

# Health & Welfare



Transit Employees' Benefits For ATU Local 689 Members



## Your Summary Plan Description

Effective July 2006

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July 2006

Dear Participant:

The Board of Trustees of the Transit Employees' Health and Welfare Plan is pleased to issue this Summary Plan Booklet. This handbook provides a summary of the benefits that are available to you through the Transit Employees Health and Welfare Plan ("Health and Welfare Plan").

This handbook has been designed to be easy to read and understand. Words that appear in bold type are defined in the "Glossary of Terms" section, on page 44. "Fast Facts" appear at the beginning of each section to give you a quick overview of what is contained within that section. Also, useful information—such as phone numbers and websites—are listed on the next page.

These benefits are provided to you based on the terms of the collective bargaining agreement between METRO and ATU Local 689. Although this summary is intended to reflect the terms of the Collective Bargaining Agreement, in the event of any conflict between this summary and the collective bargaining agreement, the collective bargaining agreement governs.

We encourage you and your family to read this Summary Plan Booklet carefully to make the best use of the benefits the Transit Employees' Health and Welfare Plan offers.

If you have any questions concerning the benefits or your eligibility, please feel free to contact the Health and Welfare office by calling 301-568-2294.

Sincerely,  
Board of Trustees

## Important Contact Information

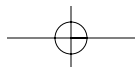
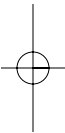
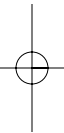
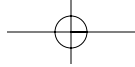
	Phone Number	Website
The Health and Welfare office	(301)-568-2294	
CareFirst PPO Plan	(202) 479-6096 (800) 296-5555	www.carefirst.com
Kaiser Permanente HMO Plan	(301) 468-6000 (800) 777-7902	www.kaiserpermanente.org
CareFirst BlueChoice HMO Plan	(202) 479-6096 (202) 484-6318 (800) 296-5555	www.carefirst.com
CIGNA Dental Plan (DHMO)	(800) 367-1037	www.cigna.com
Prescription Solutions (PPO drug benefit provider)	(800) 797-9791	www.rxsolutions.com
Argus (CareFirst HMO drug benefit provider)	(800) 241-3371	www.carefirst.com
CareFirst Dental Plan	(202) 479-6096 (800) 424-7474	www.carefirst.com
Delta Dental Plan (Retirees only)	(800) 932-0783	www.deltadental.com
National Vision HMO (for Kaiser enrollees only)	(800) 672-7723	www.e-nva.com
CareFirst Vision (through Davis Vision)	(800) 783-5602	www.carefirst.com
Basic Life and Accident Insurance	(301) 568-2294	
Weekly Sickness and Accident and Disability Plan	(301) 568-2294	
Local 689 Retirement Plan*	(202) 962-1076	
Long-Term Disability Plan*	(800) 300-4296	
Dependent Care Assistance Program*	(202) 962-1076	
ATU Local 689	(301) 568-6899	
WMATA Benefits Office	(202) 962-1076	

\* Pension, Long Term Disability and Dependent Care Assistance Benefits are not provided through the Fund, but the contact information is provided for your convenience.

**Note:** You may now contact the Transit Employees' Health and Welfare office via e-mail at [TEHW-Info@wmata.com](mailto:TEHW-Info@wmata.com).

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## An Overview of Your Health and Welfare Plan

### FAST FACTS

- ▶ The Plan provides several options for medical, dental and life insurance benefits.
- ▶ Full-time members and part-time members who are enrolled in medical benefits also receive disability insurance.
- ▶ If you are a full-time employee, you select medical coverage for yourself and your dependents. If you do not select a Plan, you will be covered automatically under the default medical plan (Kaiser, as of July 1, 2006), single coverage.

As a Washington Metropolitan Area Transit Authority (“Authority,” “WMATA” or “METRO”) Employee under the ATU Local 689 collective bargaining agreement, you and your family members are eligible for comprehensive health care coverage through the Transit Employees’ Health and Welfare Plan. Coverage includes medical, vision and dental care, plus income protection if you are injured or ill and cannot work.

### What is the Transit Employees’ Health and Welfare Plan?

The Transit Employees’ Health and Welfare Plan (also referred to as “the Plan”) was created in 1954 to provide health care benefits to members of ATU Local 689. The Board of Trustees of the Health and Welfare Plan administers your Plan of benefits according to the terms of a collective bargaining agreement, the governing trust agreement and applicable law. The Board of Trustees of the Health and Welfare Plan oversees the Plan’s assets and makes decisions and Plan design recommendations about your health and welfare benefits.

All active members of ATU Local 689 who are either **full-time** or **part-time** employees of the Washington Metropolitan Area Transit Authority (also referred to as the Authority, WMATA or METRO), and certain **retired members** are entitled to benefits from the Fund.

### Who is a Plan Participant?

You are a Plan Participant if you are one of the following:

- A full-time or part-time METRO employee in the ATU Local 689 bargaining unit, and who has completed the probationary period. This includes an employee who is on authorized leave of absence for sickness, injury, holding union office or other leave as defined in Appendix B of the ATU Local 689 bargaining agreement with WMATA,
- A New Service Agreement employee covered under the Supplemental Agreement between METRO and ATU Local 689,
- A retiree collecting a pension under the Transit Employees Retirement Plan and who retired from eligible employment, or
- An eligible surviving spouse.

Participants can enroll for coverage for themselves and their eligible dependents.

### Enrolling for Coverage

#### Full-Time Employees

All full-time METRO employees who are active members of ATU Local 689 are automatically enrolled in the Plan. While your enrollment is automatic, you must elect the medical plan and dental plan you want to join. If you do not select a medical plan, you will be enrolled automatically for single coverage under the default HMO plan and default dental plan (as of July 1, 2006, the default HMO is Kaiser and the default dental plan is CIGNA Dental HMO).

Under certain circumstances, you may elect to “opt out” of coverage and receive compensation (See page 7).

**New Service Agreement Employees**

New Service Agreement employees have different choices, but under certain circumstances may elect to opt out of coverage and receive compensation.

**Part-Time Employees**

Part-time employees who are active members of ATU Local 689 may elect coverage. Enrollment is not automatic for part-time employees.

**Retirees**

At retirement, you may elect to continue your medical coverage. Enrollment is not automatic for retirees.

**Your Coverage Options****Full-time Employees**

The Plan provides *three choices* for medical care—two HMO programs and one PPO program. To enroll in the PPO program, you must have 39 months of service. Anyone with less service must elect one of the HMO options.

All three plans offer coverage for office visits, hospitalization and surgery, preventive care and wellness care, mental health treatment and substance abuse treatment, and vision care.

Employee coverage includes dental care. You have three dental coverage options—a dental HMO plan with orthodontia, a PPO without orthodontia, and a PPO with orthodontia.

Full-time employees also receive life insurance, accidental death and dismemberment benefits, short-term disability benefits, and long-term disability benefits.

**New Service Agreement Employees**

New Service Agreement employees are eligible for the medical HMO options only, and for a life insurance benefit. New Service Agreement Employees are not eligible for dental benefits, disability benefits or accidental death and dismemberment benefits.

**Part-Time Employees**

Part-time employees are eligible for the medical and dental options as described above. Part-time employees also receive life insurance and long-term disability insurance. If a part-time employee elects medical coverage, the part-time employee also receives the same life insurance, accidental death and dismemberment insurance and short-term disability coverage as full-time employees.

**Retirees**

Retirees are eligible for the medical options described above and for a separate dental benefit. Retirees are also eligible for a life insurance benefit.

## Changing Your Coverage

If you would like to change or opt out of your coverage, you will have the opportunity to do so during the **Open Enrollment** period unless you experience a qualified family or employment status change (see page 9). Open Enrollment generally occurs every two years, in May of even numbered years.

If you fail to enroll a new dependent during the initial enrollment window described on page 8, you have the opportunity to enroll dependents annually in May of each year.

A “**qualified status change**,” such as a marriage, change in work status, or birth of a child, may allow you to make certain changes to your benefits outside the Open Enrollment period. See the section called “Enrolling for Coverage” and “Life Events” on pages 8 and 11 for more details.

## Paying for Your Coverage

Most benefit options require a monthly contribution from you to help pay the cost of the benefit. If you are an active employee, your share of the cost of benefits will be deducted from your pay and not be subject to federal income tax. The necessary enrollment materials will be provided by the Fund Office and will indicate the required contribution for each benefit option. Contact the Health and Welfare office for more information.

If you are not an active employee (for example, on leave or a retiree), you may pay your contributions by:

- Direct pay (mailing in a check or money order)
- Cash payments made at the Health and Welfare office (exact change only)
- Pension check deduction

The collective bargaining agreement determines your contribution rates. Contribution rates are normally adjusted January 1 of each year.

### MAKING YOUR PAYMENTS

If you are on leave, don't forget to make your monthly payments to the Health and Welfare office. You will lose your coverage unless you mail your payments by the first of the month to:

**The Transit Employees' Health and Welfare Office**  
**2701 Whitney Place**  
**Forestville, MD 20747**

## Eligibility

### FAST FACTS

- ▶ You become eligible for Plan coverage on the first day of the month in which you satisfy your probationary period.
- ▶ You have the opportunity to change your health plan election every two years during the "Open Enrollment" period.
- ▶ All full-time employees are automatically enrolled in the Plan unless they opt out.
- ▶ If you are a full-time employee and you do not select one of the Plan's programs of benefits, you automatically will be enrolled in the default HMO medical plan (Kaiser as of July 1, 2006), single coverage.
- ▶ You become eligible to enroll in PPO coverage 36 months after completion of your probationary period.

If you are a METRO employee and a member of ATU Local 689, you are eligible to enroll for coverage in the Health and Welfare Plan upon completion of your probationary period.

### Eligibility for Your Spouse and Children

You may cover your eligible dependents under the Plan. Your dependents are your:

- Legal spouse, as determined by applicable law;
- Unmarried children including stepchildren, legally adopted children or children placed with you for adoption; who share the same principal place of abode with you for more than half the year; is dependent upon you for over half of their support; and meet at least one of the following requirements:
  - Under age 22;
  - Between the ages of 22 and 24 (inclusive) and registered as a full-time student at an accredited educational institution (full-time is the equivalent of 12 credit hours per semester). School vacation periods during any calendar year that interrupt, but do not terminate, a continuous course of study will be considered school attendance for those individuals who attend school on a full-time basis; and
  - Age 22 or older; has a mental or physical incapacity that began prior to age 22 (or age 24 if a full-time student) and that prevents the child from engaging in any self-sustaining employment.

There is a special rule in cases of divorce/separation or where the child's parents live apart. If the child does not have the same principal place of abode as you for more than half the year, or if you do not provide over half of the child's support, the child will be an eligible dependent provided that:

- You and the child's other parent are:
  - Divorced or legally separated under a decree of divorce or separate maintenance;
  - Separated under a written separation agreement; or
  - Live apart at all times during the last six months of the calendar year;
- You and the child's other parent provide over half of the child's support;
- The child is in the custody of one or both of his or her parents for more than half of the year; and
- The child meets all other eligibility criteria.
- Unmarried child for whom you are the court-appointed guardian and who meets all of the following requirements:
  - Is under age 22, or between the ages of 22 and 24 (inclusive) and a full-time student; or is age 22 or older and has a permanent physical or mental condition that began prior to age 22 (or age 24 if a full-time student) and that prevents the child from engaging in any self-sustaining employment;
  - Came under your guardianship prior to turning age 22;
  - Has the same principal place of abode as you for the full year;
  - Is a member of your household; and
  - Is dependent upon you for over one-half of his or her support.

**If your child does not live with you or the child's other parent, or does not meet the guardianship criteria set forth above, please contact the Health and Welfare office for further information.**

You will be required to document dependent relationships by bringing to the Health and Welfare office one or more of the following:

- Original Marriage Certificate;
- Proof of divorce or death if you add a different spouse;
- Original Birth certificate—for your children it must list you and/or your spouse as a parent;
- Social Security Number or W9 number; or
- Proof of Guardianship as described above.

