DASH
ALEXANDRIA TRANSIT

2025-2026 Benefits Guide

Transit Management of Alexandria (TMA)

NON-UNION

Table of Contents

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Benefits Overview

Benefits at a Glance

BENEFITS	COVERAGE OPTIONS
COSTS SHARED BY YOU AND TMA	
Medical (Kaiser Permanente)	• Kaiser Permanente HMO Plan
Medical (UnitedHealthcare and CVS / CareMark)	• UnitedHealthcare Choice HMO • UnitedHealthcare Choice Plus POS • UnitedHealthcare Choice Plus HDHP with Health Savings Account (DASH Contributes $500 to Employee Only and $700 to Employee + 1 or Family) • CVS / CareMark Prescription included on both UHC plans
Dental (The Standard)	• Dental PPO Plan – Ameritas Network
BENEFITS PROVIDED BY TMA	
Basic Life and AD&D (The Standard)	• Operators and non-drivers if hired prior to 7/1/2009, 2x annual salary to maximum of $450,000 • Operators and non-drivers hired after 7/1/2009, 1x annual salary to maximum of $150,000
Short-Term Disability (The Standard)	• 60% of weekly earnings to $2,000
Employee Assistance Plan (The Standard)	• 24/7 Counseling
Vision (The Standard)	• Vision PPO Plan – EyeMed Insight Network
VOLUNTARY EMPLOYEE PAID BENEFITS	
Long-Term Disability (The Standard)	• 60% of monthly earnings to $5,000
Additional Life and AD&D for Employees (The Standard)	• Up to $300,000 in coverage
Additional Life and AD&D for Dependents (The Standard)	• Up to $150,000 coverage (spouse) • Up to $10,000 coverage (child/ren)
Healthcare FSA (HealthEquity)	• $3,300 maximum plan year contribution
Dependent Care FSA (HealthEquity)	• $5,000 maximum plan year contribution
Accident (The Standard)	• 4-Tier Rates
Critical Illness (The Standard)	• $20,000 or $10,000 Employee Benefit Elections
Hospital Indemnity (The Standard)	• 4-Tier Rates
Commuter Benefits (Smartbenefits)	• DASH provides up to $300 a month based on commuting distance for use on Metro, MARC, and more.
RETIREMENT PLAN	
401(k)	• PCS Retirement (DASH contributes 8% of your earnings to your account every pay period)

Want to learn more about your benefi ts? Scan the QR code or visit https://www.brainshark.com/gallagher/TMAlexOpenEnrollment2025 for an in-depth review!

Eligibility and Employee Resources

Flexible Solutions For Your Benefits Needs

We consider our employee benefits program to be one of our most important investments. Because we recognize the value our employees bring to our company, we are committed to providing you with a complete benefits program as part of your total compensation.

This guide has been prepared to assist you in making informed decisions regarding your employee benefits. We urge you to read this guide carefully and keep it as a reference. If you are well-informed, you will be better able to make the benefit choices that best meet your needs.

Employee Eligibility

All employees working at least 30 hours per week are eligible for group insurance benefits.

New hires: Your benefits are effective the 1st of the month following your date of hire.

Dependents Eligibility

Your eligible dependents include your legally married spouse, registered domestic partner, and children. Due to the Affordable Care Act, your medical, dental, and vision plans cover dependents to age 26. However, for other plans, age limits may apply.

Coverage may be available for a mentally or physically disabled child who is age 26 or older. Requirements for such coverage and documentation of disability depend on the insurance carrier. Please contact Human Resources if you believe this issue applies to your family

Benefit Advocacy Center

Gallagher Benefit Services provides a dedicated team of specialized representatives ready to assist DASH employees and dependents. Your Gallagher team is available to you Monday through Friday, 8 a.m. to 6 p.m. (ET).

Gallagher can support you as you utilize your employee benefits by providing education, resources and resolution to billing / claim issues. The licensed representatives will work with both providers and the insurance companies on your behalf while protecting the privacy of your healthcare information.

If you or your dependents have any questions, need assistance with selecting the right plan for you, or need assistance please call the Benefit Advocacy Center at **833.229.3752**.

When You Can Enroll

New Hires / Newly Eligible for Benefits

When you become eligible for benefits, you have 30 days to enroll. If you do not enroll within that time period, you will not be eligible for benefits until the next Open Enrollment, unless you have a Qualifying Family Status Change.

Open Enrollment

During Open Enrollment, you will have the opportunity to make changes to your benefit elections. You must enroll by the Open Enrollment deadline for your benefits to be effective July 1st. Except for a Qualifying Status Change, you will not be able to change your elections during the year until the next year's Open Enrollment.

Qualifying Status Change

If you have a qualifying family status change, you may be able to change your benefits before the next Open Enrollment. You must notify Human Resources within 30 days of the change

Qualifying Status Includes:

- Newly hired as full-time benefits-eligible
- Change in work schedule for you or your spouse (part-time to full-time)
- Change in employment for you, your spouse or dependent (i.e. your spouse loses their job and benefits)
- Change in marital status
- Change in dependents
- Change in benefits eligibility for you, your spouse or dependent
- Gaining other coverage through your spouse
- Loss of other coverage for your dependent
- Change in residence causing loss of coverage
- Federal and state family medical leave, if qualified
- Medicare or Medicaid entitlement for you, your spouse or dependent
- Qualified Medical Child Support Order (QMCSO)

Contact Human Resources for a complete explanation of qualifying family status changes.

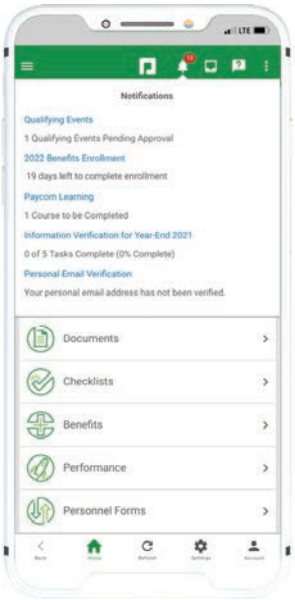
Show Me How

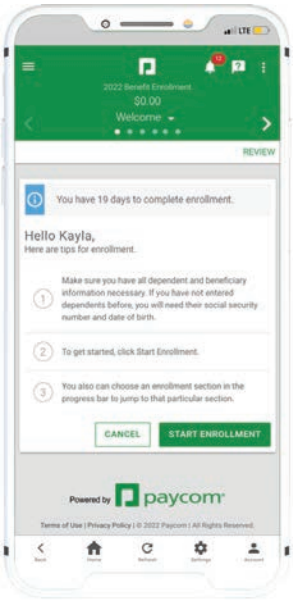
to Enroll in Benefits

BENEFITS ADMINISTRATION

STEP 1

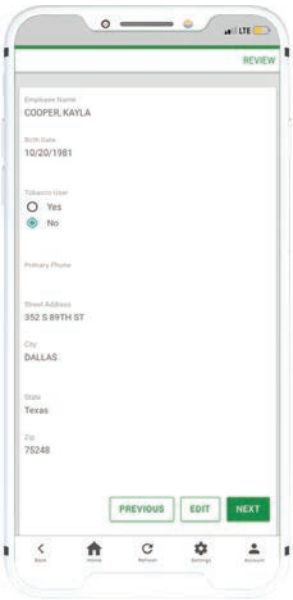
From the Notifications Center, tap the current year's Benefits Enrollment. Review the instructions and tap "Start Enrollment."





STEP 2

Review your information. Tap "Edit" to change anything or "Next" to continue.



EMPLOYEES

Visit the Help Menu for the most up-to-date version of this guide.

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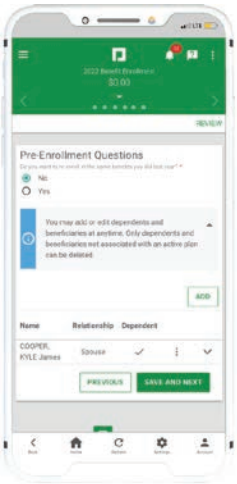
Show Me How
to Enroll in Benefits

BENEFITS ADMINISTRATION

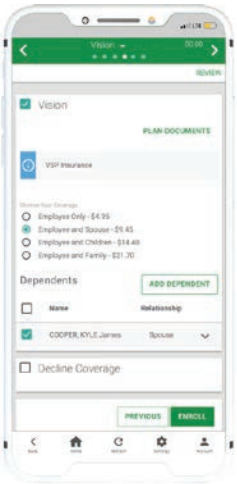
STEP 3

Complete the Pre-Enrollment Questions and tap "Save and Next." *You can also edit existing dependent and beneficiary information on this screen, as well as add a dependent or beneficiary.*



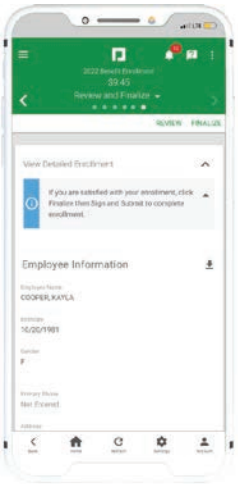
STEP 4

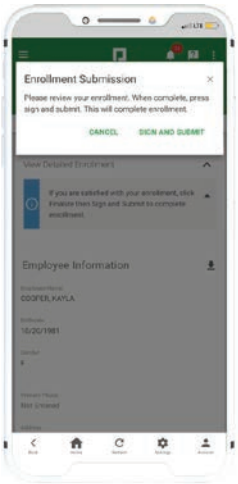
Choose to enroll in or decline a plan by checking the appropriate option. If necessary, choose which dependents to add. When finished, tap "Enroll." Continue for each benefit plan.



