2026

Transit Employees' Health and Welfare Plan Enrollment & Summary of Health Benefits Guide

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A Message
from the Board of Trustees

Dear Members,

Our benefits program reflects our ongoing commitment to supporting your health, well-being, and peace of mind. Designed with flexibility in mind, it offers a comprehensive range of options to help you and your family maintain a healthy, balanced lifestyle. You have the opportunity to choose the coverage that best meets your individual needs.

This guide provides a clear overview of the benefits available to you and your eligible dependents. By reviewing the information in this booklet, you will be better prepared to make informed decisions that support your physical, emotional, and financial well-being.

Within these pages, you will find key information about the Transit Employees' Health and Welfare Plan (the "Plan"), including eligibility requirements and benefit options. For more detailed descriptions, please refer to the materials provided by individual benefit providers and the Transit Employees' Health and Welfare Summary Plan Description (SPD).

We are pleased to share important details about the upcoming Open Enrollment Period for your health insurance coverage. Open Enrollment is your once-a-year opportunity to review your benefits, make changes to your health plan elections, and ensure your coverage continues to meet the needs of you and your family.

This year's Open Enrollment will run from October 27, 2025 through November 14, 2025.

During this period, you may:

- Enroll in medical, dental, prescription drug, and vision coverage
- Add or remove dependents
- Change your existing plan elections
- Update your contact or personal information

All changes made during Open Enrollment will take effect on January 1, 2026. If you do not make any changes, your current coverage will remain the same for the following year.

A Message
from the Board of Trustees (cont.)

What You Need to Do:

- Review your current coverage and consider any changes in your health needs.
- Complete your enrollment or submit changes by November 14, 2025, at 5:00 PM.

Our benefits team is here to help. If you have questions or need assistance with your enrollment, please call 301-568-2294 or email info@tehw.org. You may also stop by our office or visit www.tehw.org for detailed plan documents and FAQs.

The Board of Trustees remains dedicated to ensuring that your health benefits provide quality, affordable coverage for you and your family. We encourage you to take full advantage of Open Enrollment to select the options best suited to your needs.

In Health,

The Board of Trustees

ATU Local 689
Raymond Jackson, Secretary
Keith Bullock, Trustee
Esker Bilger, Trustee

WMATA
Sherri Dickerson, Chairman
Leroy Jones, Trustee
Robert Tang, Trustee

2026 Highlights

The Board of Trustees of the Transit Employees' Health and Welfare Plan (Plan) has adopted the changes below that are designed to improve the health and welfare of Local 689 members and their families.

Opt-Out Guidelines:

- Active members with State Medicaid coverage may opt out of Plan coverage but will not be eligible for the $1,500 annual premium conversion payment.
- Active members with an outstanding premium balance may opt out of Plan coverage. However, they will not be eligible for the $1,500 premium conversion payment until the past-due balance is paid in full.
- Members on a leave of absence status are ineligible to opt-out until they return to active status.

Retiree Benefits (Effective 1/1/2025):

- All employees hired on or after January 1, 2010, and who are retired are eligible for coverage under the Health and Welfare benefit plan, subject to satisfaction of the Plan's eligibility requirements.

Dental Benefits (Effective 1/1/2025):

- Active and retired members enrolled in the Plan will be eligible to enroll in dental benefits through CareFirst Dental, CareFirst Dental with Orthodontics, or Cigna Dental.
- The CareFirst Dental annual maximum benefit increased from $1,500 to $3,500 per year.

Pharmacy Benefit Management (Effective 1/1/2025):

- Capital Rx is the pharmacy benefit manager for active and pre-Medicare retired members enrolled in CareFirst HMO and PPO plans.
- Express Scripts Medicare (PDP) is the Medicare Part D pharmacy benefit manager for retired members enrolled in CareFirst Traditional HMO and PPO Medicare plans.

Hearing Benefits (Effective 1/1/2025):

Coverage for active and retired members includes:

- An annual hearing exam covered at no cost.
- Hearing aids covered at no cost (no maximum benefit)
- One hearing aid per ear every 36 months.

Vision Benefits (Effective 1/1/2025):

Coverage for active and retired members includes:

- A vision wellness exam covered at 100%.
- Frame allowance: Two pairs of frames per year, up to $200 per pair, with eyeglass lenses provided at no cost when using an in-network provider (or one frame and one contact lens option).
- A 20% discount on the cost of frames exceeding the $200 frame allowance.
- Contact lenses: Two dispenses per year, up to $200, or one frame and one contact lens option when using an in-network provider.

MetLife Full Life Benefit and Long-Term Disability:

- MetLife has replaced The Hartford as the provider of long-term disability coverage.
- MetLife administers Basic Life, Supplemental Life, and beneficiary elections.
- Supplemental Life coverage is available only to active members and their covered dependents.
- Members can enroll in Supplemental Life coverage and update their beneficiary information by visiting www.metlife.com/mybenefits

689 Moving Metro:

- The 689 Moving Metro wellness platform powered by Propel, launched in August 2024 to promote a healthier work-life balance.
- Through the portal, Propel offers hundreds of resources — videos, science-based articles, interactive programs, and much more across a range of well-being topics for you to find the well-being pathway that meets members needs.
- Members can sign up by visiting 689movingmetro.com.

Stay Connected!

Don't miss important updates, helpful tips, and resources to make the most of your benefits.

Follow us on social media or scan the QR code to visit our website and stay connected with the Transit Employees' Health and Welfare Plan.

Transit Employees' Health and Welfare Plan

@TEHWOfficial

Eligibility for **Benefits**

Eligibility for benefits under the Transit Employees' Health and Welfare Plan is determined by the Collective Bargaining Agreement between the Amalgamated Transit Union (ATU) Local 689 and the Washington Metropolitan Area Transit Authority (WMATA).

Full-time employees are required to enroll in the Plan's medical, vision, and dental coverage unless they can provide proof of coverage under another employer-sponsored health care plan.

Eligible dependents may include:

- ☑ Legal Spouse (opposite sex or same sex)[1]
- ☑ Domestic Partner
- ☑ Dependent children (Natural-born, step, adopted, foster children, children appointed legal guardianship, or children under a Qualified Medical Child Support Order (QMSCO)[2], subject to the plan's eligibility[3]
- ☑ Surviving spouse and dependents of active or retired employees

1 *Legally married couples are eligible to enroll within 90 days of their marriage. If the marriage has lasted more than three years, a copy of the most recent joint tax return may be required for verification.*

2 *Children covered under a Qualified Medical Child Support Order (QMSCO) cannot be removed from coverage without a written court order.*

3 *If your dependent is disabled, they may be eligible for coverage beyond age 26 when they have met criteria established by the health plans. Please contact the Health and Welfare office 6 months prior to their 26 birthday to complete a "Disability Certification for Over-Age Dependents" form. Otherwise, coverage for dependent children ends on the last day of the month in which they turn age 26.*

DON'T FORGET

When enrolling a dependent for the first time, you must provide required documentation to enroll a spouse, domestic partner, or dependent children in the Health and Welfare Plan.

