

2026-27

Retiree Benefits

Amalgamated Transit Union Local 1277



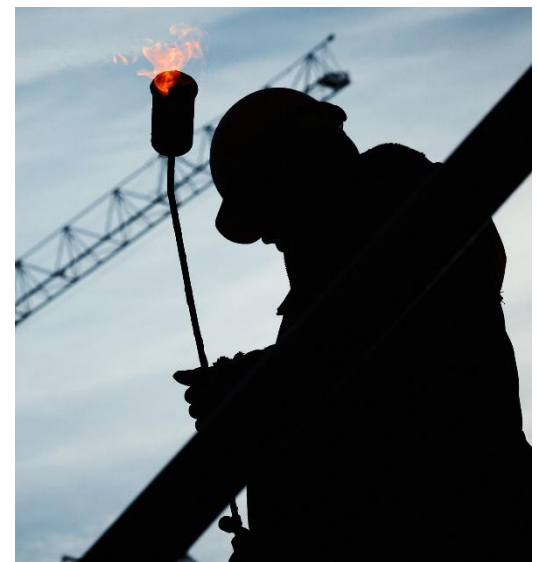
Prevent the
Breakdown: Tune Up
Your Health This
Year



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) support 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 the specific terms and provisions of the governing plan documents, which 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.

2026-2027 Benefits Coverage

Coverage Period: October 1, 2026 – September 30, 2027

Open Enrollment September 8 - September 18, 2026.

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 2027, unless you experience an eligible life event,

Open Enrollment begins September 8th through September 18th, 2026.

Any changes made during OE will be effective on **October 1, 2026.**

What's new or changing?

Our current benefit program will continue into 2026/2027 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, 2026.

Vision:

NEW plan enhancement for your vision benefit:

- Your VSP vision plan now has a \$0 copay for contact lens fitting (see page 18 for more details)

Medical:

NEW plan enhancement for your medical benefit:

- For Medicare part D eligible retirees, your Medicare plans participate in a Bridge program that gives members access to GLP-1 medication (See page 7 for more details).

Do I need to enroll?

If you do not have any changes to make to your 2026/2027 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 18, 2026:

- 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

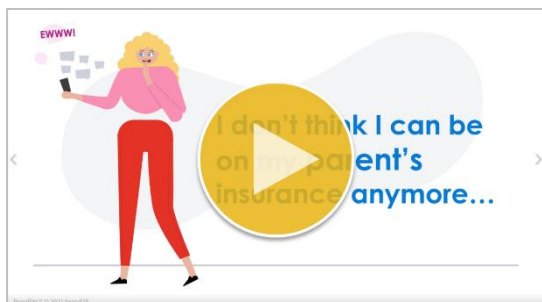
LIFE HAPPENS

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 MYBENEFITS.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](#) or use this QR code:



MEDICARE CONSIDERATIONS UNDER LA METRO-ATU

For those who enroll under Medicare with LA Metro-ATU

- **Medicare Eligibility Age:** Members become eligible for Medicare upon turning age 65, or earlier if they qualify due to a disability.
- **ATU Plan Enrollment Requirement:** To maintain full secondary coverage and maximize benefits under the ATU Health Fund, Medicare-eligible members and their dependents are strongly encouraged and required to enroll in both **Medicare Part A** (Hospital Insurance) and **Medicare Part B** (Medical Insurance) as soon as they become eligible.
- **Coordination of Benefits:** Once enrolled, Medicare acts as the primary payer for medical services, while the ATU plan acts as secondary coverage to help pay remaining deductibles and coinsurance.
- **Failure to Enroll:** If a member or dependent fails to enroll in Medicare Part A and Part B when eligible, the ATU plan will still process claims as if Medicare had already paid its portion, **leaving the member personally responsible for any unpaid medical costs.**
- **Maintaining Part B Coverage:** Retirees must continue paying their monthly Medicare Part B premium to keep their ATU secondary coverage active.