The Health and Welfare office staff will copy the documents and return the originals to you.

**Note:** You may not add a dependent to the Plan who is already 22 years of age and has never been previously enrolled in the Plan.

**Also note:** Once added, you cannot drop a dependent from coverage except at Open Enrollment unless you can demonstrate proof of other coverage for the dependent.

### Eligibility for Domestic Partners

Your domestic partner as defined below, may be eligible to receive benefits through the Plan.

Domestic partners are defined as two adults of the same or opposite sex, engaged in a spouse-like relationship characterized by cohabitation, mutual caring and dependency who:

- Share a permanent residence and intend to do so indefinitely;
- Are each other's sole domestic partner and intend to remain so indefinitely;
- Are no less than 18 years of age and mentally competent to consent to a contract;
- Are engaged in a committed relationship of mutual caring and support, and are jointly responsible for each other's common welfare and living expenses, and are financially interdependent and have proven such interdependence by providing documen-

tation of at least three of the following arrangements:

- Common ownership of real property (joint deed or mortgage agreement or common leasehold interest in such property);
  - Common ownership of a motor vehicle;
  - Proof of joint bank accounts or joint credit accounts;
  - Proof of designation as the primary beneficiary for life insurance or retirement benefits or primary beneficiary designation under a partner's will; or
  - Assignment of a durable property power of attorney or health care power of attorney.
- Have registered a declaration of domestic partnership with the appropriate government offices pursuant to state or local law in jurisdictions that authorize such registration;
  - Are not related by blood to a degree of closeness that would prohibit legal marriage;
  - Are not in the relationship solely for the purpose of obtaining insurance coverage;
  - Have signed jointly, a notarized affidavit that can be made available to the insurance provider upon request; and
  - Have resided together on a continuous basis for no less than one year immediately prior to the date of the required affidavit.

In addition, the domestic partners must meet the following conditions:

- Neither partner has signed a domestic partner affidavit or declaration with any other person within twelve months prior to designating each other as domestic partners hereunder;
- Neither partner is currently legally married to or legally separated from another person; or
- Neither partner has any other domestic partner, spouse or spouse equivalent of the same or opposite sex.

The "Affidavit of Domestic Partnership" forms are available at the Health and Welfare office.

Under certain circumstances, coverage for a Domestic Partner may be considered taxable income to the Participant. Participants receiving coverage for their Domestic Partners will receive an annual income statement indicating the value of the cost of this coverage for tax purposes.

### Eligibility While on Leave

If you are not working, but you are still eligible for Plan coverage under the collective bargaining agreement, you may continue your coverage under the Plan by making monthly payments to the Plan during your period(s) of leave. Likewise, if you are out on Workers' Compensation, you must also make your monthly payments directly to the Health and Welfare office because they are not deducted from your paycheck or from your workers' compensation benefits.

Payments are due on the first of the month. **It is your responsibility to make your Health and Welfare payments on time. The Fund is not required to send you notice of delinquent payments, nor is it required to send you an invoice.** If you do not make your payments on time, your coverage under the Plan will end.

#### MAKE YOUR PAYMENTS ON TIME!

It is your responsibility to make your Health and Welfare payments on time.

Coverage shall retroactively cease as of the contribution due date if the required contribution is not paid within thirty (30) days from the contribution due date (e.g., if the contribution for September, which is due on September 1, is not paid by September 30th, coverage would be terminated as of September 1). If coverage is terminated due to non-payment of the required contribution, you may again become covered (on a prospective basis) by remitting the required contribution for such future coverage. Such coverage will re-commence as of the first day of the month following receipt of the required contribution. You will not be permitted to retroactively reinstate coverage for any period of coverage that terminated due to non-payment of the required contribution.

### Military Leave

If you are on a leave of absence for military duty, you are permitted to continue hospital, medical, dental, prescription drug, benefit coverage under this Plan for you and your covered dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Please see page 15 for more information.

### The Family Medical Leave Act (FMLA)

If you take leave in certain circumstances such as serious illness, birth of a child, or caring for a seriously ill parent or spouse, you may qualify for leave under the Family Medical Leave Act (FMLA) for up to 12 weeks. In that case, as long as you continue paying your share of your Health and Welfare contributions, METRO will be obligated to continue paying its share to continue your coverage under this Plan. Contact Human Resources at METRO for details regarding your eligibility under the FMLA.

### Retiree Coverage

If you retire from eligible employment under the Plan and under the Transit Employees Retirement Plan, you are eligible for life insurance (a reduced amount compared with active coverage), medical coverage through the Plan and dental coverage provided through participant contributions. If you do not elect to continue your medical coverage, you cannot re-enroll at a later time.

### Paying for Retiree Coverage

As a retiree, you must make monthly contributions to the Health and Welfare office to pay for your coverage. Your contributions will be deducted from your pension check, however, it can take up to a few months to set up this procedure. Therefore, you should submit your first month's contribution payment directly to the Health and Welfare office.

Retirees are permitted to change health plans when they retire and at the regular Open Enrollment periods available to active employees. You must contact the Health and Welfare office at the time of your retirement.

### Dental Coverage

Retirees automatically lose their active dental coverage and are enrolled for single coverage in a retiree dental plan. For an additional contribution, you can add your dependents to the Dental plan. You will receive information from the Plan describing your dental options when you retire.

If you prefer, you may pay the additional cost to continue your active dental coverage for 18 months under COBRA. Contact the Health and Welfare office for the appropriate forms. See page 6 for more information about benefits for Retirees.

### If You Work Part Time

All part-time employees (except for New Service Agreement employees) receive long-term disability and life insurance. Part-time employees who are receiving a retirement allowance from the Transit Employees Retirement Plan receive the benefits that they qualify for as a retiree.

Part-time employees can elect to pay and participate in the Health and Welfare Plan program for medical/vision and dental coverage, in which case they are also eligible for the same short-term disability benefits and life insurance benefits as full-time employees

### Employees Working Under the New Service Agreement

If you are working under the New Service Agreement, you are eligible for medical benefits from the Plan through Kaiser Permanente or the BlueChoice HMO (see page 24 for details) and life insurance. However, you are not eligible for dental, short-term or long-term disability, accidental death or dismemberment, or supplemental life insurance.

New Service Agreement employees who can demonstrate they have other coverage can opt out of the Plan and receive cash compensation.

### When Your Coverage Ends

Your coverage under this Plan will end at the end of the month in which one of the following occurs:

- You stop working as a Local 689 employee of METRO for reasons other than retirement;
- You are no longer eligible under the terms of a collective bargaining agreement;
- You do not make your monthly payments (if required) on time; or
- The Plan is terminated or modified to end your coverage.

When your coverage ends, coverage for your dependents ends, too, unless the cause of your termination of coverage is your death. (See Survivor Benefits below).

### When Coverage Ends for Your Spouse

Your spouse ceases to be a dependent if you are divorced or if your marriage has been annulled. If you are separated but still legally married, your spouse is covered.

### When Coverage Ends for Your Children

Coverage for your dependent children will end on the last day of the month in which they no longer meet the Plan's definition of dependent.

### Survivor Benefits

If you die while you are covered under this Plan as an active or retired employee, your surviving dependents are eligible to continue coverage for medical and dental benefits. Survivor coverage will terminate on the last day of the month in which any of the following occurs:

- Remarriage;
- Attain age 65 or, if later, two years from beginning of survivor coverage;
- In addition to the above, for a child dependent, survivor coverage terminates upon attainment of age 22, or if a full-time student, upon attainment of age 25; or
- You fail to make your monthly payments.

### Continuation Coverage

When coverage terminates, you or your dependents may be eligible to pay for a period of COBRA (see page 18) continuation coverage.

## Enrolling for Coverage

### FAST FACTS

- ▶ All new Local 689 bargaining unit employees become eligible to participate in the Plan the first of the month in which they complete their probationary period.
- ▶ If you are a full-time employee, your participation in the Plan is automatic unless you choose to “opt out.”
- ▶ If you are a full-time employee and you do not select one of the Plan’s programs of benefits, you automatically will be enrolled for single coverage in the default medical and dental plan, as of July 1, 2006. The default medical plan is Kaiser HMO and the default dental plan is the Cigna Dental HMO.
- ▶ Part-time employees can choose not to participate in the Health and Welfare Plan.
- ▶ Generally, you may make changes to the medical, dental, vision and life insurance options that you elect once every two years during the “Open Enrollment period.” If you experience a qualified status change, you may be eligible to make certain changes as necessary outside of the Open Enrollment period.

### New Member Enrollment

When you start working for WMATA, you will be asked to complete certain enrollment forms. It is important to list all of your dependents at this time, even if you do not plan to enroll them as dependents.

Before the end of your probation period, you will receive information from the Health & Welfare office about the benefit choices available to you. You must return those forms to the Health and Welfare office by the date indicated. Full-time employees who do not make a selection will automatically be enrolled for single coverage in the default HMO (Kaiser), and the Cigna Dental HMO.

### The Open Enrollment Period

If you would like to make a change to your current plan of benefits, you may only do so during the Open Enrollment period. Open Enrollment occurs every two years in the even numbered years (2004, 2006, 2008, etc.) during the month of May. Changes that you make will be effective on the following July 1st.

Prior to the Open Enrollment period, you will receive an Open Enrollment guide to explain your benefit options. To make changes, you must complete the enrollment form and return it to the Health and Welfare office. Mailed forms must be postmarked by the date indicated, usually the last Friday in May. Changes take effect on the following July 1. If you are adding dependents, you must bring the documentation (described on page 5) to the Health and Welfare office. If you miss the deadline, your next opportunity to make changes will be the next Open Enrollment period.

30 Days to Make a Change	90 Days to Make a Change
To enroll for Plan coverage if you or a dependent lose other health care coverage	To add a new dependent, to be effective the first day of the calendar month following enrollment
To enroll a newborn, to be effective from the date of birth, or to enroll a child adopted or placed for adoption, to be effective from the date of adoption or placement for adoption	
Change from part-time to full-time or from full-time to part-time or attaining 36 months of service beyond probation	

### Change in Status

Outside of Open Enrollment, you are not permitted to make changes to your benefits unless you experience a “qualified status change.” Qualified status changes include:

- Marriage or divorce;
- Birth, adoption, or placement for adoption of a child;
- Death of a dependent;
- Change in work status (from full- to part-time, part-time to full-time or attaining 36 months of service beyond probation); and
- Change in your spouse’s health insurance coverage (unless due to spouse’s failure to pay contributions or due to spouse’s termination for cause).

Depending on the status change, you will have either 30 days or 90 days from the date of the event to make changes to your health care elections, as shown in the chart above.

If you have a change in status because of loss of other health coverage, you must request enrollment within 30 days after your previous coverage ends. You will need supporting documentation, normally a “Certificate of Coverage” from your former health care provider as proof of the previous health coverage. Coverage in this Plan will be effective the first of the month following completion of the enrollment request.

If you are adding a new dependent, you must submit a completed enrollment form within 90 days of the marriage, birth, adoption, or placement for adoption. Coverage in the Plan will be effective on:

- The date on which your child is born, if you enroll the child within 30 days; or
- The first day of the first calendar month beginning after the date the Health and Welfare office receives your completed enrollment form; or
- The date of your new dependent’s adoption or placement for adoption with you, if you enroll the child within 30 days.

You will also have the opportunity to add dependent(s) each year during annual enrollment in the month of May.

Once added, you cannot drop a dependent from coverage except at Open Enrollment unless you can demonstrate proof of other coverage for the dependent.

### Election of Cash Payment / Waiver of Coverage

Under certain circumstances you may be eligible to opt out of your coverage and receive a cash payment. This opt out of coverage is only available if you are a full-time METRO employee or you are working under the supplemental collective bargaining agreement between ATU Local 689 and METRO (the “New Service Agreement”) and you can provide proof that you have coverage from a source other than WMATA.

