



2026-2027 Benefits Guide Transit Management of Alexandria (TMA)

NON-UNION

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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 TRANSIT MANAGEMENT OF ALEXANDRIA	
Medical (Kaiser Permanente)	<ul style="list-style-type: none"> • Kaiser Permanente HMO Plan
Medical (UnitedHealthcare and CVS / Caremark)	<ul style="list-style-type: none"> • 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 Card included on all 3 UHC plans
Dental (The Standard)	<ul style="list-style-type: none"> • Dental PPO Plan – Ameritas Network
BENEFITS PROVIDED BY TRANSIT MANAGEMENT OF ALEXANDRIA	
Basic Life and AD&D (The Standard)	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 60% of weekly earnings to \$2,000. Must be employed for 1 year to receive benefits; 14-day waiting period applies.
Employee Assistance Plan (The Standard)	<ul style="list-style-type: none"> • 24/7 Counseling
Vision (The Standard)	<ul style="list-style-type: none"> • Vision PPO Plan – EyeMed Access Network
VOLUNTARY EMPLOYEE PAID BENEFITS	
Long-Term Disability (The Standard)	<ul style="list-style-type: none"> • 60% of monthly earnings to \$8,000
Additional Life and AD&D for Employees (The Standard)	<ul style="list-style-type: none"> • Up to \$300,000 in coverage
Additional Life and AD&D for Dependents (The Standard)	<ul style="list-style-type: none"> • Up to \$150,000 coverage (spouse) • Up to \$10,000 coverage (child/ren)
Healthcare FSA (HealthEquity)	<ul style="list-style-type: none"> • \$3,400 maximum plan year contribution
Dependent Care FSA (HealthEquity)	<ul style="list-style-type: none"> • \$7,500 maximum plan year contribution
Accident (The Standard)	<ul style="list-style-type: none"> • 4-Tier Rates
Critical Illness (The Standard)	<ul style="list-style-type: none"> • Employee: increments of \$5,000 up to \$50,000 • Spouse: increments of \$5,000 up to \$30,000 (up to Employee coverage amount) • Child(ren): 25% of the Employee coverage amount
Hospital Indemnity (The Standard)	<ul style="list-style-type: none"> • 4-Tier Rates
Legal Benefits (MetLife)	<ul style="list-style-type: none"> • Unlimited access to experienced attorneys to assist with multiple legal matters
Commuter Benefits (Smartbenefits)	<ul style="list-style-type: none"> • DASH contributes up to \$300 per month based on commuting distance, for use on Metro, MARC, VRE, MTA Commuter Bus, and vanpools
RETIREMENT PLAN	
401(k)	<ul style="list-style-type: none"> • PCS Retirement (DASH contributes 8% of your earnings to your retirement account)

Want to learn more about your benefits? Scan the QR code or visit <https://www.brainshark.com/gallagher/TMAlexOpenEnrollment2026> 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](tel: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 from your eligibility date. If you do not enroll, you will not be eligible for benefits until the next Annual Enrollment, unless you have a qualifying life event.

Annual Enrollment

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

Qualifying Life Event

If you have a Qualifying Life Event, you may be able to change your benefits before the next Annual Enrollment. You must notify Human Resources within 30 days of the change.

Qualifying Life Event 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 Life Events.

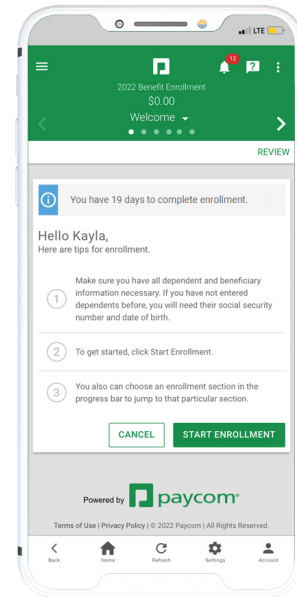
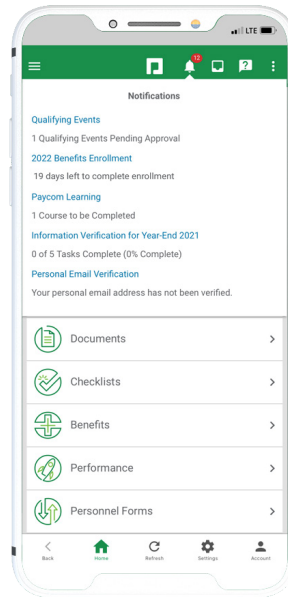
Show Me How