ATU Plan Rules:

1. **Partial Premium Subsidy:** For eligible retirees who retired on or after June 1, 1974, the transit authority will pay ****one-third (33.3%)**** of their monthly Medicare Part B premium.
2. **Mandatory Medicare Part A & B Enrollment:** Any retiree becoming eligible for Medicare on or after April 1, 2014, will apply for and enroll in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance). Specifically note the Medicare Plans:
 1. Anthem – Medical 65+ MAPD Plan (PPO Plan)
 - (Note: Medicare is the primary plan and payor, and Anthem is the secondary plan and payor.)
 2. Kaiser – Kaiser Senior Advantage (HMO Plan)
 - (Note: Medicare is the primary plan and payor, and Kaiser is the secondary plan and payor.)
3. **Proof Required to Start Reimbursement:** Reimbursements do not begin automatically upon reaching age 65. The retiree must submit physical proof (a copy of their Medicare card showing Part B coverage) to trigger the monthly contribution payments.

Note for those approaching age 65 and covered:

- Anthem and Kaiser Permanente will send their members a reminder 3 months before age 65, at age 65, and 3 months after turning age 65 about their Medicare plan.
- Kaiser will reach out via mail at age 64 to sign up for their Medicare plan
- UnitedHealth Care **will not** reach out so for those nearing the age of 65



MEDICAL

Early Retiree Plans:

- Anthem Fee For Service
- Anthem Prudent Buyer
- Anthem Blue Card (For out-of-state retirees)
- UnitedHealthcare Harmony Narrow Network
- UnitedHealthcare Signature Value
- Kaiser HMO

Medicare Retirees Plans:

- Anthem Medicare Advantage Plan (MAPD)
- Kaiser Senior Advantage Plan (KPSA)

Note: Starting July 1, 2026, Medicare will begin a **short-term demonstration (a pilot program)**, called the Medicare GLP-1 Bridge, that will provide eligible Medicare Part D beneficiaries with access to certain GLP-1 drugs.

Go to

<https://www.cms.gov/medicare/coverage/prescription-drug-coverage/medicare-glp-1-bridge>

to find out more.

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?

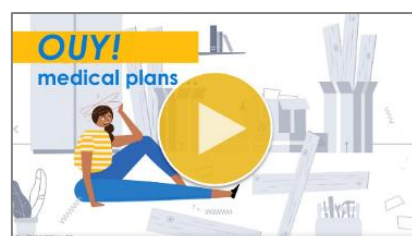
If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

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.



All About Medical Plans

Anthem Early Retiree Fee-for-Service (FFS) PPO Plan



	Anthem Fee-for-Service (FFS)	
	In-Network	Out-of-Network
Calendar Year Deductible Individual Family	\$0 \$0	\$0 \$0
Calendar Year Out-of-Pocket Maximum Individual Family	Unlimited (Not Applicable Benefit) Unlimited (Not Applicable Benefit)	Unlimited (Not Applicable Benefit) Unlimited (Not Applicable Benefit)
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	Not Applicable Benefit	Not Applicable Benefit
Out-of-Pocket Maximum	Not Applicable Benefit	Not Applicable Benefit
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 Covered
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.

For those enrolled with the separate Anthem Medicare part D plan with the Anthem Fee-for-Service, go to page 14 for more details on your prescription plan.

Anthem Early Retiree Prudent Buyer PPO Plan



	Anthem Custom Premier PPO Plan - Prudent Buyer PPO	
	In-Network	Out-of-Network
Calendar Year Deductible Individual Family	\$0 \$0	\$0 \$0
Calendar Year Out-of-Pocket Maximum Individual Family	\$889 Same as individual	\$1,500 Same as individual
Office Visit Primary Care Specialist	\$20 copay \$20 copay	30% coinsurance 30% coinsurance
Online Visit*	\$20 copay per visit	30% coinsurance
Preventive Services	\$20 copay (up to age 7) \$25 copay (ages 7+)	30% coinsurance (up to age 7) Not covered (ages 7+)
Chiropractic (Up to 24 visits/per benefit period)	\$20 copay	30% coinsurance
Lab and X-ray	20% coinsurance	30% coinsurance
Urgent Care	\$20 copay	30% coinsurance
Emergency Room	20% coinsurance	Covered as in-network
Inpatient Hospitalization	20% coinsurance	30% coinsurance
Outpatient Surgery	20% coinsurance	30% coinsurance
PRESCRIPTION DRUGS		
Calendar Year Deductible	Not Applicable Benefit	Not Applicable Benefit
Out-of-Pocket Maximum	Not Applicable Benefit	Not Applicable Benefit
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 Covered
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.