You can opt out of medical coverage when you first become eligible as a full time employee. After that, you can elect to opt out only during the Open Enrollment periods every two years. You must provide proof of other coverage during each subsequent enrollment period; otherwise you will be re-enrolled in the last plan that you selected.

The annual cash payment amount is set by the collective bargaining agreement between METRO and Local 689. For 2006, it is \$1500 for active full time members and \$500 for New Service Agreement employees.

If you opt out of participation in the Plan's health care coverage, but you later lose your other coverage due to loss of eligibility or termination of employer contributions, or have a change in family or work status, you and/or your dependents may be able to enroll in this Plan. See "Change in Status" on page 8 for more information.

#### **Health Coverage for Participants Who Are Married to Each Other**

If one participant in this Plan is married to another participant, one of the participants must carry family health coverage, and the other will be a dependent on that participant's plan (not an "opt out" from coverage). Both participants will continue to be eligible for life, disability, accidental death and dismemberment benefits.

If a participant in this Plan is married to a participant in another plan sponsored by METRO, contact the Health and Welfare office for information about coverage.

## Life Events

### FAST FACTS

- ▶ You have the right to change your benefit election when certain life events occur, but you must act within a specific time frame. You should notify the Health and Welfare office as soon as possible if you experience a life event that may affect your coverage.
- ▶ You and/or your dependents may qualify to continue coverage under COBRA in the event of a loss of eligibility, divorce, or your termination.
- ▶ This plan provides benefits to your family in the event of your death.
- ▶ When you add or drop dependents, you should also consider whether you want to change your designated beneficiary for life and accidental death insurance.

Your benefits are designed to meet your needs at different stages of your life. This section describes how your coverage is affected when you experience certain “life events” and what you must do to make sure you get the most from your coverage.

#### The following life events may affect your coverage:

Moving to a new address
Getting married
Having a baby
Adopting a child or placement for adoption
Taking Family Medical Leave
Termination of employment
Divorce
Losing coverage
Change in full time or part time status
Entering active military service
Becoming disabled
Retiring
Becoming eligible for Medicare
Taking a leave of absence
Death

### IF YOU MOVE

If you have a change of address, notify METRO if you are an active employee, or the Health and Welfare office if you are a retiree. Do this as soon as possible to make sure your records are up to date and to avoid a delay in payment of claims. METRO will pass your new address information to the Health and Welfare office.

If you are retired and enrolled in an HMO, and you move out of the HMO area, you may be required to change your enrollment. Contact the Health and Welfare office for additional information.

### IF YOU GET MARRIED

If you marry, your spouse is eligible to receive dependent benefits under the Plan. You have 90 days to notify the Health and Welfare office that you are married and wish to add a new spouse. You will need to provide the Health and Welfare office with the following required documentation:

- Your original marriage certificate;
- Your spouse's birth date; and
- Your spouse's Social Security Number or W-9 number.

If you have previously been married but you are adding a new spouse to your coverage, you must present a valid divorce decree or death certificate to the Health and Welfare office.

**WHAT YOU NEED TO DO**

If you get married, provide the Health and Welfare office with:

- The original marriage certificate; (if applicable, an English translation)
- Your spouse's date of birth and Social Security Number; and
- A divorce decree or death certificate, if your new spouse is not your first spouse.

Your spouse will be enrolled on the first day of the month after you provide the Health and Welfare office with the required documentation. If you fail to enroll your spouse within 90 days of the date of your marriage, you will have to wait until the next annual enrollment period.

You may wish to change your beneficiary on your life and accidental death insurance benefit at this time. "Change of Beneficiary" forms are available at the Health and Welfare office.

**IF YOU HAVE A BABY**

If you have a baby, your child will be covered by the Plan from the date of birth if you enroll the child within 30 days, or from the first of the month following enrollment if you enroll the child within 90 days. If you miss this 90-day period, you will not be able to enroll your newborn child until the next enrollment period.

**WHAT YOU NEED TO DO**

If you have a baby, provide the Health and Welfare office with the following within 90 days of your child's birth:

- The baby's birth date;
- The baby's Social Security Number;
- A copy of the baby's birth certificate with your name or your spouse's name on it; and
- An English translation, if applicable.

**Required Documentation**

You must bring to the Health and Welfare office the child's Social Security Number and the child's birth certificate identifying the participant or spouse of the participant as a parent. If you are unable to get the paperwork to the Health and Welfare office within the 90-day period due to circumstances beyond your control, notify the Health and Welfare office immediately in writing to request an extension.

**If Your Dependent Child Has a Baby**

The Plan does not provide coverage for your dependent child's baby or for maternity and delivery services related to your child's pregnancy.

**RESTRICTION ON ADDING DEPENDENTS WHO ARE 22+**

You may not add a dependent to the Plan who is already 22 years of age and has never been previously enrolled in the Plan.

#### IF YOU ACQUIRE A CHILD THROUGH MARRIAGE

Within 90 days from the date of your marriage, you must provide the Health and Welfare office with the child's birth certificate and the name of the parent who is eligible to participate in this Plan must appear on the birth certificate. Coverage for the child will be effective on the first day of the month after you provide the Health and Welfare office with the required documentation.

If you miss this 90 day period, you will not be able to enroll your child until the next annual enrollment period.

#### IF YOU ADOPT A CHILD

You have 90 days from the date of the adoption or placement of adoption to cover your child. Your child will be covered by the Plan from the date of adoption or placement for adoption if you enroll the child within 30 days, or from the first of the month following enrollment if you enroll the child within 90 days. If you are unable to get the paperwork to the Health and Welfare office within the 90-day period due to circumstances beyond your control, notify the Health and Welfare office immediately in writing to request an extension. If you miss this 90-day period, you will have to wait until the next annual enrollment period to enroll your child for coverage.

#### WHAT YOU NEED TO DO

If you adopt a child, provide the Health and Welfare office with the following within 90 days of the date of adoption placement:

- The child's birth certificate;
- The child's Social Security Card; and
- The adoption agency official paperwork indicating the specific date that the child was placed in your home.

#### IF YOU BECOME THE GUARDIAN OF A CHILD

If you become the legal guardian of a child not otherwise eligible for benefits as a dependent under this Plan, you may be able to add him or her as a dependent provided the child meets the guardianship requirements set forth on page 4.

If you wish to enroll the child, you must do so within 90 days or wait until the next annual enrollment period.

#### IF YOU TAKE FAMILY MEDICAL LEAVE

If you take Family Medical Leave to deal with a serious illness, birth of a child, or to care for a seriously ill parent or spouse, the Family Medical Leave Act (FMLA) allows you to continue coverage for the period of authorized leave up to 12 weeks. You must continue paying your share of your health care contributions, and METRO will continue to permit coverage through the Plan. Contact METRO for details regarding your eligibility under the FMLA.

#### IF YOUR EMPLOYMENT IS TERMINATED

If your coverage ends due to termination of your employment with METRO, you may be eligible for COBRA for you and your family. METRO will notify the Health and Welfare office of your termination, but you are encouraged to also inform the Health and Welfare office to avoid confusion in the event of a delay in notification. For more information on COBRA, see page 18.

### IF YOU DIVORCE

If you divorce, your former spouse may continue plan coverage under COBRA for up to 36 months. He or she must notify the Health and Welfare office within 90 days of the day that the divorce becomes final. The Health and Welfare office will then send a COBRA election notice and enrollment information to your former spouse. For more information, see page 19. You must present proof of divorce before you can add a new spouse.

You may wish to change your beneficiary on your life and accident insurance benefit at this time. "Change of Beneficiary" forms are available at the Health and Welfare office.

### QUALIFIED MEDICAL CHILD SUPPORT ORDER

A Qualified Medical Child Support Order (QMCSO) is a court order, judgment or decree that recognizes that children residing with a custodial parent may be entitled to benefits under this Plan in the event of a divorce or other family law action. Orders must be submitted to the Health and Welfare office to determine whether the order is a QMCSO under federal law. The Plan will recognize a QMCSO that:

- Provides for health coverage to the child(ren) under state domestic relations law (including a community property law); and
- Relates to benefits under this Plan.

Please notify the Health and Welfare office if your situation involves a QMCSO. For information about how these orders are handled, you and/or your and beneficiary(ies) can obtain, without charge, a copy of the Plan's QMCSO procedures from the Health and Welfare office.

### IF YOU HAVE A CHANGE IN WORK SCHEDULE

#### If You Transfer from a Part-Time to a Full-Time Position

If you transfer from a part-time to a full-time position, and have not already selected a medical program, you must notify the Health and Welfare office to select a Medical Plan. Medical and dental coverage is mandatory for you if you are a full-time employee unless you opt out of the Plan because you have coverage from another source.

If you do not respond, you will automatically be enrolled in the default medical plan and default dental plan, with single coverage. If you have already selected a medical plan, your contribution rate will be automatically adjusted.

You have 30 days from the date you become full-time to change your coverage elections.

#### If You Transfer from a Full-Time to a Part-Time Position

If you transfer from a full-time to a part-time position, you will have to pay more for your benefits coverage. Medical/vision and dental coverage is not mandatory for part-time employees. You have 30 days to notify the Health and Welfare office if you wish to change or drop your coverage.

### IF YOU ENTER MILITARY SERVICE

If you are on military leave for 31 days or less, you will continue to receive health care coverage for up to 31 days, under to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are on military leave for more than 31 days, USERRA permits you to continue medical, prescription, vision, and dental coverage for you and your dependents at your own expense for up to 36 months. This continuation right is similar to COBRA (see page 18). Your dependent(s) also may be eligible for health care coverage under TRICARE, the military health plan. Your current carrier will coordinate coverage with TRICARE.

Coverage under the Health and Welfare Plan will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

When you are discharged (not less than honorably) from "service in the uniformed services," your full eligibility will be reinstated on the day you return to work or apply to return to work, provided that you return:

- Within 90 days from the date of discharge if the period of service was more than 180 days; or
- Within 14 days from the date of discharge if the period of service was 31 days or more, but less than 180 days; or
- At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than thirty-one (31) days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits can be extended up to two years.

### IF YOU BECOME DISABLED

If you become disabled and cannot work, you may qualify for short-term disability benefits from the Plan or long-term disability benefits from the Local 689 Pension Plan.

While you are on extended sick leave for any reason from METRO, you are required to make your Health and Welfare contributions directly to the Health and Welfare office prior to the first of the coverage month. You will receive no notice that payment is due.

**Please note: If you do not make timely payments, you will lose your medical coverage and also your short-term disability, life insurance, and accidental death and dismemberment coverage.**

Your Health and Welfare contributions can be deducted from your short-term disability payments, but not from your long-term disability payments.

### WHAT YOU NEED TO DO

If you are out of work due to a non-work-related disability, you should:

- Notify the Health and Welfare office;
- Make your Health and Welfare payments directly to the Health and Welfare office;
- Apply for short-term disability benefits; and
- Provide the Health and Welfare office with proof of your disability.

If you are out of work due to a work-related disability, you should:

- Notify the Health and Welfare office; and
- Contact your local Workers' Compensation office and apply for workers' compensation benefits.

### Short-Term Disability

Short-term disability benefits are paid to you if you suffer an illness or injury that is not work-related. You will be eligible to receive \$170 per week during your disability for up to 26 weeks. (Applicable taxes are deducted from your payment). Short-term disability benefits begin after you have used all of your sick leave or after a waiting period of 30 days, whichever occurs later.

The Medical Compliance Department of METRO will send the Health and Welfare office a referral when you approach the end of your waiting period. After receipt of the referral, the Health and Welfare office will send you an application for short-term disability benefits.

### Long-Term Disability

After 180 days of disability, you may be eligible to receive long-term disability (LTD) benefits. See your long-term disability booklet for more information, or contact the Health and Welfare office.

You will be able to continue your medical coverage through this Plan while you are disabled by making your Health and Welfare contributions on time to the Health and Welfare office. Your life insurance will continue as long as you are enrolled for health care coverage under the Plan.