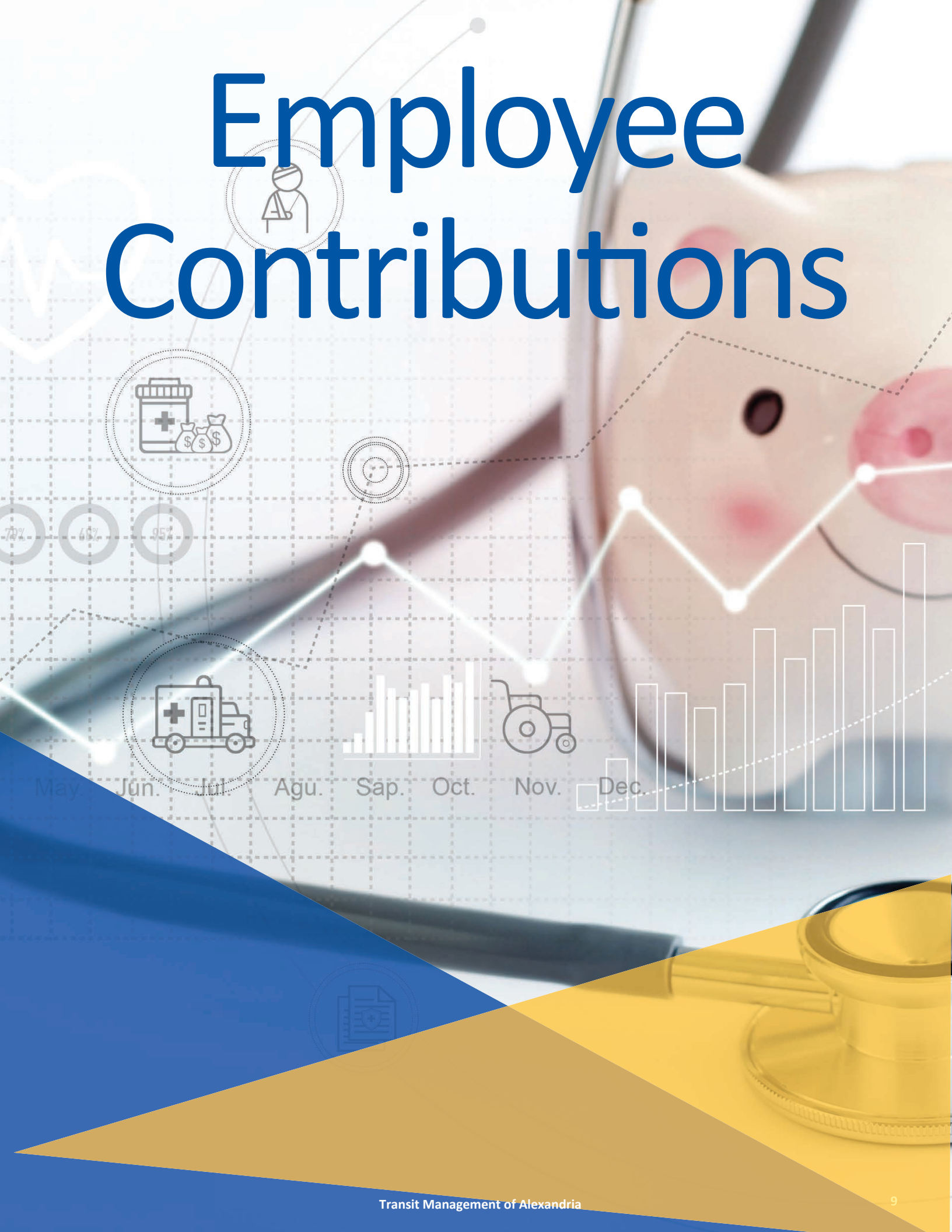
STEP 5

When finished, review your enrollment and tap "Finalize." Then, tap "Sign and Submit" in the pop-up window. *To view your current benefits at anytime, navigate to Benefits > Current Benefits.*





Employee Contributions



Employee Per Pay Contributions

MEDICAL	Kaiser Permanente	UnitedHealthcare		
	DHMO 20	Choice HMO	Choice + POS	Choice + HDHP
Employee Only	$32.47	$33.07	$47.70	$14.82
Employee + 1	$64.94	$65.92	$100.85	$63.02
Employee + 2 or More	$82.80	$84.71	$129.61	$81.58

DENTAL	The Standard
Employee Only	$1.94
Employee + 1	$2.74
Employee + 2 or More	$3.95

ACCIDENT	The Standard
Employee Only	$6.60
Employee + Spouse	$10.34
Employee + Child(ren)	$12.48
Family	$19.51

HOSPITAL INDEMNITY	The Standard
Employee Only	$8.72
Employee + Spouse	$18.44
Employee + Child(ren)	$16.94
Family	$28.50

The following benefits are offered to TMA employees at no cost:

- Vision Insurance
- Basic Life / AD&D Insurance
- Short-Term Disability Insurance
- Employee Assistance Program

The Standard Additional Life and AD&D along with Voluntary LTD will calculate in Paycom based on age and coverage amount.

Medical

Medical Plan Options

You have two medical carriers to choose from and you have a total of four plans from which to select your Medical coverage. Please note, the summaries included in this guide are not exhaustive and you should refer to your Certificates of Coverage for full details regarding your plans.

You decide which plan meets you and your family's needs:

Kaiser Permanente HMO
UnitedHealthcare Choice HMO
UnitedHealthcare Choice Plus POS
UnitedHealthcare Choice Plus HDHP with Health Savings Account

Kaiser Permanente HMO

If you choose the Kaiser Permanente option, you must visit Kaiser Permanente Centers for your medical needs. You must select a primary care physician who will manage your care and refer you to a specialist when it is needed. Most services are covered at 100% after you pay a copayment. For in-patient hospitalizations and emergency room needs, there are participating hospitals that you will be able to use that count as in-network benefits.

UnitedHealthcare Choice HMO

If you choose the Choice HMO option, you will have access to a national network. This plan is open access and allows you to see in-network physicians without referrals. You do not need to select a primary care physician. You must use in-network physicians; there is no out-of-network option.

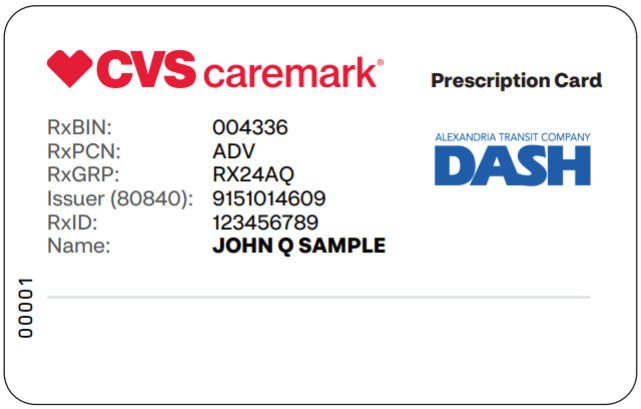
UnitedHealthcare Choice Plus POS

The PPO option provides an additional choice of providers. The in-network / contracted providers agreed to discount their fees for their services. You may choose to have your treatment provided by a PPO contracted provider and receive a higher level of benefit with a lower out-of-pocket cost to you. You may also choose to go outside the network/non-contracted provider; however, benefits are reimbursed at a lower level and you may have higher out-of-pocket costs.

UnitedHealthcare Choice Plus HDHP

The high deductible health plan (HDHP) costs you less from your paycheck, so you keep more of your money. This rewards you for taking an active role as a health care consumer and as a result could save you on your health care costs.

For those enrolling in either UnitedHealthcare plans, you will be automatically enrolled in CVS / CareMark Prescription coverage. You will receive two cards for coverage in the UnitedHealthcare / CVS CareMark plan.



Kaiser Permanente

HMO PLAN	
PLAN BENEFITS	**IN-NETWORK**
Plan Year Deductible (Single / Family)	$500 / $1,000
Coinsurance (Kaiser / You)	80% / 20%
Out-of-Pocket Maximum (Single / Family)	$3,000 / $6,000
Preventive Services	$0
Office Visits (Primary / Specialist / Virtual)	$20 (Waived for Children under 5) / $30 / $0
Lab / X-Ray (Non-Hospital)	$20
Complex Radiology (Non-Hospital)	20% After Deductible
Inpatient Hospital Services	20% After Deductible
Outpatient Surgery	20% After Deductible
Urgent Care	$30
Emergency Room (Waived if Admitted)	$100
Ambulance (Emergency Only)	$100
Physical (30 Visits)**, Speech, Occupational Therapy** (2 Months) Must be medically necessary	$30
Chiropractic (20 Visits Per Year)	$30
Acupuncture (20 Visits Per Year) Must be medically necessary	$30
MATERNITY	
Infertility Services / In Vitro Fertilization** (3 attempts)	50%
Pre-Natal and Post-Natal	No Charge
Delivery	20% After Deductible
Durable Medical Equipment	$0
Home Healthcare / Hospice Care	$0 / $0
MENTAL HEALTH AND SUBSTANCE ABUSE	
Inpatient	20% After Deductible
Outpatient	$25 Individual / $12 Group
PRESCRIPTION DRUGS	
Plan Year Drug Deductible	None
Tier 1 KP 30-Day / 90-Day Retail / 90-Day Mail Order // Par. 30-Day (i.e. prior authorization)	$20 / $60 / $40 // $30
Tier 2 KP 30-Day / 90-Day Retail / 90-Day Mail Order // Par. 30-Day (i.e. prior authorization)	$30 / $90 / $60 // $50
Tier 3 KP 30-Day / 90-Day Retail / 90-Day Mail Order // Par. 30-Day (i.e. prior authorization)	$45 / $135 / $90 // $60

**IVF – Member must have a history of infertility of at least 2 years duration or meet other criteria

Connecting With Kaiser

Start managing your health online on your time.

With Kaiser Permanente, **kp.org** is your connection to great health and great care. Once you register, you'll have easy access to time-saving tools and resources that help you stay on top of your health and keep you feeling great.

Managing your health anytime, from anywhere

Sign on anytime to:

- View most lab results
- Refill most prescriptions
- Email your doctor's office with non-urgent questions
- Schedule and cancel routine appointments
- Print vaccination records for school, sports, and camp
- Use tools to help you MANAGE your coverage and cost
- Manage a family member's healthcare

Step 1: Enter your plan information

Along with simple questions like your name and your birth date, you'll need to enter the medical record number/health record number printed on your plan ID card

Step 2: Accept the terms and conditions

Step 3: Create your user ID

Choose a user ID and enter your email address. After you're registered, you'll use this user ID to sign onto **KP.org**

Step 4: Secure your account

Complete the security steps online. After answering a few questions to confirm your identity, you'll create a password and pick 3 secret questions to help keep your account secure.

Step 5: Sign On

That's it! As soon as you have your password, you can sign on and start using the great features on **kp.org**.

Telehealth

Administered by Kaiser Permanente

Access by Phone, Email, or Video

Unlike other remote healthcare services, Kaiser Permanente gives you access to telehealth at **NO COST TO YOU**. 60% of KP's members say digital tools from KP have helped them save time by avoiding an office visit.

Talk to an advice nurse 24/7. Travel worry-free with support that goes wherever you go – whether you're on business in Tokyo or visiting Yosemite with the family.

Phone Appointments

SCHEDULE primary and specialist visits, wellness coaching, and more

- Primary Care Appointments
- Specialty Care Appointments

SCHEDULE follow-up care and specialist consults

- Wellness Coaching by Phone
- 24/7 access to medical professionals
- Consultation for urgent issues

Video

A faster path to face-to-face care

Routine and urgent primary care, dermatology, follow-up care, and more

Email

A core channel for staying connected

An easy way for members to get care and questions answered by their care team. Members can email their doctors' offices any time of day and get a response within 48 hours or sooner

Download the Kaiser Permanente app

Once you've registered, you can download the Kaiser Permanente app to your smartphone to access these tools on the go.

1. From your smartphone, go to your preferred app site.
2. Search for the Kaiser Permanente app, then download it for your smartphone.
3. Use your **kp.org** user ID and password to activate the app, and you'll be ready to go!

Registering is very easy

Go to **kp.org/registernow** from a computer (not a mobile device) and follow the sign-on instructions. You'll need your medical record number/ health record number, which you can find on your Kaiser Permanente ID card.