For those enrolled with the separate Anthem Medicare part D plan with the Anthem Fee-for-Service, go to page 14 for more details on your prescription plan.

Anthem Early Retiree Blue Card Out-of-State (OOS) PPO Plan



	Anthem Blue Card Out-of-State (OOS) plan	
	In-Network	Out-of-Network
Calendar Year Deductible Individual Family	\$0 \$0	\$0 \$0
Calendar Year Out-of-Pocket Maximum Individual Family	\$1,600 per person	\$1,600 per person
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 Covered
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.

For those enrolled with the separate Anthem Medicare part D plan with the Anthem Blue Card Out-of-State (OOS) plan, go to page 14 for more details on your prescription plan.

Medical Early Retiree HMO Plans



	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

	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	

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

ANTHEM RESOURCES



Did you know that Anthem offers several programs to help you manage your healthcare? Learn more about them here.

Sydney Health Mobile App

Meet Sydney, Anthem's mobile app. With Sydney, you can find everything you need to know about your personalized Anthem benefits all in one place. Sydney makes it easier to get things done, so you can spend more time to focus on your health.

Livehealth Online – Virtual Care

LiveHealth Online is your telemedicine provider and lets you have a video visit with a board-certified doctor using your smartphone, tablet or computer with a webcam. No appointments, no driving and no waiting at an urgent care center. Doctors are available 24/7 to assess your condition and, if it's needed, they can send a prescription to your local pharmacy. You can access Livehealth Online by logging into the **Sydney app**, go to **Care**, and then select **Virtual Care**.

Click to access the Live Health Website



[Click here to
Download the Sydney app](#)



24/7 Nurse Line

Health issues can arise at the most inconvenient times and places for you and your loved ones. Whether it's 3 a.m. at home or 10 a.m. while you're in the office. You have access to a nurse you can talk to any time, day or night, 365 days a year. Just call the number on the back of your ID card.

SilverSneakers® Fitness Program

For those on the Anthem MAPD, stay active with access to more than 22,000 fitness locations nationwide, classes designed for all fitness levels, and workout programs you can tailor to your needs. You can also participate in live and on-demand classes, use the SilverSneakers GO app, and connect with others through social events and activities.

Healthy Meals

Anthem MAPD members can receive nutritionally balanced meals delivered directly to your home following a hospital or skilled nursing facility discharge or, for qualifying members, when managing certain chronic conditions with a high risk for hospitalization. The benefit provides up to 56 meals per year, subject to eligibility requirements.

Vision Care Benefits

Anthem MAPD members can maintain healthy vision through the Blue View Vision benefit, including annual routine eye exams and access to 42,000+ eye doctors at more than 32,000 locations nationwide. Members can choose from independent providers and major retail locations and receive additional savings on eligible eyewear, contact lenses, accessories, and LASIK offers.

Non-Emergency Transportation

Anthem MAPD members can get convenient transportation to plan-approved medical visits, pharmacies, and SilverSneakers locations. Eligible retirees receive 36 one-way trips, with a 60-mile limit per trip. Transportation must be requested through the plan-approved vendor at least 48 hours in advance.

ANTHEM RESOURCES CONTINUED



Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you, such as gender, languages spoken, or location. You'll be matched with the best results based on your personal needs.

My Health Dashboard

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals. It also offers a customized experience just for you, such as syncing your fitness tracker and scanning and tracking your meals.

Chat

If you have questions about your benefits or need information, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.

Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.

Common Resources

This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and childcare.

My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

¿Prefieres obtener información en Español?

Tienes opciones. Si tu teléfono móvil ya está configurado en español, la aplicación Sydney Health también estará en español. Si no es así, selecciona el **menú** dentro de la aplicación Sydney Health y elige **el idioma de la aplicación**. También puedes visitar anthem.com/es.



Download the Sydney Health app today.

Use the app anytime to:

- Find care and compare costs.
- See what's covered and check claims.
- View and use digital ID cards.
- Check your plan progress.
- Fill prescriptions.



Scan the QR code to download the Sydney Health app.