to Enroll in Benefits

BENEFITS ADMINISTRATION

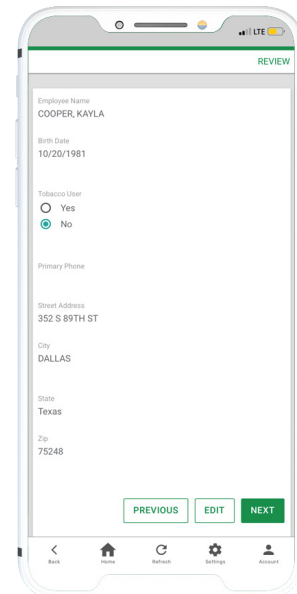
STEP 1

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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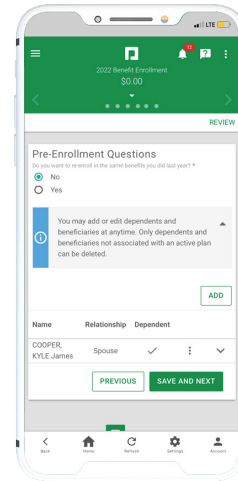
Show Me How

to Enroll in Benefits

BENEFITS ADMINISTRATION

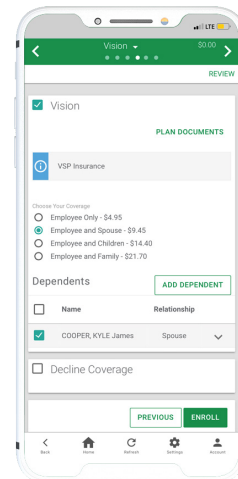
STEP 3

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.*



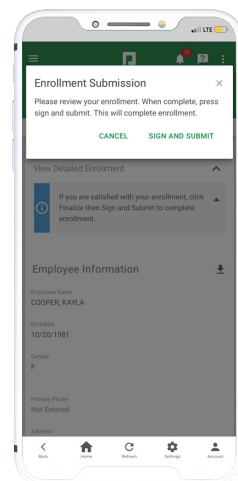
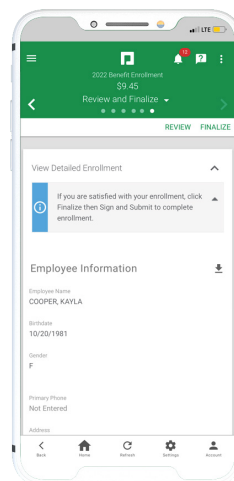
STEP 4

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.

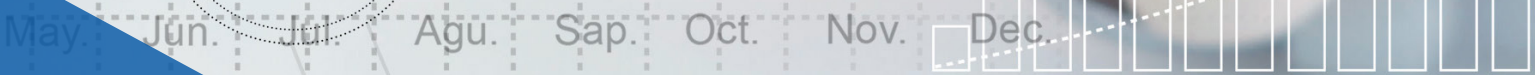
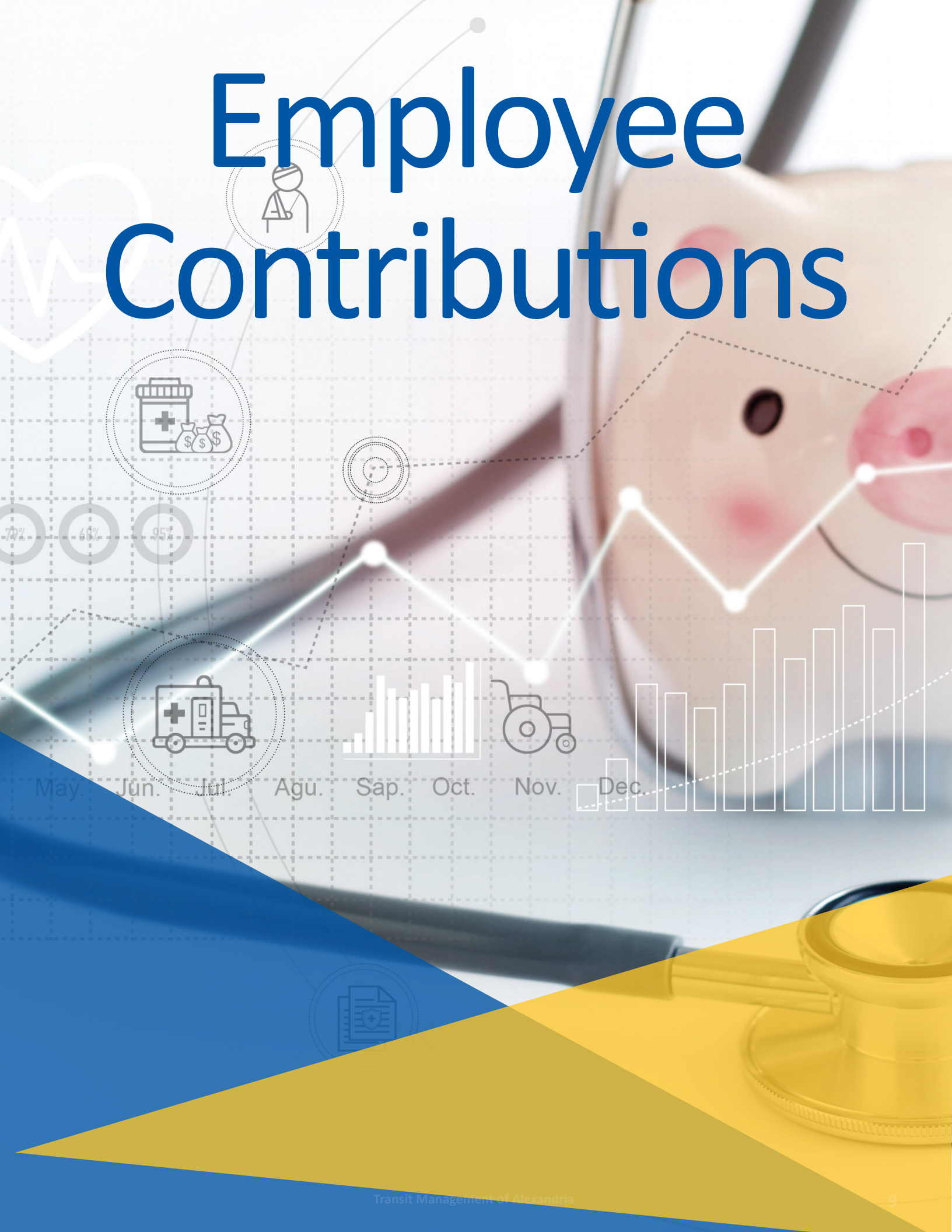


