metro

WASHINGTON METROPOLITAN AREA TRANSIT AUTHORITY
600 Fifth Street, NW, Washington, DC 20001-2651

AMENDMENT OF SOLICITATION / MODIFICATION OF CONTRACT

1. AMENDMENT/MODIFICATION	2. EFFECTIVE DATE
Amendment (A002)	November 20, 2017
3. ISSUED BY PURCHASING SECTION Office of Procurement and Materials 600 Fifth St, NW, Washington DC.	4. ADMINISTERED BY (If other than block 3)
5. CONTRACTOR N/A NAME AND ADDRESS (Street, city, county, state, and Zip Code)	6. FORM TYPE (Check only one) [X] AMENDMENT OF SOLICITATION No. **RFP No.CQ18027** Issued Date: Nov. 1, 2017 [ ] MODIFICATION OF CONTRACT/ORDER NO. _____

7. THIS BLOCK APPLIES ONLY TO AMENDMENTS OF SOLICITATIONS

The above numbered solicitation is amended as set forth in block 10. The hour and date specified for receipt of Offers is not extended. Offerors must acknowledge receipt of this amendment prior to the hour and date specified in the solicitation, or as amended, by one of the following methods; (a) By signing and returning one (1) copy of this amendment; (b) by acknowledging receipt of this amendment on each copy of the offer submitted; or (c) by separate letter or telegram which includes a reference to the solicitation and amendment numbers. FAILURE OF YOUR ACKNOWLEDGMENT TO BE RECEIVED AT THE ISSUING OFFICE PRIOR TO THE HOUR AND DATE SPECIFIED MAY RESULT IN REJECTION OF YOUR OFFER. If, by virtue of this amendment you desire to change an offer already submitted, such change may be made by telegram or letter, provided such telegram makes reference to the solicitation and this amendment, and is received prior to the opening hour and date specified.

8. ACCOUNTING AND APPROPRIATION DATA (If required) N/A

9. THIS BLOCK APPLIES ONLY TO MODIFICATIONS OF CONTRACTS/ORDERS (N/A)

(a) [ ] This Change Order is issued pursuant to _____

(b) [ ] The Changes set forth in block 10 are made to the above numbered contract/order. The above numbered contract/order is modified to reflect the administrative changes (such as changes in paying office, appropriation data, etc.) set forth in block 10.

(c) [ ] This Supplemental Agreement is entered into pursuant to authority of _____ It modifies the above numbered contract as set forth in block 10.

10. DESCRIPTION: AMEND the RFP CQ18027 HR Benefits Health and Welfare Outsourcing & Administration and Answer Questions from interested Offerors;

Amend:

1) Delete the words "self-insured" on pages 11, 86, and on the RFP letter dated October 31, 2017.
2) Use instead attached revised past performance form "Past Performance Evaluation Form (REV.1)" as required in the RFP.

Vendor Questions and WMATA Answers: (Questions were presented as is and without alterations)

1. We understand the original of Volumes 1 and 2 are to be unbound and Volume 3 is to be bound. Can you please clarify your expectations of unbound versus bound? WMATA Answer: Unbound means loose. Use of a paper clip is suggested. Bound means, a binding in which pages are fastened together such as a booklet as spiral binding.

---See continuation to A002 ---

Except as provided herein, all terms and conditions of the document referenced in block 6, as heretofore changed, remain unchanged and in full force and effect.

11.	
[X] CONTRACTOR/OFFEROR IS REQUIRED TO SIGN THIS MODIFICATION AND RETURN ONE (1) COPY TO ISSUING OFFICE.	[ ] CONTRACTOR/OFFEROR IS NOT REQUIRED TO SIGN THIS DOCUMENT
12. NAME OF CONTRACTOR/OFFICE BY _____ (Signature of person authorized to sign)	15. WASHINGTON METROPOLITAN AREA TRANSIT AUTHORITY BY Monique M. Anderson (Signature of Contracting Officer)

13. NAME AND TITLE OF SIGNER (Type or print)	14. DATE SIGNED	16. NAME OF CONTRACTING OFFICER (Type or print)	17. DATE SIGNED
		Monique M. Anderson	11/21/17

AMENDMENT (A002) OF SOLICITATION RFP No. CQ18027

2. Can a Microsoft Word copy of the RFP be provided as this will simplify the process to complete forms, redline terms and conditions, etc.? WMATA Answer: No.

3. How many FEIN(s) does WMATA have? WMATA Answer: One (1), and the WMATA Federal Tax ID Number is 52-0847040.

4. Please confirm a total of:
    a. 3,430 active employees?
        i. Of these, how many are:
            1. Benefit-eligible?
            2. Medical-enrolled?
            3. Part-time and/or variable-hour?
    b. 2,155 retirees?
        i. Of these, how many are:
            1. Life-only retirees?
            2. Medical-enrolled retirees?

    WMATA Answer:
    A. Roughly 3,479 active employees.
        1. Benefit-eligible: 3,479
        2. Medical-enrolled: 2,968
        3. Part-Time and/or variable-hour: 1
    B. Roughly 2,155 Retirees.
        1. Life-only retirees: 63
        2. Medical-enrolled retirees: 1,782

5. Do eligibility rules differ across WMATA's population? Please explain. WMATA Answer: No

6. How are benefits currently administered? WMATA Answer: Benefits are currently administered in-house by the WMATA Benefit Staff.

    a. Who is the current benefits administration provider? WMATA Answer: The current benefits administration providers are listed in the scope of work. (See page 87).
    b. Is there any documentation in addition to what was provided with the RFP to assist in outlining this detail? WMATA Answer: See attached draft procedures.

7. Please describe your current billing process. WMATA Answer: Bills are processed monthly. These are reviewed and audited by the benefit staff and processed through PeopleSoft Financials.

8. How is ACA currently managed?
    a. Who is the current provider? WMATA Answer: ADP
    b. How many 1095-C forms were sent in the 2016 reporting year? WMATA Answer:15,579 (this includes our Local 689 employees)

9. Who is the current payroll administrator (including version of system, if applicable)? WMATA Answer: In House – using PeopleSoft 9.1 HCM
    a. Does WMATA leverage multiple payroll systems? If so, how many and whom? WMATA Answer: No.

10. How COBRA is currently managed? WMATA Answer: Currently managed in house by the Benefit Staff
    a. How many participants on COBRA? WMATA Answer: 25.
    b. What is annual turnover (%)? WMATA Answer: 14%

11. How are employee benefit inquiries currently managed? WMATA Answer: In House - Benefit Staff
    a. Are call statistics available? Please provide if available. WMATA Answer: No.

12. Is an SSO with WMATA's company intranet desired? WMATA Answer: Yes.

13. What are WMATA's expectations around wellness? Are wellness initiatives in place? WMATA Answer: WMATA has an employee wellness program.

14. Are QMCSO administration services in-scope? If so, what is the volume of QMCSOs supported monthly and/or annually? WMATA Answer: No.

15. Is direct billing support for employees on leave in-scope? WMATA Answer: Yes, and it is currently administered in-house by Benefit Staff. If so, how many employees are currently on a leave of absence? WMATA Answer: 234 as of 10/10/2017.

16. Is retiree direct billing in-scope? WMATA Answer: Yes, and it is currently administered in-house by Benefit Staff. If so, how many retirees are currently being direct billed? WMATA Answer: 126.

17. Can you please define and elaborate on student certification and the corresponding requirements? WMATA Answer**:** The student has to be enrolled full-time in an accredited school. How is this handled today? WMATA Answer: It is currently administered in-house by the WMATA Benefit Staff.

18. What are WMATA's expectations around retiree administration? WMATA Answer: The vendor will be responsible for maintaining insurance enrollment data, life event changes, open enrollment, address updates, required mailings, responding to calls and processing life insurance claims, among others. Please describe the current process. WMATA Answer: It is currently administered in-house by the WMATA Benefit Staff.

19. Please provide an employee benefits communication guide. WMATA Answer: Not Available, but attached is the "New Employee Benefits Guide PY 2017" and "2018 Open Enrollment Guide".

20. Please clarify the meaning of "student certification" referenced on page 87 of your RFP. WMATA Answer: The student has to be enrolled full-time in a credited school.

21. Please provide the number of current COBRA participants/direct bill participants. WMATA Answer: 25 COBRA participants, 126 Retirees and 8 employees on LWOP.

22. Please provide the number of COBRA qualifying events on a monthly and/or annual basis. WMATA Answer: We have an annual turnover of 14%

23. Do you offer employees or retirees any voluntary "non-group rated" benefits (individually rated plan)? WMATA Answer: Both groups are offered supplemental life

24. Please provide the WMATA IT Standards Guidelines and WMATA IT Security Guidelines referenced on page 90 of your RFP:
    WMATA's policies and procedures provide a framework that establishes data security, availability and integrity of the WMATA data and its' operations. It is very important for all business units and IT to follow WMATA's policies and procedures as they ensure the integrity of business operations on IT Systems and also provide guidance on implementation of new projects and/or upgrades of existing solution. All proposed solutions and enhancements must follow the framework set by WMATA's Information Technology office. Please read the WMATA IT Standards Guidelines and the WMATA IT Security Guidelines in the appendix to this RFP. All proposers will be required to meet all the IT standards and security requirements if awarded the contract. This section must be included in the response in addition to completing the Information Security Questionnaire.
    WMATA Answer: Please refer to link:
    http://metroweb/departments/IT/Documents/WMATA_OCISO_GuidanceSecurityStandards20170519_V1_Signed.pdf

    See attachments.

----END of A002 ----

Past Performance Evaluation Form (REV.1)

This form should be completed by an authorized representative of the company that awarded the project/contract to:

COMPANY NAME:

COMPANY ADDRESS:

The information on this form will be used by WMATA for evaluation purposes only on WMATA RFP CQ18027 HR Benefits and Welfare Outsourcing & Administration.

1. Title of the Project/Contract:

2. Project/Contract Period of Performance:

3. Contract Value:

4. Brief Description of the Scope of Work:

I. Technical & Quality of Service	Yes	No	N/A
a. Was the project/contract completed as per scope of work?			
b. Was the project/contract completed on schedule?			
c. Was the Contractor properly staff and did they have the knowledge and experience to satisfactorily complete the project/contract?			
d. Was the contractor the prime contractor?			
Overall Rating: ___ Excellent ___ Satisfactory ___Unsatisfactory ___ N/A			

II. Customer Satisfaction	Yes	No	N/A
a. How would you rate the Contractor‘s customer service?			
Rating: ___ Excellent ___ Satisfactory ___Unsatisfactory ___ N/A			

Comments:

Completed by:_____ _____

Name Date

Title: _____

Company Name: _____

New Employee Benefit Guide

Plan Year 2017

MANAGEMENT AND ADMINISTRATIVE EMPLOYEES

OPEIU LOCAL 2 EMPLOYEES

metro®

TABLE OF CONTENTS

M E M O R A N D U M

SUBJECT: New Hire Benefits Information

TO: Non-Represented Employees and Local OPEIU Local 2 Employees

On behalf of the WMATA Benefits Office staff, welcome to Metro.