You can also set up an account at anthem.com/register to access most of the same features from your computer.

FINDING CARE WITH ANTHEM



Choose with confidence

You can start using **Find Care** by downloading the Sydney Health app to your mobile device or logging in to anthem.com/ca. Select **Find Care** and the Find Care tool will guide you through the steps.

We're ready to help you

The Find Care tool empowers you to take control of your healthcare by helping you connect with high quality care options. If you have questions, you can reach us using the interactive chat feature on the Sydney Health app or through the Message Center on anthem.com/ca.

The Find Care tool helps you search for doctors/dentists and compare costs

Choosing a provider you trust is important — and choosing one in your plan's network can help keep your costs down. Finding high-quality, cost-effective care is simple when you use the Find Care tool on the Sydney Health mobile app or anthem.com/ca.



Download Sydney Health today to find a provider that's right for you.

How to use Find Care

The Find Care tool brings together details about doctors, hospitals, labs, and healthcare facilities in your plan's network. You can easily compare information such as costs, locations, and office hours. You can:

1. Search for providers and facilities in your plan's network by name, specialty, or procedure.
2. Customize the list of providers you see in your search based on factors that are most important to you, such as languages spoke, affiliated hospitals, and location.
3. Review details about doctors such as their specialties, gender, educational background, and contact information.
4. Choose a doctor from the list to review their patient ratings and compare costs for services.



Use your smartphone camera to scan this QR code.

KAISER RESOURCES



Everyone needs support for total health – mind, body, and spirit. Digital tools can help you navigate life’s challenges, make small changes that improve sleep, mood, and more, or simply support an overall sense of well-being.

KAISER PERMANENTE TELEMEDICINE

Kaiser Permanente members have access to remote healthcare. For primary care, specialty care, and mental health services, KP members can connect with their care team from the comfort and safety of their homes.

Kaiser members can assess telehealth by signing in to kp.org.

KAISER CALM MEDITATION AND MINDFULNESS APP

Kaiser Permanente Members have **free access** to the highly acclaimed Calm meditation and mindfulness smart phone application.

Adult members can get the Calm app at no cost. Practice mindfulness with Calm can help you build resilience and support your overall emotional health and wellness. Anyone can benefit from Calm, and the app offers something for everyone:

- ✓ A new 10-minute Daily Calm meditation every day
- ✓ Guided meditations covering anxiety, stress, gratitude, and more
- ✓ Sleep stories (soothing bedtime tales for grown ups)
- ✓ Music or focus, relaxation, and sleep
- ✓ Calm Masterclasses taught by world-renowned experts and celebrities

KP members can get access to Calm at kp.org/selfcareapps.

HEADSPACE CARE

Text one-on-one with an emotional support coach anytime, anywhere. Support is just a text message away.

24/7 text-based emotional support coaching

- Discuss goals, share challenges, and create an action plan with your coach
- Self-care resources recommended for your needs

To get started or to learn more, go to kp.org/selfcareapps/scal to access Kaiser’s programs.

ONEPASS (FITNESS MEMBERSHIP)

For those on the Senior Advantage Plan, stay active in a way that works for you. One Pass gives you access to a large nationwide network of gyms and fitness locations, along with live digital classes and on-demand workouts you can enjoy from home. You can also create fitness routines tailored to you, participate in brain-training activities, and connect with others through group classes, local clubs, and social events. Program options and amenities may vary by plan, area, and location.

FOR IN-PERSON MENTAL HEALTH AND SUBSTANCE USE SERVICES

If you need to set up or find a participating therapist and psychiatrist, use the SoCal Kaiser Permanente Location finder at <https://healthy.kaiserpermanente.org/southern-california/health-wellness/mental-health> or call member services at **833.574.2273** (TTY 711).

All support is confidential.

Our providers will never share your information with your employer.

PHARMACY

ANTHEM PDP

For members over 65 enrolled in the Anthem Fee-for-Service (FFS) plan or Anthem Blue Card Out-of-State (OOS) plan with a separate prescription plan (Anthem Medicare Part D Plan [PDP]), your plan details are below.