The Medical Compliance Department of METRO sends the Health and Welfare office a referral after 13 weeks on short-term disability, which starts the information gathering process for the LTD application. If you are still getting sick pay after 13 weeks, you may wish to contact the Medical Compliance Department of METRO to ensure that they have sent the Health and Welfare office the necessary referral.

### IF YOU RETIRE

If you are a participant in this Plan and you retire under the Transit Employees Retirement Plan, you are eligible for life insurance, medical (including prescription drug and vision) and dental coverage through the Plan. Retirees are not eligible for short-term disability (STD), long-term disability (LTD) or accidental death and dismemberment (ADD) coverage.

Your dependents remain covered through your retiree benefits as long as they meet the requirements of an eligible dependent.

Retirees must make monthly contributions. Your Health and Welfare contributions are automatically deducted from your pension check. However, your first month's contribution should be made directly to the Health and Welfare office. Subsequent payments will be deducted from your retirement check.

Retirees are permitted to change health plans when they retire. You must contact the Health and Welfare office at the time of your retirement if you want to make a change.

Retirees who change primary residence and reside outside their HMO service area can change to the PPO with proof of residency.

As a retiree, you will lose the dental plan you had as an active employee. Instead, the retired member is automatically enrolled in the Delta Dental plan at no cost. For an additional contribution, you can add your dependents to the Delta Dental plan. You will receive information from the Plan describing your dental options. You can continue the same dental you had as an active by purchasing that coverage under COBRA for up to 18 months if you wish. Contact the Health and Welfare office for the appropriate forms.

If a retiree discontinues enrollment in the medical plan, the retiree cannot re-enroll at a later time. A retiree who does not maintain medical plan coverage also loses Delta Dental Plan coverage. A retiree who does not maintain medical coverage continues to have life insurance coverage.

#### IF YOU BECOME ELIGIBLE FOR MEDICARE

When you or your dependent becomes eligible for Medicare, you or your dependent must enroll in Medicare Part A and B—three months before becoming 65 or in certain cases when you become disabled—in order to avoid a gap in coverage. If you do not enroll in Part B, you may be required to pay a surcharge. **If you continue working past age 65, you and your spouse do not need to enroll in Medicare Part B until you retire.**

If you are retired and Medicare-eligible, your medical benefits are coordinated with Medicare so that payments made by the Plan to health care providers are offset by payments made by Medicare. Your medical plan will not pay benefits that would otherwise be paid by Medicare Part A or Part B—so be sure to enroll in Medicare Part A and B when you are retired and eligible.

If you are in the Kaiser Permanente HMO, you will be contacted when you are about to become 65, about your employment status and about your Medicare enrollment. If you are retired, you will be asked to sign up for Kaiser's Medicare plan. If you do not provide this authorization to Kaiser, you may be charged a higher premium by this Plan.

#### WHAT YOU NEED TO DO

To enroll in Medicare:

- Visit your local Social Security Office;
- Call 1-800-Medicare; or
- Visit Medicare online at [www.medicare.gov](http://www.medicare.gov).

#### IF YOU DIE WHILE A PARTICIPANT

If you die while you are covered under the Plan as an employee or retiree, your life insurance benefit will be paid to your designated beneficiary(ies). In order to receive the benefit, contact the Health and Welfare office and provide a certified copy of the death certificate.

Survivors may be eligible to continue health coverage (medical and dental) until the last day of the month in which any of the following occur:

- Remarriage;
- Attain age 65 or, if later, two years from beginning of survivor coverage; or
- You fail to make your monthly payments.

At the end of this period, your survivor(s) may be able to continue their benefits through COBRA, if the 36 month COBRA period has not expired, counting from the date of your death. (See page 18).

Surviving dependents must make their Health and Welfare contributions directly to the Health and Welfare office.

#### WHAT YOUR BENEFICIARY NEEDS TO DO

In the event of your death, your spouse, children or beneficiary must:

- Notify the Health and Welfare office;
- Provide the Health and Welfare office with an original copy of your death certificate; and
- Apply for your life insurance benefit.

## Continuing Your Coverage

### FAST FACTS

- ▶ The Plan offers generous options to continue your benefits at favorable rates during periods of leave, during retirement, and for your survivors if you should die.
- ▶ In certain other circumstances, you and your dependents may be eligible to continue coverage under COBRA. Your children are eligible to continue coverage under COBRA when they no longer qualify as dependents because of age, marriage or student status.
- ▶ To continue your coverage while on leave or coverage under COBRA, you must make timely monthly payments to the Health and Welfare office. You are fully responsible for payment of your contributions during any period of continued coverage, including COBRA.

### Continuation Coverage under the Collective Bargaining Agreement

The Plan currently permits active employees who are not actively at work for specified reasons — such as sick leave, workers' compensation, family leave, long-term disability — to continue their participation in the Health & Welfare Plan at the rates paid by active employees.

In case the Health & Welfare office does not receive timely notification of your change in status, it is very important that you know the status of your Health & Welfare contributions and that you make timely payments to the Health & Welfare office. Payments are due on the first of the month. **It is your responsibility to make your Health and Welfare payments on time. The Fund is not required to send you notice of delinquent payments, nor is it required to send you an invoice.** If you do not make your payments on time, your coverage under the Plan will end. (See "Eligibility While on Leave" on page 6).

While you may be eligible for COBRA if you are dropped from coverage, the cost of COBRA is much greater.

### COBRA Continuation Coverage

If your coverage under the Health and Welfare Plan ends due to a "qualifying event" (see below), you and/or your covered dependents may be eligible to continue your health care coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

By making monthly payments, you and/or your dependents may continue the same medical, including prescription drugs, and vision) and dental coverage that you had before your coverage ended. You may also choose to continue your medical but not your dental coverage. If the qualifying event is retirement, you also have the choice to continue your active dental coverage. If you are a retiree, your coverage can last for up to 18, 29 or 36 months, depending on the qualifying event that resulted in your loss of coverage.

#### Qualifying Events

To be eligible to elect COBRA, you and/or your dependent(s) must lose coverage due to any one of the qualifying events, shown in the chart on the next page.

#### Notifying the Fund About A Qualifying Event

The Health and Welfare office must be notified of your qualifying event in order for you to elect COBRA.

Your employer must notify the Health and Welfare office in the event of your termination of employment, reduction of your hours or your death.

Qualifying Event	Who May Purchase	Eligibility	Notification Requirements
<b>TERMINATION.</b> Employee terminated for reason other than gross misconduct (including retirement)	Employee, spouse and/or dependent children	18 months	WMATA will notify the Health and Welfare office
<b>REDUCTION IN HOURS.</b> Employee's reduction in hours worked (making employee ineligible for coverage or the same coverage under the Plan)	Employee, spouse and/or dependent children	18 months	WMATA will notify the Health and Welfare office
<b>ELIGIBILITY FOR SOCIAL SECURITY DISABILITY.</b> Employee becomes eligible for disability through Social Security at some time before 60th day of COBRA and disability lasts until the end of the 18-month COBRA period	Employee, spouse and/or children	11 months in addition to the 18 months	Employee must notify the Health and Welfare office
<b>DEATH OF EMPLOYEE*</b>	Spouse and/or dependent children	36 months*	Family member must notify the Health and Welfare office
<b>DIVORCE</b>	Spouse and/or dependent children	36 months	Employee or Spouse must advise the Health and Welfare office
<b>CHILD IS NO LONGER ELIGIBLE FOR COVERAGE</b>	Dependent child	36 months	Employee must advise the Health and Welfare office

\*If the qualifying event is your death, the 36-month COBRA period begins from the first of the month following your death. If your survivors are entitled to survivor benefits, and survivor benefits terminate prior to the expiration of the 36-month COBRA period, survivors will be entitled to purchase COBRA for the remaining balance of the 36-month COBRA period.

As an employee or qualified beneficiary, you are responsible for providing the Health and Welfare office notice within 60 days of the date you would have lost coverage for certain qualifying events:

- Your divorce or legal separation from your spouse;
- Your dependent's change in eligibility for coverage; and
- If you experience a second qualifying after a qualified beneficiary has become entitled to COBRA. This second qualifying event could include an employee's death, divorce or legal separation or child losing dependent status. The maximum COBRA period, regardless of the number or type of qualifying events, is 36 months.

In addition to these qualifying events, there are two other situations where an employee or qualified bene-

ficiary is responsible for providing the Health and Welfare office with notice within the 60-day timeframe noted in this section:

- When the Social Security Administration determines that a qualified beneficiary is no longer disabled; and
- When a qualified beneficiary becomes entitled to (i.e., enrolls in) Medicare during a COBRA period.

You must make sure that the Health and Welfare office is notified of any of these five occurrences listed above. Failure to provide this notice within the form and timeframes described below may prevent you and/or your dependents from obtaining or extending COBRA coverage.

### KEEP THE PLAN INFORMED OF ADDRESS CHANGES

In order to protect your rights, you should keep the Plan informed of any changes in your address and the addresses of family members. See page 11, "If You Move," for information.

#### When to Send Notice of the Qualifying Event

If you are providing notice due to a divorce or legal separation, a dependent losing eligibility for coverage or a second qualifying event, you must send the notice no later than 60 days after the later of (1) the date upon which coverage would be lost under the Plan as a result of the qualifying event, (2) the date of the qualifying event or (3) the date on which the qualified beneficiary is informed through the furnishing of a summary plan description or initial COBRA notice of the responsibility to provide the notice and the procedures for providing this notice to the Health and Welfare office.

If you are providing notice of a Social Security Administration determination of disability, notice must be sent no later than the end of the first 18 months of continuation coverage.

If you are providing notice of a Social Security Administration determination that you are no longer disabled, notice must be sent no later than 30 days after the later of (1) the date of the determination by the Social Security Administration that you are no longer disabled or (2) the date on which the qualified beneficiary is informed through the furnishing of a summary plan description

### WHAT TO DO IF YOU EXPERIENCE A QUALIFYING EVENT

Inform the Health and Welfare office of the qualifying event and request a COBRA election form.

Complete and mail back the election form within 60 days of the date the qualifying event occurred, whichever is later.

Make your first payment to the Health and Welfare office within 45 days from the date the Health and Welfare office receives your COBRA election form.

or initial COBRA notice of the responsibility to provide the notice and the procedures for providing this notice to the Health and Welfare office.

#### Who Should Send the Notice?

Notice may be provided by the covered employee, the dependent who loses coverage, or any representative acting on behalf of the covered employee or qualified beneficiary.

Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if an employee and his or her spouse and child are all covered by the Plan, and the child ceases to become a dependent under the Plan, a single notice sent by the spouse would satisfy this requirement.

#### Who May Elect COBRA?

Under the law, only "qualified beneficiaries" are entitled to elect COBRA. A qualified beneficiary is any employee or his or her spouse or dependent who was covered by the Plan when a qualifying event occurs. A child who becomes a dependent child by birth, adoption or placement for adoption with the employee during a period of COBRA is also a qualified beneficiary. However, a spouse you acquire as a spouse during COBRA is not a qualified beneficiary.

One or more of your family members may elect COBRA even if you do not. Additionally, one member may elect COBRA for all qualified beneficiaries. However, in order to elect COBRA, the members of the family must have been covered by the Plan on the date of the qualifying event. A parent may elect or reject COBRA on behalf of dependent children living with him or her.

#### **How to Elect COBRA Continuous Coverage**

When the Health and Welfare office receives notice of the qualifying event, you will be mailed an election form, information about COBRA and the date on which your coverage will end if you do not elect COBRA.

Under the law, you and/or your covered dependents have 60 days from the later of the date:

- You would have lost coverage because of the qualifying event; or
- You and/or your covered dependents received the election form and COBRA information.

If you and/or any of your covered dependents do not elect COBRA within 60 days of the qualifying event, you and/or your covered dependents will not have any group health coverage from the Health and Welfare Plan after your coverage ends.

#### **Paying for COBRA**

You are responsible for the entire cost of COBRA. When you and/or your dependents become eligible for this coverage, the Health and Welfare office will notify you of the COBRA premium amounts that you must pay.