Support for emotional wellness

Try our on-demand self-care apps today at no additional cost

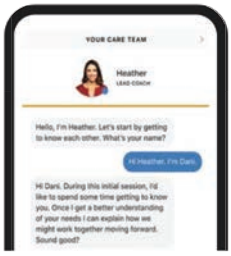
Get help with anxiety, stress, sleep, mood, and more. Anytime you need it.

Kaiser Permanente members can explore 3 evidence-based apps:[1,2,3]

Calm

The #1 app for meditation and sleep. You can choose from hundreds of programs and activities, including:

- Guided meditations
- Sleep Stories
- Mindful movement videos



ginger

1-on-1 emotional support coaching and self-care activities to help with many common challenges.

- Coaches are available by text 24/7
- You can use Ginger's text-based coaching services at no cost, no referral needed[4,5]

myStrength by Teladoc Health

myStrength Complete offers:

- Teletherapy with a licensed therapist—in the comfort of your own home
- Telecoaching via live video sessions with a certified coach
- Digital courses and content personalized for your interests and goals[6]

Visit kp.org/selfcareapps to get started.

[1] The apps and services described above are not covered under your health plan benefits, are not a Medicare-covered benefit, and are not subject to the terms set forth in your *Evidence of Coverage* or other plan documents. The apps and services may be discontinued at any time.

[2] The apps and services are neither offered nor guaranteed under contract with the FEHB Program, but are made available to enrollees and family members who become members of Kaiser Permanente.

[3] Calm can be used by members 13 and over. The Ginger app and services are not available to any members under 18 years old.

[4] Some individuals who receive health care services from Kaiser Permanente through state Medicaid programs are not eligible for the Ginger app and services.

[5] Eligible Kaiser Permanente members can text with a coach using the Ginger app for 90 days per year. After the 90 days, members can continue to access the other services available on the Ginger app for the remainder of the year at no cost.

[6] Psychiatry is not included in the myStrength Complete membership. myStrength Complete by Teladoc Health is available to members 18 and older who do not have a Maryland Medicaid health plan. Some of these services may not be covered under your health plan benefits and may not be subject to the terms set forth in your Evidence of Coverage or other plan documents. These services may be discontinued at any time without notice. myStrength® is a wholly owned subsidiary of Livongo Health, Inc.

Calm, Ginger, and myStrength Complete are not available to Kaiser Permanente Dental-only members.

Learn more at **kp.org/selfcareapps**.

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. 2101 E. Jefferson St., Rockville, MD 20852 2023ML0813 MAS 7/1/23-12/31/24

UnitedHealthcare – Choice HMO

CHOICE HMO	
PLAN BENEFITS	**IN-NETWORK**
Plan Year Deductible (Single / Family)	$400 / $800
Coinsurance (UHC / You)	90% / 10%
Out-of-Pocket Maximum (Single / Family)	$3,175 / $6,350
Preventive Services	$0
Office Visits (Primary / Specialist / Virtual)	$15 / $25 / $15
Lab / X-Ray (Non-Hospital)	Deductible, then $0
Complex Radiology (Non-Hospital)	Deductible, then $100
Inpatient Hospital Services (Per Stay)	Deductible, then $500
Outpatient Surgery (Non-Hospital)	Deductible, then $100
Urgent Care	$25
Emergency Room (Waived if Admitted)	Deductible, then $150
Ambulance (Emergency Only)	Deductible, then $0
Physical, Speech, Occupational Therapy	$25 (60 Visits Each)
Chiropractic (60 Visits Per Condition Per Year)	$25
Acupuncture (12 Visits Per Year)	$25
MATERNITY	
Infertility Services*	Deductible, then 50% ($30,000 Lifetime Max.)
Pre-Natal and Post-Natal	$0
Delivery	$500
OTHER SERVICES	
Durable Medical Equipment	Deductible, then 50%
Home Healthcare / Hospice Care	Deductible, then $0
MENTAL HEALTH AND SUBSTANCE ABUSE	
Inpatient	$500
Outpatient	$15
VISION	
Vision Examinations	$25 (1 Exam Per Year)
PRESCRIPTION DRUGS – ADMINISTERED BY CVS / CAREMARK	
Plan Year Drug Deductible	None
Tier 1 (30-Day Supply / 90-Day Supply)	$15 / $37.50
Tier 2 (30-Day Supply / 90-Day Supply)	$30 / $75
Tier 3 (30-Day Supply / 90-Day Supply)	$50 / $125

Your copays don't count toward meeting the deductible unless otherwise described within the specific covered health service. All individual deductible and out-of-pocket maximum amounts will count toward meeting the family deductible and out-of-pocket maximum, but an individual will not have to pay more than the individual deductible or out-of-pocket maximum amount.

**Amount you pay is based on where the covered healthcare service is provided

UnitedHealthcare – Choice Plus POS

CHOICE PLUS POS		
PLAN BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Plan Year Deductible (Single / Family)	$400 / $800	$800 / $1,600
Coinsurance (UHC / You)	90% / 10%	80% / 20%
Out-of-Pocket Maximum (Single / Family)	$3,175 / $6,350	$3,175 / $9,525 (Combined)
Preventive Services	$0	Deductible, then 20%
Office Visits (Primary / Specialist / Virtual)	$15 / $25 / $15	Deductible, then 20%
Lab / X-Ray (Non-Hospital)	Deductible, then $0	Deductible, then 20%
Complex Radiology (Non-Hospital)	Deductible, then $100	Deductible, then 20%
Inpatient Hospital Services (Per Stay)	Deductible, then $500	Deductible, then 20% + $500
Outpatient Surgery (Non-Hospital)	Deductible, then $100	Deductible, then 20%
Urgent Care	$25	Deductible, then 20%
Emergency Room (Waived if Admitted)	Deductible, then $150	Deductible, then $150
Ambulance (Emergency Only)	Deductible, then $0	Deductible, then 20%
Physical, Speech, Occupational Therapy	$25 (60 Visits Each)	Deductible, then 20%
Chiropractic (60 Visits Per Condition Per Year)	$25	Deductible, then 20%
Acupuncture (12 Visits Per Year)	$25	Deductible, then 20%
MATERNITY		
Infertility Services*	Deductible, then 50% ($30,000 Max)	Deductible, then 50%
Pre-Natal and Post-Natal	$0	Deductible, then 20%
Delivery	Deductible, then $500	Deductible, then 20% + $500
OTHER SERVICES		
Durable Medical Equipment	Deductible, then 50%	Deductible, then 50%
Home Healthcare / Hospice Care	Deductible, then $0	Deductible, then 20%
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient	Deductible, then $500	Deductible, then 20% + $500
Outpatient	$15	Deductible, then 20%
VISION		
Vision Examinations	$25 (1 Exam Per Year)	Deductible, then 20%
PRESCRIPTION DRUGS – ADMINISTERED BY CVS / CAREMARK		
Plan Year Drug Deductible	None	
Tier 1 (30-Day Supply / 90-Day Supply)	$15 / $37.50	
Tier 2 (30-Day Supply / 90-Day Supply)	$30 / $75	
Tier 3 (30-Day Supply / 90-Day Supply)	$50 / $125	

Your copays don't count toward meeting the deductible unless otherwise described within the specific covered health service. All individual deductible and out-of-pocket maximum amounts will count toward meeting the family deductible and out-of-pocket maximum, but an individual will not have to pay more than the individual deductible or out-of-pocket maximum amount.

**Amount you pay is based on where the covered healthcare service is provided

UnitedHealthcare – Choice Plus HDHP

CHOICE PLUS HDHP		
PLAN BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Plan Year Deductible (Single / Family)	$1,650 / $3,300	$3,300 / $6,600
Coinsurance (UHC / You)	90% / 10%	60% / 40%
Out-of-Pocket Maximum (Single / Family)	$3,300 / $6,600	$6,600 / $13,200
Preventive Services	$0	Deductible, then 40%
Office Visits (Primary / Specialist / Virtual)	Deductible, then $10 / $20 / $10	Deductible, then 40%
Lab / X-Ray (Non-Hospital)	Deductible, then $20	Deductible, then 40%
Complex Radiology (Non-Hospital)	Deductible, then $100	Deductible, then 40%
Inpatient Hospital Services (Per Stay)	Deductible, then $250	Deductible, then 40%
Outpatient Surgery (Non-Hospital)	Deductible, then $150	Deductible, then 40%
Urgent Care	Deductible, then $25	Deductible, then 40%
Emergency Room (Waived if Admitted)	Deductible, then $1,500	Deductible, then 40%
Ambulance (Emergency Only)	Deductible, then 10%	Deductible, then 40%
Physical, Speech, Occupational Therapy	Deductible, then $20 (60 Visits Each)	Deductible, then 40%
Chiropractic (60 Visits Per Condition Per Year)	Deductible, then $20 (60 Visits Each)	Deductible, then 40%
Acupuncture (12 Visits Per Year)	Deductible, then $20	Deductible, then 40%
MATERNITY		
Infertility Services*	Deductible, then 50% ($30,000 Max)	Deductible, then 40%
Pre-Natal and Post-Natal	$0	Deductible, then 40%
Delivery	Deductible, then $500	Deductible, then 40%
OTHER SERVICES		
Durable Medical Equipment	Deductible, then 50%	Deductible, then 40%
Home Healthcare / Hospice Care	Deductible, then 10%	Deductible, then 40%
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient	Deductible, then $500	Deductible, then 40%
Outpatient	Deductible, then $15	Deductible, then 40%
VISION		
Vision Examinations	Deductible, then $25 Copay (1 Exam Per Year)	Deductible, then 40%
PRESCRIPTION DRUGS – ADMINISTERED BY CVS / CAREMARK		
Plan Year Drug Deductible	Combined with Medical Deductible	
Tier 1 (30-Day Supply / 90-Day Supply)	Deductible, then $15 / $37.50	
Tier 2 (30-Day Supply / 90-Day Supply)	Deductible, then $30 / $75	
Tier 3 (30-Day Supply / 90-Day Supply)	Deductible, then $50 / $125	

Your copays count toward the deductible as described within the specific covered health service. All individual deductible and out-of-pocket maximum amounts will count toward meeting the family deductible and out-of-pocket maximum, but an individual will not have to pay more than the individual deductible or out-of-pocket maximum amount.

**Amount you pay is based on where the covered healthcare service is provided

HDHP Advantages

A Closer Look at the High Deductible Health Plan

The high deductible health plan (HDHP) costs you less from your paycheck, so you keep more of your money. This rewards you for taking an active role as a health care consumer, as a result could save you on your health care costs.

1. Lower Paycheck Costs

Your per-paycheck costs are lower compared to DASH's other health plans, giving you the opportunity to contribute the cost savings to a taxfree (federal taxes) Health Savings Account (HSA).

You pay for your initial medical costs until you meet your annual deductible, and then you pay a percentage of any further costs until you reach the annual out-of-pocket maximum.

2. Tax-Advantaged Account

To help you pay your deductible and other out-of-pocket costs, the HDHP lets you open a Health Savings Account (HSA) and make tax-free contributions directly from your paycheck. All withdrawals from your HSA are tax-free, if you use the money to pay for eligible health care expenses.