STEP 5

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 Paycheck Contributions

MEDICAL	Kaiser Permanente	UnitedHealthcare		
	DHMO 20	Choice HMO	Choice + POS	Choice + HDHP
Employee Only	\$37.99	\$37.03	\$53.42	\$16.60
Employee + 1	\$75.98	\$73.83	\$112.95	\$70.59
Employee + 2 or More	\$96.87	\$94.87	\$145.16	\$91.37

DENTAL	The Standard
Employee Only	\$1.45
Employee + 1	\$2.96
Employee + 2 or More	\$4.27

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	\$8.05
Employee + Spouse	\$17.02
Employee + Child(ren)	\$15.64
Family	\$26.31

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 Voluntary coverage rates (Critical Illness, Life and AD&D, and Long Term Disability) will calculate in Paycom based on age and coverage amount.

LEGAL PLAN	MetLife
Unlimited access	\$9.00

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 any of the 3 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](https://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.

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!

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

Registering is very easy

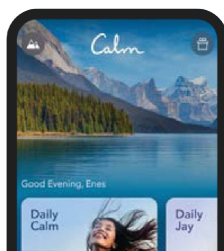
Go to kp.org/registernow from a computer (not a mobile device) and follow the sign-on instructions. You'll need your medical record number/ health record number, which you can find on your Kaiser Permanente ID card.

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.

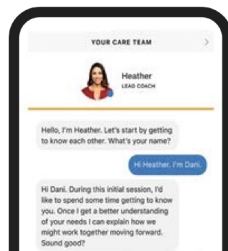
Kaiser Permanente members can explore 3 evidence-based apps:^{1,2,3}



Calm

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

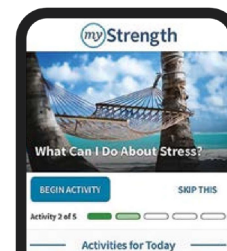
- Guided meditations
- Sleep Stories
- Mindful movement videos



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 goals⁶



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.



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

Additional Diagnostic Coverage includes coverage for the first in network diagnostic mammogram, diagnostic breast MRI, and diagnostic colonoscopy of the calendar/plan year at 100%, with subsequent diagnostic services processing according to the standard UHC cost share.

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	

Additional Diagnostic Coverage includes coverage for the first in network diagnostic mammogram, diagnostic breast MRI, and diagnostic colonoscopy of the calendar/plan year at 100%, with subsequent diagnostic services processing according to the standard UHC cost share.

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)	\$1,700 / \$3,400	\$3,400 / \$6,800
Coinsurance (UHC / You)	90% / 10%	60% / 40%
Out-of-Pocket Maximum (Single / Family)	\$3,400 / \$6,800	\$6,800 / \$13,600
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 tax-free (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 well-woman 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.

Take advantage of the DASH contribution to your HSA:

\$500 to Employee only plan

\$700 to Employee + 1 or Family plan



Using a HDHP

Free Preventive Care

You pay nothing for in-network preventive care.