Your COBRA premiums may be as high as 102% of the Plan's cost, except in the case of Social Security disability. (See the section below entitled "COBRA for Disabled Participants.")

You must send the first COBRA payment to the Health and Welfare office within 45 days from the date on which the Health and Welfare office receives your COBRA election form, as determined by postage cancellation. You must make payments on time so that there is no lapse in coverage.

If you choose COBRA within the election period but after the date on which your eligibility ended, you must pay the required COBRA premiums retroactively to the date you lost coverage to cover the entire elapsed period.

#### **Late COBRA Payments**

Your monthly payments are due on the 1st day of each month. You will have a 30-day grace period in which to pay. Payments should be mailed to the Health and Welfare office. If you do not make payment by the end of the grace period, your coverage will be cancelled retroactively to the last day of the previous month. You will not be billed for future months and you will not be permitted to reenroll.

#### **COBRA for Disabled Participants**

If you are covered under COBRA for 18 months, and within the first 60 days of coverage you (or your covered dependent) become disabled, you (and your qualified beneficiaries who elected COBRA) may be eligible to continue your COBRA coverage for an additional 11 months for a total of 29 months (or until you are no longer disabled).

To be eligible, the Social Security Administration must make a formal determination that you (or your dependent) were disabled effective within the initial 60-day period of the start of your COBRA coverage and therefore entitled to Social Security Disability income benefits. You (or your dependent) must notify the Health and Welfare office of the Social Security determination of disability by the end of the 18-month initial COBRA period if you wish to continue with the 11-month extension.

If you are eligible for the 11-month extension, your COBRA premiums may be as high as 150% of the regular premiums for the additional 11 months of coverage.

This extended period of COBRA coverage will end on the earlier of:

- The last day of the month that occurs 30 days after Social Security has determined that you and/or your dependent(s) are no longer disabled;
- The end of the 29 months' COBRA; or
- The date the disabled person becomes entitled to Medicare.

If you recover from your disability before the end of the initial 18 months of COBRA, you will not have the right to purchase extended coverage. You must notify the Health and Welfare office within 30 days of:

- The date that you receive a final Social Security determination that you and/or your dependent(s) are no longer disabled; or
- The date that the disabled person becomes entitled to Medicare.

#### **Multiple Qualifying Events While Covered Under COBRA**

The maximum period of coverage under COBRA is 36 months, even if you experience another qualifying event while you are already covered under COBRA. If you are covered under COBRA for 18 months because of your termination of employment or reduction in hours, your affected spouse or dependent may extend coverage for another 18 months in the event of your death or if:

- You get divorced or legally separated; or
- Your child is no longer a dependent under the Plan's definition.

For example, you stop working (the first COBRA-qualifying event), and you enroll yourself and your dependents for COBRA for 18 months. Three months after your COBRA begins, your child turns 22 and no longer qualifies as a dependent child under the Plan's definition. Your child then can continue COBRA coverage separately for an additional 33 months, for a total of 36 months' COBRA.

You, as the employee, are not entitled to COBRA for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA on account of disability). Therefore, if you experience a reduction in hours

followed by a termination of employment, the termination of employment is not treated as a second qualifying event and you may not extend your coverage.

#### **Special HIPAA Enrollment Rights**

If you marry, have a newborn child, adopt a child or have a child placed with you for adoption while you are enrolled in COBRA, you may enroll that spouse or child for coverage for the balance of the period of COBRA. You must enroll your new dependent within 90 days of the marriage, birth, adoption or placement for adoption, with proper documentation. If you enroll the child within 30 days of birth, adoption or placement for adoption, coverage will be effective from the date of birth, adoption or placement for adoption; otherwise coverage is effective the first of the month following enrollment.

In addition, if you are enrolled for COBRA and your spouse or dependent child loses coverage under another group health plan, you may enroll that spouse or child for coverage for the balance of the period of COBRA within 31 days after the termination of the other coverage.

To be eligible for this special enrollment right, your spouse or dependent child must have been eligible for coverage under the terms of the Plan, but declined when enrollment was previously offered because they had coverage under another group health plan or had other health insurance coverage, with proper documentation.

Loss of other coverage must be due to loss of eligibility, not failure to pay contributions on timely basis or termination for cause.

#### **Confirmation of Coverage to Health Care Providers**

When a physician or provider is requesting confirmation of coverage when you are eligible for, but have not yet elected, COBRA coverage, or you have elected COBRA coverage but have not yet paid for it, federal rules require the Plan to inform your physician and health care providers as to whether you have elected and / or paid for COBRA.

### Termination of COBRA

COBRA will terminate on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

- You do not make all required payments on time;
- The person receiving the coverage becomes covered by another group health plan that does not contain any legally applicable exclusion or limitation with respect to preexisting conditions that the covered person may have;
- The person receiving the coverage becomes entitled to Medicare; or
- The Plan terminates its group health Plan and no longer provides group health insurance coverage to its employees.

If continuation coverage is terminated before the end of the maximum coverage period, the Health and Welfare office will send you a written notice as soon as practicable following the Health and Welfare office's determination that continuation coverage will terminate. The notice will set out why continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

### Notice of Unavailability of COBRA

In the event the Health and Welfare office is notified of a Qualifying Event, but the Health and Welfare office determines that an individual is not entitled to the requested COBRA, the individual will be sent an explanation indicating why the COBRA is not available. This notice of the unavailability of the COBRA will be sent according to the same timeframe as a COBRA election notice.

### If You Have Questions

If you have questions concerning the Plan or your COBRA rights, contact the Health and Welfare office. For more information about your rights under COBRA, HIPAA and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

## Medical Benefit Options

### FAST FACTS

- ▶ During the Open Enrollment period, you may elect or change to one of the other health programs offered by the Plan.
- ▶ You must have at least three years of service beyond your probationary period (up to 90 days) to elect the PPO option.
- ▶ If you are covering your dependents, all must elect the same plan.
- ▶ Compare the different plan health care programs costs and services by referring to the chart on page 25.

### How Your Medical Plans Work

The Health and Welfare Plan provides *three choices* for medical care—two HMO plans and one PPO plan. To enroll in the PPO program, you must have at least three years of service beyond your probationary period. New hires must elect one of the HMO options.

All three plans offer coverage for:

- Medical services such as office visits, hospitalization and surgery, wellness care, mental health treatment and substance abuse treatment;
- Prescription drugs; and
- Vision care.

### What's the Difference Between a PPO and an HMO?

#### Preferred Provider Organization (PPO)

A PPO (Preferred Provider Organization) is a network of healthcare providers—doctors, specialists, hospitals, laboratory facilities, etc.—who have agreed to provide health care services at a contracted rate for employees. The PPO rate is called the **Allowance**. When you visit a provider in the PPO (an **"in-network provider"**), there is no deductible to meet and many services are covered at 100% of the Allowance.

If you choose to be covered under the PPO plan you do not have to elect a primary care physician. You have the flexibility to see any doctor or specialist in the network without a referral.

### COINSURANCE VS. COPAYMENT

When you are required to share the cost for services by paying a percentage, your share is called "coinsurance." For example, if a covered service were covered at 75%, your coinsurance would be 25%.

A copayment is a flat fee for covered services. Certain HMO and PPO services require a copayment.

If you elect the PPO, you are not required to visit a PPO provider. You can visit any provider and you will still receive benefits for covered services. However, your out-of-pocket costs are generally greater and you will have to meet an annual deductible before benefits are paid. And while you will be covered for a percentage of the allowance, if the out-of-network provider charges more than the PPO allowance, you are responsible for paying the difference between the amount the out-of-network provider charges and the PPO Allowance.

The Plan utilizes the **CareFirst Blue Cross Blue Shield PPO** for covered employees and retirees. The Health and Welfare office has copies of PPO directories to help you find an in-network provider near you. Or, you can search for a provider on the internet by typing in [www.carefirst.com](http://www.carefirst.com).

## PLAN COMPARISON AT A GLANCE

	Preferred Provider Organization (PPO)	Health Maintenance Organization (HMO)
<b>Options</b>	CareFirst PPO	Kaiser Permanente or BlueChoice
<b>Description</b>	A PPO is a network of preferred providers. You may visit preferred providers at a contracted rate, or visit out-of-network providers and pay coinsurance for covered services.	Must visit providers in the HMO and select a primary care physician to coordinate care.
<b>Restrictions</b>	Available at Open Enrollment only to employees with at least 36 months of service beyond the probation period.	Available at conclusion of probationary period.
<b>The Plan Pays</b>	Generally, PPO covered services are paid at 100% of the Allowance. Out-of-network covered services are paid at 75% of the Allowance.	The full cost for covered services, minus your copayment, if applicable.
<b>You Pay</b>	A copayment or a percentage of the cost (your coinsurance), if applicable. If you visit an out-of-network provider, you are also responsible for paying the amount, if any, that the provider charges that is more than the PPO Allowance.	A copayment for services, if applicable.
<b>Deductible</b>	None for PPO providers. For out-of-network providers, \$300 per individual or \$600 per family.	None
<b>Filing Claims</b>	The PPO provider will file claims for you. You may have to file claims if you use an out-of-network provider.	The HMO provider will file claims for you.

### Health Maintenance Organizations (HMOs)

Health Maintenance Organizations (HMOs) are managed health care programs that provide health care services through a system of healthcare network facilities.

Through an HMO, you select a primary care physician who becomes familiar with your health status and medical needs, then treats you or refers you to specialists in the HMO when necessary.

Depending on the provider you see and the services you receive, an HMO generally has lower out-of-pocket costs than a PPO. If you elect an HMO, you can see only the physicians that are associated with the HMO plan to receive benefits. The Plan contracts with two HMO plans—**Kaiser Permanente** and **BlueChoice**.

<b>YOUR MEDICAL BENEFITS</b>				
<b>Covered Service</b>	<b>Kaiser Permanente HMO*</b>	<b>Blue Choice HMO</b>	<b>CareFirst PPO In-Network</b>	<b>CareFirst PPO Out-of-Network**</b>
<b>Annual Deductible</b>	None	None	None	\$300 per individual \$600 per family
<b>Office Visits</b>	No charge	No charge	\$10 copayment per visit	Plan pays 75% of allowance after deductible
<b>Hospital Stays</b>	No charge	No charge	No charge (from day 1 to 365)	Plan pays 75% of allowance after deductible
<b>Outpatient Hospital Visits</b>	No charge	No charge	No charge	Plan pays 75% of allowance after deductible
<b>Physician Expenses</b>	No charge	No charge	No charge	Plan pays 75% of allowance after deductible
<b>Surgery</b>	No charge	No charge	No charge	Plan pays 75% of allowance after deductible
<b>X-Rays and Labs</b>	No charge	No charge	No charge	Plan pays 75% of allowance after deductible
<b>Emergency Care</b>	\$35, waived if admitted	\$25	No charge	Plan pays 75% of allowance after deductible
<b>Well-Child Care</b>	No charge	No charge	\$10 per visit copayment (birth to age 17)	Plan pays 75% of allowance after deductible (birth to age 17)
<b>Mammograms and Annual Pap Tests</b>	No charge	No charge	No charge	Plan pays 75% of allowance after deductible
<b>Mental Health Inpatient Care</b>	No charge up to 45 days	No charge up to 45 days per calendar year. (May substitute 2 partial hospitalization for 1 full inpatient day)	No charge up to 45 days per calendar year	Plan pays 75% of allowance after deductible up to 45 days per calendar year
<b>Mental Health Outpatient Care</b>	No charge	No charge	25% of allowance up to 40 visits, 40% after that.	Plan pays 75% of allowance after deductible up to 40 visits, 60% after that
<b>Substance Abuse Inpatient Care</b>	No charge up to 30 days	No charge	No charge	Plan pays 75% of allowance after deductible
<b>Substance Abuse Outpatient Care</b>	No charge up to 30 days	No charge	No charge	Plan pays 75% of allowance after deductible
<b>Hospice Care</b>	No charge	No charge	No charge up to 180 days Hospice eligibility period. Inpatient care limited to 60 days per Hospice Eligibility period	Plan pays 75% of allowance after deductible
<b>Chiropractic Care</b>	\$15 copay up to 20 visits	No charge, up to 20 visits per calendar year	25% of allowance plus \$10 copayment	Plan pays 75% of allowance after deductible
<b>Physical Therapy</b>	90 days	No charge, up to 60 visits per calendar year	\$10 per visit copayment	Plan pays 75% of allowance after deductible

\* Benefits for Kaiser enrollees who are retired and Medicare-eligible differ in some respects from the benefits for active employees and pre-Medicare retirees.

