. In a recent research study, 24,000 employees were asked if personal issues outside of work caused them any problems on the job. Over 47% said their work has suffered due to personal problems and family conflicts. At Browning Therapy Group, they specialize in all workplace behavioral stressors – both on-the-job conflicts, as well as outside issues that may affect workplace performance and job satisfaction.

EPIC HEARING HEALTHCARE

Your Hearing Service Plan and How to Use It

For more information or to contact EPIC:

EPIC Hearing Healthcare

3191 W. Temple Ave, Ste 200

Pomona, CA 91768

Call Toll Free:
(866) 956-5400
Please inform the Customer Service Representative that you have ATU/MTA benefits.

Hearing Impaired:
Call 711 national relay service

Fax:
(909) 348-0073

Email:
hear@epichearing.com

Website:
www.epichearing.com

Hearing is one of the five natural senses that allow us to enjoy life and the world around us. Music, radio, television, movies, and theater – all become less accessible and enjoyable without the benefits of hearing. And hearing loss can lead to more serious problems such as social disengagement, increased stress and even cognitive decline.

Hearing is a values life asset that can be protected, treated and assisted through a program for hearing healthcare. The EPIC Hearing Service Plan provides easy access to hearing health professionals – primarily physicians and audiologists- who can help you achieve your maximum hearing potential throughout your life.

With this program you'll receive:

- A national alliance of independent ear physicians and audiologists dedicated to high-quality hearing care
- Substantial savings – between 30% and 60% - on name-brand hearing aids and products to protect and improve your hearing
- Routine Hearing Exam: $70 benefit
- Hearing Aid Benefit: $4,000 per ear, every 3 years

How the EPIC Plan works:

- Call EPIC today to start your hearing program.
- A hearing counselor will register you and assist in determining your hearing care needs.
- You will receive a Hearing Service Plan booklet outlining all plan series and pricing.
- A hearing counselor will coordinate a referral to a provider located near your home or work.
- Contact the provider; follow through with an appointment, examination and treatment.
- EPIC will coordinate and manage all payments and assist you in coordinating insurance benefits or coverage when applicable.
- Our hearing counselors are available to help you, and to provide advice or additional information.

Call EPIC today at (866) 956-5400 to access your hearing health services!

Hearing impaired: Dial 711 national relay service.

COST OF COVERAGE AND BENEFITS CONTACTS

YOUR MONTHLY BENEFIT COSTS

Medical, Dental & Vision

ATU Local 1277 members **under 65** pay a flat amount of $80 a month for their medical, dental and vision plans whether they are covering just themselves or their entire family.

ATU Local 1277 members **over 65** pay a flat amount of $60 a month for their medical, dental and vision plans whether they are covering just themselves or their entire family.

For Benefits Assistance:

Cindy McLean
Pension & Benefits Analyst
McLeanC@metro.net

Nicole Patino
Sr. Pension & Benefits Analyst
PatinoNi@metro.net

Amalgamated Transit Union Local 1277
Benefits Assistance
(213) 922-1266 | benefitsa@metro.net

GLOSSARY

-A-

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

GLOSSARY

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

IMPORTANT PLAN INFORMATION

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

IMPORTANT PLAN INFORMATION CONTINUED

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located on pages 37-44.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Notice of Grandfathered Plan Status:** Notifies you that a plan is grandfathered and does not include all Affordable Care Act (ACA) provisions

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available on pages 37-45. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- Kaiser Senior Advantage Plan
- Anthem Medicare Advantage Plan
- Anthem Fee For Service Plan

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available on your MyBenefits.life page.

- Kaiser Senior Advantage Plan
- Anthem Medicare Advantage Plan
- Anthem Fee For Service Plan

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Kaiser Permanente and Anthem Blue Cross plans. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Medicare Part D Notice

Important Notice from ATU Health & Welfare Fund About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Anthem Blue Cross, Kaiser Permanente or United Healthcare and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The ATU Health & Welfare Fund has determined that the prescription drug coverage offered by Anthem Blue Cross, Kaiser Permanente and United Healthcare 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. YOU PAY NOTHING EXTRA FOR THE PRESCRIPTION DRUG COVERAGE THROUGH THE ATU HEALTH AND WELFARE FUND.

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 December7th. 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, 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 ATU Health & Welfare Fund -sponsored coverage. In this case, the ATU Health & Welfare Fund-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 ATU Health & Welfare Fund-sponsored coverage, Medicare will be your only payer. You can reenroll in the ATU Health & Welfare Fund-sponsored coverage at annual enrollment or if you have a special enrollment event as defined in your benefit plan material for the ATU Health & Welfare Fund-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 ATU Health & Welfare Fund-sponsored medical or prescription drug coverage. Your ATU Health and Welfare Fund – sponsored medical and prescription drug coverage may be reinstated at an annual open enrollment if you drop Medicare Part D and your account with the ATU Health and Welfare Fund is in good standing. Before you decide to enroll in a Medicare Prescription drug plan you should compare your ATU Health and Welfare Fund – sponsored medical plan options – including which drugs are covered – with the coverage and cost of the plans offering Medicare medical and prescription drug coverage in your area.

Remember - Retired employees and their dependents who enroll in a Medicare prescription drug plan and drop their ATU Health & Welfare Fund-sponsored prescription drug coverage may be reinstated at an annual open enrollment if you drop Medicare Part D and your account with the ATU Health and Welfare Fund is in good standing.

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, Kaiser Permanente or United Healthcare 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 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 year to enroll.

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

You may contact the Pension and Benefits Administration office at (213) 922-1266 for further information. 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 ATU Health & Welfare Fund 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 & your handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you may call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 1, 2025
Name of Entity/Sender:	ATU Health & Welfare Fund
Contact-Position/Office:	Nicole Patino and Cindy McLean, Pension & Benefits Administration
Address:	One Gateway Plaza, 99-PL-9, Los Angeles, CA 90012-2952
Phone Number:	(213) 922-1266

Women's Health and Cancer Rights Act

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

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

These benefits are subject to the same deductible and co-payments applicable to other medical and surgical procedures provided under this plan. You can contact the ATU Benefits line at 213-922-1266 for more information.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

Michelle's Law

Some medical plans may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify the ATU Benefit Line as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in the ATU Health & Welfare Fund health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in the ATU Health & Welfare Fund health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the ATU Health & Welfare Fund plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

The federal Health Insurance Portability and Accountability Act (HIPAA) requires that we periodically remind you of your right to receive a copy of the Insurance Carriers' HIPAA Privacy Notices. You can request copies of the Privacy Notices by contacting the ATU Health & Welfare Fund or by contacting the insurance carriers directly.

Notice of Grandfathered Plan Status

The ATU Health & Welfare Fund believes that some coverage maybe considered a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the U.S. Department of Health and Human Services at https://www.hhs.gov/.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 | Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov | KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 | Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 617-886-8102
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp | Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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