This package provides important information regarding your benefit plans.

You will be involved in four days of orientation activities to familiarize you with Our structure, mission, and polices. It is very important that you complete these materials before you come to orientation. The completed forms must be emailed to HRCB_Benefit_Inquiries@wmata.com.

Representatives from the WMATA Benefits Office will be on hand to answer any questions you may have on your first and second day at the new hire orientation.

The WMATA Benefits Office is located in Corridor 7E in the Jackson Graham Building, 600 5th St. NW, Washington, DC 20001.

If anything contained in this package is not clear to you, please do not hesitate to contact us.

Washington
Metropolitan Area
Transit Authority

600 5th St NW
Washington, D.C., 20001
202/962-1234

By Metrorail:
Judiciary Square-Red Line
Gallery Place-Chinatown
Red, Green and
Yellow Lines

A District of Columbia,
Maryland and Virginia
Transit Partnership

Welcome!

This guide is designed to provide you with an overview of our benefit programs and assist you in making an informed benefits decision.

EFFECTIVE DATE OF COVERAGE

All Insurance benefits become effective the first day of your employment.

You may enroll your eligible dependents to your benefit plans, in order to enroll you must provide proof of eligibility Eligible dependents for medical/prescription/dental and life insurance policies are defined as:

- Legal Spouse
- Qualified domestic partner (same sex or opposite sex),
- Dependent children (includes natural children, stepchildren, adopted children, or children for whom you or your spouse are legal guardians) up to their 26th birthday for medical benefits.
- Dental benefits cover your children until age 23. You must provide documentation that they are a full time student with an accredited college/university or trade school to cover them until age 26.

As a new employee, you may enroll in any available plan, within 30 days after your hire date. If you do not enroll during your initial allowable period, the next available opportunity will be during Open Season or within 30 days of a Qualifying Event. A Qualifying event is a change in your situation- like getting married, having a baby, or losing health coverage. These events are acceptable by the IRS and may allow participants to change their benefit election outside of Open Enrollment.

WAIVER OF MEDICAL COVERAGE

You may waive medical coverage only if you are covered under another medical plan. If you choose to waive medical coverage you must provide us with evidence that you are covered under another plan. You must re-certify your status every year.

WHAT DOCUMENTS DO I NEED TO BRING TO THE NEW HIRE ORIENTATION?

Documentation supporting your relationship with your dependents (i.e. marriage license, birth certificates, 1st page of your prior year tax forms) names, social security numbers and date of birth. Also you will need to bring a blank check to make sure direct deposit is established.

Below you will find a checklist of documents that are required to be submitted in order to process your enrollment. All enrollment forms as well as verification documents must be submitted to the Benefit Department by your second day of employment.

DOCUMENTS FOR PERSONNEL FILE AND PAYROLL

- ☐ IN CASE OF EMERGENCY FORM
- ☐ FEDERAL TAX FORM
- ☐ STATE TAX FORM
- ☐ DIRECT DEPOSIT FORM
- ☐ WELLS FARGO PAY CARD FORM (COMPLETE ONLY IF YOU DO NOT HAVE AN ACCOUNT FOR DEPOSIT DEPOSIT)
- ☐ ELECTRONIC PAY STATEMENT FORM

DOCUMENTS FOR BENEFITS

- ☐ MEDICAL/DENTAL INSURANCE ENROLLMENT FORM
- ☐ LIFE INSURANCE ENROLLMENT FORM
- ☐ LIFE INSURANCE BENEFICIARY FORM
- ☐ GROUP LONG TERM DISABILITY FORM
- ☐ PREMIUM CONVERSION ENROLLMENT FORM
- ☐ SICK LEAVE BANK ENROLLMENT FORM
- ☐ FLEXIBLE SPENDING ACCOUNT (HEALTH & DEPENDENT CARE) - OPTIONAL
- ☐ EMPOWER RETIREMENT ENROLLMENT FORM
- ☐ EMPOWER RETIREMENT BENEFICIARY FORM

2017 Summary and Comparison of Medical and Dental Benefits for Non-Represented Employees

UNITEDHEALTHCARE® (UHC)

KAISER PERMANENTE

CIGNA OPEN ACCESS PLUS

DELTA DENTAL

This guide presents highlights of your WMATA Benefits. For detailed information about plan provisions and eligibility, please refer to the information provided in the plan documents.
In the event of a conflict between the information on this guide and a plan document, the plan document will prevail.

Effective January 1, 2017

DESCRIPTION	United Healthcare ® (OPEN ACCESS - No referral necessary to a National Network of Participating Providers)	Kaiser Permanente	CIGNA Open Access Plus Plan	
			In-Network	Out-of-Network
PLAN CONDITIONS				
Insurance Deductible	$100 Individual $200 Family	$100 Individual $200 Family	$100 Individual $200 Family	$200 Individual $400 Family
Dependent Coverage	Dependent coverage to age 26.	Dependent coverage to age 26.	Dependent coverage to age 26.	Dependent coverage to age 26.
Medical Out of Pocket Maximum (includes copays, deductibles)	Individual: $2,500 Family: $5,000	Individual: $2,500 Family: $5,000 (includes Rx copay)	Individual: $2,500 Family: $5,000	Individual: $5,000 Family: $10,000
HOSPITAL				
In-Patient	95% covered after deductible. Unlimited days (semi-private). All hospital admissions requires Health Plan notification.	95% covered after deductible. Unlimited days (semi-private).	95% covered after deductible. Unlimited days (semi-private). All hospital admissions must be certified.	75% covered after deductible and $200 per admission copay. Benefit payment will be reduced if not pre-certified.
Service and Supplies	95% covered after deductible.	95% covered after deductible.	95% covered after deductible.	75% covered after deductible.
Surgical Benefits	Inpatient - 95% covered after deductible. Outpatient – 95% covered after deductible	95% covered after deductible	95% covered after deductible	75% covered after deductible.
Physician Hospital Visits	95% covered after deductible.	95% covered after deductible.	95% covered after deductible.	75% covered after deductible.

***Note: All out of network benefits will be based on reasonable and customary amounts.*

DESCRIPTION	United Healthcare ® (OPEN ACCESS - No referral necessary to a National Network of Participating Providers)	Kaiser Permanente	CIGNA Open Access Plus Plan	
			In-Network	Out-of-Network
OUT-PATIENT				
Emergency (copayment waived if admitted to the hospital from the ER) Urgent Care Centers	$100 copayment (ER). $15 copayment (Urgent Care) Call the number on the back of your identification card for advice or authorization.	$100 copayment (ER) $5 copayment (Urgent Care)	$100 copayment (ER) $25 copayment (Urgent Care)	$100 copayment (ER) $25 copayment (Urgent Care)
Skilled Nursing Facility	95% covered after deductible Note: Semi-private room up to 60 days per Policy Year.	95% covered after deductible Note: medically necessary care up to 100 days.	95% covered after deductible Note: Maximum benefit 60 days per year	75% covered after deductible Note: Limited to semi-private room rate. Maximum benefit 60 days per year
Hospice	95% covered after deductible	95% covered after deductible when appropriate and approved by Kaiser Permanente Physician	95% covered after deductible.	75% covered after deductible.
MATERNITY				
Hospital	95% covered after deductible.	95% covered after deductible.	95% covered after deductible Note: Precertification required by preferred physician, not by member.	75% covered after deductible and $200 per admission copay. Note: Precertification required.
Newborn	95% covered after deductible.	95% covered after deductible.	95% covered after deductible.	75% covered after deductible and $200 per admission copay.
Nursery Physician Office Visits	95% covered after deductible. $10 copay – initial visit.	95% covered after deductible. $5 copay - Initial All subsequent visits 100% covered.	95% covered after deductible. $10 copay for initial visit to confirm pregnancy. All subsequent visits covered at 100%.	75% covered after plan deductible and $200 per admission copay. 75% covered after deductible.

DESCRIPTION	United Healthcare ® (OPEN ACCESS - No referral necessary to a National Network of Participating Providers)	Kaiser Permanente	CIGNA Open Access Plus Plan	
			In-Network	Out-of-Network
OTHER COVERAGE				
Physical, Speech and Occupational Therapy (All Therapies Combined)	Short-term care coverage. Covered 100% after $10 copay. Up to 60 visits maximum per calendar year for each therapy.	$5 copay per visit Note: up to 90 days per incident	95% covered after deductible Note: up to 60 visits all therapies combined.	75% covered after deductible up to 60 visits all therapies combined.
Radiotherapy	95% covered after deductible.	100% covered after applicable copay.	95% covered after applicable copay.	75% covered after deductible.
Eye Exams	Eye Exam 100% covered after $10 copay. Administered through UnitedHealth Allies. One eye exam covered every 2 years Discounts on eyeglasses and contact lenses available. Visit www.myuhc.com and link to the health discount site via the health and wellness tab or call 1-800-860-8773. *Purchase of eyeglasses and contact lenses do not count towards Out of Pocket Minimum	$5 per visit for examination. 25% discounts on glasses and frames. 15% discount for initial fitting and purchase of contact lenses at Kaiser Permanente Medical Centers For children: No charge and 1 pair of glasses per year limited to single or bifocal lenses or 1st purchase of contact lenses per year or 2 pair per eye per year medically necessary contacts.	Vision Care - Eye Exam: $20 copay Lenses & Frames: $20 copay Covers frames with a retail value up to $100; Contact lens allow- ance: up to $100 - available every 24 months.	Vision Care Allowances - Eye Exam: $45 Frames: $55 Lenses: single $32, bifocal $55, trifocal $65, contacts $87, lenticular lenses $80 - available every 24 months.
Hearing Prosthetics	95% covered after deductible. Benefits limited to $5000 per year. Limited to a single purchase including repair/replacement. Available every 3 years.	Not covered.	First $400 covered at 95%; 75% for amounts remaining thereafter. Note: One hearing aid per ear every 36 months.	First $400 covered at 95%; 75% for amounts remaining thereafter. Note: One hearing aid per ear every 36 months. Not subject to plan deductible.
Home Health Care	95% covered after deductible. Must be medically necessary. Up to 60 visits per policy year.	95% covered after deductible, - must be authorized by Kaiser Permanente Physician.	95% covered after deductible, unlimited visits.	75% covered after deductible, unlimited visits.