In addition, all the money in the account is yours and will never be forfeited. It rolls over from year to year, and you can take it with you if you leave the Company or retire. After age 65, you can withdraw funds for any reason without a tax penalty — you pay ordinary income tax only if the withdrawal isn't for eligible health care expenses.

Note: You won't pay federal taxes on HSA contributions. However, you may pay state taxes depending on your residence. Consult your tax advisor to learn more.

3. Free In-Network Preventive Care

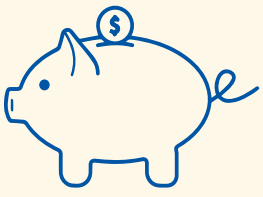
As with all DASH's health plans, preventive care is fully covered under the HDHP — you pay nothing toward your deductible and no copays if you receive care from in-network providers. Preventive care includes annual physicals, well-child and wellwoman exams, immunizations, flu shots, and cancer screenings.

4. DASH Contributes to your Health Savings Account, $500 to Employee Only and $700 to Employee + 1 or Family.

Note: HSA tax deduction rules/permissions may vary from state to state and based upon your dependent relationship (i.e., domestic partnership). Please consult with your tax advisor.

Money-Saving Tip

If you enroll in the HDHP, put the money you save through lower paycheck deductions into your tax-free HSA so you'll have money available when you need to pay out-of-pocket costs.



Using a HDHP

Free Preventive Care

You pay nothing for in-network preventive care.

Deductible

You pay 100% of your medical expenses up to the annual deductible amount. Use your HSA to plan for these costs.

Copays

You and the plan share costs once you meet your deductible, until you reach the out-of-pocket maximum.

Out-of-Pocket Maximum

You're protected by an annual limit on costs. The plan starts to pay 100% once you've met this maximum.

Virtual Visits

Administered by UnitedHealthcare

Easy, fast doctor visits.

All from the comfort of your own computer or mobile device.

With any of our UHC health plans, you can talk to a doctor today, tonight, anytime – 365 days a year. Just sign up at **myuhc.com** or on the free UHC mobile app. Now you can get the healthcare you need without all the hassle.

Have a health question? Feeling under the weather? With UHC Virtual Visits, you don't have to deal with scheduling an appointment or long wait times at the urgent care center. In fact, you don't even have to leave your home or office. Using Virtual Visits, you can see a doctor who can answer questions, make a diagnosis, and even prescribe basic medications, when needed (as legally permitted in certain states).

With UHC Virtual Visits, you get:

- Immediate doctor visits through live video.
- Your choice of board-certified doctors.
- Private, secure and convenient online visits.
- $15 Copay applies / HDHP members: $10 copay applies after meeting the deductible.

What are the qualifications of the doctors you see using Virtual Visits?

- Board-certified.
- Average 15 years practicing medicine.
- Mostly primary care physicians.
- Specially trained for online visits.

When can you use UHC Virtual Visits?

As always, you should call 911 with any emergency. Otherwise, you can use UHC Virtual Visits whenever you have a health concern and your own doctor isn't available. Doctors are available 24 hours a day, seven days a week, 365 days a year. Some of the most uses include:

- Cold and flu symptoms such as a cough, fever and headaches
- Allergies
- Sinus infections

Start a conversation now!

Just enroll for free at **www.myuhc.com** or on the UHC mobile app, and you're ready to see a doctor.

UHC Provider Search

Use the below steps to find In Network physicians, urgent cares, and hospitals. The two Choice plans utilize the same in-network physicians. Save in premiums by opting for the HMO plan if your doctors are in-network

	CHOICE NETWORK
TO BEGIN	Visit **www.uhc.com** and click on **Find a Doctor.**
STEP 1	You can search the general directory by clicking on **"Find a Physician, Hospital or Healthcare Facility,"** OR you can log in to your member account by clicking on **"Log in to myuhc.com to Find a Physician"**
STEP 2	Select which type of provider you are looking for: **Medical Directory or Mental Health Directory**
STEP 3	Click on **"All UnitedHealthcare Plans"**
STEP 4	Click on **"Shopping Around"**
STEP 5	Select **CHOICE PLUS**
STEP 6	Search by your location and the type of service you may need

Provider contracts are always changing with the carriers. Please call your provider to ensure that they are still in-network before going to see them.

Please sign up on **www.myuhc.com** and login as a member for a more accurate provider search specific to your elected plan.

Additional UHC Information

UHC Preventive Care Guidelines

Visit **www.uhcpreventivecare.com** to specifically determine what UHC deems as no charge preventive care.

Getting the Most from Your Plan

Register on **www.myuhc.com** to get the most from your medical coverage with UnitedHealthcare! Find a doctor, check claims and benefits, compare plans, get discounts, and read up about your health. Signing up will allow you to take better control of your healthcare needs and costs.

UnitedHealthcare Mobile App

UnitedHealthcare Mobile App provides instant access to your family's critical health information— anytime/anywhere. Whether you want to find a physician near your, check the status of a claim or speak directly with a healthcare PROFESSIONAL, UnitedHealthcare Mobile App is your go-to resource. Download UnitedHealthcare Mobile App for free on the Apple App Store for iPhone or on Google play for Android.

Your Money. Your Health.

Quickly and easily estimate your healthcare costs on **www.myuhc.com** and in the UnitedHealthcare Health4Me app with myHealthcare Cost Estimator. Using your benefit information, myHealthcare Cost Estimator shows you the estimated costs for a treatment or procedure, displays how that cost is impacted by your Deductible, coinsurance and out-of-pocket maximum, gives you an estimate of what you'll be responsible to pay and provides you with usable information for planning and budgeting.

Choose your level of care.

CVS / Caremark Rx (Bundled with UHC Medical)

If you enroll in UnitedHealthcare Medical, you will automatically be enrolled in the CVS / CareMark Prescription program. Please be aware to use the correct card when obtaining medical services (UHC) or pharmacy services (CVS / CareMark).

Using Your Formulary

Tier 0: $0 Drugs	• Preventive drugs (e.g. statins, aspirin, folic acid, fluoride, iron supplements, smoking cessation products and FDA-approved contraceptives for women) are available at a zero-dollar cost share if prescribed under certain medical criteria by your doctor. • Oral chemotherapy drugs and diabetic supplies (e.g. insulin syringes, pen needles, lancets, test strips, and alcohol swabs) are also available at a zero-dollar cost share.
Tier 1: Generic Drugs$	• Generic drugs are the same as brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. • Generic drugs generally cost less than brand-name drugs.
Tier 2: Preferred Brand Drugs $$	• Preferred brand drugs are brand-name medications that do not have a generic equivalent. • They are chosen for their cost-effectiveness compared to alternatives. • Your cost-share will be more than generic drugs but less than non-preferred brand drugs. • If a generic drug becomes available, the preferred brand drug may be moved to the non-preferred brand tier.
Tier 3: Non-preferred Brand Drugs $$$	• Non-preferred brand drugs often have a generic or preferred brand drug option where your cost-share will be lower.

Prescription Drug Online Tools and Resources

If you are an existing member, you should log in to your MyAccount with CVS / CareMark (**www.caremark.com)** and select “Drug and Pharmacy Resources” under Quick Links to find a pharmacy, refi ll prescriptions, or use the drug pricing tool. You can also call Pharmacy Services at **800.241.3371**.

Prior Authorization

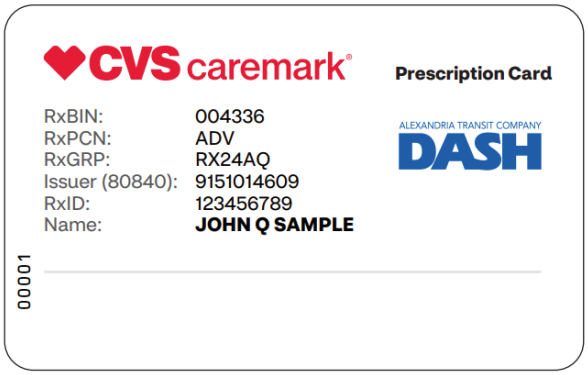
Prior Authorization from CVS / CareMark is required before you fill prescriptions for certain drugs. Your doctor may need to provide some of your medical history or laboratory tests to determine if these medications are appropriate. Without prior authorization from CVS / CareMark, your drugs may not be covered.

Step Therapy

Step Therapy requires that you try lower-cost equally effective drugs that treat the same medical condition before trying a higher-cost alternative. Your doctor will need to provide information to CVS / CareMark about your experience with these alternatives prior to dispensing a more expensive drug.

Save money

Save half a month’s copay on a 90-day fi ll on your prescriptions by having your physician write a 90-day script for your daily medications.



Dental and Vision

Dental and Vision Plans

TMA shares in the cost of your dental plan. TMA pays 100% of the vision plan. You do not need to elect any of the TMA medical plans to enroll in The Standard Dental or Vision plans.

The Standard Dental PPO Care

You may see any dentist, but you will have a higher benefit level and lower out-of-pocket costs if you visit a Standard (Ameritas Network) PPO network dentist. Savings are greater when you visit an In-Network provider because The Standard contracted dentists have agreed to provide care at a negotiated rate.

Out-of-Network benefit amounts are subject to the The Standard's contracted fee schedule. You will be responsible for the difference between the plan payment and the dentist's usual charge.

The Standard Vision PPO Care

A vision plan is one of the most requested benefit options. We are pleased to provide a comprehensive vision plan. The plan utilizes the EyeMed Access Network.

The Standard has one of the largest networks of private practicing optometrists, ophthalmologists, and opticians. In addition to the vision plan benefits provided through your benefits program, The Standard offers a number of non-covered services at a discount.

Dental

Administered by The Standard

DENTAL PPO PLAN BENEFITS	WHAT YOU PAY	
	IN-NETWORK[1]	OUT-OF-NETWORK[1]
PLAN MAXIMUMS		
Calendar Year Deductible (Single)	$50	$50
Calendar Year Deductible (Family)	$150	$150
Calendar Year Maximum Benefit	$1,500 Per Person	
PREVENTIVE & DIAGNOSTIC CARE		
Oral Examinations, Bitewing or Full Mouth X-rays, Cleanings	0% (Deductible Waived)	0% (Deductible Waived)
BASIC RESTORATIVE CARE		
Fillings, Endodontics (root canal therapy), Periodontics, Sealants, Simple Oral Surgery and Simple Extractions	20%	20%
MAJOR RESTORATIVE CARE		
Crowns, Inlays, Onlays and Cast Restorations, Bridges and Dentures	50%	50%
ORTHODONTIA (NEW THIS YEAR!)		
Orthodontia Lifetime Maximum (Adult and Child)	50%	
Orthodontia Benefit (Adult and Child)	$1,500	

[1]Reimbursement is based on PPO contracted fees for PPO dentists, and MAC for non-Standard dentists.