All About Prescription Drugs

Retail - 100 Day Supply (Specialty is limited to 30 days)		
Select Generics	\$0 copay	\$0 copay
Generics	\$10 copay	\$10 copay
Preferred Brands	\$15 copay	\$15 copay
Non-Preferred Drugs , Specialty and Non-Formulary	\$15 copay	\$15 copay
Diabetic Supplies	\$10 copay	\$10 copay
Mail Order - 100 Day Supply (Specialty is limited to 30 days)		
Select Generics	\$0 copay	\$0 copay
Generics	\$10 copay	\$10 copay
Preferred Brands	\$15 copay	\$15 copay
Non-Preferred Drugs, Specialty and Non-Formulary	\$15 copay	\$15 copay
Diabetic Supplies	\$10 copay	\$10 copay
Part D Catastrophic Coverage Once a member's true out-of-pocket costs reach \$2,100, they enter catastrophic coverage and pay \$0 for covered Part D drugs for the remainder of the calendar year.		
Select Generics	\$0	
Generics	5% coinsurance with a minimum of \$2.50 and a maximum of \$10	
Brand-Name Drugs	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.



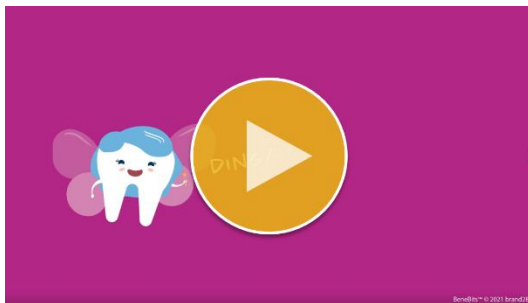
DENTAL

Retiree Dental Plans:

Delta Dental HMO Plan – **EARLY
RETIREE ONLY**

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.

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 HMO Plan	Delta Dental PPO Plan	
	In-Network Only	In-Network	Out-of-Network
Annual Deductible Individual/Family	None	None	\$25/person
Annual Plan Maximum	Unlimited	\$3,500 per person	\$3,500 per person
Waiting Period	None	None	None
Diagnostic & Preventive	\$5-\$45 copay then plan pays 100% (varies by services; see contract for fee schedule)	No Charge	No Charge
Basic Services Fillings Root Canals Periodontics	\$5-\$90 copay then plan pays 100% (varies by services; see contract for fee schedule)	10% coinsurance	20% coinsurance
Major Services	\$5-\$195 copay then plan pays 100% (varies by services; see contract for fee schedule)	10% coinsurance	20% coinsurance
Orthodontia Adults Children (up to age 26)	\$1,700-\$1,900 copay then plan pays 100% (varies by services; see contract for fee schedule)	25% coinsurance	50% coinsurance
Ortho Lifetime Max	None	\$2,500	\$2,500

More details about these plans:

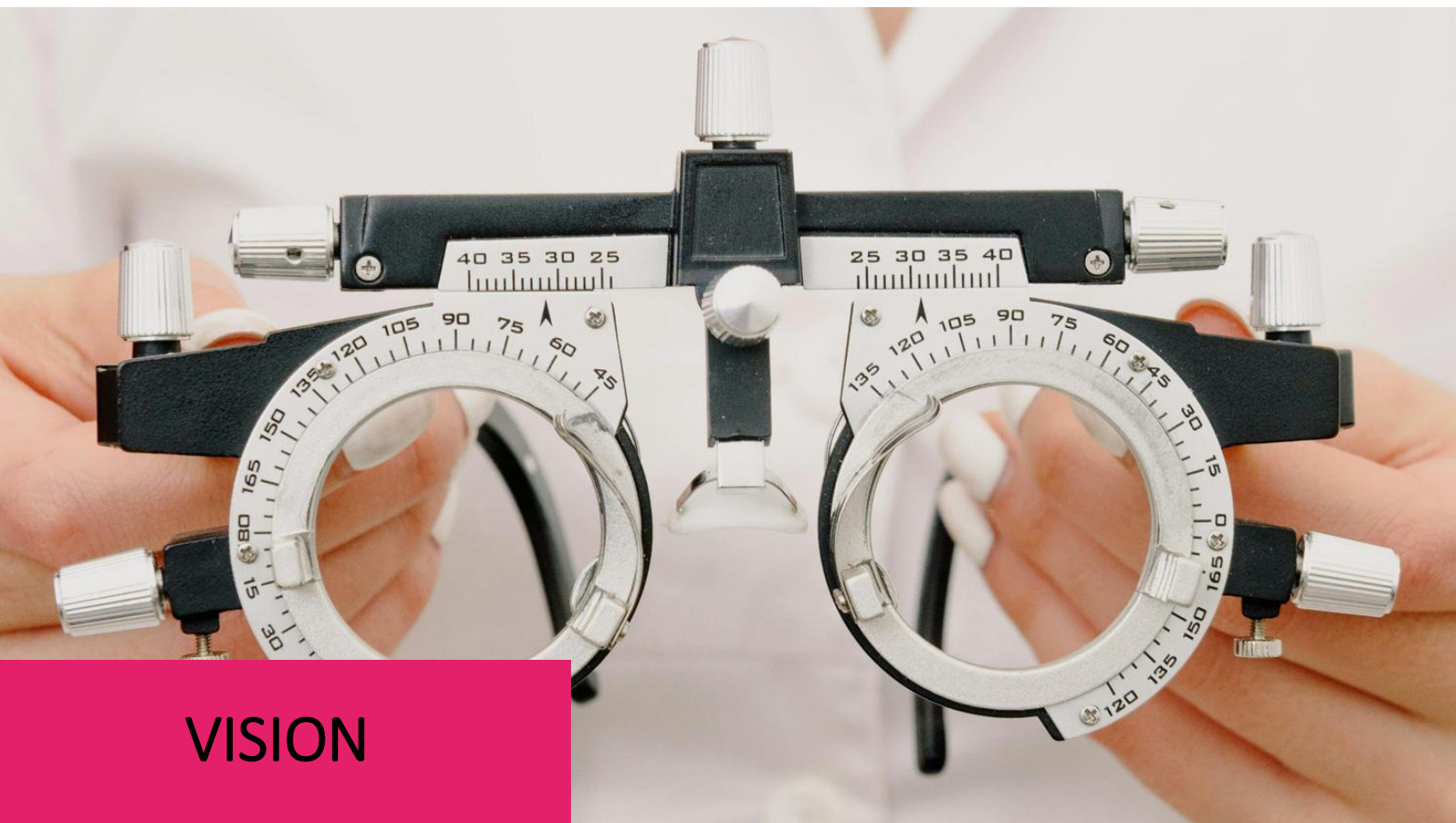
Get Lasik & hearing aid discounts!

Delta Dental members have access to QualSight and Amplifon Hearing Health Care[®], 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 plan enhancements for your vision benefit:

- Your vision plan now has a \$0 copay for contact lens fitting

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.

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 Contact Lens Examination Frequency	\$10 copay Up to \$60 copay Once every 12 months	Up to \$45 copay Up to \$60 copay Once every 12 months
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	\$0 \$0 \$0 Once every 12 months	Up to \$45 Up to \$65 Up to \$85 Once every 12 months
Frames Benefit Costco Frequency	\$300 allowance \$165 allowance Once every 12 months	Up to \$47 allowance N/A Once every 12 months
Contacts (in lieu of glasses) Benefit Frequency	\$300 allowance Once every 12 months	Up to \$105 allowance Once every 12 months

NEW: Your vision plan now has a \$0 copay for contact lens fitting.

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!

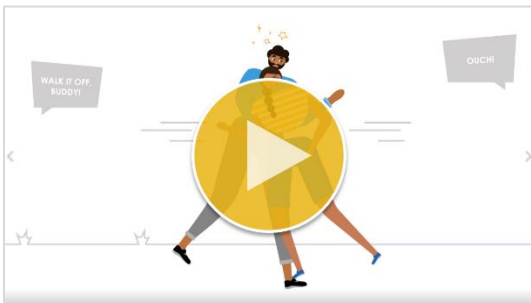
The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and even hearing aids.

Where can I get more details?

Visit www.vsp.com or call 800.877.7195



ENGAGE WITH YOUR BENEFITS!



Urgent Care vs ER

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:

- **Headspace (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 chances of long-term physical damage.

Is Substance Abuse Treatment Right For You or a Loved One?

Those who are suffering from addictions, or an 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.