DESCRIPTION	United Healthcare ® (OPEN ACCESS - No referral necessary to a National Network of Participating Providers)	Kaiser Permanente	CIGNA Open Access Plus Plan	
			In-Network	Out-of-Network
OTHER COVERAGE				
Durable Medical Equipment/Prosthetic and Orthopedic Devices	95% covered after deductible. Requires prior authorization.	100% covered.	95% covered after deductible.	75% covered after deductible.
Ambulance	95% covered after deductible. Emergency ambulance transportation covered in full when medically necessary.	No charge, in emergency situations or when approved by Health plan.	95% covered after deductible.	95% covered after deductible - Ambulance services used a non-emergency (e.g. Transportation to and from hospital) are generally not covered.
Diagnostic X-Ray and Lab Tests	95% covered after deductible.	100% covered. Specialty Imaging (MRI/CT/CAT) - 95% covered after deductible.	95% covered after deductible.	75% covered after deductible.
PHYSICIAN SERVICES				
Allergy Testing and Injections	100% covered, including sera, after physician office visit copay.	100% covered, after applicable copay.	95% covered after deductible.	75% covered after deductible.
Routine Health Assessment	100% covered for preventive care.	100% covered for preventive care.	100% after $10 copay. Routine Preventive Care.	75% covered after deductible.
Well Baby Care and Immunizations	100% covered, including sera, after physician office visit copay.	100% covered, after applicable copay.	100% after $10 copay. No charge for immunizations.	75% covered after deductible, including immunizations. Routine Preventive Care.
Office Visits	100% covered after $10 copay. Preventive Care 100% covered.	100% covered after $5 copay. Copayment waived for children up to age 5.	100% covered after $10 copay.	75% covered after deductible.
Routine OB/GYN	100% covered after $10 copay. Preventive Care 100% covered.	100% covered, all subsequent visits have a $5 copay.	Exam/Office Visit: 100% after $10 copay - PAP covered at 100%.	Exam/Office Visit: 75% after deductible - PAP covered at 100%, no deductible.
Specialists (Office Visit)	$10 copay.	$5 copay.	$10 copay.	25% copay.
Mammogram	100% covered.	100% covered.	100% covered.	100% covered, no deductible.

DESCRIPTION	United Healthcare ® (OPEN ACCESS - No referral necessary to a National Network of Participating Providers)	Kaiser Permanente	CIGNA Open Access Plus Plan	
			In-Network	Out-of-Network
PRESCRIPTION DRUGS				
	Retail: Tier 1: $10 Tier 2: $25 Tier 3: $45 Prescription Drug Copayment at participating pharmacies. Member must pay difference between the cost of generic and brand name drug where generic is available. Mail Order Maintenance drugs up to 90 days with two (2) copays. *Rx copays are subject to Prescription Out of.	Kaiser Pharmacies: Generic: $10 Preferred Brand: $20 Non-Preferred Brand: $35 Up to 30 day supply Participating Community Pharmacies: Generic: $20 Preferred Brand: $35 Non-Preferred Brand: $50 90 day supply for 3 copays Kaiser Mail Order: Generic: $20 Preferred Brand: $40 Non-Preferred Brand: $70 90-day supply for 2 copays	Retail: Generic: $10 Preferred Brand: $25 Non-Preferred Brand: $40 30 day supply at participating pharmacies. Cigna Mail Order: Generic: $20 Preferred Brand: $50 Non-Preferred Brand: $80 90-day supply for 2 copays *Rx copays are subject to Prescription	75% covered. Mail order available In-network only.
Prescription Out of Pocket Maximum (includes Rx copay	$1,500 Individual $3,000 Family.	Rx Copay are included with Medical Out of Pocket Maximum.	$1,500 Individual $3,000 Family.	$1,500 Individual $3,000 Family.
MENTAL HEALTH				
In-Patient	95% covered after deductible.	95% covered after deductible.	95% covered after deductible - Note: Precertification (performed by the provider) is required.	75% covered after deductible and $200 per admission copay (Precertification may be required).
Out-Patient	100% covered after $10 co-pay.	$5 per individual/group session Unlimited visits.	$10 per individual or group session.	75% after deductible.

DESCRIPTION	United Healthcare ® (OPEN ACCESS - No referral necessary to a National Network of Participating Providers)	Kaiser Permanente	CIGNA Open Access Plus Plan	
			In-Network	Out-of-Network
ALCOHOL AND DRUG ABUSE TREATMENT				
Hospital In-Patient	In-Patient: 95% covered after deductible.	95% covered after deductible.	100% covered.	75% covered after deductible and $200 per admission copay.
Treatment Facility In-Patient	95% covered after deductible.	95% covered after deductible.	95% covered after deductible.	75% covered after deductible and $200 per admission copay.
Treatment Facility Out-Patient	100% covered after $10 co-pay per session for Partial Hospitalization /Intensive Outpatient Treatment.	$5 per individual visit $5 per group visit Unlimited visits for medically necessary services.	95% covered, after $10 co-pay.	75% covered after deductible.
DENTAL PLAN - DELTA DENTAL				
Deductible	$50 - Individual $100 – Family *Does not apply to Type A expenses.			
Annual Benefit Max.	$1500* * Does not apply to Orthodontic expenses.			
Orthodontic Lifetime Maximum (Dependent Up to Age 19 Only)	$2,000.			
Benefit Coverage Amounts	Preventive Care — 100% Type A expenses - routine exams and cleaning. Outpatient Treatment.			
	Basic Care — 75% Type B expenses - - x-rays, simple extractions, fillings.			
	Major Care — 50% Type C expenses — crowns, inlays, bridge work			

This is intended only as a brief summary of the benefit plans offered to WMATA Non-Represented Employees. Complete descriptions are provided in the plan document. In the case of any discrepancies, the provisions of the plan document prevail.

MONTHLY COST FOR NON-REPRESENTED AND LOCAL 2 EMPLOYEES SUPPLEMENTAL LIFE INSURANCE PROGRAM

Basic Life Insurance

The Washington Metropolitan Area Transit Authority provides you with Basic Life insurance in the amount of one and one half times your salary at no cost to you through Aetna Life Insurance Company

Supplemental Life Insurance

In addition to the Basic Life Insurance you may purchase supplemental Life Insurance for yourself, your spouse or your children through Aetna. Participation is voluntary and premiums are paid 100% by the employee.

Employee Supplemental Life: You may purchase in increments of 1x, 2x, 3x, and 4x your Salary. Amounts above two times your salary require evidence of "Good Health"

Spousal Supplemental Life: You have the option to elect voluntary Supplemental Life insurance in increments of $10,000 up to $100,000. Amounts above $40,000 require evidence of "Good Health"

Monthly Rates for Each of the Employee Paid Components:

Supplemental Life

Age	Rate per $1000
Less than 30	$.06
30-34	.08
35-39	.09
40-44	.11
45-49	.17
50-54	.29
55-59	.51
60-64	.85
65-69	1.41
70-74	2.27
75+	3.37

***This chart is applied to both Employee Supplemental Life, Spouse or **Domestic Partner Life**

Dependent Child Life

$1.00 covers eligible children for a $10,000 benefits amount each.

Example:

47 year old employees, $40,000 annual salary, with 44 year old spouse and 3 children, wants Supplemental and AD&D at 2 times salary, $30,000 for spouse and $10,000 for children

Costs

Supplemental:	2 x 40 x .17	= $13.60
AD&D:	2 x 40 x .03	= 2.40
Spouse:	30 x .11	= 3.30
Children:		= 1.00
TOTAL MONTHLY COST:		$20.30
PAY PERIOD DEDUCTION:		$9.36

Employee AD&D

$ .03 PER $1,000

Note: The Employee Paid portion of this program is also portable, which means that employees can continue participating even if they terminate employment with the Authority, except in the case of retirement. Upon retirement from the Authority, employees are eligible to participate in the Retiree Life Insurance program.

LONG TERM DISABILITY

This coverage is administered by the SunLife Insurance Company. After a 90-day waiting period, the benefit pays 60% of income (to a maximum benefit of $4,000 or $6,000) per month until you are able to return to work.

Employees who are disabled prior to age 60 and 64 will receive benefits for three years or to age 65. Employees who are disabled for mental or psychological reasons receive benefits for up to two years. Employees disabled at or after age 65 will receive two years of benefits, but not beyond age 70. There are certain offsetting amounts, primarily Workers' Compensation, and Social Security disability benefits.

(Please review the summary description for benefit details.)

$4,000 (Local 2 maximum benefit)
$6,000 (Non-represented maximum benefit)

The cost (shared on a 50/50 basis with WMATA) is based on your annual salary as follows:

Group	Rate
Non-represented	0.440
Local 2	0.535

DEPENDENT VERIFICATION PROCESS

The following documents must be provided when adding a dependent to your insurance plans:

Spouse – Photocopy of Marriage Certificate and one (1) copy of proof of joint debt/ownership showing you and your spouse's names dated within the past 90 days. Acceptable documents include:

- Joint bank account monthly statement
- Monthly mortgage payment statement or lease/rent statement
- Motor vehicle loan statement
- Credit card bill
- Utility bill
- An employee's will that designates the spouse as primary beneficiary
- Employee retirement plan or life insurance policy designating spouse as primary beneficiary
- Homeowner's or auto insurance policy *
- Property tax statement (home or auto) *
- First Page of your most recent tax return (1040 form)

**May be older than 90 days, but must be current insurance or tax statement. Insurance binders are acceptable if current.*

Child – Photocopy of birth certificate showing employee's name

Stepchild – Photocopy of birth certificate showing employee's spouse's name and a photocopy of a marriage certificate showing the employee's and parent's name.

Legal Dependent – One (1) of the following as applicable to the child dependent type:

- Photocopy of an Adoption Final Decree or an Interlocutory Decree of Adoption with the presiding judge's signature and seal.
- Photocopy of the child's birth certificate showing the employee as the adopting parent.
- Photocopy of the final court order, with the presiding judge's signature and seal, affirming the employee as the child's legal guardian.
- Photocopy of the Qualified Medical Child Support Order

Dependent Child with Disability – Photocopy of birth certificate showing employee's name and dependent must be medically certified by health insurance provider.

Student Verification – Current enrollment such as a letter from the school on their letterhead or a transcript indicating full-time attendance must be submitted.

ALL DOCUMENTS MUST BE RECEIVED WITHIN 30 DAYS

RETIREMENT PLANS

WMATA provides two valuable retirement plans a 401(a) retirement plan and a 457 retirement plan to help you prepare for your financial future and long term financial goals.