The Standard Provider Search

Use the below steps to find In Network dentists, specialists and orthodontists

	DENTAL PPO NETWORK
STEP 1	Go to **https://www.standard.com**
STEP 2	Click on **"Find a Dentist"**
STEP 3	Click **"Continue to Ameritas"**
STEP 4	Enter City, County State or Zip Code
STEP 5	Select "Classic PPO Network"
STEP 6	You may apply additional filters to refine your search

Vision

Administered by The Standard

VISION PLAN BENEFITS	WHAT YOU PAY	
	IN NETWORK	OUT-OF-NETWORK
EXAMS		
Vision Exam (every 12 months)	$0 Exam Deductible	Up to $35 Reimbursement
LENSES (EVERY 12 MONTHS)		
Single	$20 Materials Deductible	Up to $25 Reimbursement
Bifocal		Up to $40 Reimbursement
Trifocal		Up to $55 Reimbursement
FRAMES		
Frames (every 12 months)	$100 allowance, then 20% off amount over frame allowance	Up to $45 Reimbursement
CONTACTS[1] (IN LIEU OF GLASSES)		
Medically Necessary (every 12 months)	Covered in Full	Up to $200 Reimbursement
Elective (every 12 months)	$115 allowance, then 15% off amount over frame allowance	Up to $92 Reimbursement

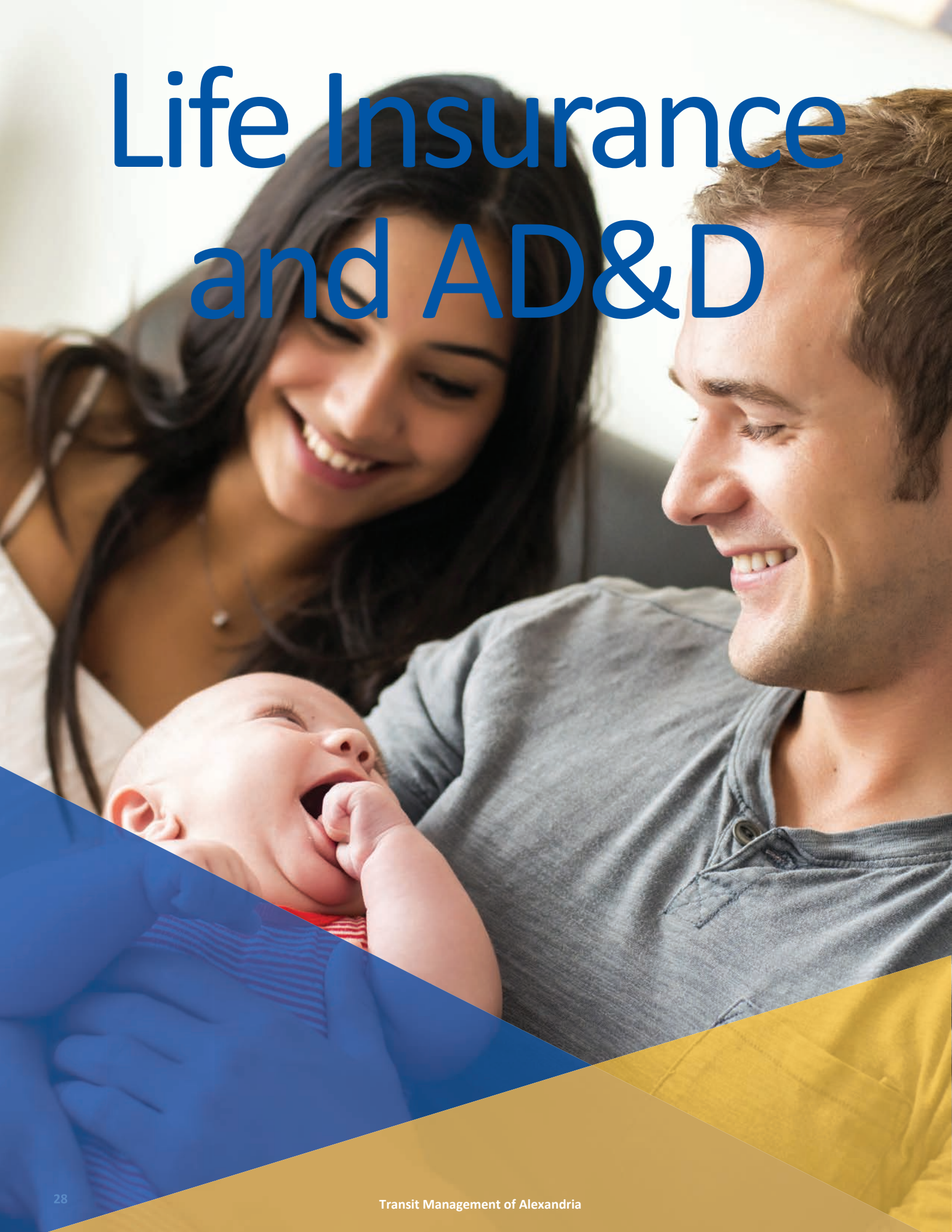
1 Contact lens allowance can only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases made during the same benefit period, nor can any unused amount be carried over to the following benefit period.

Find a provider:

Visit **eyemed.com** and choose the "Access" Network!

If you utilize Out-of-Network services, you may be required to make a full payment and submit a claim form for reimbursement.

Life Insurance and AD&D



Basic Life Insurance

Administered by The Standard

This benefit is paid for 100% by DASH. There is no cost to you, the employee.

All benefit eligible employees with DASH are provided with employer paid Life and Accidental Death & Dismemberment (AD&D) coverage. All eligible employees are automatically enrolled in Life and AD&D plans – you do not need to actively enroll in this benefit.

Employee Basic Life Insurance

- Operators and non-drivers if hired prior to 7/1/2009, 2x annual salary to maximum of $450,000
- Operators and non-drivers hired after 7/1/2009, 1x annual salary to maximum of $150,000

Accidental Death & Dismemberment (AD&D)

- 100% of the Basic Life benefit
- Provides specified benefits for a covered accidental bodily injury that directly causes dismemberment.
- In the event of death that occurs from a covered accident, both Life and AD&D benefits would be payable each in the amount of the basic life insurance.

Benefits After Age 65

Your life benefits will reduce after age 65, and the reduction schedule is as follows:

- Reduce by 35% at age 65
- Reduce by 50% at age 70
- Reduce by 65% at age 75
- Benefits will terminate at retirement

Refer to the Standard plan documents for a complete description of this plan.

Reminder: Please update your Life Insurance beneficiary information in the Paycom online enrollment site during Open Enrollment. You may make changes to this election throughout the year.

Additional Life Insurance

Administered by The Standard

This benefit is paid for 100% by the employee.

Because you may need additional coverage, TMA offers you an opportunity to purchase extra life insurance at competitive group rates. The Additional Life and Accidental Death & Dismemberment (AD&D) insurance is available for employees, their spouses, and/or child(ren).

This benefit is voluntary and paid for 100% by eligible employees through after-tax payroll deductions. You do not need to enroll in medical, dental, or vision plans to be eligible to enroll in this plan.

Additional Employee Life / AD&D

Employees may purchase additional coverage in $10,000 increments, not to exceed 5 times annual salary or $300,000, whichever is less.

- Guaranteed Issue amount is up to $100,000 for newly eligible employees
- Evidence of insurability required for employees who enroll after their initial eligibility period, during life events, and when requesting coverage greater than $100,000

Additional Spouse Life / AD&D

You may purchase additional coverage for your spouse in $5,000 increments, not to exceed 100% of employee coverage or $150,000, whichever is less.

- Guaranteed Issue amount of $25,000 for newly eligible employees
- Spouse coverage may only be elected if the employee is enrolled
- EOI is required if the coverage is above $25k or for late entrants

Additional Child(ren) Life / AD&D

You may purchase additional coverage for your child(ren) in the following amounts:

- Birth to 26 years = $10,000
- Child coverage may only be elected if the employee is enrolled

Benefits reduce at employee age 65 by 35%, additional 15% at employee age 70, and an additional 15% at employee age 75

Refer to the Standard plan documents for a complete description of this plan.

Should you choose to elect amounts over the guaranteed issue amount OR you are a late entrant, you or your spouse / domestic partner will need to complete the Evidence of Insurability Form for medical underwriting purposes.

Employee Resource Programs

Administered by The Standard

These added value services are available to anyone enrolled in the employer paid or additional life and disability policies. Some services may require out of pocket expense.

The Life Services Toolkit

The time after a loved one has died is difficult for a beneficiary. Tasks like planning a funeral and settling estate matters demand your immediate attention. At the same time, daily obligations continue as you grieve your loss. Standard Insurance Company (The Standard) is here to help. We have partnered with Morneau Shepell to offer comprehensive and compassionate services to Group Life insurance beneficiaries.[1] These services are available to you for 12 months after the date of death.

Call the Life Services Toolkit phone assistance line at **800.378.5742**.

Or you can log in online at **standard.com/mytoolkit**.

Login: **support**

Family Benefits Package

This comprehensive package of family-oriented Accidental Death & Dismemberment (AD&D) benefits includes the following when a claim is filed:

- Higher Education Benefit that pays for qualifying tuition expenses incurred by an employee's eligible children
- Career Adjustment Benefit that pays for qualifying tuition expenses incurred by an employee's spouse for training aimed at obtaining employment or increasing earnings
- Child Care Benefit that pays for qualifying child care costs incurred by an employee's spouse in order to work or obtain training aimed at securing employment or increasing earnings