\*\* Remember, 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.

### Your Medical Benefits

The chart at left summarizes the amounts paid for the stated covered services. This is only a brief summary—please refer to your benefit booklet from the carrier (Kaiser Permanente or CareFirst) for more detailed information about covered benefits and limitations. If you have any question about coverage for a particular service, call Kaiser, CareFirst or the Health and Welfare office to find out about benefits payable for that service (See contact information on page iii).

### Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal (or state) 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 may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay up to 48 hours (or 96 hours).

### Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have 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;
- Protheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to medical and surgical benefits provided under this Plan.

### Limitations and Exclusions

Covered medical services must be medically necessary as determined under the rules of the carrier. Cosmetic procedures and experimental procedures are generally not covered. In addition, some medical services may be subject to exclusion, limitation or prior authorization for medical necessity. Refer to the benefit booklet from your carrier or contact your carrier for more details.

## Your Prescription Drug Benefit

### FAST FACTS:

- ▶ Each medical plan offers a prescription drug program that provides a pharmacy and a mail delivery option for you.
- ▶ 90-day prescriptions for maintenance medications can be purchased through the mail for a small copayment.
- ▶ If you are a BlueChoice or CareFirst PPO participant, you will save money if you ask for the generic version for your prescription medication, if available.

No matter which medical plan you elect, prescription drug coverage is included for you and your family. You can purchase your prescription medications at a pharmacy or through a mail order program.

Generally, you can fill a prescription for up to a one-month supply at a retail pharmacy. If you use mail order, your prescription can be filled for up to 90 days. If you are on medication that you must take on a regular and continuing basis, like blood pressure or cholesterol medication, you will pay less by getting your prescription filled at mail order because one co-payment can purchase a 90-day supply.

If you are in the Kaiser or CareFirst HMOs, your prescription drug ID card is the same as your medical ID card. If you are in the PPO, your prescription drug ID card is a separate card provided by Prescription Solutions.

When you visit a network pharmacy, you will need to present your ID card and pay a copayment for each prescription.

Many pharmacies participate in the above networks. If you fill a prescription at a non-participating pharmacy, you are responsible for the entire charge by the pharmacy if you are a Kaiser Permanente HMO participant. If you are in the CareFirst HMO or PPO, you will generally pay in full for the prescription; then you must file a claim with your prescription drug program to be reimbursed for the allowed amount.

### Limitations and Exclusions

Covered prescription drugs must be medically necessary as determined under the rules of the carrier. In addition, certain prescription drugs may be subject to exclusions, limitations or prior authorization for medical necessity. Refer to the benefit booklet from your carrier or contact your carrier for more details.

If your medical plan is:	Your prescription drug program is:	Your Co-Payment is:	
		Retail	Mail Order
Kaiser Permanente HMO	Kaiser Permanente	\$3 at Kaiser facilities; \$10 at participating pharmacies	\$3
BlueChoice HMO	Argus	\$5 Generic / \$8 Brand	\$5
CareFirst PPO	Prescription Solutions	\$5 Generic / \$15 Brand	\$5 Generic / \$15 Brand

## Vision Care

### FAST FACTS

- ▶ Vision benefits include eye exams, frames, lenses for glasses and contact lenses.
- ▶ The vision plans offer annual eye exams for you and your family.

Routine eye exams and eyewear are provided by all three medical plans for you and your family.

Your medical coverage comes with a vision plan. Your vision plan benefits depend on which medical plan you have elected.

### Your Vision Benefits At-A-Glance

The chart below shows the amount that you pay for vision benefits, depending on the health care plan you have elected.

If your medical plan is:	Your vision care program is:
Kaiser Permanente HMO	Kaiser Vision (and also National Vision Administrators)
BlueChoice HMO	Davis Vision
CareFirst PPO	Davis Vision

### Limitations and Exclusions

Refer to the benefit booklet from your carrier or contact your carrier for limitations and exclusions to vision care services.

	Kaiser Vision*	CareFirst HMO - Davis Vision	CareFirst PPO - Davis Vision
Eye Exams	No charge when you use Kaiser HMO	\$10 copayment for routine eye exam done by optometrist or ophthalmologist without a referral from your primary care physician	\$10 copayment for routine eye exam done by optometrist or ophthalmologist without a referral from your primary care physician. Out of network, Plan pays \$20 allowed benefit, you pay balance.
Lenses	Single vision lenses you pay \$30 (\$31 plastic) Bifocals you pay \$41.00 (\$45.00 plastic) Trifocals you pay \$50.00 (\$55.00 plastic) Lenticular you receive a 25% discount	Single vision lenses you pay \$35 Bifocals you pay \$55 Trifocals you pay \$65 Lenticular you pay \$110	Single vision lenses you pay \$35 Bifocals you pay \$55 Trifocals you pay \$65 Lenticular you pay \$110
Frames	You select any frame type from a participating NVA provider and pay the wholesale price plus 50%. (You save because retail price is often 3 times the wholesale cost.)	Priced up to \$70 retail, you pay \$40; Priced above \$70 retail, you pay \$40 plus 90% of the amount over \$70	Priced up to \$70 retail, you pay \$40; Priced above \$70 retail, you pay \$40 plus 90% of the amount over \$70
Contact Lenses	Discount on contact lenses when purchased at a participating NVA vision center	Contact lens evaluation and fitting, you pay 85% of retail price Conventional Lens, employee pays 80% of retail price	Contact lens evaluation and fitting, you pay 85% of retail price Conventional Lens, you pay 80% of retail price
Laser Surgery	Discount provided through TLC for laser surgery for Kaiser Permanente members	25% discount on allowance	25% discount on allowance

\* If you are enrolled in Kaiser, you will receive a National Vision ID card which provides a vision benefit program through National Vision Administrators.

## Dental Care

### FAST FACTS

- ▶ In order to elect dental coverage, you must be enrolled in one of the Plan's medical plan options.
- ▶ The Plan offers three dental care plans for active employees:
  - The CIGNA Dental DHMO;
  - CareFirst Dental; and
  - CareFirst Dental with Orthodontia.
- ▶ Retirees are provided dental coverage through Delta Dental provided they remain enrolled in a medical plan.

Your Health and Welfare Plan offers dental benefits for you and your family.

### CIGNA Dental Health Maintenance Organization

The CIGNA Dental Health Maintenance Organization (DHMO) is a network of dentists and dental care providers. If you elect dental coverage through the CIGNA Dental DHMO, you must select a dental care provider from within the DHMO network in order to receive benefits. This dentist will serve as your primary dental care provider and will coordinate your care.

#### NEED TO FIND A PROVIDER IN THE DMO?

The Health and Welfare office can provide you with a DHMO directory of providers. Or, visit [www.cigna.com](http://www.cigna.com) to find a provider online.

The DHMO provides preventive services, like exams and cleanings, at no charge. Other procedures require a copayment (refer to the "Patient Charge Schedule" in your CIGNA DHMO booklet for exact amounts). Also, there are no claim forms to file—your network dentist will submit your claims for you.

There is no annual limit (annual benefit maximum) on the services you can receive when you use the DHMO. Refer to the chart on page 31 for more information.

### Orthodontia

The DHMO provides orthodontia benefits for both children and adults. In 2006, adults are responsible for a copayment of \$2,590 for a 24-month treatment plan. For children, the copayment is \$2,090 for a 24-month treatment plan. Retainers and related orthodontic expenses are covered according to the Patient Charge Schedule. To find out more about the CIGNA DHMO plan, visit [www.cigna.com](http://www.cigna.com).

### CareFirst Dental

The CareFirst Dental plan offers you the freedom to visit any dental care provider you would like and still receive benefits for covered services. However, if you take advantage of the network and use a participating CareFirst dental provider, your savings will be greater.

Most covered services are paid at 80% of the Allowance established by CareFirst with its providers. You pay 20% of the program Allowance. If you use a non-participating dentist, you are also responsible for charges in excess of the network Allowance.

The Plan will pay up to \$3,500 per individual each year for dental services (annual benefit maximum). If you reach that limit, you will be fully responsible for the remainder of the charges you incur for the rest of the year.

	<b>CIGNA Dental DHMO (Employees)</b>	<b>CareFirst Dental (Employees)</b>	<b>CareFirst Dental with Orthodontia (Employees)</b>	<b>Delta Dental (Retirees Only)</b>
<b>Annual Deductible</b>	None	None	None	\$100 per individual; \$300 per family (maximum)
<b>Annual Maximum Benefit</b>	None	\$3,500 individual	\$3,500 individual	\$1,000
<b>Preventive Services</b> (Exams and Cleanings)	No charge	No charge when you visit a participating dentist	No charge when you visit a participating dentist	Plan pays 50% of allowance
<b>Basic Restorative Services</b> (Fillings)	No charge or copayment*, depending on type of procedure	Plan pays 80% of allowance	Plan pays 80% of allowance	You pay 50% of R&C charges; Plan pays 50% of allowance
<b>Major Restorative Services</b> (Stainless Steel Crowns)	Copayment*	Plan pays 80% of allowance	Plan pays 80% of allowance	Not covered
<b>Root Canal</b>	Copayment*	Plan pays 80% of allowance	Plan pays 80% of allowance	Plan pays 50% of allowance
<b>Extractions</b> Single Tooth Partial Bony Impaction	Copayment*	Plan pays 80% of allowance	Plan pays 80% of allowance	Plan pays 50% of allowance
<b>Complete Mandibular Dentures</b>	Copayment*	Plan pays 80% of allowance	Plan pays 80% of allowance	Not covered
<b>Orthodontia</b>	Adult: \$2,590 for a 24-month treatment plan Child: \$2,090 for a 24-month treatment plan	Not covered	Plan pays 50% of Allowance to a lifetime maximum of \$1,000	Not covered
<b>Crowns and Bridges</b>	Five-year replacement	Ten-year replacement	Ten-year replacement	Not covered

\*Copayments apply to certain services. Refer to your CIGNA DHMO Patient Charge Schedule for exact copayment amounts.

### CareFirst Dental With Orthodontia

You have the option to elect coverage for orthodontia through CareFirst Dental. CareFirst pays 50% with a separate \$1,000 lifetime maximum benefit per participant.

### Your Dental Benefits At-A-Glance

The chart above shows the amount that you must pay for dental services.

### Limitations and Exclusions

Covered services must be medically necessary as deter-

mined under the rules of the carrier. Cosmetic procedures and experimental procedures are generally not covered. In addition, certain procedures and appliances may be subject to prior authorization for medical necessity, or to limitations or exclusions. For example, dentures or other appliances can typically only be replaced after a certain number of years, depending on the reason for the replacement. Up to two routine dental exams are generally covered per year. Experimental procedures are also generally excluded. Refer to the benefit booklet from your carrier or contact your carrier for more details.

## Short-Term Disability

### FAST FACTS

- ▶ Short-term disability benefits are provided to help replace a portion of your income while you are out of work and recovering from your illness or injury.
- ▶ Under the short-term disability plan, you are eligible for \$170 per week for up to 26 weeks while you are disabled. When your short-term disability coverage period expires, you may be eligible for long-term disability. See page 34 for more information.

If you cannot work due to an illness, non-work-related injury or pregnancy, you may be eligible for short-term disability benefits through the Plan. The short-term disability benefit is self-administered.

Short-term disability benefits are paid to you if you suffer an illness or injury that does not occur while you are on the job. You will be eligible to receive \$170 per week during your disability for up to 26 weeks. Employee FICA taxes are deducted from your payment.