Please view the **Required Documentation for Enrollment Changes** section on page 10.

HELP!

Need Assistance?

For enrollment questions, contact the Benefits and Eligibility Department.

info@tehw.org | 301-568-2294

Our staff is available to answer questions Monday through Friday from 8:30am to 5:00pm EST.

Opting Out Of Coverage

As a Local 689 member, you have the option to enroll in any plan, change your plan election, or terminate dependent coverage during the annual open enrollment period. The 2026 Open Enrollment period is from October 27 through November 14, 2025.

All benefit changes made during Open Enrollment will go into effect on January 1, 2026. Members should expect medical, vision, dental, and prescription cards to be mailed to their registered address no later than December 2025. Please ensure your mailing address is correct through the WMATA kiosk at your site division or by contacting the Health and Welfare office (retirees only).

Opt-Out Policy for Medical and Dental Coverage

Active and Retired members may opt out of medical and dental coverage for themselves and their dependents if they have proof of other employer-sponsored group health insurance.

- Part-time, Retired, and members with a premium balance who opt out are not eligible to receive the $1,500 payment from the Premium Conversion Plan.
- Members enrolled in Medicaid may opt out but are not eligible for the $1,500 premium conversion payment.
- Retired members who opt out may only re-enroll in the Plan if they lose their employer-sponsored coverage, lose coverage under their spouse's group health plan, or if they enroll in Medicare Part B.
- Members on a leave of absence are not permitted to opt out; however, once they return to active status, they may do so and receive a prorated payment.
- Members who submit an opt-out form after November 30, 2025 will receive a prorated share of the annual opt-out payment.

All active members who previously opted out must renew their opt-out election by November 14, 2025.

If a member or dependent loses other health coverage, they must notify the Plan and enroll within 30 days of the coverage ending. In addition to standard enrollment documentation, a certificate or letter confirming loss of prior coverage is required.

Coverage will become effective on the first day of the month following completion of the enrollment process.

DON'T FORGET

Part-time active, retired, or members on Medicaid who opt out do not receive the $1,500 payment from the Premium Conversion Plan.

Coverage Guidelines **for Local 689 Members**

Spousal Credit

The Collective Bargaining Agreement allows members to receive a premium credit of up to $1,200 annually ($100 per month) if their spouse is not enrolled in the Transit Employees' Health & Welfare Plan health insurance program.

To receive this credit, you must provide the following documentation (if not already on file):

- A marriage certificate
- Your spouse's Social Security card
- Proof of your spouse's coverage under another employer's health plan
- If a participant has previously received the spousal credit and has already provided a marriage certificate and their spouse's Social Security card, only proof of the spouse's other coverage is required.

This monthly credit is applied toward your portion of medical and dental premium expenses.

- You must elect the spousal credit option each year.
- You are not eligible for the spousal credit if your spouse is also a WMATA employee and your spouse is covered under a WMATA-sponsored group health plan that is not TEHW.

Spousal/Child Dual Coverage

If two Local 689 members are married and both members are eligible for coverage under TEHW, one member must elect family coverage, and the other must waive their coverage.

If a Local 689 member is covered under TEHW as the child of another member, they will remain covered as a dependent until age 26 unless they elect separate coverage.

If an active member is married to a retired member, the retired spouse should be listed as a dependent on the active member's plan.

Each Local 689 member is entitled to their own life insurance, short-term disability, long-term disability, and other voluntary benefits.

Coverage Guidelines
for Local 689 Members (cont.)

Retired Employees Living Outside the Service Area

The Kaiser HMO and BlueChoice HMO plans have limited coverage for individuals residing outside of the designated HMO service areas. Retired employees should choose a plan that includes medical facilities and participating physicians near their residence. Selecting an HMO plan without local coverage may result in difficulty accessing care and increased out-of-pocket costs.

Retirees living outside the HMO service areas must enroll in the CareFirst PPO, CareFirst Medicare PPO, or CareFirst Medicare Advantage Plan (MAPD) which provides nationwide coverage across the United States.

Please contact the Health & Welfare office with questions regarding the HMO service areas.

Premium **Payments**

Making Your Premium Payments – Fast, Easy, and Secure

Starting March 1, 2025, members can make premium payments online through Xpress-Pay, in addition to the existing options of paying by check or money order.

Introducing Xpress-Pay – your convenient, secure way to make premium payments online at www.tehw.org. Whether you're an active or retired member, you can make an online payment anytime — 24/7, 365 days a year through our trusted payment portal.

How to Pay:

1. Visit www.tehw.org
2. Click “Active Members”
3. Select “Paying for Your Coverage”
4. Or simply scan the QR code to get started!

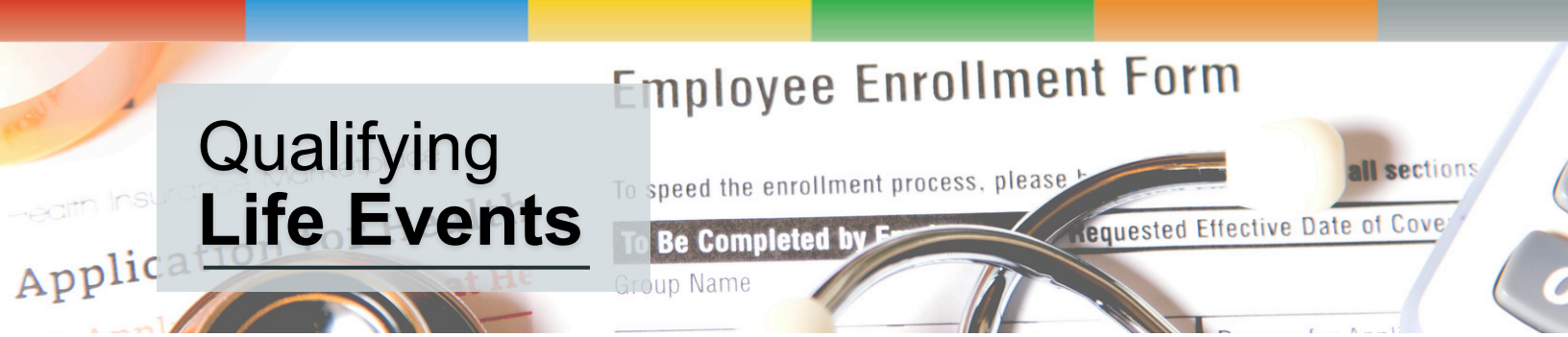
Timely payment of premiums is essential to maintain your Health and Welfare coverage. Late or missed payments may result in loss of benefits. If you are on a leave of absence, Short Term, or Long Term Disability, you are responsible for making premium payments by the first of the month.