Deductible

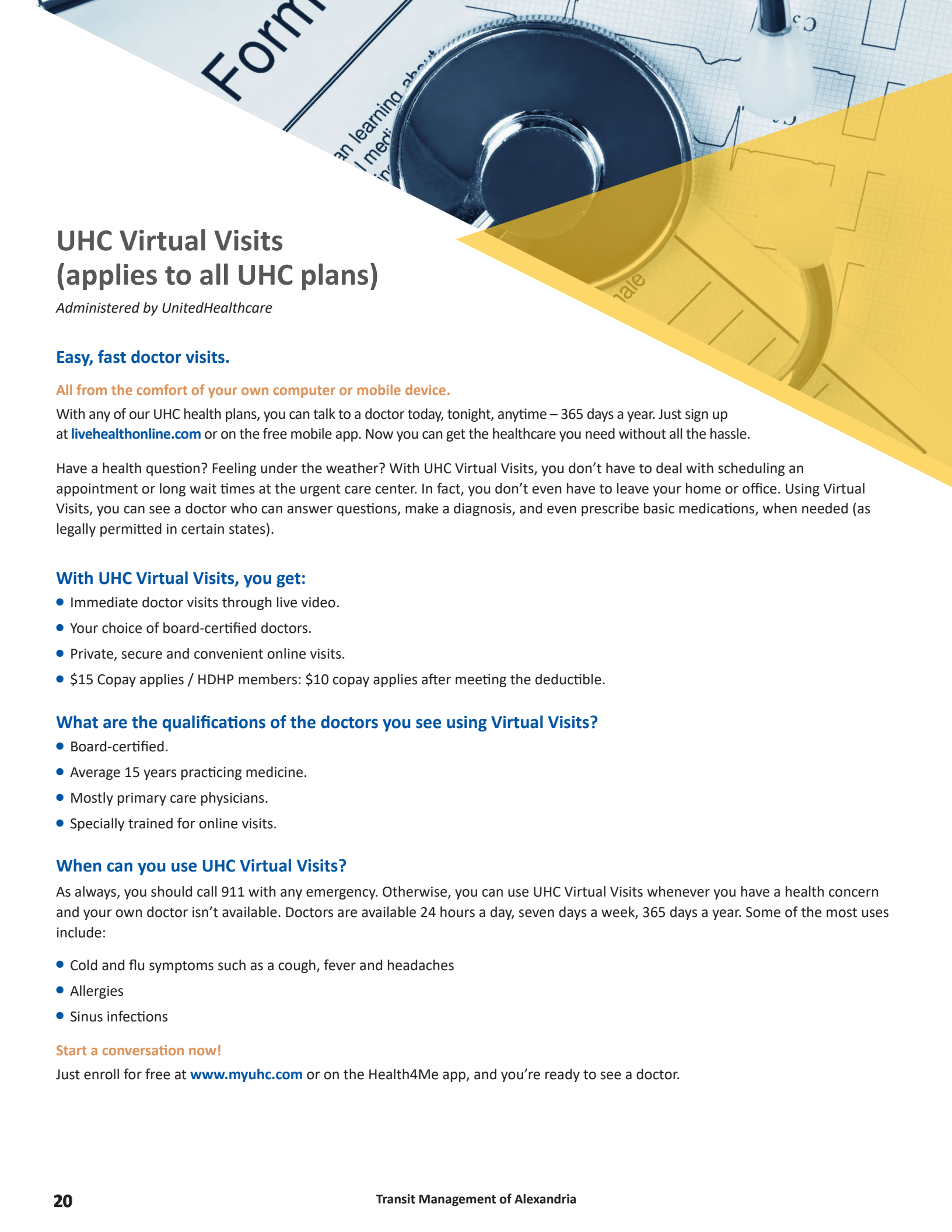
You pay 100% of your medical expenses up to the annual deductible amount. Use your HSA to plan for these costs.

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.



UHC Virtual Visits (applies to all UHC plans)

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 livehealthonline.com or on the free 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 Health4Me 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 you, 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.





A wellness program built for personalization

Get support to help you make sustainable changes at your own pace

Your Wellos journey starts now



Tracking to help you learn

Personalized suggestions based on your real-life data



Coaching that comes to you

Online coaches and behavior change lessons by your side as you build sustainable habits



Personalized support

Challenges designed to help keep you excited about the changes you're making

Wellos is a voluntary digital wellness program for fully insured business. A buy-up option, which includes 1:1 live coaching, is available for purchase for certain groups (buy up option not available in NM and pending approval in CA, HI and MT). The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult with an appropriate health care professional to determine what may be right for you. Insurance coverage provided through UnitedHealthcare Insurance Company or its affiliates.

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Enroll today

Join Wellos at no cost to you!



Download the app or go to wellos.com/member to get started today!

United
Healthcare®

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	<ul style="list-style-type: none"> 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\$	<ul style="list-style-type: none"> 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 \$\$	<ul style="list-style-type: none"> 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 \$\$\$	<ul style="list-style-type: none"> 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, refill prescriptions, or use the drug pricing tool. You can also call Pharmacy Services at **800.241.3371**.

Prior Authorization

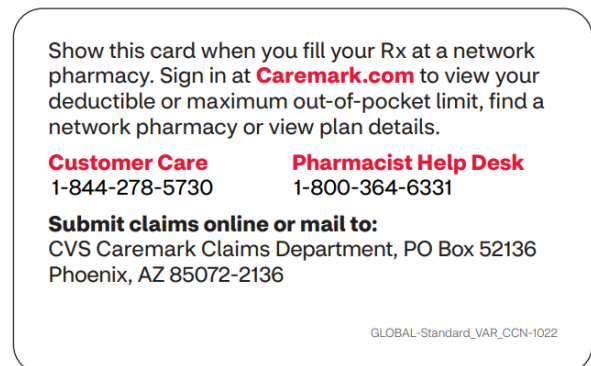
Prior Authorization from CareFirst is required before you fill prescriptions for certain drugs. Your doctor may need to provide some of your medical history or laboratory tests to determine if these medications are appropriate. Without prior authorization from CVS / Caremark, your drugs may not be covered.