Travel Assistance

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

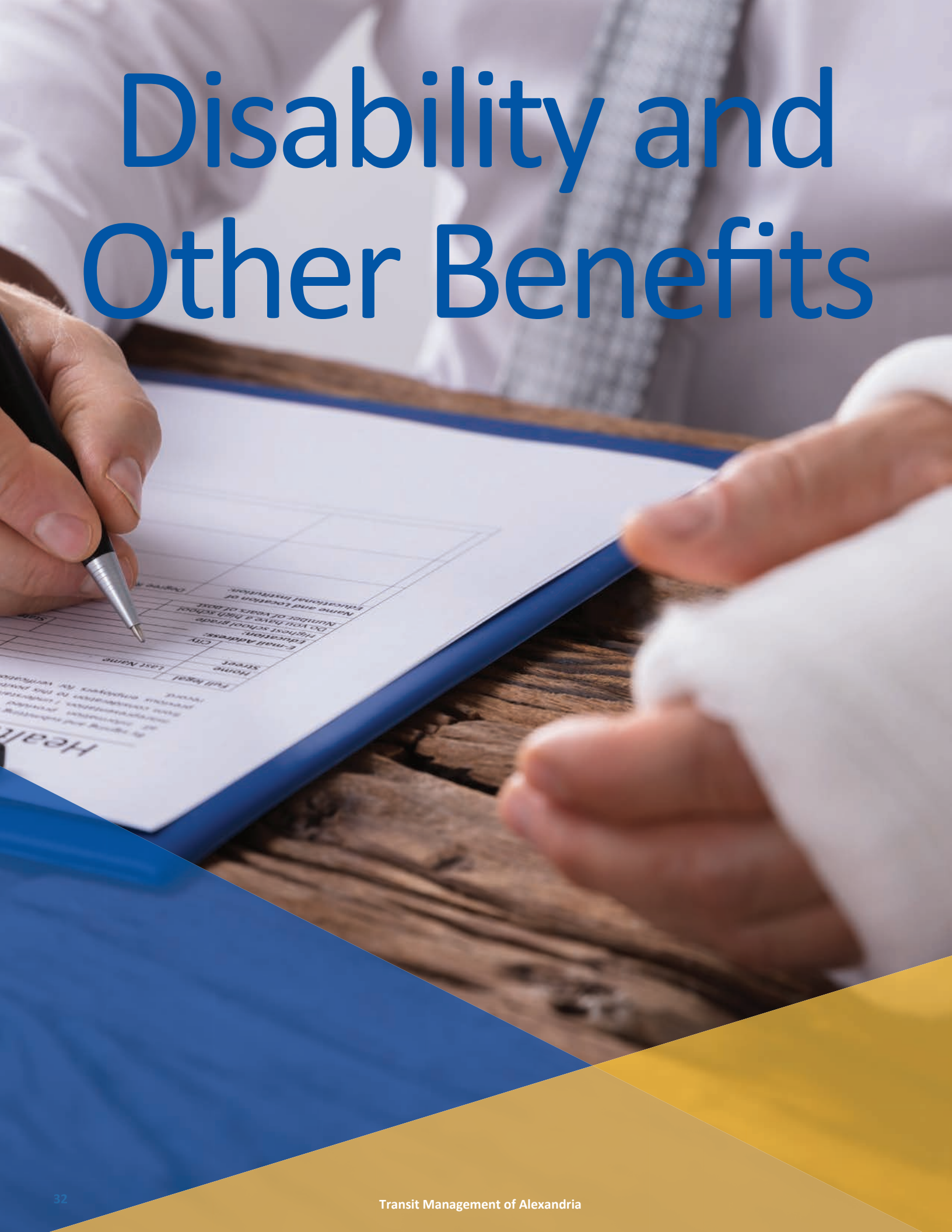
Contact Travel Assistance
866.455.9188

United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda
+1.240.330.1380

Everywhere else
ops@gga- usa.comstandard.com/travel

- Passport, visa, weather and currency exchange information, health hazards advice and inoculation requirements
- Emergency ticket, credit card and passport replacement, funds transfer and missing baggage
- Help replacing prescription medication or lost corrective lenses and advancing funds for emergency medical payment
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains
- Connection to medical care providers, interpreter services, a local attorney, consular office or bail bond services
- Return travel companion if travel is disrupted due to emergency transportation services or return dependent children if left unattended due to prolonged hospitalization
- Logistical arrangements for ground transportation, housing and/or evacuation in the event of a natural disaster, political unrest and social instability

Disability and Other Benefits



Short-Term Disability

Administered by The Standard

This benefi t is paid for 100% by TMA. There is no cost to you, the employee.

As a valued employee, you are offered Short-Term Disability. You do not need to enroll in this benefit. Your disability plan is available to help supplement your income (in addition to State Disability Insurance) when you are not able to continue employment for a certain period of time.

Short-Term Disability

You will need to satisfy a 14-day waiting period before short-term disability benefits would begin. If you are totally disabled beyond the elimination period due to a covered injury or sickness, you will be eligible to receive a weekly benefit equal to 60% of your earnings to a maximum of $2,000 / week.

The Maximum benefit duration is 13 weeks including the elimination period.

Voluntary Long-Term Disability

Administered by The Standard

This benefit is 100% paid for by you, the employee.

Employees can elect Voluntary Long Term coverage for those unexpected situations that may keep you from performing the daily responsibilities of your job. Your disability plan is available to help supplement your income when you are not able to continue employment for a certain period of time.

Long-Term Disability

You will need to satisfy a 90-day elimination period before long-term disability benefits would begin. If you are totally disabled beyond the elimination period due to a covered injury or sickness, you will be eligible to receive a monthly benefi t equal to 60% of your basic monthly income, up to $5,000 per month.

This benefi t is only available at New Hire without having to complete an Evidence of Insurability form. EOI is required for late entrants (i.e. enrolling past the initial eligibility period or during any subsequent annual enrollment).

Voluntary Group Accident

Administered by The Standard

With the high cost of medical care today, a trip down the stairs can hurt your bank account as much as your body. Accident insurance can pay you money based on the injury and the treatment you receive, whether it's a simple sprain or something more serious, like an injury from a car accident. Your plan can pay you a benefit for an emergency room treatment, stitches, crutches, injury-related surgery and a list of other accident-related expenses. The money is paid directly to you and you decide how to spend it. This benefit is voluntary, paid for 100% by employees through after-tax payroll deductions

Benefit Type[1]	PREMIER PLAN The Standard
	Insurance Pays YOU
INJURIES	
Fractures[2]	$200 – $10,500
Dislocations[2]	$200 – $7,000
Burns	$500 – $12,500
Concussions	$200
Cuts / Lacerations	$100 – $800
Eye Injuries	$300
MEDICAL SERVICES & TREATMENT	
Ambulance / Air Ambulance	$1,500
Emergency Care / Urgent Care	$60 – $200
Major Diagnostic Exam	$300
Physician Follow-Up	$70 up to 3 days
Therapy Services (including physical therapy)	$50 up to 4 days
Medical Appliances	$200
Surgery Facility (Outpatient)	$500
HOSPITAL[2] COVERAGE (ACCIDENT)	
Admission	$1,500
Confinement (up to 365 days)	$400/day
Inpatient Rehab (up to 90 days per accident)	$150/day
Critical Care Unit Admission	$1,000
ADDITIONAL BENEFITS	
Lodging (up to 30 days per accident)	$200/day
Transportation (up to 30 days per accident)	$200/day
Common Carrier AD&D	$100,000 Employee; $50,000 Spouse; $25,000 Child

Health Screening Benefit: After your coverage has been in effect for thirty days, The Standard will provide an annual benefit of $50 per calendar year for taking one of the eligible screening/prevention measures. The Standard will pay only one health screening benefit per covered person per calendar year.

[1]Covered services/treatments must be the result of a covered accident as defined in the group policy/certificate. See the Outline of Coverage for more details.

[2]Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See your Disclosure Statement or Outline of Coverage/ Disclosure Document for full details.

These plans offer additional benefits such as Accidental Death, Dismemberment, Loss, Paralysis, Lodging, etc. Please refer to the The Standard Documents for a complete description of the plan benefits.

Voluntary Critical Illness

Administered by The Standard

What's a critical illness? Some common examples are heart attack, stroke and cancer. But this coverage also includes serious conditions like permanent paralysis – the kind of injury that can happen to a healthy person in a car or skiing accident, for example. The medical treatment for these conditions can be very expensive. Critical illness insurance can help by paying a lump sum payment directly to you at the first diagnosis of a covered condition. You decide how to spend it. You can use this coverage more than once for different conditions, but each condition is payable once per lifetime.

This benefit is voluntary, paid for 100% by employees through after-tax payroll deductions.

- Lump sum payment to use as you see fit upon diagnosis verification
- To enroll your spouse, you must be enrolled as an employee in this plan. The spouse coverage amount cannot exceed the employee amount.
- You have a choice of a $10k or $20k benefit amount, and either $5k or $10k for your spouse[1] when you are enrolled
- Recurrence benefit – 25% of coverage, 12-month treatment-free period[1]
- No EOI is required; even if enrolling after your initial eligibility period
- No waiting periods or age restrictions
- No limitations between filing claims for covered conditions
- No pre-existing condition
- Portable (continuation of coverage) when you change jobs
- Rate does not increase as you age

This benefit is 100% paid for by you, the employee. Below shows the Bi-Weekly amounts.

Premier	<30	30-39	40-49	50-59	60-70
NON-TOBACCO					
$10,000	$3.05	$5.35	$9.18	$18.14	$33.42
$20,000	$6.09	$10.71	$18.37	$36.28	$66.83
TOBACCO					
$10,000	$4.06	$8.35	$16.57	$36.69	$70.89
$20,000	$8.12	$16.71	$33.14	$73.38	$141.78

[1]Please review the Disclosure Statement or Outline of Coverage / Disclosure Document for specific information about these benefits.

[2]The Listed Conditions are cancer, carcinoma in situ, end stage renal failure, major organ failure, myocardial infarction (heart attack), severe coronary artery disease with recommendation for bypass*, stroke, 21 childhood diseases[3], coma, paralysis, loss of sight, occupational hepatitis, occupational HIV, advanced Alzheimer's, advanced MS, advanced Parkinson's disease, amyotrophic lateral sclerosis, benign brain tumor, bone marrow transplant, loss of hearing, and loss of speech.

[3]The Listed Childhood Diseases are anal atresia, anencephaly, biliary atresia, cerebral palsy, cleft lip or cleft palate, club foot, coarctation of the aorta, cystic fibrosis, diaphragmatic hernia, Down syndrome, gastroschisis, Hirschpung's disease, hypoplastic left heart syndrome, infantile hypertrophic pyloric stenosis, muscular dystrophy, ornphalocele, patent ducturs arteriosis, spina bifida cystica with myelomeningocele, tetralogy of fallot, transpotion of the great arteries.

This plan is based on issued age which is the age of the insured individual at the time the policy is issued. Premiums are based on this age and remain level throughout the life of the policy. This means that the cost of the insurance does not increase as the insured person gets older.

Voluntary Hospital Indemnity

Administered by The Standard

What is Group Hospital Indemnity Insurance

Hospital Indemnity insurance from The Standard helps pay for hospitalization expenses that medical insurance and savings don't cover. Adding this coverage can help employees be ready for the costs of a hospital stay. This coverage doesn't necessarily apply only to your medical bills, but you can also use it to pay for your rent and other bills that might accumulate.

Details

- Portability lets employees keep their policies even if you leave your job with no change in coverage
- **Health Maintenance Screenings** pay a yearly benefit of $50 when you receive one of 20 covered health screening tests, including lipid panel, mammography, or colonoscopy
- Coverage options: Employee Only; Employee + Spouse; Employee + Child(ren); Family
- 12/12 pre-existing limitation: Any medical condition for which the insured received treatment or advice within 12 months prior to the policy's effective date will not be covered for the first 12 months of the policy
- Terminates at age 80 for employees and spouse; age 26 for children

Benefits

- Daily Hospital Confinement – $250/day
- Hospital Admission – $1,000
- Daily CCU Confinement (15 days) – $50/day
- Health Maintenance Screening – $50

The intent of the above information is to provide you with general information about your employee benefit plans. It does not necessarily address all the specific issues which may be applicable to you and does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. If you have a specific benefit concern, please contact The Standard for further guidance or review the policies for those details

Financial Benefits

Employee Assistance Plan (EAP)

Administered by The Standard

This benefit is paid for 100% by DASH.
Your privacy matters. EAP participation is completely confidential.