Need Assistance?

For payment questions, contact Live Support via Xpress-Pay.

Support@Xpress-Pay.com 607-753-6156 (select option #2)

Live Support is available to answer questions Monday through Friday from 9am to 5pm EST.



Qualifying Life Events

A qualifying life event can result from the following:

- **MARRIAGE OR DIVORCE**
- **DEATH OF A SPOUSE OR DEPENDENT CHILD**
- **ISSUANCE OF A QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) FOR COVERAGE OF A DEPENDENT CHILD**
- **CHANGE IN SPOUSE'S MEDICAL COVERAGE**
- **CHANGE IN EMPLOYMENT STATUS**
- **CHANGE IN QUALIFYING DEPENDENT STATUS**
- **BIRTH OF A CHILD, LEGAL ADOPTION, OR FOSTER PLACEMENT**

Required Documentation for Enrollment Changes

- ☑ **Self:** WMATA ID
- ☑ **Spouse:** Marriage Certificate and Social Security Card
- ☑ **Birth Children:** *Birth Certificate and Social Security Card

  **The birth certificate must list the member, eligible spouse or eligible domestic partner as a parent*
- ☑ **Adopted children, children placed for adoption, and children for whom you are the legal guardian:** Birth certificate, adoption or legal guardianship papers, social security card
- ☑ **Domestic Partnership:** Notarized Affidavit of Domestic Partnership, accompanied by documentation of financial interdependence and a Social Security card. *(Domestic Partners can only be added during the annual Open Enrollment period).*

DON'T FORGET

You have 30 days from the date of a qualifying event to make changes to your coverage. To add a new spouse or dependent, you have up to 90 days.

Medical Plans
Active/Retired (Non-Medicare)

A comprehensive medical plan is essential in supporting your overall health and wellbeing. As an active full-time Local 689 employee, you are automatically enrolled in the default medical and dental plans. However, we encourage you to review your options and select the medical/vision and dental plans that best suit your individual needs.

Active and Retired Non-Medicare members currently have three medical plan options, which include prescription drug and vision coverage.

BlueChoice HMO

- ☑ Must stay within the BlueChoice HMO network of providers
- ☑ Vision coverage through Davis Blue Vision
- ☑ Prescription coverage through Capital RX

Kaiser Permanente HMO

- ☑ Must stay within the Kaiser Permanente HMO network of providers
- ☑ Vision coverage through NVA and discount through Kaiser Permanente
- ☑ Prescription coverage through Kaiser Permanente

CareFirst BlueChoice Advantage PPO

- ☑ Provides both in-network and out-of-network coverage
- ☑ Vision coverage through Davis Blue Vision
- ☑ Prescription coverage through Capital RX

DID YOU KNOW?

An HMO, or a **Health Maintenance Organization**, is a traditional managed healthcare plan aimed at keeping healthcare costs lower, though services tend to be less flexible.

A PPO, or a **Preferred Provider Organization**, is a traditional type of managed healthcare plan that offers more flexibility.

Medical Plans
Active/Retired (Non-Medicare) (cont.)

	*Kaiser Permanente HMO	CareFirst BlueChoice HMO	CareFirst BlueChoice Advantage PPO (In Network)	**CareFirst BlueChoice Advantage PPO (Out Of Network)
Covered Services				
Annual Deductible	$0	$0	$0	$300/Individual $600/Family
Office Visits	$15 Copay/per visit	$15 Copay/per visit	$15 Copay/per visit	Plan pays 75% of allowance after deductible
Hospital Visits	$0	$0	$0	Plan pays 75% of allowance after deductible
Outpatient Hospital Visits	$15 Copay/per visit	$15 Copay/per visit	$15 Copay/per visit	Plan pays 75% of allowance after deductible
Surgery	$0	$0	$0	Plan pays 75% of allowance after deductible
X-Rays and Labs	$0	$0	$0	Plan pays 75% of allowance after deductible
Emergency Room Care	$50 (Waived if Admitted)	$50 (Waived if Admitted)	$50 (Waived if Admitted)	Plan pays 75% of allowance after deductible
Preventive Services	$0	$0	$15 Copay/per visit	Plan pays 75% of allowance after deductible
Urgent Care	$0	$0 (Participating Facilities Only)	$15 Copay/per visit	Plan pays 75% of allowance after deductible (Birth to Age 17)
Mammograms/ Annual Pap Tests	$0	$0 (Participating Facilities Only)	$0	$50 Copay

Medical Plans
Active/Retired (Non-Medicare) (cont.)

	*Kaiser Permanente HMO	CareFirst BlueChoice HMO	CareFirst BlueChoice Advantage PPO (In Network)	**CareFirst BlueChoice Advantage PPO (Out Of Network)
Mental Health Inpatient Care	$0	$0	$0	$0
Mental Health Outpatient Care	$0	$0	$0	Plan pays 75% of allowance after deductible
Substance Abuse Inpatient Care	$0	$0	$0	Plan pays 75% of allowance after deductible (Up to 40 visits; 60% remaining)
Substance Abuse Outpatient Care	$0	$0	$0	Plan pays 75% of allowance after deductible
Hospice Care	$0	$0	$0	Plan pays 75% of allowance after deductible
Chiropractic/ Acupuncture	$15 Copay/per visit (20 total)	$15 Copay/per visit (20 total per calendar year)	$15 Copay/per visit	Plan pays 75% of allowance after deductible
Physical Therapy	$15 Copay/per visit (30 visits per injury (incident or condition), contract, and calendar year)	$15 Copay/per visit (20 visits per calendar year)	$15 Copay/per visit	Plan pays 75% of allowance after deductible
Weight Loss/Surgery	Limited Coverage	***Limited Coverage	***Limited Coverage	Plan pays 75% of allowance after deductible
Hearing Exams	$0	$0	$0	$0
Hearing Aids (1 per ear every 3 years)	$0	$0	$0	$0
In Vitro Fertilization (IVF)	$15 Copay/per visit	$15 Copay/per visit	$15 Copay/per visit	Plan pays 75% of allowance after deductible

Medical Plans
Retired/Medicare

Retired Medicare members have four medical plan options, which also include vision and prescription drug coverage.