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 for one hearing aid and \$8,000 for two hearing aids, 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:

Contact
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.

PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available on your portal. 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.

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

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.

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

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.

IMPORTANT PLAN INFORMATION

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 29-37.

- **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
- **Availability of Privacy Practices Notice:** Describes how health information about you may be used and disclosed
- **Notice of Grandfathered Plan Status:** Notifies you that a plan is grandfathered and does not include all Affordable Care Act (ACA) provisions
- **Michelle's Law:** Describes right to extend dependent medical coverage during student leaves
- **ACA Disclaimer:** This is a notice stating that information, services, or statements related to the Affordable Care Act (ACA) are provided with certain limitations, conditions, or legal qualifications.
- **The 'No Surprises' Rules:** Explains rules that protect you from surprise medical bills.
- **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.

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 ATU Health & Welfare Fund 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:

1. 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.
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. 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 ATU Health & Welfare Fund coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. Important Note for Retiree Plans: Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

Since the existing prescription drug coverage under ATU Health & Welfare Fund is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your ATU Health & Welfare Fund prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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.

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 ATU Health & Welfare Fund 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...

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 the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you may call them at 800-772-1213 (TTY 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, 2026
Name of Entity/Sender:	ATU Health & Welfare Fund
Contact-Position/Office:	LACMTA, Pension & Benefits
Address:	One Gateway Plaza, 99-PL-9, Los Angeles, CA 90012-2952
Phone Number:	(213) 922-1266
Email:	BenefitsA@Metro.net

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. Therefore, the following deductibles and coinsurance apply:

Early Retiree Plans: Anthem Fee For Service, UnitedHealthcare Signature Value, UnitedHealthcare Harmony, and Kaiser HMO

Medicare Retirees Plans: Anthem Medicare Advantage Plan & Kaiser Senior Advantage 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.

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

We maintain the HIPAA Notice of Privacy Practices for ATU Health & Welfare Fund describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the Pension and Benefits Administration office at (213) 922-1266.

Notice of Grandfathered Plan Status

Anthem and United Healthcare believes the Anthem Fee for Service, Anthem Blue Card OOS (Out-of-state) Plan, UnitedHealthcare Signature Value, and UnitedHealthcare Harmony is 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 at Pension and Benefits Administration office at (213) 922-1266.

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.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.96% of your modified adjusted household income in 2026.

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.

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, 2026**. Contact your State for more information on eligibility.

Alabama – Medicaid

Website: myalhipp.com

Phone: (855) 692-5447

Alaska – Medicaid

The AK Health Insurance Premium Payment Program

Website: myakhipp.com

Phone: (866) 251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid eligibility:

health.alaska.gov/dpa/Pages/default.aspx

Arkansas – Medicaid

Website: myarhipp.com

Phone: (855) MyARHIPP (692-7447)

California – Medicaid

Health Insurance Premium Payment (HIPP) Program

website: dhcs.ca.gov/hipp

Phone: (916) 445-8322

Email: hipp@dhcs.ca.gov

Fax: (916) 440-5676

Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado website: healthfirstcolorado.com

Health First Colorado Member Contact Center: (800) 221-3943 (TTY: 711)

CHP+: hcpf.colorado.gov/child-health-plan-plus

CHP+ Customer Service: (800) 359-1991 (TTY: 711)

Health Insurance Buy-In Program (HIBI): mycohibi.com

HIBI Customer Service: (855) 692-6442

Florida – Medicaid

Website:

flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp

Phone: (877) 357-3268

Georgia – Medicaid

GA HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

Phone: (678) 564-1162, press 1

GA CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra

Phone: (678) 564-1162, press 2

Indiana – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: in.gov/medicaid
Website: in.gov/fssa/dfr
Family and Social Services Administration
Phone: (800) 403-0864
Member Services phone: (800) 457-4584

Iowa – Medicaid and CHIP (Hawki)

Medicaid website: hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid phone: (800) 338-8366
Hawki website: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: (800) 257-8563
HIPP website: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: (888) 346-9562