457 Deferred Compensation Plan.

In calendar year 2017, employees may contribute up to $18,000 or 100% of "includible" compensation, whichever is less, on a pre-tax basis.

Lincoln Financial is the administrator for your 457 plan. You will be able to register on Lincoln Financials website, the Monday after your 1st paycheck is issued. Please login to (www.lfg.com) to register and start your contribution. You are in control of your investments (many options are available)

The 457 plan provides immediate 100 percent vesting of your tax deferred and rollover contributions as well as its earnings.

401 (a) Plan

(Applies to Non Rep and Local 2 employees hired after 1/1/1999 only, employees hired before 1/1/1999 participate in the defined benefit)

All Contributions are made by the company.

Basic Contribution	4% of Pay
Vesting Period	3 Years (No Interim Vesting)
Additional Contributions:	If employee contributes 1% or more to the 457 Plan, the company contributes up to 3% to the basic 4% for a total of 7% per pay. (Company only contributes 3% to 401(a) Plan in pay periods when employee contributes 3% to 457 Plan) ***Example: Employee contributes 1.5% per paycheck to his 457 plan 1.5% will be deposit into his 401(a) account.*

WMATA 457 DEFERRED COMPENSATION PLAN SUMMARY

PLAN TYPE	A voluntary, deferred compensation plan created as a trust under the terms of the IRS code section 457(g). The 457 Trust receives and invests employee contributions. There are NO employer contributions to this Plan.
CONTRIBUTIONS	Employee can contribute up to $18,000 or 100% of "includible" compensation (gross pay minus all pre-tax deferrals/ contributions) per year, whichever is lower. Contributions are made by payroll deduction. Federal, state, and local income taxes on contributions are deferred until withdrawal. Social security taxes are not deferred. *If you have contributed to another Employer's 457 Plan during this calendar year, you must subtract those contributions to determine your IRS limit for this year.*
WHO INVESTS CONTRIBUTIONS	Employee chooses investment funds for his or her account from those made available by the Plan provider.
WHEN CONTRIBUTIONS CAN START	Contributions start on the first payday of the month following online completion by the employee of the 457 provider enrollment. (For a new employee whose hire date falls on the first of a month, contributions can start on the first payday of the month of hire if the online enrollment is completed on the day of hire.)
MAKING CHANGES DURING THE YEAR	Employee can change contribution amount and fund allocation for future contributions at any time during the year. However, investment options should be carefully chosen since some funds have transfer restrictions.
WITHDRAWAL OF FUNDS	457 funds can be withdrawn anytime upon separation from service (e.g., retirement, resignation, or death). Withdrawals may be paid as a lump-sum, rollover, or annuity. Funds are subject to federal, state, and local income taxes upon withdrawal. The only withdrawal allowed by the IRS while still employed is for an unforeseen emergency, which is very strictly defined by the IRS. The Plan also has a loan provision.
PLAN PROVIDER	Lincoln Financial Group www.LincolnFinancial.com

Lincoln Financial is the administrator for your 457 plan, please login to (www.lfg.com) to register and start your contribution. You direct your investments (many options are available)

WMATA 401 (A) PLAN SUMMARY

PLAN TYPE	TWO PLANS created as trusts under the terms of the IRS code sections 401(a) & 457(g), respectively. -401(a) Trust receives/invests Authority contributions; - 457 Trust receives/invests employee contributions	
CONTRIBUTIONS	Employer Trust. 4.0% of employee base salary. Additional employer contribution of up to 3.0% to equal employee contribution to the 457 Trust. *(Payable only in pay periods when a 457 contribution is made.)*	Employee Not required. Up to 3.0% of base salary may be contributed to the 457 Trust. (*Additional contributions to 457 Trust are permitted but are NOT part of the Retirement Plan.)*
WHO INVESTS CONTRIBUTIONS	Employee chooses investment options for his/her accounts.	
VESTING	401(a): 100% vesting after 3 years of service. A Year of Vesting is 1,000 Hours of Service in a calendar year. No interim vesting. Contributions to the 457 Trust are not subject to a vesting requirement. Time for vesting (but not benefit amount) is measured from the 1st date of employment with the Authority.	
NORMAL AGE FOR BENEFIT PAYMENT	65 years of age. 401(a) benefits paid as lump-sum or rollover. 457 benefits also payable as an annuity. Accrued 401(a) & 457 benefits will be paid to employee (or rolled over) upon leaving Authority employment any time after full vesting.	
EARLIEST PAYMENT	Accrued vested 401(a) & all 457 benefits will be paid anytime upon leaving employment.	
DISABILITY	Accrued 401(a) & 457 benefits paid in case of total/permanent disability.	
BENEFIT COMPUTATION	The value of employee 401(a) & 457 Trust account.	

Long Term Disability (LTD) Premium Conversion Plan

MANAGEMENT, ADMINISTRATIVE,
AND LOCAL 2 EMPLOYEES

M E M O R A N D U M

SUBJECT: Long Term Disability (LTD) Premium Conversion Plan

TO: Management, Administrative, and Local 2 Employees.

All Management, Administrative, and Local 2 employees are eligible to deduct their benefit contributions on a pre-tax basis. The advantage is that your Social Security, Federal, and State taxes will be reduced because your taxable earnings are less. Consequently, your take home pay will increase as indicated in Attachment 1. These tax reductions are real savings and you do not have to make up these taxes at any time in the future.

The Premium Conversion Plan allows employee contribution toward the cost of Medical, Dental and Long-Term Disability insurance to be made with pretax dollars. The Internal Revenue Service requires that each eligible employee elect to continue participation in the program on an annual basis. There will be an open enrollment period each November.

Potential disadvantages exist if your adjusted earnings are below the maximum amount taxed for Social Security (currently $127,200). As a result of the plan your Social Security (FICA) taxes will be reduced. This could cause a small reduction in your benefits from Social Security. This reduction in Social Security benefits could grow if the premiums for the benefits increase. Even though there may be a minor reduction in the Social Security benefit, the money saved in taxes should make up for this reduction.
As an alternative you may want to consider increasing payroll deductions to your credit union, or, if eligible, contribute to the deferred compensation program, or adjust personal savings arrangements to compensate for any small reductions in Social Security benefits. Further, if you participate in the Long-Term Disability (LTD) program and should you become disabled and qualify to receive disability benefits later, your disability income will be taxed at a higher proportion rather than having half of the disability income being taxable as is now the case. As a result you have an option of either including or excluding LTD premiums from the Plan if you elect to participate.

As indicated, the Pre-Tax Payment Program, allows your bi-weekly pay to be reduced by your contributions to the term life insurance program. This pre-tax payment program, however, may not provide any reduction in your tax liability for the value of the group life insurance in excess of $50,000.
In 1986, the tax code was amended to include as taxable income the “IRS cost of more than $50,000 of life insurance minus the employee’s contributions”.

Washington
Metropolitan Area
Transit Authority

600 5th St NW
Washington, D.C., 20001
202/962-1234

By Metrorail:
Judiciary Square-Red Line
Gallery Place-Chinatown
Red, Green and
Yellow Lines

A District of Columbia,
Maryland and Virginia
Transit Partnership

Under the pre-tax program, your bi-weekly contributions for life insurance will be paid with pre-tax dollars. As a result, your W-2 statement will reflect the IRS value of the life insurance, if any, without a credit for the contributions made by you because your salary will have already been reduced by these contributions. At the end of the year the increase in taxable income, if any, due to the IRS value of the term life insurance will be reflected in your W-2 statement and will be treated as normal income with any FICA still being withheld from the last pay check. (See Attachment 2, Examples A and B).

For those employees who do not have additional income added at the end of the year, the premium conversion plan results in additional tax savings. Attachment 2 provides four examples using difference assumptions.

It is important to note the reducing your salary for benefit plan premiums does not affect the value of your salary-related benefits such as life insurance, long- term disability, or retirement. Those benefits are based upon your base (before tax) salary, not your net (after tax) pay. Please call the staff of the Benefits Branch at 202-962-2818 or 202-962-2247 if you have any questions on the operation of the program. We recommend that you consult with your personal tax advisor if you have questions on the merits of the program for your individual situation.

PREMIUM CONVERSION EXAMPLES

	EMPLOYEE WITHOUT PREMIUM CONVERSION	EMPLOYEE WITH PREMIUM CONVERSION
EXAMPLE A:		
Base Salary	$25,000	$25,000
Pre-Tax Benefit Deductions	-0	-1250
Net Base Salary	$25,000	$23,750
FICA (7.65%)	1,913	1,817
Income Tax (20%)	5,000	4,750
After Tax Premium	1,250	-0
Net Income	$16,837	$17,183
Increase in Take- Home Pay	$0	$346

	EMPLOYEE WITHOUT PREMIUM CONVERSION	EMPLOYEE WITH PREMIUM CONVERSION
EXAMPLE A:		
Base Salary	$40,000	$40,000
Pre-Tax Benefit Deductions	-0	-1650
Net Base Salary	$40,000	$38,350
FICA (7.65%)	3,060	2,934
Income Tax (20%)	8,000	7,670
After Tax Premium	1,650	-0
Net Income	$27,290	$27,746
Increase in Take- Home Pay	$0	$456

Sick Leave Bank Program Guidelines and Procedures

MANAGEMENT, ADMINISTRATIVE,
AND LOCAL 2 EMPLOYEES

THE SICK LEAVE BANK GUIDELINES AND PROCEDURES

I. PURPOSE

The primary purpose of the Sick Leave Bank is to provide employees with financial security through additional sick leave should they suffer a catastrophic event requiring an extended absence due to a non-work related illness or injury, as well as a means to help fellow employees in a time of need. The sick leave bank in administered by the Benefits Manager, HR Strategy and Development.

II. MEMBERSHIP AND ELIGIBILITY REQUIREMENTS

The primary purpose of the Sick Leave Bank is to provide employees with financial security through additional sick leave should they suffer a catastrophic event requiring an extended absence due to a non-work related illness or injury, as well as a means to help fellow employees in a time of need. The sick leave bank in administered by the Benefits Manager, HR Strategy and Development

III. ENROLLMENT

A. HOW TO ENROLL

Eligible employees electing to participate in the SLBP must donate one (1) day of accrued sick leave. For Transit Authority (TA) employees, one day equals 7.5 hours and for Transit Systems (TS) employees, one day equals 8.0 hours. Enrollment is accomplished by completion of the "Sick Leave Bank Program Election to Participate" form.