Life can be complicated. Getting help can be simple. EAP can help turn problems into solutions. TMA offers a free EAP Program!

TMA acknowledges a strong commitment to the health and well-being of its employees. To that end, TMA offers an Employee Assistance Program (EAP) to employees and their immediate family members to assist them with personal problems including substance abuse or dependency, which may adversely affect the employee's job performance.

When you toss in everyday challenges that we all face from time to time, be it work, home or something very personal, it's not always easy to handle everything on your own. In fact, sometimes it makes sense to reach out for help.

	The Standard EAP
Availability	All Employees
Online Access	Unlimited Access **healthadvocate.com/standard3**
Face-to-Face Visits	3 per person per issue per year
Telephonic Access	**888.293.6948**
EAP services can help with:	Depression, grief loss and emotional well-being Family, marital and other relationship issues Life improvement and goal-setting Addictions such as alcohol and drug abuse Stress or anxiety with work or family Financial and legal concerns Identity and fraud resolution Online will preparation and other legal documents

Flexible Spending Accounts

What is FSA?

Flexible Spending Accounts (FSA) provide you with an important tax advantage that can help you pay for healthcare and dependent care expenses on a pretax basis. As an eligible employee, you agree to set aside a portion of your pre-tax salary in an account, and that money is deducted from your paycheck over the course of the plan year. The amount you contribute to the FSA is not subject to social security (FICA), federal, state or local income taxes—effectively adjusting your annual taxable salary.

Type 1: Healthcare Reimbursement FSA

The Healthcare Reimbursement FSA allows you to pay for certain IRS-approved healthcare expenses not covered by your insurance or reimbursed by any other benefit plan. Eligible expenses include those incurred by you, as well as your spouse and dependents. Typical expenses include copays, coinsurance, deductibles, and prescription drug expenses. Employees enrolled in the High Deductible Health Plan cannot enroll in the Healthcare Reimbursement FSA. For more information about eligible expenses, please refer to IRS Publication 502 available at **www.irs.gov/publications/p502/index.html**

The annual maximum contribution to the Healthcare Reimbursement FSA is $3,300. You are able to rollover up to $660 into the following plan year.

Type 2: Dependent Care Reimbursement FSA

The Dependent Care Reimbursement FSA allows you to use pre-tax dollars toward qualified dependent care. Care must be for a tax-dependent child under age 13 who lives with you, or a tax-dependent spouse or child who lives with you and is incapable of caring for themselves. Also, the care must be needed so that you and your spouse (if applicable) can go to work. Care must be given during normal working hours and cannot be provided by another of your dependents. Typical expenses include baby-sitters, nursery schools, pre-schools, and day care centers.

The annual maximum contribution to the Dependent Care Reimbursement FSA is $5,000, for the 2025 tax year. You are able to incur claims for 90 days after the end of the plan year.

"Use-It-or-Lose-It" Rule

The Healthcare and Dependent Care Reimbursement FSAs run on a plan year. The current plan year is from July 1, 2025 through June 30, 2026; claims can only be for services / expenses incurred during this time period for the Healthcare FSA. For the Dependent Care FSA, you will have an additional 90 days to INCUR claims after the plan year ends.

Healthcare FSA claims MUST be submitted no later than September 28, 2026 (90 days from end of plan year) for reimbursement. Any unused funds in excess of $660 will be forfeited. DASH has elected to offer a $660 rollover option, which will allow you to roll over up to $660 of unused contributions into the next plan year. Be conservative when making elections. Please refer to your plan documents for additional information.

Have leftover funds at the end of the year?

Visit **www.fsastore.com** to purchase FSA-eligible items before the end of the plan year. You may also review the updated FSA Eligibility list.

FSA Worksheet

When determining how much you would like to contribute to your Flexible Spending Account, you should keep in mind the following:

- In most cases, an employee may not make a mid-year change in the amount he or she has elected to contribute to a Flexible Spending Account.
- Money remaining in a Flexible Spending Account at the end of the plan year must be forfeited.
- Over-the-counter medicines and drugs are now reimbursable expenses!
- This worksheet can be used to estimate how much you should elect to contribute to your Flexible

Spending Accounts.

HEALTH FLEXIBLE SPENDING ACCOUNT	
EXPENSES NOT COVERED BY INSURANCE MAY INCLUDE:	
Deductibles, coinsurance or copayments	$_____
Dental care (exams, fillings, crowns)	$_____
Hearing care (exams, hearing aids and batteries)	$_____
Infertility treatment	$_____
Insulin and diabetic supplies	$_____
Prescription drugs (e. g. generic, brand, formulary, injectables)	$_____
Transportation expenses (to receive medical care)	$_____
Vision care (exams, contacts, eyeglasses, laser surgery)	$_____
Weight loss program (done at doctor's direction to treat an existing disease)	$_____
Wheelchairs	$_____
Total:	$_____
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT	$_____
TOTAL PRE-TAX CONTRIBUTIONS TO FLEXIBLE SPENDING ACCOUNTS:	$_____

Your FSA is administered through HealthEquity. Please contact them with questions:

866.346.5800
www.healthequity.com

Health Savings Account (HSA)

If you enroll in the High Deductible Health Plan (HDHP) you are eligible for an HSA. An HSA is a tax-free savings account you can use to pay for eligible health expenses anytime, even in retirement.

DASH contributes to your HSA. Employees enrolled in the Employee Only tier of the UHC Choice Plus HDHP will receive $500. Employees enrolled in the Employee + 1 or Employee + Family tier of the UHC Choice Plus HDHP will receive $700 annually. New Hires will see a prorated amount based on their benefi ts effective date.

How Does an HSA Work?

Build tax-free savings for health care. You can make before-tax deductions from your paycheck into your HSA, allowing you to save money by using tax-free dollars to pay for eligible medical, prescription, dental, and vision expenses. The total amount that can be contributed to your HSA each year is limited by the IRS. The following are limits for 2025-2026:

- Up to $4,300 for employee-only coverage.
- Up to $8,550 if you cover dependents.
- Add $1,000 to these limits if you're age 55 or older.
- Dash Contributes $500 to Employee Only and $700 to Employee + 1 or Family

Keep your money. Unlike an FSA, the money in your HSA is always yours to keep and can be rolled over from year to year. You can take your unused balance with you when you retire or change jobs.

Use it like a bank account. Pay for eligible medical, prescription, dental, and vision expenses for yourself and your family by using your HSA debit card or reimburse yourself for payments you've made (up to the available balance in your account). Keep in mind that you may only access money that is in your HSA when making a purchase or withdrawal. There's no need to turn in receipts (but keep them for your records).

Earn interest and invest for the future. Once your interest-bearing HSA reaches a minimum balance, you can invest in a variety of no-load mutual funds like 401(k) investments.

Never pay taxes. Contributions are made on a before-tax basis, and your withdrawals will never be subject to federal income taxes when used for eligible expenses. Any interest or earnings on your HSA balance build tax-free, too.*

*Money in an HSA grows tax-free and can be withdrawn tax-free if it is used to pay for qualified health care expenses (for a list of eligible expenses, see IRS Publication 502, available at **www.irs.gov**). If money is used for ineligible expenses, you will pay ordinary income tax on the amount withdrawn plus a 20% penalty tax if you withdraw the money for ineligible expenses before age 65. After age 65, withdrawals for ineligible expenses are only subject to ordinary income tax. Please review your state regulations as you may have to pay state taxes depending on your residency.

Note: These contribution limits are for the calendar year 2025 HSA tax deduction rules/permissions which may vary from state to state and based upon your dependent relationship (i. e., domestic partnership). Please consult with your tax advisor.

HSA Eligibility

To establish and contribute to an HSA, you:

- Must be enrolled in the UHC high deductible health plan.
- Cannot be covered by any other medical plan that is not a qualified high deductible plan. This includes a spouse's medical coverage unless it's an HSA-qualified plan.
- Cannot be enrolled in a Healthcare Reimbursement FSA in plan year 2025-26.
- Cannot be enrolled in Medicare, including Parts A or B, Medicare, or TRICARE.
- Cannot be claimed as a dependent on another person's tax return.
- Cannot be a veteran who has received treatment, other than preventive care, through the Department of Veterans Affairs within the past three months.

401(k) Retirement Plan

Saving for retirement is one of the most important things you can do to provide for your financial future. That's why TMA has partnered with PCS Retirement to offer you an easy, convenient, and powerful way to help you prepare for a more secure retirement. We're offering a wide array of investment choices. You decide what investments to place your contributions in; even small contributions can add up over time.

Enrollment and Eligibility

Eligible employees are automatically enrolled the first of the month following 90 days of service. Employees can invest up to the IRS maximum allowable limit in the plan.

Employer Contributions

TMA will contribute to each employee's 401(k) account an amount equal to eight percent (8%) of the employees' earnings for the pay period. Employees shall not be required to contribute to the plan in order to receive the employer's contribution. Employer contributions will be contributed to the plan on behalf of the participant on the same cycle as the employee's pay cycle.

Vesting

Employees shall be 100% vested in the company contributions after 4 years. Employees are always 100% vested in their own contributions.

Employee's shall be vested in Company's contributions in the following scale:	
(i) 1 Year Anniversary – 25%	(ii) 2 Year Anniversary – 50%
(iii) 3 Year Anniversary – 75%	(iv) 4 Year Anniversary – 100%

Manage your account online

PCS Retirement offers a convenient website for enrollment and managing your plan benefits. Enroll in the plan by visiting **www.pcsretirement.com**. When you enroll online you have access to:

- Investment balances by fund and source, generate statements, and view your personal rate of return.
- Find a collection of tools, by current life stage, to help you plan for your retirement.
- View documents in the document library, request a distribution or loan, view account history.
- Review your salary deferral election, update investment elections, request transfers, realignments, or rebalances.
- View available investments, prices and performance related to your plan.

For more information about your Plan's investment options, please contact our advisor Bart Kershner of Gallagher Benefit Services, Inc. at 410.353.1608 or bart_kershner@ajg.com.

Commuter Benefits Program

100% employer funded Commuter Benefit Program

We are thrilled to announce the launch of our new Commuter Benefits Program, designed to make your daily commute more convenient, affordable, and environmentally friendly. As part of our ongoing commitment to employee well-being and sustainability, we have partnered with SmartBenefits to bring you this exciting benefit.

WHAT IS THE SMARTBENEFITS PROGRAM?

SmartBenefits is a transit benefit program administered by the Washington Metropolitan Area Transit Authority (Metro). SmartBenefits are autoloaded to your SmarTrip card – Metro's rechargeable card.

The monthly benefit is up to $300.00 and will be assigned to registered SmarTrip cards for those eligible and enrolled in the program. The funds can be used for rail, van pool and bus travel throughout the D.C metropolitan region. Any unused balance at the end of the month will NOT carry over to the following month.

WHO IS ELIGIBLE?

All NON-UNION Employees who commute to work in the Washington metropolitan area, are eligible to participate in this program.

WHERE CAN I USE IT?