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 CareFirst 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 fill 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 – Ameritas Network

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 – EyeMed Access Network

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 – Ameritas Network

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	

¹Reimbursement 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 – EyeMed Access Network

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)	\$150 allowance, then 20% off amount over frame allowance	Up to \$45 Reimbursement
CONTACTS¹ (IN LIEU OF GLASSES)		
Medically Necessary (every 12 months)	Covered in Full	Up to \$200 Reimbursement
Elective (every 12 months)	\$150 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.

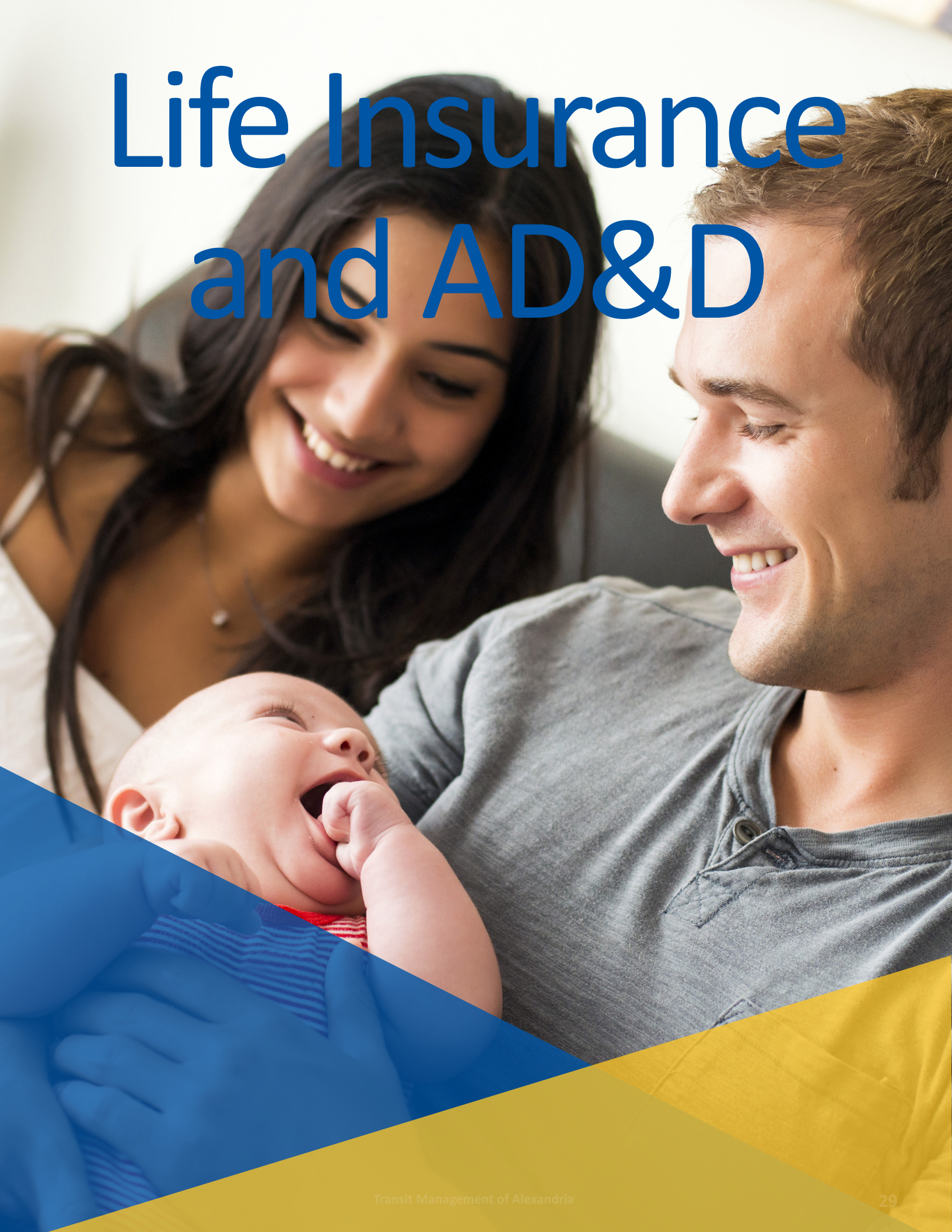
Find a provider:

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: Review and update your Life Insurance beneficiary information in Paycom during Annual Enrollment. You may make changes to your beneficiary at any time.

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
- Evidence of Insurability is required if the coverage is above \$25,000 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 After Age 65 – applies to Employee and Spouse Coverage

- 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.

Should you choose to elect amounts over the guaranteed issue amount OR you are a late entrant, you and/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 voluntary 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:

- 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

Contact Travel Assistance
medservices@assistamerica.com

**United States, Canada, Puerto Rico,
U.S. Virgin Islands and Bermuda**
800.872.1414

Everywhere else
+1.609.986.1234

Disability and Other Benefits



Health

in signing and submitting
all information, please
provide a copy to
your supervisor / manager
provide employees for verification

Full legal name	Home street
Last Name	City
E-mail Address:	
Highest school grade	
Do you have a high school diploma?	
Number of years of post-secondary education	
Name and location of educational institution	
Degree	

Short-Term Disability

Administered by The Standard

This benefit 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. You are eligible to receive benefits under this plan, after you have been employed by TMA for 1 year.