Short-term disability benefits begin after you have used all of your sick leave or after a waiting period of 30 days, whichever occurs later.

Benefits are payable only for periods during which you are certified as unable to perform the duties of your job by your attending physician. Physician certification may be required at least monthly. Periods of disability less than one week will be pro-rated based on a five-day work week.

Benefits are not payable if your disability is the result of:

- Injuries or diseases resulting from or sustained during service in the armed forces of the United States or any other nation;
- Injuries or diseases resulting from or sustained by you while in the service of another employer during a period of leave or absence or furlough from METRO; or
- Illness or injury caused or resulting directly or indirectly from the use of narcotics or from your criminal misconduct.
- If you become disabled due to a work-related illness or injury, you may be eligible for Workers' Compensation, or compensation under similar legislation.

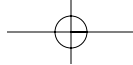
### Applying for Short-Term Disability Benefits

The medical compliance department of METRO will send the Health and Welfare office a referral when you approach the end of your waiting period. After the referral is received from the Medical Compliance Department of METRO, the Health and Welfare office will send you an application for short-term disability benefits.

### Continuing Your Health and Welfare Coverage While You are Disabled

While you are on short-term disability for any reason from METRO, you are required to make your Health & Welfare contributions directly to the Health and Welfare office prior to the first of the coverage month. The Health and Welfare office does not bill you or send notice that payment is due. If you do not make your payments, you will lose your medical coverage as well as your life insurance and your short-term disability coverage.

Your Health & Welfare contributions can be deducted from your short-term disability payments.



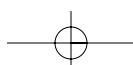
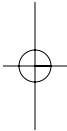
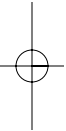
### **Collecting Disability Benefits While You Wait for a Worker's Compensation Appeal Determination**

If you agree to re-pay your benefits to the Plan if your injury or illness is compensable under Worker's Compensation or similar legislation, you can receive your disability pending the appeal determination.

### **When Disability Benefits End**

Your short-term disability benefits will end the earliest of the following: when you return to work, or are deemed able to return to work by your attending physician, when you retire, or when your maximum benefit of 26 weeks has expired.

Employees voluntarily participating in the Employee Assistance Program may be eligible for short term disability benefits for up to 26 weeks as long as they comply with the program.



## Long-Term Disability

### FAST FACTS

- ▶ Long-term disability coverage is provided to replace a portion of your income during your disability.
- ▶ Long-term disability coverage is provided automatically through METRO—you do not need to elect this coverage.

The Health and Welfare office administers the long-term disability program under a policy maintained by the Transit Employees Retirement Plan.

If you are unable to work due to a disability that lasts longer than 180 days, you may be eligible for long-term disability coverage through this Plan.

### How Long-Term Disability Benefits Work

Long-term disability coverage protects you against loss of income if you are totally disabled for more than 180 days.

After you have filed a claim and have been disabled for a period of at least 180 days, you will be paid 60% of your base monthly earnings up to \$5,000 per month during your disability. However, note that the amount you receive will be reduced by any other income you receive, like Social Security, pension benefits and workers' compensation.

### Eligibility

To be eligible for long-term disability:

- Your period of disability begins while you are an active employee (not retired);
- You must have been totally disabled (as defined below) for a period of at least 180 days; and
- You must be off probation, and regularly scheduled to work at least 30 hours per week full-time or at least 12 hours per week part-time.

### Definition of Disabled

"Disabled" or "Disability" means that, due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment from a doctor on a continuing basis and:

- During the 180-days of continuous disability before your long-term disability benefit begins and the 24-month period of time after that (or 12-month period, if you are a part-time employee) you are unable to earn more than 80% of the salary that you earned before your disability occurred, in the same job; ("own occupation" rule) and
- After the 24-month period (or 12-month period, if you are a part-time employee) you are unable to earn more than 80% of the salary that you earned before your disability occurred in any job for which you are reasonably qualified based on your training, education, experience and former salary ("any occupation" rule).

## Duration of Long-Term Disability Benefits

Your long-term disability benefits are paid according to the chart below.

Your Age on the Date Your Disability Starts	Benefits Are Paid
Younger than age 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

## How to File a Claim for Long-Term Disability Benefits

The Medical Compliance Department of METRO sends the Health and Welfare office a referral after you have been off work for 13 weeks, which starts the information gathering process for the LTD application. If you have been off work for 4–5 months and have not received an application for Long-Term Disability, you may wish to contact the Medical Compliance Department of METRO to ensure that they have sent the Health and Welfare office the necessary referral. You have one year from your last day worked to file a claim for long term disability benefits.

You will need to provide MetLife with:

- Proof of your disability;
- Evidence of continuing disability;
- Proof that you are under the appropriate care and treatment of a doctor throughout your disability;
- Information about other income benefits; and
- Any other material information related to your disability that is requested, including:
  - The date the disability started;
  - The cause of the disability; and
  - The prognosis of the disability.

Refer to your MetLife Long-Term Disability Plan booklet for more information.

**Please Note:** Questions related to coordination of your long-term disability payment with payments from the Transit Employees Retirement Plan should be directed to the Retirement Plan.

## Life and Accident Insurance

### FAST FACTS

- ▶ Full-time active and part-time employees are automatically provided with basic life insurance and accidental death insurance.
- ▶ Retirees are automatically provided life insurance.
- ▶ Your designated beneficiary is eligible to receive a lump-sum benefit upon your death.
- ▶ To change your beneficiary designation, contact the Health and Welfare office.

Your designated beneficiary will be eligible for a benefit from this Plan if you die while you are an employee or retiree and you are covered by the Health and Welfare Plan.

The Health and Welfare Plan provides both basic life insurance and an additional benefit for accidental death or dismemberment. Under certain conditions you may also be eligible to receive up to half of your life insurance benefits if you are terminally ill. You may also purchase supplemental life insurance at your own expense. Your insurance booklet provides full details.

The amount of the benefit that your beneficiary is eligible to receive is based on your work status and the other coverage that you have, as shown in the chart below.

### Supplemental Life Insurance

Full-time active employees can elect an additional \$10,000 in supplemental life insurance without evidence of insurability. In addition, full-time active employees can elect up to \$250,000 in supplemental life insurance with evidence of insurability.

You pay the full cost of this program. Premiums for this supplemental coverage will be deducted from your pay. Rates are available with the enrollment material and change from time to time. The rates are expressed in cents per thousand. If you elect \$20,000 in supplemental life insurance and you are 37 years old, you would pay \$1.80 per month (20 x \$0.09 / \$1,000).

### Supplemental Life Insurance Exclusion

The supplemental life benefit is not payable if you commit suicide within two years of obtaining the coverage.

Your Work Status	Life Insurance Benefit	Accidental Death Benefit*	Available Supplemental Life Insurance
Active Full-Time Employees	\$50,000	\$50,000	Without evidence of insurability, an additional \$10,000. With evidence of insurability, up to \$250,000.
Active Part-Time Employees with Medical / Vision and Dental Coverage from the Plan	\$50,000	\$50,000	Without evidence of insurability, an additional \$10,000. With evidence of insurability, up to \$250,000.
Active Part-Time Employees without Medical / Vision and Dental Coverage from the Plan	\$25,000	None	\$35,000
New Service Employees	\$20,000	None	None
Retired Employees	\$10,000	None	None

\* The dismemberment benefit is a percentage of the accidental death benefit up to 100% based upon the nature of the loss. See your certificate for details.

## Accidental Death & Dismemberment Exclusions

The accidental death and dismemberment benefit is not payable for any loss caused or contributed to by:

1. physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
2. infection, other than infection occurring in an external accidental wound;
3. suicide or attempted suicide;
4. intentionally self-inflicted injury;
5. service in the armed forces of any country or international authority, except the United States National Guard;
6. any incident related to:
  - travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
  - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
  - parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self preservation;
  - travel in an aircraft or device used:
    - for testing or experimental purposes;
    - by or for any military authority; or
    - for travel or designed for travel beyond the earth's atmosphere;
7. committing or attempting to commit a felony;
8. the voluntary intake or use by any means of:
  - any drug, medication or sedative, unless it is:
    - taken or used as prescribed by a Physician, or
    - an "over the counter" drug, medication or sedative taken as directed;
  - alcohol in combination with any drug, medication, or sedative; or
  - poison, gas, or fumes;
9. war, whether declared or undeclared; or act of war, insurrection, rebellion.
10. We will not pay accidental death and dismemberment benefits for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident. Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

## Life Insurance: Conversion Option for You

If your life insurance ends for any of the reasons stated below, you have the option to buy an individual policy of life insurance from the insurance carriers in accordance with the time limits, conditions and requirements as described in the insurance booklet. This is referred to as the "option to convert". Evidence of your insurability will not be required.

You will have the option to convert when your life insurance ends because:

- You cease to be in an eligible class;
- Your employment ends;
- The group policy ends, provided you have been insured for life insurance for at least five years; or
- The group policy is amended to end life insurance for an eligible class of which you are a member provided you have been insured for life insurance for at least five years.

## If You Die Within 31 Days After Your Life Insurance Ends

If you die within 31 days after your life insurance ends, proof of your death must be sent to the Health and Welfare office. When we receive such proof with the claim, we will review the claim and if we approve it will pay the beneficiary the amount of life insurance you were entitled to convert.

## Designating a Beneficiary

You may choose anyone to be the beneficiary for your life insurance / accidental death insurance benefit; however, this person's name must be on file with the Health and Welfare office in order to be valid. You may also choose separate beneficiaries for your basic life insurance and for your supplemental life insurance.

Make sure your beneficiary designation is up to date. To make any changes, contact the Health and Welfare office.

## Coordination of Benefits

### FAST FACTS

- ▶ You must report any duplicate group health coverage for yourself and/or your dependents on any claim you submit.
- ▶ This Plan will coordinate benefits with coverage that you receive from other sources, such as Medicare.

Members of a family are often covered under more than one group health plan, which could result in duplication of health coverage. To avoid this, the health care benefits provided by this Plan are coordinated with similar benefits payable under other plans.

Under the Coordination of Benefits provision, if you are covered under any other group health plan, the total payment you receive from all programs may not be more than 100% of the "allowable expenses." Allowable expenses are the necessary and reasonable expenses for treatment or supplies covered by the plan.

The plan under which benefits are payable first is the primary plan. All other plans are called secondary plans. In general, the Plan that covers you as an employee is primary.

The coordination rules are specific to each carrier and you should direct any questions to the carriers.

### Medicare

This Plan coordinates with Medicare. If you are an active employee, this Plan is primary and Medicare is secondary. For Covered Persons who have Medicare coverage due to End Stage Renal Disease (ESRD) this Plan will be primary for a period of up to 30 months starting with the first month of ESRD-based eligibility, and then Medicare will be primary. Contact the Health and Welfare office for more information.

If you are retired and Medicare eligible, Medicare is primary. If you are retired (or a dependent of a retiree) and you are Medicare eligible, this Plan will coordinate as if you are enrolled in both Part A and Part B of Medicare, even if you have not enrolled in Medicare.

### Motor Vehicle No-Fault Coverage Required by Law

If you are covered by both this Plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and this Plan pays second.

### Workers' Compensation

This Plan does not provide benefits if the medical expenses are covered by Workers' Compensation or similar legislation.

### Subrogation

You or one of your eligible dependents may incur medical expenses in a situation where a third party—for example, Workers' Compensation or an auto insurance carrier—may be held responsible for their payment. Like Coordination of Benefits, the rules for subrogation are determined by each carrier.

## Filing Your Claims

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures. Claim filing procedures will depend on the type of benefit and the carrier.

Claims for medical, prescription drug, dental and vision benefits follow the procedures required by each carrier. Questions about claim filing procedures should be directed to the carrier. Refer to page iii for carrier contact information. Generally, if you use a network provider, your hospital, doctor or other healthcare provider will file your claim directly with the carrier.