B. ENROLLMENT PERIOD

1. A new employee may elect to participate at the time of his/her employee benefits orientation. The employee is enrolled in the SLBP as of his/her date of hire.

2. An employee may also enroll during the annual Open Enrollment period. However, employees who elect to participate during Open Enrollment must provide medical evidence of good health at their own expense within 90 days of enrollment. The condition of pregnancy at the time of enrollment will not prevent Acceptance into the SLBP, as long as evidence of overall good health is provided. The employees must be enrolled in the program for six (6) months prior to becoming eligible to utilize the benefits. While satisfying the six (6) month eligibility requirement, the employee must be in an active payroll status.

IV. ADDITIONAL ASSESSMENTS

A. OCCURRENCE

1. Members of the SLBP will automatically be assessed annually one (1) additional day of sick leave. This assessment will take place in the first period in the month of July. SLBP will be reviewed monthly by the Benefits Office and if the SLBP balance falls below 400 days (3000 hours), each member will be reassessed no more than one-half (½) day of additional sick leave per year.

2. Annual or compensatory leave may not be contributed to the SLBP.

B. REASSESSMENT NOTIFICATION

1. Participants in the SLBP consent to reassessments at the time they complete the enrollment form to join the program.

2. Participants will be notified at least 30 days in advance regarding the need for any other than the annual reassessment of sick leave the will be deducted from their sick leave balance. If a reassessment outside of the annual assessment is determined to be required by the Benefits Office and approved by the Director, HRCB, the contribution will be deducted by the Office of Accounting (ACCT) from participants with positive sick leave balances.

3. Participants who do not have a positive sick leave balance at the time of reassessment will be required to make the additional contribution at the time they acquire a positive sick leave balance.

4. Members who do not have the required sick leave to contribute during two (2) consecutive reassessments will automatically be terminated from the program with no opportunity to rejoin. Even when termination occurs, the reassessments owed will be taken from their sick leave when accrued.

V. WITHDRAWAL

A. TERMINATION OF MEMBERSHIP

1. During annual open enrollment, employees may elect to terminate their participation in the program by completing an “Election of Withdrawal” form. Once a contribution has been made, it cannot be withdrawn. An employee who elects to terminate participation in the program cannot rejoin.

2. Once a participant has received benefits from the SLBP, he/she may withdraw from the program after repayment of all leave that has been granted is refunded. If this condition of withdrawal is not met, the employee will remain a participant of the SLBP. Even when the participant’s lifetime of 90 days has been met, the participant will continue to be reassessed days.

3. Participants who retire will not receive reimbursement or credit for contributions to the SLBP.

4. Participants who terminate employment either voluntarily or involuntarily will not receive reimbursement for contributions to the SLBP.

VI. PROCEDURES FOR ENTITLEMENT

A. QUALIFICATION PERIOD PER ILLNESS

1. Participants will be eligible to receive benefits after participating in the SLBP for at least six (6) months in an active pay status.

2. After a participant has been out for an illness for 30 consecutive calendar days and after using all accumulated sick leave, he/she is eligible to use the SLBP.

3. If a participant, within 30 calendar days after returning to work, experiences a relapse due to the same illness or disability which necessitated the initial use of the SLBP, the participant does not have to wait before receiving additional sick leave from the SLBP.

4. A participant who returned to work and requires period absences due to the same illness or disability for which benefits were originally authorized, may receive consideration for SLBP benefits for such absences based on the nature of the illness/disability and medical certification.

5. If additional days beyond those originally approved are needed, the participant is required to provide additional medical certification prior to the approval or disapproval of the request for additional days.

B. APPLICATION FOR BENEFITS

1. To initiate the benefit process, the participant must complete the "Sick Leave Bank Program Application for Benefits" form.

2. The SLBP application must be accompanied by medical certification regarding the nature of the illness/ injury; dates(s) of treatment; expected duration of the illness; and treating physician(s) name(s), address (es), and telephone number(s). The medical certification must verify that the employee is incapacitated from performing all gainful employment with the Authority. The Authority's Medical Director may obtain and review all pertinent medical records and as requested consult with the employee's physician in order to determine eligibility for SLBP benefits. BENEFIT APPLICATION AND MEDICAL DOCUMENTATION WILL BE HANDLED IN THE STRICTEST CONFIDENCE.

3. The application is to be reviewed with completeness by the employee's supervisor. The supervisor confirms with the Benefits Office, the employee's participation in the program.

4. If the employee is eligible for sick leave from the SLBP, the application is signed the employee's Office Director or equivalent and sent to the Benefits Office.

5. The Benefits Office reviews the application along with supporting documents and forwards it to the Medical Director, Medical Services Branch.

6. The Medical Director reviews the application and medical documents and approves or denies the request for SLBP benefits based on the medical sufficiency of the request in conjunction with the number of days requested.

7. If the application is approved, ACCT is notified by the Benefits Office to add the approved days to the employee's sick leave balance.

8. If the application for benefits is denied, or if the terms of approval differ from the terms of the employee's request (e.g. a different or shorter leave approved than requested), the employee can appeal the decision in writing to the Director, HRCB, through the employee's Office Director or equivalent. The appeal must be

accompanied by additional medical documentation that was not previously submitted to support the need for reconsideration of the SLBP application. The employee's appeal should be received by HRCB/Benefits Office within 10 working days of receipt of the denial notification.

9. If a participant makes application to the SLBP and has been unable to be reassessed due to a negative sick leave balance, he/she will have their eligible days reduced by the number of days owed to the program.

C. MAXIMUM BENEFIT ENTITLEMENT

1. The maximum duration of benefits to be provided from the SLBP for any one (1) episode will be the lesser of 45 working days per 12 month period or commencement of worker's compensation, retirement, Long Term Disability (LTD), or social security benefits.

2. Employees receiving retroactive worker's compensation, retirement, LTD and/or social security disability benefits covering any period of time the employee received benefits from the SLBP will be required to reimburse the SLBP for payments.

3. Employees are eligible to receive disability leave pay will not receive SLBP benefits.

4. Employees who return to work prior to using all approved SLBP days are required to repay unused days. Failure to provide notification of an early return to work date will result in forfeiture of future SLBP benefits. The notification of early return to work must be done in writing through the employee's Office Director or equivalent and sent to the Benefits Office.
5. In no case will a participant be granted SLBP benefits for more than 45 working days during any 12 month period with a lifetime maximum sick leave grant not to exceed 90 working days.

6. Each episode of sick leave usage by a participant will reduce that participant's lifetime maximum benefit of 90 working days.

VII. DEFINITION OF ILLNESS

All illnesses and disabilities that would otherwise qualify for approved sick leave usage will qualify for SLBP benefits.

VIII. SOURCES OF MEDICAL DOCUMENTATION

All medical documents must be certified by a duly licensed physician who is practicing within the scope of his or her license. The physician must not be a relative of the participant.

IX. MONITORING OF THE SICK LEAVE BANK

The Benefits Office of HR Strategy and Development is responsible for maintaining the SLBP current balance and overall usage.

2018

Non Represented
Local 2
Special Police

Table of Contents

Attachment 1

Accessing Personalized Benefits Information

Employees are now able to access personalized benefit information in PeopleSoft HCM. To view current employee and dependent benefit options, please use the following navigation:

Begin Navigation	On the MetroWeb go to Metro Applications and click on the PeopleSoft – HCM link ***OR*** type the following address in your browser: http://ssoproxy.wmata.com:7778/psp/phrprodsso/EMPLOYEE/HRMS/h/?tab=DEFAULT
Employee Benefit Options	➢ Main Menu ➢ Self Service ➢ Benefits ➢ Benefits Summary
Dependent Benefit Information	➢ Main Menu ➢ Self Service ➢ Benefits ➢ Dependents and Beneficiaries ➢ Health Care Dependent Summary

Please review your information carefully to verify that:

- **All dependent information is accurate and complete, and**
- **All plan coverage information is also accurate and complete.**

If corrections are necessary, please contact the Benefits Office by phone or in person. **Please note that any corrections must be made by 5 p.m. on Friday, November 17, 2017.**

Attachment 2

Open Enrollment Process

Open Enrollment begins October 30, 2017 and ends on November 17, 2017. During this period employees may:

- Enroll in or cancel participation in any plan
- Change health insurance providers and/or increase or decrease your life insurance options.

Please note:
Enrolling or making changes in Life Insurance or Long Term Disability during this period may require submitting evidence of good health.

Making Changes to Your Benefits

Changes to your benefits plans during the 2018 Open Enrollment period requires the completion of an enrollment/change form. **These forms will be available at the Open Enrollment meetings (see Attachment 3 for schedule and locations), the HR Compensation & Benefits Intranet or directly from the HR Benefits Office in JGB on the 7th floor**.

All properly completed forms and supporting documentation must be received in the Benefits Office by 5 p.m. on November 17, 2017. The mailing address for the Benefits Office is listed below:

Via Interoffice Mail	**or**	Via U.S. Mail
HR/Office of Benefits 7E, JGB		HR/Office of Benefits WMATA, 7th Floor 600 Fifth Street, NW Washington, DC 20001

Medical Plans

Effective January 1, 2018, **non-represented employees** will receive the same comprehensive package of benefits coverages, however the employee's share of the contribution will increase from **20% to 25%.**

It is important to consider options provided by flexible spending accounts that allow healthcare expenses to be deducted from your pay on a pre-tax basis, which also spreads the costs out over a year.

Attached you will find the 2018 plan comparisons of medical benefits. They will also be available in the Benefits Office and at Open Enrollment meetings.

Attachment 2 (Cont'd)

Open Enrollment Process

Pease find below the websites and Customer Service numbers for each health insurance providers. They will be able to answer questions about their plans and how to locate participating providers:

Kaiser – www.kp.org, 301.468.6000 or 800.777.7902
(Plan network for participating doctors/facilities is called Signature)

United Healthcare - www.myuhc.com, 866.633.2446
(Plan network for participating doctors/facilities is called Choice)

Cigna – www.cigna.com, 800.244.6224
(Plan network for participating doctors/facilities is called OAP)

Flexible Spending Accounts (FSA)

Healthcare Flexible Spending Account is a pre-tax benefit account that you can use to pay for eligible medical, dental, and vision care expenses that aren't covered by your health insurance plan. You decide how much to contribute to your Healthcare FSA each year, and funds are withdrawn automatically from each paycheck for deposit into your account before taxes are deducted. The total amount you elect to contribute to your Healthcare FSA each year is available on the first day of your plan year. For 2018, the maximum amount you can contribute for healthcare spending is $2,650.