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 benefit equal to 60% of your basic monthly income, up to \$8,000 per month.

If enrolling in this benefit when first becoming benefits eligible, no Evidence of Insurability is required. If enrolling past the initial eligibility period or during any subsequent annual enrollment, Evidence of Insurability is required.

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 (refer to the Standard benefits Guide for more details)
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
HOSPITAL² 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.

¹Covered 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.

²Hospital 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 \$10,000 or \$20,000 benefit amount, and either \$5,000 or \$10,000 for your spouse¹ when you are enrolled
- Recurrence benefit – 25% of coverage, 12-month treatment-free period¹
- 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 by you, the employee. The chart below indicates your bi-weekly cost

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

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

²The 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 diseases³, 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.

³The 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, Hirschprung's disease, hypoplastic left heart syndrome, infantile hypertrophic pyloric stenosis, muscular dystrophy, orophalocele, patent ductus arteriosus, spina bifida cystica with myelomeningocele, tetralogy of fallot, transposition 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



Cover the costs on a wide range of common legal issues with a Legal Plan.

Access experienced attorneys to help with estate planning, home sales, tax audits and more.

Powerful legal protection on your side

Quality legal assistance can be pricey. And it can be hard to know where to turn to find an attorney you can trust. With MetLife Legal Plans, you have access to the expert guidance and tools you need to navigate a broad range of personal legal needs. Whether you're buying or selling a home, starting a family, or caring for aging parents, the benefit provides protection at every step.

Reduce the out-of-pocket cost of legal services with MetLife Legal Plans.

How it works

Our service is tailored to your needs. With network attorneys available in person, by phone or by email and online tools to do-it-yourself — we make it easy to get legal help. And, you will always have a choice in which attorney to use. You can choose one from our network of prequalified attorneys, or use an attorney outside of our network and be reimbursed some of the cost.¹

Best of all, you have unlimited access to our attorneys for all legal matters covered under the plan. For a monthly fee conveniently paid through payroll deduction, an expert is on your side as long as you need them.

Estate planning at your fingertips

Our website provides you with the ability to create wills, living wills and powers of attorney online in as little as 15 minutes. Answer a few questions about yourself, your family and your assets to create these documents instantly. In states where available, you also have access to sign and notarize your documents online through our video notary feature.²

How to use the plan

1. Find an attorney

Create an account at members.legalplans.com to see your coverages and select an attorney for your legal matter. Or, give us a call at **800-821-6400** for assistance.

2. Make an appointment

Call the attorney you select and schedule a time to talk or meet.

3. That's it!

There are no copays, deductibles or claim forms when you use a network attorney for a covered matter.

Helping you navigate life's planned and unplanned events.

For a monthly fee, you, your spouse and dependents get legal assistance for some of the most frequently needed personal legal matters — with no waiting periods, no deductibles and no claim forms when using a network attorney for a covered matter. And, for non-covered matters that are not otherwise excluded, your plan provides four hours of network attorney time and services per year.³

Money Matters	<ul style="list-style-type: none"> Debt Collection Defense Identity Theft Defense Identity Restoration⁴ 	<ul style="list-style-type: none"> Identity & Fraud Protection⁴ Negotiations with Creditors Personal Bankruptcy 	<ul style="list-style-type: none"> Promissory Notes Tax Audit Representation Tax Collection Defense
Home & Real Estate	<ul style="list-style-type: none"> Boundary or Title Disputes Deeds Eviction Defense Foreclosure 	<ul style="list-style-type: none"> Home Equity Loans Mortgages Property Tax Assessments Refinancing of Home 	<ul style="list-style-type: none"> Sale or Purchase of Home Security Deposit Assistance Tenant Negotiations Zoning Applications
Estate Planning	<ul style="list-style-type: none"> Codicils Complex Wills Healthcare Proxies Living Wills 	<ul style="list-style-type: none"> Powers of Attorney (Healthcare, Financial, Childcare, Immigration) 	<ul style="list-style-type: none"> Revocable & Irrevocable Trusts Simple Wills
Family & Personal	<ul style="list-style-type: none"> Adoption Affidavits Conservatorship Demand Letters Divorce (20 hours) Garnishment Defense Guardianship 	<ul style="list-style-type: none"> Immigration Assistance Juvenile Court Defense, Including Criminal Matters Name Change Personal Property Protection 	<ul style="list-style-type: none"> Prenuptial Agreement Protection from Domestic Violence Review of ANY Personal Legal Document School Hearings
Civil Lawsuits	<ul style="list-style-type: none"> Administrative Hearings Civil Litigation Defense 	<ul style="list-style-type: none"> Disputes Over Consumer Goods & Services Incompetency Defense 	<ul style="list-style-type: none"> Pet Liabilities Small Claims Assistance
Elder-Care Issues	Consultation & Document Review for your parents: <ul style="list-style-type: none"> Deeds Leases 	<ul style="list-style-type: none"> Medicaid Medicare Notes Nursing Home Agreements 	<ul style="list-style-type: none"> Powers of Attorney Prescription Plans Wills
Traffic & Other Matters	<ul style="list-style-type: none"> Defense of Traffic Tickets⁵ 	<ul style="list-style-type: none"> Driving Privileges Restoration 	<ul style="list-style-type: none"> Repossession

To learn more about your coverages, view our attorney network or grant your dependents access, create an account.