BlueChoice Traditional Medicare HMO
(refer to HMO chart on pg.14-15)

- ☑ Must stay within the BlueChoice HMO network of providers
- ☑ Vision coverage through Davis Blue Vision
- ☑ Prescription coverage through Express Scripts

CareFirst BlueChoice Advantage Traditional Medicare PPO
(refer to HMO chart on pg.14-15)

- ☑ Provides both in network and out of network coverage
- ☑ Vision coverage through Davis Blue Vision
- ☑ Prescription coverage through Express Scripts

CareFirst Medicare Advantage Prescription Drug PPO (MAPD)

- ☑ Uses the CareFirst local PPO network and the national BCBS MAPD PPO plan network
- ☑ Vision coverage through Davis Blue Vision
- ☑ Prescription coverage is combined all in one

Kaiser Permanente Medicare Advantage Prescription Drug (MAPD)

- ☑ Must stay within the Kaiser HMO network of providers
- ☑ Vision coverage through NVA and discount through Kaiser Permanente
- ☑ Prescription coverage is combined all in one

Medical Plans
Retired/Medicare (cont.)

	Kaiser Permanente Medicare Advantage Plan (HMO) with Part D and NVA Vision
Medical Plan Highlights	
Deductible	$0
Hospital Coverage	
In Patient	$0
Outpatient Hospital Coverage	$15 per visit
Ambulatory Surgery Center	$15 per visit
Doctor's Visits	
Primary Care Providers (PCP)	$15 per visit
Specialists	$15 per visit
Preventive Care	$0
Emergency Care	$50 per visit
Urgent Care	$15 per visit
Diagnostic Services, Lab, and Imaging (EKG,MRI, CT, PET)	$0
Hearing Exam	$0
Hearing Aids	$0 / One per ear every 36 months
Dental Services	
Preventive	$30 per visit (Limit 2 Visits a year)
Comprehensive	Coverage of services vary

Vision Services	
Routine Eye Exams	$15 per visit
Eyeglasses/ Contact Lenses (After Cataract Surgery)	20% Coinsurance (after Medicare pays its share)
Other Eyewear Allowance	$200 allowance/ per 24 months (eyeglasses or contact lenses)
Mental Health Services	
Outpatient Individual Therapy	$15 per visit
Outpatient Group Therapy	$15 per visit
In Patient Mental Health	$0
Skilled Nursing Facilites	None per benefit visit (Limited to 100 days)
Physical Therapy	$15 per visit
Transportation	
Kaiser Non-Urgent Medical Appointments	$0 per one-way ride (24 one-way rides per calendar year)
Ambulance Rides	$0
Medicare Part B Drugs (30 Day Supply)	
Generic	$10 (Preferred Network Pharmacy)
	$15 (Standard Network Pharmacy)
Brand Name	$25 (Preferred Network Pharmacy)
	$35 (Standard Network Pharmacy)

For a detailed summary of benefits, visit www.kp.org.

Medical Plans
Retired/Medicare (cont.)

	BlueCross BlueShield Medicare Advantage Plan (PPO) with Part D and Davis Vision
Medical Plan Highlights	
Deductible	$0
Annual Out-of-pocket Maximum (Applies to Medicare-covered medical benefits only)	$1,000
Annual Physical Exam	$0
All Medicare-Covered Preventive Services	$0
Office Visit (Mental Health)	$0
Primary Care Providers (PCP)	$15 copay
Specialists	$15 copay
Urgent Care	$15 copay
Emergency Care	$50 copay
Lab Services	$0
Diagnostic Services	$0
Occupational Therapy, Physical Therapy, Speech Pathology	$15 copay
Cardiac Rehabilitation	$15 copay
Durable Medical Equipment	20% coinsurance
Chiropractic & Acupunture (Routine)	$15 per visit (up to 12 visits)
Hearing Exams	None (one exam per year)
Hearing Aids	$0 / One per ear every 36 months
***In Patient Hospital	$0
Outpatient Hospital Surgery/ Ambulatory Surgical Center	$0
Inpatient Hospital Stay	$0 (per admission/stay)
Skilled Nursing Facility	None per benefit visit (Limited to 100 days)

***When you see an out-of-network provider for care, the provider may charge more than the CareFirst allowance. If this is the case, you are responsible for paying the balance in addition to your coinsurance, deductible, and co-pay.*

****Surgical benefits only available at Centers of Blue Distinction.*

Medical Plans
Retired/Medicare (cont.)

	BlueCross BlueShield Medicare Advantage Plan (PPO) with Part D and Davis Vision
Prescription Drug Highlights	
Deductible	$0
30 Day Supply (Retail Pharmacy/Mail Order)	
Tier I (Preferred Generic)	$10 copay
Tier II (Generic)	$10 copay
Tier III (Preferred Brand)	$25 copay
Tier IV (Non-Preferred Drug)	$40 per visit
Tier V (Speciality Tier)	$40 per visit
60 Day/90 Day Supply (Retail Pharmacy/Mail Order)	
Tier I (Preferred Generic)	$20 copay
Tier II (Generic)	$20 copay
Tier III (Preferred Brand)	$50 copay
Tier IV (Non-Preferred Drug)	$80 copay
Tier V (Speciality Tier)	Not Covered

Medicare Eligibility Guidelines

- **Still Working at Age 65:** If you are 65 and actively employed, you and your spouse are not required to enroll in Medicare Part B. Your Health & Welfare benefits will remain your primary coverage, as well as for you and your covered spouse, until you retire.
- **Planning to Retire at 65:** If you are 65, still working, and considering retirement, you should contact the Social Security Administration and apply for Medicare Part B three months before your retirement date.
- **Retired at Age 65 or Older:** If you are retired and age 65 or older, you and your spouse (if also 65 or older) must enroll in Medicare Part B. Medicare will become your primary insurance, and your Health & Welfare Plan will become secondary. You must provide the Health & Welfare office with a copy of your Medicare card to coordinate benefits.
- **Failure to Enroll:** If you do not enroll in Medicare Part B, the Health & Welfare Plan will not pay for services that Medicare would have covered. You will be also responsible for additional costs, penalties, and may incur a premium surcharge.
- **Failure to Notify:** If you or your dependent are eligible for Medicare but fail to notify the Health & Welfare office, the Plan may recover any benefits paid in error, including interest and collection fees.

You can enroll in Medicare Part A and Part B by:

- Visiting your local Social Security office or calling (800) 772-1213.
- Mailing a signed and dated letter to the Social Security Administration with your name, Social Security number, and desired Medicare enrollment date.
- Applying online at www.ssa.gov.

DON'T FORGET

Medical, dental, vision, and prescription drug carriers will mail ID cards in early to mid-January 2026. For more information about ID cards, scan the QR code to view the TEHW ID Card Directory.

Medicare Eligibility (cont.)

Medicare Advantage Prescription Drug (MAPD) Plans (Part C)

A Medicare Advantage Plan (Part C) is an alternative to Original Medicare and is offered by private insurance companies like CareFirst BlueCross BlueShield and Kaiser Permanente. They may also include additional benefits such as vision, dental, and wellness programs.