Dependent Care Flexible Spending Account is a pre-tax benefit account used to pay for dependent care services while you are at work; such as preschool, summer day camp, before or after school programs, and child (up to age 13) or elder daycare. The money you contribute to a Dependent Care FSA is not subject to payroll taxes, so you end up paying less in taxes and taking home more of your paycheck. Under this type of account, a "dependent " is a child under 13 years of age (until the day of their 13th birthday) and adult dependents who can't take care of themselves. Please keep in mind that they must live with you and be claimed as dependents on your tax return. For 2018, the maximum amount you can contribute for dependent care spending is either $5,000 (married and filing a joint return or single parent) or $2,500 (married and filing separately).

To enroll in the FSA program for 2018 you must go to www.wageworks.com to enter your information. This must be done by November 17, 2017. Once you have enrolled please make sure you receive a confirmation email from Wage Works. If you encounter a problem enrolling you may contact a Wage Works Representative by calling 877-924-3967.

Attachment 2 (Cont'd)

Open Enrollment Process

Opt-out Waiver

Employees enrolled in non-Metro medical insurance plans may choose to opt out of Metro medical coverage and receive a lump sum of $1,000.

To receive the Opt-out Waiver, completion of the Medical Waiver is required along with proof of other medical coverage (a copy of your medical ID card is sufficient). **This must be done on an annually**. Forms and supporting documentation must be received by the Benefits Office by November 17, 2017. The lump sum will be issued in February 2018.

HEALTH CARE REFORM: SUMMARY OF BENEFITS AND COVERAGE AND UNIFORM GLOSSARY

Under Health Care Reform, group health plans are required to provide individuals with clear, consistent and comparable information about their health plan benefits and coverage. Specifically, the regulations ensure that individuals have access to two items that will help them understand and evaluate their health insurance choices. These items are a **Summary of Benefits and Coverage (SBC)** and a **Uniform Glossary**.

The SBC is intended to assist with understanding the coverage and allow for easy comparison of different coverage options. It summarizes the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. The Uniform Glossary is a resource that contains terms commonly used in health insurance coverage such as "deductible" and "co-payment". It is intended to help you understand some of the most common, but sometimes confusing jargon used in health insurance.

Dental Plan

Non-represented employees will have a 10% decrease to their dental premium. Local 2 and Special Police employee's premium will remain the same. **Student certification is required for any child over the age of 23.**

Attachment 2 (Cont'd)

Open Enrollment Process

Long Term Disability (LTD)

There are no benefit changes to LTD this enrollment period. New enrollments are subject to evidence of good health requirements. Please complete the WMATA LTD Extended Enrollment, LTD Enrollment and the Employee Pre-tax selection Forms.

Metro and employees share the cost of the LTD program 50/50. The employee deduction for Non-represented employees and Special Police is 0.440% of covered pay and for Local 2 employees it is 0.535% of covered pay.

Optional Life Insurance

The Optional Life Insurance program includes supplemental and accidental death and dismemberment (AD&D) coverage for employees, as well as the opportunity to provide coverage for spouses, domestic partners, and dependent children.

During the Open Enrollment period, employees are eligible to add or increase the level of Supplemental Life Insurance coverage by 1 times the annual salary without evidence of good health, as long as the total amount of the **combined** Basic and Supplemental Life Insurance coverage does not exceed $450,000. Please complete the Aetna Life Enrollment Change Form.

Other increases in Supplemental Life Insurance, including the addition of or increases in spouse or domestic partner life insurance in excess of $10,000 (or greater than $40,000 in total), are subject to evidence of good health requirements. Please complete the Aetna Evidence of Insurability Form. The evidence of good health requirements do not apply to AD&D or dependent child coverage.

Open enrollment is a good time to confirm or update your life insurance beneficiary(s). To update your beneficiary(s), please complete the Aetna Designation Beneficiary Form.

Premium Conversion

Premium Conversion allows certain insurance premiums to be paid with pre-tax dollars.

For Non-represented employees and Special Police Officers, premium conversion automatically applies to medical and dental insurance premiums with the option to elect premium conversion for LTD premiums.

For Local 2 employees, premium conversion applies to medical, dental, and LTD insurance premiums. Local 2 employees are strongly encouraged to consider premium conversion for medical and dental insurance premiums as a means of lowering their cost for coverage.

Attachment 2 (Cont'd)

Open Enrollment Process

Sick Leave Bank (Non-Represented and Local 2)

The Sick Leave Bank program provides sick leave hours to employees who have otherwise exhausted their own sick leave and are faced with incapacitating illness or disability.

The Sick Leave Bank program collects one day of sick leave from each new participant and an additional day from participants annually in July if needed to maintain a sufficient balance of hours for enrollees. It then uses those hours for employees who qualify under the program guidelines.

Enrollments in the Sick Leave Bank program are subject to evidence of good health requirements. Please complete the Sick Leave Bank late application form.

The enrollment/change forms will be available at the Open Enrollment meetings (see Attachment 3 for schedule and locations), the HR Compensation & Benefits Intranet or directly from the HR Benefits Office in JGB on the 7th floor.

Attachment 3

Open Enrollment Employee Meetings

Benefits staff from the Insurance Section and the Wellness Program, as well as representatives from the medical plan providers (Cigna, Kaiser, and UHC) will be on hand to answer questions and discuss plan coverage during the Open Enrollment meetings.

The schedule for this year's Open Enrollment meetings is as follows:

DATE	TIME	LOCATION
October 30	2:00 p.m.	Carmen E. Turner Facility Cafeteria
November 1	10:00 a.m.	Board Room, Lobby Level, JGB
November 14	2:00 p.m.	Meeting Room, Lobby Level, JGB

Attachment 4

Required Federal Notices

Patient Protection and Affordable Care Act Notice

The Patient Protection and Affordable Care Act was signed into law by President Obama on March 23, 2010, and the companion bill, the Health Care and Education Reconciliation Act, was signed into law on March 30, 2010. This legislation is referred to as the Health Care Reform Law.

The Health Care Reform Law requires that employers who sponsor health insurance plans for their employees provide notices to plan participants regarding certain aspects of the Law. One of those required notices is included in this Attachment and it addresses Grandfathered Health Plans.

The grandfather provisions of the Health Care Reform Law are designed to allow strong health plans to continue to grow and remain vibrant. The grandfather rule enables employers to keep their plan while adding important new benefits for all Americans with private insurance. To maintain status as a grandfathered health plan, a plan must provide a notice to plan participants that the plan believes it is a grandfathered health plan within the meaning of the Law. This notice must also include contact information for questions and complaints.

Children's Health Insurance Program Reauthorization Act (CHIPRA) Notice

On February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, Pub. L. 111-3). CHIPRA requires employers offering group health plans to notify each employee annually of potential opportunities currently available in the State in which the employee resides for premium assistance under Medicaid and the Children's Health Insurance Program (CHIP) for health coverage of the employee or the employee's dependents. This required notice is included in this Attachment.

Attachment 4 (Cont'd)

Required Federal Notices

Notice about the Grandfathered Health Plan Status
(For Local 2 and Special Police Only)

The WMATA Health Insurance Plan for salaried employees believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator: Carolyn Conquest, Insurance Manager, Benefits, at 202-962-2249 or CConquest@wmata.com. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Attachment 4 (Cont'd)

Required Federal Notices

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507

ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

Phone: 1-800-657-3739	
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration **www.dol.gov/agencies/ebsa** 1-866-444-EBSA (3272)	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services **www.cms.hhs.gov** 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

Attachment 4 (Cont'd)

Required Federal Notices

Compliance with Foreign Language Requirement

Washington Metropolitan Area Transit Authority complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

The Following notice is to Inform Individuals with Limited English Proficiency.

Language Assistance Services are provided by your healthcare carrier:

Cigna - 1-800-244-6224, TTY 1-800-244-6824
Kaiser -1-855-249-5018, TTY/TDD - 301-879-6380
UHC - 1-866-633-2446, TTY/TDD-same number

If you speak a foreign language, assistance services are available to you in the following languages.

- Language Assistance Services for **Spanish**
  ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística

- Language Assistance Services for **Amharic**
  ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ

- Language Assistance Services for **Chinese**
  注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電

- Language Assistance Services for **Francais**
  Si vies parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le

- Language Assistance Services for **Tagalog**
  PAUNAWA: Kung nagsasalita kit ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.

- Language Assistance for **Russian**
  ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните

- Language Assistance for **Portuguese**
  ATENÇÃO: Se gala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para

- Language Assistance for **Italian**
  ATTENZIONE: In caso la lingua parlata sia l'italiano, song disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero

- Language Assistance for **Vietnamese**
  CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số

- Language Assistance for **Ibo**
  Ntị: Ọ bụrụ na asụ Ibo, asụsụ aka ọasụ n'efu, defu, aka.

- Language Assistance for **Bengali**
  ল□য্ করনঃ যিদ আপিন বাংলা, কথা বলেত পা◌েরন, তাহেল ি◌নঃখরচায় ভাষা সহায়তা পিরেষবা উপল□ ◌োছ। □ফানকরন

- Language Assistance for **Japanese**
  注意事項：日本語を話される場合、無料の言語支援をご利用いただけます まで、お電話にてご連絡ください。

- Language Assistance for **Korean**
  주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 번으로 전화해 주십시오.

- Language Assistance for **Thai**
  เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร

- Language Assistance for **German**
  ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer:

- Language Assistance for **Arabic**
  ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم رقم هاتف الصم والبكم:

Attachment 5

Non-represented 2018 Plan Changes

Health insurance cost share increased from 20% to 25%

CIGNA

- Deductibles increased to $150/$300 (in-network) and $300/$500 (out of network)
- Prescription formulary changed to “Standard” (impacts which prescriptions are eligible)
- Office Visits copay increased from $10 to $15
- Emergency Room co-pay increased from $100 to $150

Kaiser

- Deductibles increased to $150/$300
- We are now part of the “Signature Network”. You can **ONLY** receive services at a Kaiser Facility.
- Office Visits increased from $5 to $10
- Emergency Room co-pay increased from $100 to $150

United Healthcare

- Deductibles increased to $150/$300
- Eye exams have changed from every 2 years to annual
- Office Visits copay increased from $10 to $15
- Emergency Room co-pay increased from $100 to $150

Delta Dental

- Deductibles increased to $50/$150
- 3 tiers of co-insurance (Non-participating dentists are reimbursed at the lowest fee)
- Posterior (resin) composites are now covered
- Insurance premium has decreased by 10%
- Annual maximum has increased from $1,500 to $2,000

Retiree Administration – Current process

The employee meets with a member of the Benefit Staff prior to retiring. During this meeting they are counseled and provided forms to complete to continue their retiree benefits (medical, life and COBRA dental).