Your account will also give you access to our self-help document library to complete simple legal forms. The forms are available to you, regardless of enrollment.

Cost:
\$19.50 per month



Create an account at members.legalplans.com or scan the QR code.

Questions? Call the **MetLife Legal Plans Client Service Center** at **800-821-6400** Monday—Friday, 8:00 a.m. to 8:00 p.m., ET.

- The Participant will be reimbursed according to the set fee schedule, the lesser of the maximum reimbursement amount or the attorney's actual charge. You will be responsible to pay the difference, if any, between the plan's payment and the non-plan attorney's charge for services. MetLife Legal Plans is not responsible for legal work performed by out-of-network attorneys.
- Digital notary and signing is not available in all states.
- No more than a combined maximum total of four hours of attorney time and service are provided for the member, spouse and qualified dependents, annually.
- Aura is a product of Aura Sub, LLC. Aura Sub, LLC is not affiliated with MetLife, and the services and benefits they provide are separate and apart from any MetLife product.
- Does not cover DUI.

Legal plans are administered by MetLife Legal Plans, Inc., Cleveland, Ohio. In California, this entity operates under the name MetLife Legal Insurance Services. In certain states, legal plans are provided through insurance coverage underwritten by Metropolitan General Insurance Company, Warwick, RI. For costs and complete details of the coverage, call or write the company. Some services not available in all states. No service, including consultations, will be provided for: 1) employment-related matters, including company or statutory benefits; 2) matters involving the employer, MetLife and affiliates and plan attorneys; 3) matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents; 4) appeals and class actions; 5) farm and business matters, including rental issues when the participant is the landlord; 6) patent, trademark and copyright matters; 7) filing fees, costs and fines; 8) frivolous or unethical matters; 9) matters for which an attorney client relationship exists prior to the participant becoming eligible for plan benefits. Coverage for defense of criminal matters is excluded from insurance coverage for individuals located in New York. For all other personal legal matters, an advice and consultation benefit is provided. Additional representation is also included for certain matters. Please see your plan description for details. [MLP4w20hrsDivorce&CM]



MetLife Legal Plans | 1111 Superior Avenue, Suite 800 | Cleveland, OH 44114
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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. Including substance abuse or dependency.

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:	<ul style="list-style-type: none">• 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

Perks at Work



Health Advocate is pleased to offer you and your family **Perks at Work**, a **FREE discount program** that offers savings on products and services from thousands of merchants.



Save on travel, electronics, tickets, restaurants, flowers, home products, apparel and more



Earn WOW points on everything you buy, that can be redeemed like cash to use towards your next purchase from your favorite merchants



Invite up to 10 family members to join the program



Access exclusive rates on electronics, cell phones and car rentals

Visit Perks at Work

1. Log on to your member website or mobile app
2. Scroll toward the bottom of the page and select **Visit Perks at Work**
3. Explore the perks and discounts available to you



888.293.6948

answers@HealthAdvocate.com

HealthAdvocate.com/Standard3

Call • Email • Message • Live Chat



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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 \$3,400. You are able to rollover up to \$680 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 \$7,500, for the 2026 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, 2026 through June 30, 2027; 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 29, 2027 (90 days from end of plan year) for reimbursement. Any unused funds in excess of \$680 will be forfeited. DASH has elected to offer a \$680 rollover option, which will allow you to roll over up to \$680 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) w/HSA, 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 benefits 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 2026-2027:

- Up to \$4,400 for employee-only coverage.
- Up to \$8,750 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, which count toward the above annual maximums

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 2026 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 2026-2027.
- 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 to begin making their own contributions upon date of hire, up to the IRS maximum allowable each calendar year. The Company contribution will begin the 1st of the month following completion of 90 days of service.

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.

Company Contribution Vesting Schedule	
1 year anniversary	25%
2 year anniversary	50%
3 year anniversary	75%
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 autoloading to your SmartTrip card – Metro’s rechargeable card.

The monthly benefit is up to \$300.00 and will be assigned to registered Smart Trip 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](mailto:HR_DASH-HR@Alexandriava.gov) or [Finance DASH-Finance@Alexandriava.gov](mailto: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. The sick leave benefit is capped at 520 hours.

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. The cost to use the Club is \$2.50 per paycheck.

Credit Union

Employees may join a local Transit Credit Union.

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
(1) Floating Holiday





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 annual 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.