General inquiries about the Plan's provisions that are unrelated to any specific benefit claim or requests to add or improve the Plan's benefits will not be treated as a claim for benefits. In addition, a request for pre-approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

### When Claims Must Be Filed

Each carrier has its own requirements for timely filing of claims. Claims should be filed as soon as practical after the date the charges were incurred.

Failure to file claims within the time required shall not invalidate or reduce any claim if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than one year from the date the charges were incurred.

### Claims Communications

All claims communications will be addressed to and sent to the Plan participant at the address on file with the Health & Welfare office unless the patient makes a written request to the Health and Welfare office or to the carrier specifically requesting that any claims communications be sent under the patient's name and/or to a different address.

### Short Term Disability Claims

Generally, the claim process for short-term disability benefits starts after the Medical Compliance Department of METRO sends the Health and Welfare office a referral when you approach the end of your waiting period. After the referral is received from the medical compliance department of METRO, the Health and Welfare office will send you an application for short-term disability benefits.

You must file a claim for short-term disability benefits with the Health and Welfare office no later than two years after the date your disability began.

For short-term disability claims, the Plan will make a decision on the claim and notify you of the decision within 45 days. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within 30 days of the time the Plan notifies you of the delay. The period for making a decision may be delayed an additional 30 days, provided the Plan administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Plan's request for the information, you will be notified of the Plan's decision on the claim, or the need for an extension, within 30 days.

### Notice of a Denied Claim

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the determination.
- Reference to the specific Plan provision(s) on which the determination is based.
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary.
- A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits.
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

### Long-Term Disability Claim

Since 2001 the Long-Term Disability Insurance policy is part of the Transit Employees Retirement Program. However, the Health & Welfare office still plays a role in helping you complete your application.

#### How to File a Claim for Long-Term Disability Benefits

You will need to contact both MetLife and the Medical Compliance Department of METRO to initiate your LTD benefits.

Generally, the claim process for long term disability benefits starts when the Medical Compliance Department of METRO sends the Health and Welfare office a referral after you have been off work for 13 weeks. After the referral is received from the Medical Compliance Department of METRO, the Health and Welfare office coordinates with other departments of METRO to gather information that MetLife will need to process your application. After all the necessary departments of METRO have responded, your information is sent to MetLife and you are mailed an application for benefits. If you have been off work for 4–5 months and have not received an application for Long-Term Disability, you may wish to contact the Medical Compliance Department of METRO to ensure that they have sent the Health and Welfare office the necessary referral.

You will need to provide MetLife with:

- Proof of your disability;
- Evidence of continuing disability;
- Proof that you are under the appropriate care and treatment of a doctor throughout your disability;
- Information about other income benefits; and
- Any other material information related to your disability that is requested, including:
  - The date the disability started;
  - The cause of the disability; and
  - The prognosis of the disability.

Refer to your MetLife Long-Term Disability Plan booklet for more information.

Any questions about how your Long Term Disability benefits integrate with your pension benefits, should be directed to the benefits branch at METRO.

### Appeal Process for Denied Claims

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may appeal the decision.

Generally, the Plan relies on the carriers that administer its various benefit plans to process claims and appeals, and your first level of appeal is to the carrier. If your appeal relates to the Short-Term Disability Plan, this is a benefit administered directly by the Fund and your first appeal must be directed to the Health and Welfare office.

If you have completed at least the first level appeal procedure with the appropriate carrier, and you believe the judgment of the carrier to be in error, you may ask the Health and Welfare office in writing to review your claim. This request for review must be made within 60 days of the first notice of denial from the carrier. While the Health and Welfare office reviews your claim, you must continue to pursue any additional levels of appeal provided in the carrier's internal appeals process. The Health and Welfare office will review the information

you provide and contact the carrier, if necessary, for additional information. The results of the Health and Welfare office review will be communicated to you verbally or in writing within 15 days of your request for a review. The results of any additional steps in the carrier's internal appeals process will be communicated to you as described in the carrier booklet.

If you are still dissatisfied and have exhausted the carrier's appeals process (if applicable), you may file a written appeal to the Board of Trustees. Your written appeal must be received by the Health and Welfare office within 180 days after you receive your final denial from the carrier, or the result of the Health and Welfare office review.

The Health and Welfare office will acknowledge receipt of your appeal within 15 days and may at that time request additional information. The Board of Trustees will review your appeal at the Board meeting following receipt of your appeal. Although if there is less than five business days between receipt of your appeal and the Board meeting, your appeal may be reviewed by the Board at the next following Board meeting.

The Board will make a determination of your appeal or determine that more information is needed, and will notify you in writing within five business days following the Board meeting. If additional information is requested, you will have up to 60 days to provide it or to indicate that the information cannot be provided; the Board will make a final determination at the Board meeting following the expiration of the 60 day period or the receipt of the information, whichever occurs first. The Board will notify you in writing of its decision within five business days.

### **Notice of Decision on Review**

The Board's decision on your appeal will be given to you in writing. The notice will state:

- The specific reason(s) for the determination.
- Reference to the specific Plan provision(s) on which the determination is based.
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your appeal, upon request and free of charge.
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

## Plan Facts

Name of Plan	Transit Employees' Health and Welfare Plan
Type of Plan	An Employee Health and Welfare Benefit Plan that provides medical care, coverage for prescription drugs, dental care, vision care, disability benefits, life insurance and accidental death and dismemberment benefits to eligible members and their qualified dependents.
Health and Welfare Office Address	2701 Whitney Place Forestville, Maryland 20747
Agent for Service of Legal Process	Service of legal process may be made upon the Executive Director of the Health and Welfare office.
Plan Administrator	Board of Trustees
Type of Administration of the Plan	Self- and Fully-Insured
Plan Fiscal Year	Calendar Year
Sources of Financing	Employer and Employee Contributions

### The Board of Trustees

The Board of Trustees is made up of an equal number of Employer Representatives and Union Representatives. Under a Trust Agreement, the Board has full authority and discretion to operate and administer this Plan, subject to the provisions of the collective bargaining agreement.

### Discretionary Authority of the Board of Trustees and its Designees

In carrying out their respective responsibilities under the Plan, the Board of Trustees, the Plan Administrator and other individuals with delegated responsibility for the administration of the Plan will have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

### Right of Recovery and Overpayments

The Fund shall have the right to recover, through any legal means, including litigation or offset, any amounts paid in excess of the Plan allowances or any amount in excess of the amount necessary at the time, in accor-

dance with the Plan's allowances and rules, to satisfy the claim submitted.

In particular, but not by way of limitation, the Trustees specifically retain the right to recover all moneys paid in error to, or on behalf of, any person from either that person or the Member upon discovery of a payment made in "error". Upon failure to repay the amount due within a reasonable time after notification, the Trustees may take such legal action as they deem appropriate, or deduct payment of eligible claims in the future until such claims equal the amount due the Fund. In this regard, the Fund also reserves the right to reduce subsequent family members' benefit payments to repay amount paid in error.

### Plan Amendment and Termination

The settlors (WMATA and ATU Local 689) reserve the right to terminate or amend the Plan including the right to amend or terminate benefits or eligibility for any class of participant, including retirees, when in their sole discretion they determine such action is in the best interest of the Plan and its participants. Eligibility requirements are reviewed regularly by the Trustees.

The Plan may also be terminated if there is no longer an agreement in effect between the Employers and the Union requiring contributions to the Health and Welfare Plan.

#### **Privacy, Confidentiality, Release of Records or Information**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that the Health and Welfare Plan protect the confidentiality of your private health information. The Plan maintains a Notice of Privacy Practices which provides a complete description of your rights under HIPAA's privacy rules. You will receive a copy of the Notice once you enroll in the Plan or you may request an advance copy from the Health and Welfare office. This summary is not intended and cannot be construed as the Plan's Notice of Privacy Practices. In the event of any inconsistency between this summary and the Notice of Privacy Practices, the terms of the Notice control.

Once you are enrolled in the Plan, the Health and Welfare office and the Board of Trustees will not use or further disclose information that is protected by HIPAA (known as "protected health information" or "PHI") except as necessary for treatment, payment, healthcare operations, or as permitted or required by law. In particular, they will not, without your written authorization, use or disclose PHI for employment-related actions and decisions or in

connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities called, "Business Associates" to observe HIPAA's privacy rules. In some cases, you will receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that organization.

Under federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

If you have questions about the privacy of your health information, or if you wish to file a privacy violation complaint once you are covered under the Plan, please contact the Plan's Privacy Official at the Health and Welfare office.

## Glossary of Common Terms

**Allowance or Allowable Expense or Allowable Charges** is the amount that the PPO network recognizes as the appropriate charge by a provider for eligible health care expenses under the Plan. Providers in the PPO network used by the Plan have agreed to charge no more than the Allowable Expense. If you use Providers who are not in the network, you are responsible for charges that are greater than the Allowable Expense.

**Cafeteria Plan** is a benefits plan that allows participants a choice in designing his or her own benefit package by selecting different types and/or levels of benefits that are funded with nontaxable employer dollars.

**COBRA** stands for Consolidated Omnibus Budget Reconciliation Act of 1985. Through COBRA, you and/or your dependents can continue your health care benefits if you experience certain qualifying events that would otherwise cause you to lose your coverage under the Plan.

**Coinsurance.** Once you satisfy your deductible, if any, the Plan will pay a portion of the allowable charges you incur for eligible health care expenses. The remaining portion of the allowable charge is your share or "coinsurance" amount. Coinsurance applies to participants in the PPO Plan.

**Collective Bargaining Agreement** is a written agreement between a union and an employer that requires the employer to make contributions to the Plan on behalf of its employees.

**Copayment** is a fixed dollar amount that you must pay for certain services provided by the Plan. If you participate in an HMO, you must make a copayment at the time of the service.

**Deductible** is the amount you (and/or your family) must pay in medical expenses each year before the Plan will pay benefits for eligible health care expenses. HMO participants are not required to meet a deductible.

**Health Maintenance Organization or HMO** is a group of doctors and other medical professionals that offer care through the network for a flat monthly rate with no deductibles. However, only visits to professionals within the HMO network or referred by a network provider are cov-

ered by the policy. All visits to specialists or for other care need a referral from your HMO physician in order to be covered. A primary physician within the HMO handles referrals. A **Dental Health Maintenance Organization or DHMO** is a network of dentist and dental specialist that operates like an HMO.

**Lifetime Maximum** is the maximum amount of money the Plan will pay toward health care services while you are covered under this Plan.

**Maintenance Medications** are medications that you take on a regular basis to treat a chronic condition such as diabetes, high blood pressure or high cholesterol.

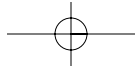
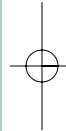
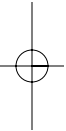
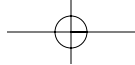
**New Service Agreement** is the Supplemental Agreement, a collective bargaining agreement between METRO and ATU Local 689.

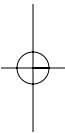
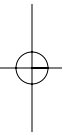
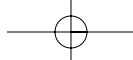
**Open Enrollment Period** is the period that occurs every two years in the even numbered years (2004, 2006, 2008 etc.) The current bargaining agreement permits you to change your benefit selections (i.e., switch to a different medical plan or dental plan, or enroll a dependent that you did not enroll within the required time frames when they first became eligible) during the Open Enrollment period.

**Out-of-Pocket Maximum** is the maximum amount of coinsurance plus deductible that you must pay for any allowable health care costs that are not covered by the Plan. Once you exceed the maximum, the Plan will pay 100% of your eligible medical expenses for the remainder of the calendar year.

**PHI or "Protected Health Information"** is information that the Plan has created or received regarding your health or payment for your health. It includes both your medical records and personal information such as your name, social security number, address, and other identifying information.

**Preferred Provider Organization (PPO)** is a network of providers that agree to accept the Plan's allowable charge for a particular medical service as payment in full. If you participate in the CareFirst PPO, you cannot be billed more than the allowable charge for a medical service when you visit a provider that participates in the PPO.





**Transit Employees' Health and Welfare Fund**

2701 Whitney Place  
Forestville, MD 20747