Once their selections are made the total cost of their benefits is provided to a member of the retirement staff. If they are receiving a retirement check the premiums will be deducted from their check. If not they will be set up for direct billing.

The retiree is entered into the area of PeopleSoft that houses the retiree data.

Each month reports are ran to identify any retiree who had a rate change due to life insurance rate changing due to birthday, COBRA Dental ending or a coverage level change that may have occurred during the month. The rate changes are entered into one of the 2 custodial banks.

Each month a process is performed to direct bill retirees who do not receive a pension check for their insurance premiums. There rates are researched for accuracy then a process is ran in PeopleSoft Financials. Retirees can elect to receive a monthly, quarterly or annual bill. A member of the Accounting Dept. mails the invoices.

Open Enrollment (OE) Administration for Active Employees

Prior to the beginning of Open Enrollment prepare your system so that we are able to test rates and offerings.

System should be set up and opened for a pre-determined 2 week period so that employees can self-enroll with ***supporting documentation*** *if needed. Employees should also be able to enroll directly with a representative.*

During this period employees may:

- **Enroll in or cancel participation in any plan**
- **Change Insurance carriers and/or increase or decrease the level of coverage with multiple options**

Please note:

Enrollments during this period require documentation of eligibility, and making changes to certain plans may require evidence of good health.

The following documents must be provided when adding a dependent to the following benefits:

Medical, Dental, and Life Insurance

Spouse – Photocopy of Marriage Certificate and one (1) copy of proof of joint debt/ownership showing you and your spouse's names dated within the past 90 days. Acceptable documents include:

- Joint bank account monthly statement
- Monthly mortgage payment statement or lease/rent statement
- Motor vehicle loan statement
- Credit card bill
- Utility bill
- An employee's will that designates the spouse as primary beneficiary
- Employee retirement plan or life insurance policy designating spouse as primary beneficiary
- Homeowner's or auto insurance*
- Property tax statement (home or auto) *
- First Page of most recent tax return

** May be older than 90 days, but must be current insurance or tax statement. Insurance binders are acceptable if current.*

Child – Photocopy of birth certificate showing employee's name

Legal Dependent - **One (1)** of the following as applicable to the child dependent type:

- Photocopy of an Adoption Final Decree or an Interlocutory Decree of Adoption with the presiding judge's signature and seal.
- Photocopy of the child's birth certificate showing the employee as the adopting parent.
- Photocopy of the final court order, with the presiding judge's signature and seal, affirming the employee as the child's legal guardian.
- Photocopy of the Qualified Medical Child Support Order

Dependent Child with Disability - Photocopy of birth certificate showing employee's name and dependent must be medically certified by health insurance provider.

Student Verification – Current enrollment such as a letter from the school on their letterhead or a transcript indicating full-time attendance must be submitted.

MEDICAL PLANS

Employees may enroll for the first time, change level of coverage or change Insurance carriers during OE

Opt-out Waiver

Employees enrolled in non-Metro medical insurance plans may choose to opt out of Metro medical coverage and receive a lump sum of $1,000.

To receive the Opt-out Waiver, completions of the Waiver of Medical Insurance Coverage form is required along with proof of other medical coverage. Forms must be received by the end of the OE period. The lump sum will be issued in February.

Long Term Disability (LTD)

During OE active employees may discontinue or apply for LTD. If they are apply for LTD they must complete LTD Evidence of Insurability (EOI) in addition to an enrollment form. The EOI is submitted to Sun Life our LTD Administrator for review. Sun Life will review and notify us of their approval.

OPTIONAL LIFE INSURANCE

The Optional Life Insurance program includes supplemental and accidental death and dismemberment (AD&D) coverage for employees, as well as the opportunity to provide coverage for spouses, domestic partners, and dependent children.

During the Open Enrollment period, employees are eligible to add or increase the level of Supplemental Life Insurance coverage by 1 times the annual salary without evidence of good health, as long as the total amount of the **combined** Basic and Supplemental Life Insurance coverage does not exceed $450,000.

Other increases in Supplemental Life Insurance, including the addition of or increases in spouse or domestic partner life insurance in excess of $10,000 (or greater than $40,000 in total), are subject to evidence of good health requirements. The evidence of good health requirements do not apply to AD&D or dependent child coverage.

Open enrollment is a good time for employees to confirm or update their life insurance beneficiary(s).

PREMIUM CONVERSION

Premium Conversion allows certain insurance premiums to be paid with pre-tax dollars.

For Non-represented employees and Special Police Officers, premium conversion automatically applies to medical and dental insurance premiums with the option to elect premium conversion for LTD premiums.

For Local 2 employees, premium conversion applies to medical, dental, and LTD insurance premiums. Local 2 employees are strongly encouraged to consider premium conversion for medical and dental insurance premiums as a means of lowering their cost for coverage.

An application is required.

Open Enrollment Administration for Retirees

As it relates to medical and dental:

A mailing should be sent to the retiree prior to the beginning of OE notifying them of open enrollment. The mailing should include OE dates, rates and plan changes.

Enrollment forms should be mailed to those retirees who do not have access to a computer. **The same supporting documentation is required as active employees.**

All changes should be included on the files that are sent to the vendors.

A deduction file reflecting the Jan 1 rates changes should be sent to the benefit office by December 1. (The files will sent to the custodial banks by WMATA staff)

Open Enrollment Administration for COBRA and employees on LTD

As it relates to medical and dental:

A mailing should be sent to prior to the beginning of OE notifying them of open enrollment. The mailing should include OE dates, rates and plan changes.

Enrollment forms should be mailed to those who do not have access to a computer. **The same supporting documentation is required as active employees.**

All changes should be included on the files that are sent to the vendors.

Flexible Spending Accounts (FSA) (Mandatory Annual Re-Enrollment)

Healthcare Flexible Spending Account is a pre-tax benefit account that employees can use to pay for eligible medical, dental, and vision care expenses that aren't covered by their health insurance plan.

Dependent Care Flexible Spending Account is a pre-tax benefit account used to pay for dependent care services while employees are at work; such as preschool, summer day camp, before or after school programs, and child (up to age 13) or elder daycare

To enroll they sign in on www.wageworks.com during the open enrollment period.

Each time an employee goes into the system to make a change to their record they should receive a confirmation e-mail. At the end of the Open Enrollment period ALL employees should be sent a confirmation statement confirming the plans they're enrolled in for the upcoming plan year.

We would like the Outsource Company to provide the Benefit office with the details of any employee who has made changes and not provided supported documentation by the close of Open Enrollment.

Enrollment files should be sent to the carriers and deduction files uploaded to WMATA's system by December 1.

Long Term Disability (LTD) – Current Practice

Employee notifies the Benefit office if they're interested in applying for LTD.

Staff member verifies enrollment.

Once enrollment is confirmed an LTD application, a letter notifying them of their ADA rights and a LTD booklet are provided to the employee.

The employee is responsible for completing their portion of the application and having their physician complete their section. Once this is done the application is returned to the Benefit Office. A member of the Benefit Office will complete the employer section; then forward the completed application to the LTD carrier along with their job description and 2 years of payroll data.

During the approval process the carrier may reach out to the Benefit Office for additional information. There may also be communication with the employee and their physician.

The carrier notifies our office if they're approved. At that time the employee's office is notified so that the employee's status will be updated in our system. If the employee still has leave they can elect to receive a minimum benefit of $100 for the LTD carrier until their leave is exhausted. The employee may also elect to keep their leave on the books and just receive the 60% LTD benefit.

If an employee does not have leave they will be set up for direct bill for their insurance premiums. They would not be responsible for an LTD premium.

Life Insurance Administration – Current Process

Upon being notified of a death basic information is taken (i.e. name, employee number, DOD, next of kin and telephone number). This information is used by Insurance, Retirement and the area that administers 457/401A program.

Each of the perspective areas will research and make changes to plans as needed. (i.e. cancel insurance, modify pension plans, set up survivor benefits)

Callers are directed to call Aetna to report the death.

Once Aetna receives the claim they will contact the Benefit Office to request the information that is needed to process the claim (i.e. DOD, DOB, DLW, DOH, Salary, Insurance Values, and Beneficiary)

After Aetna receives all of the requested information they are requesting they will communicate directly with the family and the funeral home to process the claim.

Vendor Interfaces

Currently WMATA is not set up to communicate via interface with most of its carriers. Medical and Dental updates and Changes are done manually on the Carrier's employer site. We transmit electronically to:

- Aetna
  - Group Life Insurance Enrollment
  - Supplemental Life Insurance Enrollment
  - Accidental Death and Dismemberment Enrollment
  - Supplemental Spousal Life Insurance Enrollment
  - Dependent Life Insurance Enrollment
- Wage Works
  - FSA Enrollment
  - DFSA Enrollment
  - Commuter Benefits Enrollment
  - Eligibility Enrollment
  - Funding Files
- John Hancock
  - Long Term Care Enrollment and Funding files

The File feeds are ran from out PeopleSoft Application into our PGP Folder where they are converted to a secured file. Once converted they are uploaded to the carriers secure site (SFTP)

Student Verification Process Overview

Under the terms of The Washington Metropolitan Area Transit Authority Health Benefits Program, covered dependent children are eligible for dental coverage until the end month prior of them attaining age 23. Eligible dependents that meet the criteria and complete the Student Verification process may be able to remain on our dental plan until they reach age 26.

Process:

- A Report named **"DENTAL_CDEP_REACHING_23OR26"** is run from our PeopleSoft system to identify those employees with children attaining age 23 the following month.
- An email is sent to the employees pointing out that his/her dependent will be terminated from the plan as of the last day of the month in which they turn 23. This email explains to the employee that if his/her dependent is currently enrolled as a full time student at a Trade school or University they can continue to be covered under the plan.
  We request the admission letter as well as the transcript for the term in which the dependent reached age 23.
- Employee is responsible to keep submitting the transcripts at the start of a new term to remain in the plan.

Initial Benefit Enrollment

Who is eligible for benefits?

All employees

- Health Insurance Benefits are effective on the date of hire.
- Deductions are taken on the first paycheck the employee receives, and biweekly after that.