- Retirees age 65 and older who retired on or after January 1, 2019, are strongly encouraged to enroll in a Medicare Advantage Prescription Drug (MAPD) Plan.
- Retirees who left employment before this date are eligible but not required to enroll.

Health and Welfare offers the following MAPD options, which include Part D prescription drug and vision coverage:

- Kaiser Permanente Medicare Advantage Plan (HMO) with Part D and NVA Vision
- BlueCross BlueShield Medicare Advantage Plan (PPO) with Part D and Davis Vision

You must be enrolled in Medicare Part B to be eligible for an MAPD plan.

You are encouraged to compare these MAPD plans with your current plan to ensure you are receiving the best available benefits and cost savings.

DON'T FORGET

Enrolling in a Medicare Advantage plan, Part C, or Part D Prescription Drug Plan outside of your Health & Welfare plan may result in loss of eligibility and coverage under the Plan. Contact the Health and Welfare office with any enrollment questions.

Medicare Eligibility (cont.)

These plans combine your:

- Medicare Part A (Hospital insurance)
- Medicare Part B (Medical insurance)
- Medicare Part D (Prescription drug coverage)

Medicare Part A covers:

- ☑ Inpatient hospital stays
- ☑ Skilled nursing facility care after a hospital stay
- ☑ Hospice care
- ☑ Home health care (via a Medicare-certified agency)

Medicare Part B covers:

- ☑ Doctor visits (inpatient and outpatient)
- ☑ Preventive care (e.g., screenings, flu shots, annual physicals)
- ☑ Lab services and diagnostic tests
- ☑ Mental health services
- ☑ Durable medical equipment
- ☑ Physical and speech therapy
- ☑ Annual wellness visits

Medicare Part C covers:

- ☑ Medicare Part A (Hospital insurance)
- ☑ Medicare Part B (Medical insurance)
- ☑ Medicare Part D (Prescription drug coverage)

Medicare Part D covers:

- ☑ Prescription drugs

DON'T FORGET

Medicare Part B requires a monthly premium, which varies based on income. Enrollment in Part B is required to join a Medicare Advantage Plan.

Dental Plans

There are three dental plan options available for both active and retired members:

- ☑ **Cigna Dental DMO** [1]
- ☑ **CareFirst Dental** [2]
- ☑ **CareFirst Dental with Orthodontics** [2]

	CareFirst Dental	CareFirst Dental with Orthodontics	Cigna Dental DMO
Annual Deductible	$0	$0	$0
Annual Benefit Maximum	Individual: $3,500	Individual: $3,500 (For Non-Orthodontic Services)	$0
Preventive Services (Exams/Cleanings)	No Charge (For services completed by participating dentist)	No Charge (For services completed by participating dentist)	$0
Basic Restorative Services (Fillings)	Plan pays 100% of Allowance	Plan pays 100% of Allowance	$0
Major Restorative Services (Crown, Porcelain/Ceramic)	Plan pays 80% of Allowance	Plan pays 80% of Allowance	$245
Root Canal	Plan pays 80% of Allowance	Plan pays 80% of Allowance	$31
Extraction			
Single Tooth	Plan pays 80% of Allowance	Plan pays 80% of Allowance	$12
Partial Bony Impaction	Plan pays 80% of Allowance	Plan pays 80% of Allowance	$21
Dentures	Plan pays 80% of Allowance every 5 years	Plan pays 80% of Allowance every 5 years	Copay
Orthodontics			
Child	Not Covered	Plan pays 50% of Allowance to a lifetime maximum of $1,000	$1,584 (24 month treatment plan)
Adult	Not Covered	Plan pays 50% of Allowance to a lifetime maximum of $1,000	$2,328 (24 month treatment plan)
Crowns/Bridges	5 year replacement	5 year replacement	5 year replacement

1 *If you enroll in the CIGNA Dental Maintenance Organization (DMO), you must choose a dentist from the CIGNA provider list and receive all your dental care from that provider.*

2 *For a non-participating dentist, you are responsible for paying any amount that exceeds the reasonable and customary allowance.*

Pharmacy Plans

The prescription drug benefit for active members and pre-Medicare retired members enrolled in the CareFirst HMO and PPO plans is administered by Capital-Rx.

Members enrolled in a Kaiser Permanente medical plan will receive their prescription drugs through Kaiser.

The Medicare Part D prescription drug benefit for retired members enrolled in the CareFirst Traditional HMO and PPO Medicare plans is administered by Express Scripts (ESI). The plan is called Express Scripts Medicare® (PDP) for Transit Employees' Health & Welfare Plan.

Members enrolled in the CareFirst Medicare Advantage (MAPD) and Kaiser Medicare Advantage (MAPD) plans will continue to receive their prescription drugs through their current plans.

	Kaiser Permanente HMO			CareFirst BlueChoice Advantage PPO			CareFirst BlueChoice Advantage HMO		
Prescription Drug	Kaiser Permanente			Capital RX (Active Participants/Pre-Medicare Retirees			Express Scripts (Medicare Retirees/Part D)		
	Retail Network (30 Day Supply)	Retail Non-Network (30 Day Supply)	Mail Order (90 Day Supply)	Retail Network (30 Day Supply	Retail Non-Network (30 Day Supply)	Mail Order (90 Day Supply)	Retail Network (30 Day Supply)	Retail Non-Network (30 Day Supply)	Mail Order (90 Day Supply)
Generic	$10 $20 (Other Participating Network Pharmacy)	Full Cost	$20	$10	Full Cost	$20	$10	Full Cost	$20
Formulary	$25 $50 (Other Participating Network Pharmacy)	Full Cost	$50	$25	Full Cost	$50	$25	Full Cost	$50
Non-Formulary	$40 $80 (Other Participating Network Pharmacy)	Full Cost	$80	$40	Full Cost	$80	$40	Full Cost	$80

Vision Plans

Good vision is not only essential to your overall health, it also plays a key role in your quality of life. With your enrollment in both a medical and dental plan, you automatically receive vision coverage through either Davis Vision or National Vision Administrators.