SmartBenefits can be used on Metrorail, Metrobus and the following bus systems:

- ART (Arlington Transit)
- CUE (Fairfax City)
- DC Circulator
- Fairfax Connector
- Loudoun County Transit
- PRTC OmniRide
- Ride On (Montgomery County)
- TheBus (Prince George's County)

You can also reallocate transit benefits for eligible van pools, MetroAccess, MTA Commuter Bus, VRE, MARC and select long distance bus systems through the SmartBenefits Passenger Allocation System. Or you can use SmartBenefits to purchase transit passes on MetroRide On, or MTA local service through the Transit Pass Benefit program. For more information on these options, visit **www.wmata.com/smartbenefits.**

WHAT ARE THE ADVANTAGES OF USING THIS BENEFITS?

1. Convenient Commuter Card: once you link your Smart Trip card to the benefit program, you can customize the amount of the benefit based on your monthly commuting costs. It's a hassle-free and efficient way to manage your commuting costs.

2. Flexible Transportation Options: Whether you prefer public transit or ridesharing services our Commuter Benefits Program supports a variety of transportation options. You have the flexibility to choose the most suitable mode of transportation that suits your needs and helps reduce your carbon footprint.

3. Online Commuter Portal: Access a user-friendly online portal where you can easily manage your commuter benefits account. The portal also provides valuable resources, such as commute planning tools, real-time transit updates, and eco-friendly commuting tips.

4. Enhanced Work-Life Balance: By alleviating the financial burden of commuting expenses, we aim to enhance your overall work-life balance. You can focus more on your professional growth and personal well-being, knowing that your daily commute is taken care of.

We are excited to bring this valuable program to you all, and we encourage you to take full advantage of the Commuter Benefits Program. Please see Human Resources for Benefit Program Guide and Enrollment Form.

For immediate questions about the SmartBenefits program, please contact **HR DASH-HR@Alexandriava.gov** or **Finance DASH-Finance@Alexandriava.gov.** We are here to assist you every step of the way.

Additional Employee Benefits

Vacation

TMA recognizes the importance of vacation time in providing rest, recreation, and personal enrichment. Vacation time will be earned at the completion of each year of service as follows:

YEARS OF SERVICE COMPLETED	VACATION EARNED
After 90 days of employment	80
At 3 Year Anniversary	120
At 5 Year Anniversary	160
At 8 Year Anniversary	200
Senior Management Team	
YEARS OF SERVICE COMPLETED	**VACATION EARNED**
After 90 days of employment	160
At 3 Year Anniversary	200
At 5 Year Anniversary	240

Sick Leave

Eligible employees accrue eight (8) hours of sick leave per month throughout their employment, starting on the first Saturday of the month following their date of hire.

Wellness and Fitness Club

Starting or staying with an exercise routine isn't always easy! To help you stay motivated and achieve your fitness goals, DASH provides an on-site wellness and fitness center to employees. To access our on- site facility, please complete a deduction / waiver and authorization release form and return to Human Resources.

Credit Union

Employees may join a local Transit Credit Union.

Holiday Schedule

Holiday Schedule
New Year's Day
Martin Luther King Day
President's Day
Memorial Day
Juneteenth
Independence Day
Labor Day
Indigenous Peoples' Day
Veterans' Day
Thanksgiving Day
Day After Thanksgiving
Christmas Eve
Christmas Day
Floating Holiday*

***In addition to the above, each employee will receive one (1) Floating Holiday after completing one (1) year of service to use with supervisor approval. Juneteenth becomes an additional floating holiday should it not be observed by the employee on the date the Company observes it – this must be approved by your department director.**

Gallagher | Marketplace

Benefits With Gallagher Marketplace

Giving you year-round access to additional benefits that could save you money.

Gallagher Marketplace is your gateway for discovering and accessing unique benefits that best fit your lifestyle. Our program offers significant savings on things you are already buying—like home and auto, pre-paid legal services, identity theft protection, pet insurance, renters insurance, boat or RV insurance, employee discount perks as well as extended vehicle warranties.

With a centralized hub, you can explore an array of benefit options, available not only to Gallagher clients but also to their friends and families.

Discover what benefits your organization offers through Gallagher Marketplace.

The Value

- Whether full-time, part-time or contract workers, all employees and their families are eligible
- Benefit access and potential savings through bundling with the ability to choose from multiple carriers
- Potential costs savings compared to shopping on your own
- Licensed insurance advisors to help find the policy that meets your needs

The Convenience

- Enroll any time of the year, not just during open enrollment
- Simple sign-up with payment options
- Easily compare rates from multiple carriers
- Schedule a callback from licensed insurance advisors for a time that's most convenient
- All programs are portable so you can keep the coverage no matter where life takes you

How It Works

1. Visit Gallagher Marketplace to see your available benefits.
2. Select a product to view more details.
3. Click on the partner link to learn more, get a free no obligation quote or apply for coverage.
4. Enter your employer name when prompted

Scan the QR code to learn more

AJG.com **The Gallagher Way.** Since 1927.

Glossary of Health Terms

This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

Coinsurance: Your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your Ded., your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Copayment: A fixed amount (for example, $15) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

Deductible: The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered healthcare services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME): Equipment and supplies ordered by a healthcare provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services you get in an emergency room.

Health Insurance: A contract that requires your health insurer to pay some or all of your healthcare costs in exchange for a premium.

Home Healthcare: Healthcare services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient: Care in a hospital that usually doesn't require an overnight stay.

In-Network Coinsurance: The percent (for example, 20%) you pay of the allowed amount for covered healthcare services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

In-Network Copayment: A fixed amount (for example, $15) you pay for covered healthcare services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Medically Necessary Healthcare: services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide healthcare services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Network Coinsurance: The percent (for example, 40%) you pay of the allowed amount for covered healthcare services to providers who do not contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-Network Copayment: A fixed amount (for example, $30) you pay for covered healthcare services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-Pocket Limit: The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or healthcare your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit.

Physician Services: Healthcare services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Preauthorization: A decision by your health insurer or plan that a healthcare service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium: The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of healthcare services for a patient.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), healthcare professional or healthcare facility licensed, certified or accredited as required by state law.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services: Healthcare services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing: Care Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of healthcare.

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

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Important Employee Notifications

Women's Health & Cancer Rights Act

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

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

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

If you would like more information on WHCRA benefits, please call your Plan Administrator.

Newborns' and Mothers' Health Protection Act

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

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866.444.EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.mycohibi.com/ HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP: https://medicaid.georgia.gov/ health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/ childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2
INDIANA – Medicaid
Health Insurance Premium Payment Program Family and Social Services Administration http://www.in.gov/fssa/dfr/ | 800.403.0864 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid 800.338.8366 Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki 800.257.8563 HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.967.4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kynect.ky.gov | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
https://mn.gov/dhs/health-care-coverage/ 800.657.3672
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178

NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 15218 | Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 800.356.1561 CHIP: http://www.njfamilycare.org/index.html 800.701.0710 (TTY: 711) | Premium Assistance: 609.631.2392
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid and CHIP
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program 800.440.0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) https://medicaid.utah.gov/upp/ | Email: upp@utah.gov | 888.222.2542 Adult Expansion: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: https://medicaid.utah.gov/buyout-program/ CHIP: https://chip.utah.gov/
VERMONT – Medicaid
https://dvha.vermont.gov/members/medicaid/hipp-program 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid and CHIP
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2026)

Paperwork Reduction Act Statement

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

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

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

TMA is committed to the privacy of your health information. The administrators of the (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting your Benefits Administrator.

Primary Protection

UnitedHealthcare and Kaiser Permanente HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in UHC or Kaiser networks who is available to accept you or your family members. Until you make this designation, UHC or Kaiser designate(s) one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact UHC or Kaiser.

HIPAA Special Enrollment Rights

Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the plan (to actually participate, you must complete an enrollment form and may be required to pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan – your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact your Benefits Administrator.

Notice of Creditable Coverage

Important Notice from TMA About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with TMA and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **TMA has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current TMA coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current TMA coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with TMA and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage:

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through TMA changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For More Information About Medicare Prescription Drug Coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call **800.MEDICARE (800.633.4227)**. TTY users should call **877.486.2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **800.772.1213** (TTY **800.325.0778**).

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

Date:	July 1, 2025
Name of Entity/Sender:	TMA
Contact:	Human Resources
Address:	3000 Business Center Drive Alexandria, VA
Phone Number:	703.459.4821
Email:	DASH-HR@alexandriava.gov

COBRA General Notice

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your employer.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, **Children's Health Insurance Program (CHIP),** or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov.**

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

1 **https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods**

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **https://www.medicare.gov/medicare-and-you.**

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefi ts Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa.** (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov.**

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

TMA's benefit plan information can be obtained by contacting **Human Resources.**

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1] [2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

1 Indexed annually; see **https://www.irs.gov/pub/irs-drop/rp-22-34.pdf** for 2023.

2 An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit **HealthCare.gov** or call the Marketplace Call Center at **800.318.2596**. TTY users can call **855.889.4325**.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days aft er the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confi rm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any ti me by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name TMA		4. Employer Identification Number (EIN) 54-1264014
5. Employer address 3000 Business Center Drive		6. Employer phone number (703) 459-4821
7. City Alexandria	8. State Virginia	9. ZIP code 22314-5205
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	12. Email address DASH-HR@alexandriava.gov	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Contacts

Benefit Plan Contact Information

Coverage Type	Provider	Phone and Web
Medical	Kaiser Permanente	800.777.7902 www.kaiserpermanente.org
	United Healthcare	866.844.4864 www.myuhc.com
Pharmacy	UHC / CVS Caremark	844.278.5730 www.caremark.com
Dental	The Standard	800.547.9515 www.standard.com
Vision	The Standard	800.547.9515 www.standard.com
Life and AD&D (Basic / Supplemental) **Voluntary Long-Term Disability** **Short-Term Disability**	The Standard	800.628.8600 / 800.368.1135 / 800.368.2859 www.standard.com
Voluntary Accident **Voluntary Critical Illness** **Voluntary Hospital Indemnity**	The Standard	800.348.3226 www.standard.com
Flexible Spending Account (FSA)	HealthEquity	866.346.5800 www.healthequity.com
Employee Assistance Plan	The Standard	888.293.6948 http://www.healthadvocate.com/standard3
401(k) Retirement Benefits	PCS Retirement	888.621.5491 www.pcsretirement.com
Commuter Benefits	SmartBenefits (WMATA)	202.962.2784 www.wmata.com/smartbenefits
Auto / Home Insurance, Extended Warranties	Gallagher Marketplace	ajg.com/GallagherMarketplace

Gallagher Benefit Services

Benefit Advocacy Center:

833.229.3752

BAC.TransitManagementofAlexandriaAdvocates.com

Monday – Friday | 8 a.m. – 6 p.m. (EST)

Want to learn more about your benefi ts? Scan the QR code or visit https://www.brainshark.com/gallagher/TMAlexOpenEnrollment2025 for an in-depth review!

This benefit guide prepared by

Gallagher

Insurance | Risk Management | Consulting

DCN25BG1TMAnu