Kansas – Medicaid

Website: kancare.ks.gov
Phone: (800) 792-4884
HIPP Phone: (800) 967-4660

Kentucky – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) website:
chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: (855) 459-6328
Email: KIHIPPPROGRAM@ky.gov
KCHIP website: kynect.ky.gov
Phone: (877) 524-4718
Medicaid website: chfs.ky.gov/agencies/dms

Louisiana – Medicaid

Louisiana Medicaid website: ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: (888) 342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP)
Website: ldh.la.gov/lahipp
LaHIPP phone: (877) 697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: (888) 716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084

Maine – Medicaid

Enrollment website: mymaineconnection.gov/benefits
Phone: (800) 442-6003 (TTY: 711)
Private Health Insurance Premium webpage:
maine.gov/dhhs/ofi/applications-forms
Phone: (800) 977-6740 (TTY: 711)

Massachusetts – Medicaid and CHIP

Website: mass.gov/masshealth/pa
Phone: (800) 862-4840 (TTY: 711)
Email: masspremassistance@accenture.com

Minnesota – Medicaid

Website: mn.gov/dhs/health-care-coverage/
Phone: (800) 657-3672

Missouri – Medicaid

Website: mydss.mo.gov/mhd/healthcare
Phone: (573) 751-2005

Montana – Medicaid

Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: (800) 694-3084
Email: HSHIPPProgram@mt.gov

Nebraska – Medicaid

Website: ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

Nevada – Medicaid

Medicaid website: dhcfp.nv.gov
Medicaid phone: (800) 992-0900

New Hampshire – Medicaid

Website: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: (603) 271-5218
Toll free number for the HIPP program: (800) 852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

New Jersey – Medicaid and CHIP

Medicaid website:
state.nj.us/humanservices/dmahs/clients/medicaid
Phone: (800) 356-1561
CHIP Premium Assistance Phone: (609) 631-2392
CHIP website: njfamilycare.org/index.html
CHIP phone: (800) 701-0710 (TTY: 711)

New York – Medicaid

Website: health.ny.gov/health_care/medicaid
Phone: (800) 541-2831

North Carolina – Medicaid

Website: medicaid.ncdhhs.gov
Phone: (919) 855-4100

North Dakota – Medicaid

Website: hhs.nd.gov/healthcare

Phone: (866) 614-6005

Oklahoma – Medicaid and CHIP

Website: insureoklahoma.org

Phone: (888) 365-3742

Oregon – Medicaid and CHIP

Website: healthcare.oregon.gov

Phone: (800) 699-9075

Pennsylvania – Medicaid and CHIP

Website: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html

Phone: (800) 692-7462

CHIP website: dhs.pa.gov/CHIP/Pages/CHIP.aspx

CHIP phone: (800) 986-KIDS (5437)

Rhode Island – Medicaid and CHIP

Website: eohhs.ri.gov

Phone: (855) 697-4347 or (401) 462-0311 (Direct Rlte Share Line)

South Carolina – Medicaid

Website: scdhhs.gov

Phone: (888) 549-0820

South Dakota – Medicaid

Website: dss.sd.gov

Phone: (888) 828-0059

Texas – Medicaid

Website: hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program

Phone: (800) 440-0493

Utah – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)

website: medicaid.utah.gov/upp

Phone: (888) 222-2542

Email: upp@utah.gov

Adult Expansion website: medicaid.utah.gov/expansion

Utah Medicaid Buyout Program website:

medicaid.utah.gov/buyout-program

CHIP website: chip.utah.gov

Vermont – Medicaid

Website: dvha.vermont.gov/members/medicaid/hipp-program

Phone: (800) 250-8427

Virginia – Medicaid and CHIP

Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select

Website: coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs

Medicaid/CHIP phone: (800) 432-5924

Washington – Medicaid

Website: hca.wa.gov

Phone: (800) 562-3022

West Virginia – Medicaid and CHIP

Website: dhhr.wv.gov/bms

Website: mywvhipp.com

Medicaid phone: (304) 558-1700

CHIP toll-free phone: (855) MyWVHIPP (699-8447)

Wisconsin – Medicaid and CHIP

Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm

Phone: (800) 362-3002

Wyoming – Medicaid

Website:

health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/

Phone: (800) 251-1269

To see if any other states have added a premium assistance program since **January 31, 2026**, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Notes



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Amalgamated Transit Union Local 1277
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