	Kaiser Permanente HMO	CareFirst BlueChoice HMO/PPO	BlueChoice Advantage PPO
Benefits Managed By	National Vision Administrators (NVA)	Davis BlueVision	Out of Network Provider
Vision Exam	Covered 100%	Covered 100%	$35 Allowance
Contact Lenses			
Daily Wear	Covered 100% / Up to $200	Covered 100% / Up to $200	$20 Allowance
Extended Wear	Covered 100% / Up to $200	Covered 100% / Up to $200	$30 Allowance
Speciality	Covered 100% / Up to $200	Covered 100% / Up to $200	$50 Allowance
Lenses			
Single Vision	Covered 100%	Covered 100%	$25 Allowance
Bifocal	Covered 100%	Covered 100%	$45 Allowance
Trifocal	Covered 100%	Covered 100%	$75 Allowance
Lenticular	Covered 100%	Covered 100%	$75 Allowance
Polycarbonate (SV, BI, TRI)	Covered 100%	Covered 100%	N/A
Solid Tint	Covered 100%	Covered 100%	N/A
Fashion Gradient Tint	Covered 100%	Covered 100%	N/A
Gradient Tint	Covered 100%	Covered 100%	N/A
Standard Scratch Coating	Covered 100%	Covered 100%	N/A
UV Coating	Covered 100%	Covered 100%	N/A
Standard Transitions	Covered 100%	Covered 100%	N/A

**Contact Lenses: 15% off of balance over $200 for Conventional lenses and 10% off of balance over $200 for disposable lenses.*

Vision Plans (cont.)

	Kaiser Permanente HMO	CareFirst BlueChoice HMO/PPO	BlueChoice Advantage PPO
Progressives			
Tier 1	Covered 100%	Covered 100%	N/A
Tier 2	Covered 100%	Covered 100%	N/A
Tier 3	Covered 100%	Covered 100%	N/A
Tier 4	Covered 100%	Covered 100%	N/A
Tier 5	Covered 100%	Covered 100%	N/A
Tier 6	Covered 100%	Covered 100%	N/A
Tier 7	Covered 100%	Covered 100%	N/A
Tier 8	Covered 100%	Covered 100%	N/A
Anti-Reflective Coating			
Tier 1	Covered 100%	Covered 100%	Covered 100%
Tier 2	Covered 100%	Covered 100%	Covered 100%
Tier 3	Covered 100%	Covered 100%	Covered 100%
Tier 4	Covered 100%	Covered 100%	Covered 100%
Frame Allowance (once per calendar yr.)			
Number of Covered Frames/Lenses	2 Frames/Lenses ($200 Allowance)	2 Frames/Lenses ($200 Allowance)	2 Frames/Lenses (Covered up to $45)
Discount	20% on Balance	20% on Balance	N/A

Disability **Benefits**

If you are unable to work due to an illness, non-work-related injury, or pregnancy, you may be eligible for short-term and/or long-term disability benefits through the Transit Employees' Health & Welfare Plan.

Short Term Disability

Short-term disability benefits cover non work related disabilities lasting up to 180 days. If eligible, you will receive $170 per week or $270 per week if you are pregnant — for up to 26 weeks. Benefits begin after all available sick leave has been used or after a 30-day waiting period, whichever is later. Payments are subject to federal, state, and FICA tax deductions and will be mailed to the address provided on your application upon approval.

To remain eligible, you must be certified by your attending physician as unable to perform your job duties. Certification is required monthly, and periods of disability lasting less than one week will be pro-rated based on a five-day workweek.

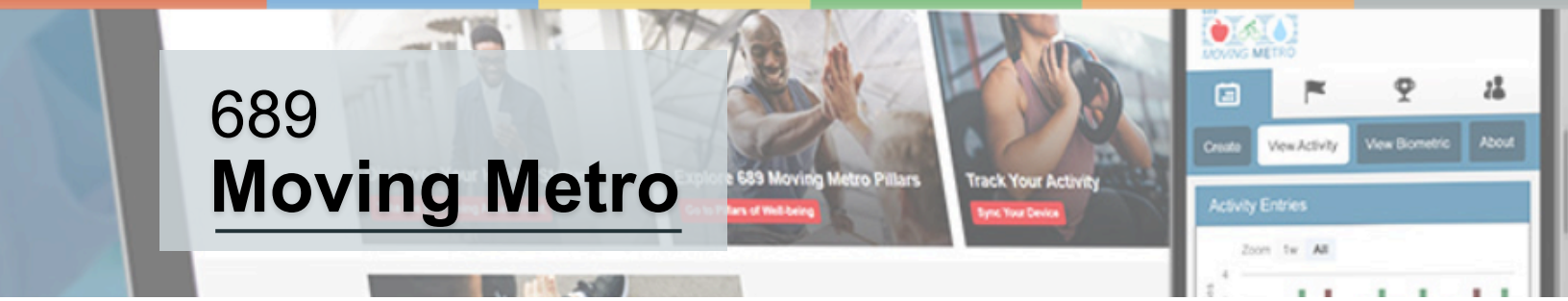
Long Term Disability

If your disability continues beyond 180 days, you may qualify for long-term disability benefits through MetLife, which provide continued income protection if you are considered totally disabled.

Approved LTD claims offer 55% of your base monthly earnings, up to a maximum of $5,000 per month. This benefit is reduced by other sources of income such as Social Security, pension benefits, or Workers' Compensation. If Social Security disability benefits are paid retroactively, you are responsible for reimbursing the LTD carrier for any corresponding overpayments. Unlike short-term disability, eligibility for long-term disability is not affected by your workers' compensation status.

To be eligible for LTD, you must be an active full-time or part-time employee participating in the Transit Employees' Health & Welfare Plan and represented by the Amalgamated Transit Union Local 689. This includes employees on leave while serving in official Union roles or working for affiliated labor organizations. Rehired retired employees may not be eligible.

For more information or to apply for short-term or long-term disability benefits, please contact the Disability Analyst at 301-568-2294, extension 323.



689 Moving Metro

689 Moving Metro is a wellness initiative under the Transit Employees' Health and Welfare Plan, dedicated to supporting the hardworking members of Local 689.

Our mission is to promote a holistic approach to wellness by empowering members with the awareness, knowledge, and resources needed to make intentional, healthy choices, for themselves and their families. We are committed to helping our members lead well-balanced lives by encouraging sustainable, positive behaviors.

A New Way to Well-Being

689 Moving Metro is a wellness initiative under the Transit Employees' Health and Welfare Plan, designed to support Local 689 members in leading healthy, balanced lives. Through our partnership with Propel, members gain access to a wide variety of wellness tools and resources, including fitness videos, mindfulness sessions, healthy recipes, podcasts, and personalized well-being programs.

Members can also join wellness challenges, access health coaching, and earn incentives for healthy behaviors.

Get Started

Scan the QR code to visit 689movingmetro.com, click Register, and follow the steps to create your account.

Once registered, you'll have access to hundreds of resources to support your physical, mental, and emotional well-being.

SCAN HERE

Earning Incentives

Beginning January 1, 2025, Active 689 Members and Pre-65 Retirees will be eligible to receive up to $400 in premium discounts throughout the year.

To participate and track your progress, log in to the 689 Moving Metro portal and select the "Incentive" tab from the main navigation menu.