Insurance is subject to availability and individual eligibility.
Consulting and insurance brokerage services to be provided by Gallagher Benefit Services, Inc. and/or its affiliate Gallagher Benefit Services (Canada) Group Inc. Gallagher Benefit Services, Inc. is a licensed insurance agency that does business in California as "Gallagher Benefit Services of California Insurance Services" and in Massachusetts as "Gallagher Benefit Insurance Services." Neither Arthur J. Gallagher & Co., nor its affiliates provide accounting, legal or tax advice.
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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 deductible, 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 \$1,000, your plan won't pay anything until you've met your \$1,000 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. Therefore, the following deductibles and coinsurance apply:

Plan 1: HMO PLAN (Individual: 80% / 20% coinsurance and \$500 deductible; Family: 80% / 20% coinsurance and \$1,000 deductible)

Plan 2: CHOICE HMO (Individual: 90% / 10% coinsurance and \$400 deductible; Family: 90% / 10% coinsurance and \$800 deductible)

Plan 3: CHOICE PLUS POS (Individual: 90% / 10% coinsurance and \$400 deductible; Family: 90% / 10% coinsurance and \$800 deductible)

Plan 4: Choice Plus HDHP (Individual: 90% / 10% coinsurance and \$1,700 deductible; Family: 90% / 10% coinsurance and \$3,400 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at [703.459.4821](tel:703.459.4821) or yvonne.jung@alexandriava.gov.

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 January 31, 2026. 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://hcpf.colorado.gov/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.flmedicaidtprerecovery.com/flmedicaidtprerecovery.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
All other Medicaid
<https://www.in.gov/medicaid/> | 800.457.4584
Family and Social Services Administration
<http://www.in.gov/fssa/dfr/> | 800.403.0864

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

Medicaid: www.ldh.la.gov/healthy-louisiana
Customer Service Line: 888.342.6207
Medicaid Email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP):
<https://www.ldh.la.gov/lahipp>
LaHIPP Phone: 877.697.6703 | LaHIPP Email: La.HIPP@la.gov
LaHIPP Fax: 888.716.9787
LaHIPP Mailing Address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – Medicaid

Enrollment: 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: masspreassistance@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: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

<http://www.ACCESSNebraska.ne.gov>
Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178

NEVADA – Medicaid

<http://dhcnp.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://dhr.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 January 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
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 4/30/2026)

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

Transit Management of Alexandria is committed to the privacy of your health information. The administrators of the Transit Management of Alexandria Health Plan (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 Yvonne Jung – Chief Labor Relations and Engagement Officer at [703.459.4821](tel:703.459.4821) or yvonne.jung@alexandriava.gov.

HIPAA Special Enrollment Rights

Transit Management of Alexandria health Plan 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 Yvonne Jung - Chief Labor Relations and Engagement Officer at [703.459.4821](tel:703.459.4821) or yvonne.jung@alexandriava.gov.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children’s health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan’s annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan.

Notice of Creditable Coverage

Important Notice from Transit Management of Alexandria

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 Transit Management of Alexandria 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. Transit Management of Alexandria 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 15th to December 7th.

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

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

If you decide to join a Medicare drug plan, your current Transit Management of Alexandria coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current Transit Management of Alexandria 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 Transit Management of Alexandria 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 Transit Management of Alexandria 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, 2026
Name of Entity/Sender: Transit Management of Alexandria
Contact: Yvonne Jung
Chief Labor Relations and Engagement Officer
Address: 3000 Business Center Drive
Alexandria, VA
Phone Number: 703.746.5648

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 period¹ 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 Benefits 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

Transit Management of Alexandria
Yvonne Jung – Chief Labor Relations and Engagement Officer
3000 Business Center Drive
Alexandria, Virginia 22314-5205
United States
703.459.4821

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](https://www.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 after 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. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time 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 Yvonne Jung.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.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 Transit Management of Alexandria		4. Employer Identification Number (EIN) 54-1264014	
5. Employer address 3000 Business Center Drive		6. Employer phone number 703.746.DASH	
7. City Alexandria	8. State Virginia	9. ZIP code 22314-5205	
10. Who can we contact about employee health coverage at this job? Yvonne Jung			
11. Phone number (if different from above)		12. Email address yvonne.jung@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:
Employees working at least 30 hours per week are eligible for group insurance benefits.

Some employees. Eligible employees are:

- With respect to dependents:

We do offer coverage. Eligible dependents are:
Your eligible dependents include your legally married spouse, registered domestic partner, and children.

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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

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 – Ameritas Network	The Standard	800.547.9515 www.standard.com
Vision – EyeMed Access Network	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 www.standard.com
Voluntary Accident Voluntary Critical Illness Voluntary Hospital Indemnity	The Standard	800.348.3226 www.standard.com
Absence Management	The Standard	866.756.8116
Flexible Spending Account (FSA)	HealthEquity	866.346.5800 www.healthequity.com
Legal Plan	MetLife Legal	800.821.6400 www.members.legalplans.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 benefits? Scan the QR code or visit <https://www.brainshark.com/gallagher/TMAlexOpenEnrollment2026> for an in-depth review!





This benefit guide prepared by



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