Site Visits

Each month, the Wellness Team will visit WMATA divisions to promote the 689 Moving Metro Wellness Portal, take orders for safety glasses, and answer questions about Health and Welfare benefits.

To request a visit from the Wellness Team at your division, please email wellness@tehw.org.

689 MOVING METRO

Voluntary Benefits

At Transit Employees' Health and Welfare, we recognize that one size doesn't fit all when it comes to benefits. As a valued Local 689 member, you have access to a variety of voluntary benefits designed to help you tailor your coverage to meet your individual and family needs.

These benefits are optional and are generally paid through payroll deduction. You may elect or make changes to these benefits during the annual open enrollment period.

For information about each benefit offering, including enrollment and coverage details, please contact the benefit provider directly.

MetLife Supplemental Life Insurance Enrollment

To enroll in or increase the Supplemental Life Insurance coverage for yourself, your spouse, or your dependent children — visit metlife.com/mybenefits.

Eligibility and Enrollment Guidelines:

- ☑ New Hires: May enroll in coverage up to $200,000 without completing a Statement of Health form. *(Must enroll 30 days from date of hire).*
- ☑ Current Participants: May increase coverage by one level during the open enrollment period. Increases beyond one level require a Statement of Health.
- ☑ Late Entrants: Current members who have never enrolled in coverage must submit a Statement of Health for all levels of coverage.

Coverage elected during open enrollment becomes effective January 1, 2026, upon receipt of a completed application. You must be actively at work on the effective date.

Your spouse and eligible children must not be:

- ☑ Hospitalized,
- ☑ Confined at home for medical reasons, or
- ☑ Receiving or eligible to receive disability income on that date.

If additional medical information is required by MetLife and approval is not received by January 1, 2026, coverage will begin on the first of the month following MetLife's approval.

Voluntary Benefits (cont.)

MetLife Insurance Rates

Coverage Choices for Member per $1,000 of Coverage (Monthly Cost)

		Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8	Option 9	Option 10
		$10,000	$50,000	$75,000	$100,000	$150,000	$200,000	$250,000	$300,000	$400,000	$500,000
Below 25	$0.059	$0.59	$2.95	$4.43	$5.90	$8.85	$11.80	$14.75	$17.70	$23.60	$29.50
25-29	$0.071	$0.71	$3.55	$5.33	$7.10	$10.65	$14.20	$17.75	$21.30	$28.40	$35.50
30-34	$0.094	$0.94	$4.70	$7.05	$9.40	$14.10	$18.80	$23.50	$28.20	$37.60	$47.00
35-39	$0.106	$1.06	$5.30	$7.95	$10.60	$15.90	$21.20	$26.50	$31.80	$42.40	$53.00
40-44	$0.118	$1.18	$5.90	$8.85	$11.80	$17.70	$23.60	$29.50	$35.40	$47.20	$59.00
45-49	$0.189	$1.89	$9.45	$14.18	$18.90	$28.35	$37.80	$47.25	$56.70	$75.60	$94.50
50-54	$0.302	$3.02	$15.10	$22.65	$30.20	$45.30	$60.40	$75.50	$90.60	$120.80	$151.00
55-59	$0.492	$4.92	$24.60	$36.90	$49.20	$73.80	$98.40	$123.00	$147.60	$196.80	$246.00
60-64	$0.730	$7.30	$36.50	$54.75	$73.00	$109.50	$146.00	$182.50	$219.00	$292.00	$365.00
65-69	$1.391	$13.91	$69.55	$104.33	$139.10	$208.65	$278.20	$347.75	$417.30	$556.40	$695.50
70+	$2.256	$22.56	$112.80	$169.20	$225.60	$338.40	$451.20	$564.00	$676.80	$902.40	$1,128.00

Coverage Choices for Spouse per $1,000 of Coverage (Monthly Cost)

		Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8	Option 9	Option 10	Option 11
		$5,000	$10,000	$25,000	$37,500	$50,000	$75,000	$100,000	$125,000	$150,000	$200,000	$250,000
Below 25	$0.046	$0.23	$0.46	$1.15	$1.73	$2.30	$3.45	$4.60	$5.75	$6.90	$9.20	$11.50
25-29	$0.056	$0.28	$0.56	$1.40	$2.10	$2.80	$4.20	$5.60	$7.00	$8.40	$11.20	$14.00
30-34	$0.074	$0.37	$0.74	$1.85	$2.78	$3.70	$5.55	$7.40	$9.25	$11.10	$14.80	$18.50
35-39	$0.083	$0.42	$0.83	$2.08	$3.11	$4.15	$6.23	$8.30	$10.38	$12.45	$16.60	$20.75
40-44	$0.093	$0.47	$0.93	$2.33	$3.49	$4.65	$6.98	$9.30	$11.63	$13.95	$18.60	$23.25
45-49	$0.148	$0.74	$1.48	$3.70	$5.55	$7.40	$11.10	$14.80	$18.50	$22.20	$29.60	$37.00
50-54	$0.236	$1.18	$2.36	$5.90	$8.85	$11.80	$17.70	$23.60	$29.50	$35.40	$47.20	$59.00
55-59	$0.426	$2.13	$4.26	$10.65	$15.98	$21.30	$31.95	$42.60	$53.25	$63.90	$85.20	$106.50
60-64	$0.629	$3.15	$6.29	$15.73	$23.59	$31.45	$47.18	$62.90	$78.63	$94.35	$125.80	$157.25
65-69	$1.175	$5.88	$11.75	$29.38	$44.06	$58.75	$88.13	$117.50	$146.88	$176.25	$235.00	$293.75
70+	$1.906	$9.53	$19.06	$47.65	$71.48	$95.30	$142.95	$190.60	$238.25	$285.90	$381.20	$476.50

Coverage Choices for Dependent Children

Coverage	Cost
$5,000	$0.77
$10,000	$1.54

Voluntary **Benefits (cont.)**

Effective August 1, 2024, MetLife is the administrator and record keeper for Transit Employees' Health and Welfare Plan Group Term Life Insurance program.

To complete or update your beneficiary form, scan the QR code or visit www.metlife.com/mybenefits

SCAN HERE

All active and retired Local 689 members must designate a beneficiary through Metlife's MyBenefits website.

Basic Life Insurance

MetLife

STATUS	BASIC LIFE INSURANCE	AD&D
Active (Full Time Employee)	$50,000	$50,000
Active (Part Time Employee) with Medical/Dental insurance under TEHW Plan	$50,000	$50,000
Active (Part Time Employee) without Medical/Dental insurance under TEHW Plan	$25,000	N/A
Retired Employee	$10,000	N/A

Life Insurance Enrollment Summary

Active Full-Time & Part-Time Employees with Medical/Dental (H&W Plan)

- Coverage: $10,000 to $500,000 (10 options)
- Increase by 1 level up to $200K without health questions
- Over $200K or new enrollments require answering 5 health questions

Spouse/Partner of FT & PT Employees with H&W Plan

- Coverage: $5,000 to $250,000 (11 options)
- Must not exceed 50% of employee's coverage
- Increase up to $25K without questions
- Higher/new amounts: Statement of Health Questions required
- Employee must have/apply for own MetLife coverage

Part-Time Employees without H&W Plan

- Coverage: $10,000 or $35,000
- Statement of Health Questions required

Spouse/Partner of PT Employees without H&W Plan

- Coverage: $5,000 or $17,500
- Same rules as above

Dependent Child(ren)

- Coverage: $5,000 or $10,000
- No health questions required

Voluntary Benefits (cont.)

MetLife Advantages

Your Supplemental Life Insurance includes access to MetLife Advantages — a suite of valuable support, planning, and protection services, at no cost to you:

- ☑ Estate Planning & Will Preparation
- ☑ Estate Resolution Services
- ☑ Grief Counseling & Funeral Assistance
- ☑ Total Control Account

Questions? Contact MetLife at 866-492-6983

Safety Glasses

Safety glasses are crucial in safeguarding your vision against potential hazards within the workplace.

Local 689 Maintenance and Construction workers are eligible to order one pair of safety glasses per year.

Items required:

- ☑ Frame selection from SafeVision's website or the Health & Welfare office
- ☑ Valid RX Prescription and Pupillary Distance (PD) Number from your Optometrist

Questions?
Contact 301-568-2294 to speak with a TEHW staff member.

ORDER NOW

To place an order, email communications@tehw.org or visit our office with the required items.

Please note: Your order will not be processed until you provide all of the required items.

National Group Protection (NGP)

WMATA Health and Welfare and Local 689 partner with National Group Protection (NGP) to offer voluntary benefits to actively employed Local 689 members.

Options Include:

- ☑ Accident Insurance
- ☑ Hospital Indemnity
- ☑ Whole Life / Permanent Life Insurance
- ☑ Critical Illness Insurance
- ☑ Short -Term Disability

Members pay the full cost of these plans through payroll deduction (except for permanent term life insurance), and coverage may be continued if employment ends, with the exception of disability plans.

Questions?
Contact National Group Protection at 800-344-9016

Flexible Spending Account (FSA) & Dependent Care Account

The WMATA FSA Open Enrollment Period is Monday, October 27 – Friday, November 14, 2025.

To enroll:

- ☑ Call WageWorks at 877-924-3967
- ☑ Visit www.wageworks.com

Questions?
Contact WageWorks at 877-924-3967
or the WMATA Call Center at 202-962-1076

Contact **Information**

Kaiser Permanente HMO
301-468-6000
800-777-7902
www.kaiserpermanente.org

Blue Choice HMO
877-691-5856
www.carefirst.com

CareFirst BlueChoice Advantage PPO
877-691-5856
www.carefirst.com

CareFirst Dental
866-891-2802
www.carefirst.com

Cigna Dental DMO
800-244-6224
www.cigna.com

Davis Vision
800-783-5602
www.davisvision.com

National Vision Administrators
800-672-7723
www.e-nva.com

SafeVision
314-961-7406
www.safevision.net

Capital RX | Non-Medicare
833-463-1656
www.cap-rx.com

Express Scripts | Medicare
866-716-7353
www.express-scripts.com

Long Term Disability | MetLife
800-300-4296
www.metlife.com

Long Term Disability | The Hartford
800-752-9713
www.thehartfordatwork.com

National Group Protection (NGP)
800-344-9016

Work Life Solutions
866-440-6556

Wage Works | FSA
877-924-3967
www.wageworks.com

Lincoln Financial | 457 Plan
800-234-3500
www.lfg.com

WMATA Benefits
202-962-6070

WMATA | OHAW
202-636-7141

WMATA | Payroll
202-962-1182

WMATA | EAP
202-636-7181

ATU Local 689
301-568-6899

Transit Employees' Health and Welfare
301-568-2294
Fax: 240-745-3956
www.tehw.org | info@tehw.org

Reporting and Disclosure **Notices**

The benefits described herein are subject to the rules and provisions outlined in Appendix B of the Collective Bargaining Agreement between the Washington Metropolitan Area Transit Authority (WMATA) and Local 689 of the Amalgamated Transit Union, AFL-CIO, including any successor agreements. The specific terms of the contract between the Plan and each benefit provider, including applicable exclusions and limitations, will govern the coverage available to you and your dependents.

The Board of Trustees comprising representatives from WMATA management and ATU Local 689, has the authority to interpret Plan documents and rules, in accordance with the Collective Bargaining Agreement. All interpretations and determinations made by the Board are final and binding on all parties.

The Transit Employees' Health and Welfare Plan (the "Plan") is required to take reasonable steps to ensure the privacy of your personally identifiable health information in accordance with the privacy provisions contained in the **Health Insurance Portability and Accountability Act of 1996 ("HIPAA")**, as amended by the **Health Information Technology for Economic and Clinical Health {"HITECH") Act and the Genetic Information Nondiscrimination Act ("GINA").**

If you have any questions or concerns about the Plan's privacy practices or this Notice, if you wish to obtain additional information about the Plan's privacy practices, or if you want to exercise one of the rights described above concerning your PHI, please submit a written request to the Privacy Officer at the Transit Employees' Health and Welfare Office.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows employees, their spouses, and eligible dependents to continue group health coverage on a self-pay basis if coverage is lost due to a qualifying event. Qualifying events may include termination of employment, retirement, divorce, death of the employee, or a dependent aging out of the plan.

Depending on the event, COBRA coverage may be available for up to 18 or 36 months. The Health & Welfare Office will notify you of your right to elect COBRA continuation coverage, including the cost of coverage, which is subject to change annually.
If you wish to elect COBRA coverage, you must notify the Health & Welfare Office within 60 days of the date you receive the COBRA notice or the date coverage is lost—whichever is later.

For a full explanation of your COBRA rights and responsibilities, please refer to the Summary Plan Description (SPD).

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans that provide mastectomy coverage to also cover related services. If you elect breast reconstruction following a mastectomy, coverage includes:

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

Reporting and Disclosure **Notices (cont.)**

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. If you or your children aren't eligible for Medicaid or CHIP, 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, visit https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf 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 Virginia, you may be eligible for assistance paying your employer health plan premiums. Contact your State for more information on eligibility.

Virginia (Medicaid/CHIP)

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

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

Medicaid/CHIP Phone: 1-800-432-5924

To see if any other states have added a premium assistance program since January 31, 2024, 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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WWW.TEHW.ORG

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