Current Initial Enrollment Process to complete Health Insurance Enrollment for a New Hire/Rehire/ Part-Time to Full time and Departmental Transfers (Union to Non-Union and Non-Union to Union)

- All Employees are sent a new hire material package that contains documents with their insurance and premium information as well as a comparison of their benefits offerings. The package currently include
    - 1. Welcome Memorandum
    - 2. Benefit Summary and Comparison
    - 3. Benefit Enrollment Application
    - 4. FSA_DFSA Election Form
    - 5. Aetna Life Enrollment Form
    - 6. Aetna Designation Beneficiary Form
    - 7. LTD Enrollment Form
    - 8. Long Term Disability Premium Conversion Plan Enrolment Form and Plan Specifics
    - 9. Sick Leave Bank Policy and Enrolment Forms
    - Payroll related Forms (W4, I9, Direct Deposit Forms)

- Employee completes the WMATA Benefits Enrollment Form by selecting a Benefit plan Option as well as their coverage level. They also must complete all other forms by declining or electing to participate in voluntary benefits.
- Employee brings their completed paperwork to their new hire orientation which is held on their first date of employment.
- Benefit staff provides during New Hire Orientation a Benefit overview and answers all employee questions.
- The Completed Benefit package is turned in to the benefit staff during the first day of NEO.
- The Benefit staff reviews the package and it is checked for missing forms and incomplete information.
- Dependent verification is completed by reviewing the documents provided by the employee comply with the definition of a dependent. *
- Manual entry on the Vendors' website is completed.
- Manual entry of employee tier and benefit election in PeopleSoft is completed.

Enrollment Changes/ Life Events

- All enrollment changes outside of open enrollment must be **made within 30 days from date of the event**
- Eligibility and premium changes are effective the date of the Qualifying event. A qualifying event is defined by Section 125 of the Internal Revenue Code as Marriage, Birth, Adoption, Divorce, Death of a Spouse or Dependent, Gain or Involuntary Loss of Coverage, Retirement, and Reduction in work hours and/or relocation.
- Changes made to Employee benefits must be consistent with the qualifying event.
-

QUALIFYING LIFE EVENT	Actions
Marriage	Employee may enroll in new coverage for Employee and/or Employee's spouse.
	Employee may change Employee's coverage to add new dependents.
	Employee may cancel coverage if Employee become a covered by Employee's spouse's plan.
Dissolution of marriage	Employee may enroll in new coverage if Employee lost coverage in the separation.
(includes divorce, annulment and legal separation)	Employee may change coverage if Employee's dependents lost coverage in the separation.
	Employee must remove Employee's former spouse from Employee's policy.
	Employee may not remove dependents from Employee's policy unless they become covered by Employee's former spouse's policy.
Death of spouse	Employee may remove Employee's spouse from Employee's coverage.
	Employee may enroll in new coverage if the death caused Employee to lose Employee's coverage.
	Employee may change Employee's coverage to include dependents who lost coverage due to the death.
Birth	Employee may enroll himself, Employee's spouse and Employee's dependents.
Adoption	Employee may change Employee's plan to reflect the new size of Employee's family.
Placement for adoption	Employee may cancel coverage if Employee become covered by Employee's spouse's plan.
	Newborn added during SEP has coverage from day of birth applied retroactively.
Dependent moves to own policy	Employee may remove a dependent from Employee's policy.
Dependent becomes ineligible at age 26	Employee may remove a dependent from Employee's policy.
Dependent's death	Employee may cancel enrollment for the deceased dependent.
Job change within the same organization	Employee may change coverage if Employee's current plan is no longer available to Employee in Employee's new position.

(includes promotion, demotion and transfer)	
	Employee will be insured through the end of the month.
Loss of employment	Employee may continue Employee's employee coverage through COBRA at Employee's own expense for 18 months.
	Employee may enroll in Employee's spouse's health plan, if available.
Loss of full-time status	Employee may cancel coverage for Employee's and family members.
(20-29 hours per week)	Employee may change Employee's coverage.
Loss of full-time status	If Employee's employer does not provide insurance for part-time employees at this level, Employee coverage will lapse at the end of the month.
(0-19 hours per week)	Employee may continue Employee's employee coverage through COBRA at Employee's own expense for 18 months.
Newly benefit-eligible	Employee may obtain new coverage for him/herself and for Employee's family members.
Part-time to full-time	Employee may obtain new coverage for him/herself and for Employee's family members.
	Employee may enroll him or herself and eligible family members in a plan if the job loss caused Employee and Employee's dependents to lose insurance.
Spouse loses employment	Employee may change Employee's plan if Employee is adding dependents that lost coverage.
Spouse becomes employed	Employee may cancel Employee's coverage if Employee or Employee's dependents become covered under the spouse's new plan.
	Employee may enroll in a plan if the change caused Employee or Employee's dependents to lose insurance.
Spouse's employment status changes	Employee may add dependents to Employee's plan if the change caused dependents to lose insurance.
	Employee may change or cancel Employee's plan if the change causes the spouse's insurance to be a better option for Employee or Employee's dependents.
	Coverage will cease at the end of the month.
Retirement	Employee may enroll in Medicare, if eligible.
	Employee may continue Employee's employee coverage through WMATA's Retiree Program
	Employee may enroll in a Marketplace or individual health insurance plan.
Spouse loses traditional or retiree coverage	Employee may add Employee's spouse to Employee's coverage.
	Employee may change Employee's health plan.
Begin unpaid leave	Employee may change Employee's coverage.
(30+ days)	Employee may cancel Employee's coverage.
Return from unpaid leave	Employee may change Employee's coverage.
(30+ days)	
	Employee may enroll him/herself, spouse and dependents to Employee's coverage.

Return from military leave	Employee may change Employee's health plan.
	Employee may cancel coverage if Employee, Employee's spouse or a dependent has become ineligible for Employee's insurance due to a move.
	Employee may change coverage if Employee, Employee's spouse or a dependent has become eligible for Employee's insurance due to a move.
Change of residence	Employee may add or change coverage if Employee or a dependent have become ineligible for Employee's spouse's insurance due to a move.
Become eligible for Medicare/Medicaid	Employee may cancel private coverage for the person who has enrolled in Medicare.
Lose eligibility	Employee may add coverage for the affected family member.
for Medicare or Medicaid	
Court order	Employee may add, change or suspend coverage if a court order or other official decree requires it.
Significant Coverage Changes	Employee may change plans if services are drastically restricted; (i.e, if a large health network stops accepting the Employee's insurance)

Terminations

- Health Insurance benefits will terminate on the last day of the month of the event of termination, retirement, unpaid absence or when a covered leave is exhausted.
- COBRA, if elected, will be effective the first of the month following date of termination

COBRA Process Overview

Upon termination of employment, Group Health Insurance continues through the last day of the calendar month in which the termination occurred. COBRA is offered to those employees that meet the criteria below

COBRA only applies to Medical and Dental Benefits

Benefit Duration Requirements

Qualifying Event	Duration of Benefits Under Cobra	Qualified Beneficiaries
Termination of Employment (for reasons other than gross misconduct) or reduction of hours of employment	18 months*	Employee, Spouse, Dependent Child
Employee enrollment in Medicare	36 Months*	Spouse/Dependent Child
Divorce or legal separation	36 Months*	Spouse/Dependent Child
Death of the Employee	36 Months*	Spouse/Dependent Child
Loss of "Dependent Child" status under the Plan	36 Months*	Dependent Child

* If a qualified dependent is disabled and meets certain requirements, all of the qualified beneficiaries in that family are entitled to an 11 month extension.

* Up to 150% of the cost of coverage may be charged on the 11 month extension

* End of employment or reduction of employee hours and employee is entitled to Medicare less than 18 months before the qualifying event

Mailing Requirements

General Notices

- This notices are sent to employees 90 days from enrollment on a COBRA plan.

Election Notices – Terminations, Reduction in Hours, and death of an employee

- Form must be sent within 44 days from the date coverage is lost due to termination or reduction of hours

Election Notices – Divorce, Legal Separation, and Loss of dependent Status

- Form must be sent within 14 days from the date coverage is loss due to Divorce, Legal Separation and/or loss of dependent status.

Maximum Continuation Notice

- This notice must be sent to the employee at least 60 days in advance of COBRA duration expiring.

Termination Letter

- If payment is not received by the 20th of the month letter is generated to caution termination of benefits.

Open Enrollment Package (Once a Year)

- COBRA Participants receive an Open Enrollment Package with new rates and new benefit offerings information for the new plan year.
- Upon receipt of their enrollment package COBRA participant benefits must be updated.

Current Internal Process:

- Benefits Department receives the termination PAR Report on a daily basis to identify terminated employees
- All Benefits are terminated in PeopleSoft to reflect the last day of the month in which the termination occurred.
- A package is created for the employee, the package contains the below forms, The forms are completed manually and printed
    - Certificate of Coverage Form
    - Important Notice Form
    - Election Form
    - Premium Rates
    - Enrollment Forms
    - Life Insurance Conversion Letter
    - 401(a) Plan Rollover Information (If the employee has met the vesting period)
    - 457 Plan Rollover Information
- Packages are mailed to the employee's address on file.
- A copy of the package is then printed and placed on a binder for reference

Electing COBRA

- The employee mails the completed forms along with the first month of COBRA payment to the WMATA Benefit's office located at 600 Fifth Street, N.W Washington D.C 20001
- Medical and Dental Carrier Systems are manually updated with COBRA elections
- Billing is set up with accounting department for subsequent billing.

ACA Process Overview

By law we are required to report the type and cost of medical plans offered to our full time employee population in order to be compliant with the ACA mandate.

WMATA currently has one self-funded and three fully insured medical plans. Our current ACA administration vendor is ADP. Vendor maintains eligibility, enrollment and program specifications.

Benefit Staff works closely with vendor to generate and submit reporting files for validation and verification

Benefit staff runs file feeds from PeopleSoft environment. The data is provided to our vendor on a weekly, biweekly, daily and monthly basis.

- **HR Demographic files**
  Contains new hire information, terminations and changes within our population
- **Benefit File**
  Contains Employee enrollment, dependent and rate information.
- **Leave file**
  Includes everyone that is on leave status in our HRIS system
- **Payroll Data File**
  Pay check and Salary data
- N**on-employee file (Retiree Benefit Enrollment data)**
  WMATA offers Retiree Benefits. This data contains all retiree enrollment, elections and covered dependent information

Standard Data a third party administrator manages all benefits for our employees members of Local 689. They transmit benefit and non-employee data to our ACA Administrator.

Benefit Staff conducts data testing once ACA Administrator processes the files to verify

- Coding
- Rate Accuracy
- Data reflect correct employee information, offer and coverage for fully insured plans
- Data reflect correct employee, dependent, offer and coverage for participant on the Self Insured Plan.
- ADP and WMATA benefit staff validate the data to identify basic errors that may cause rejection of forms by the IRS.
- Measurement period runs from 1/1 through 12/31

Reports are produced once the data has been processed to verify it meets IRS standards. ACA Administrator vendor verifies that our plans offer minimum essential coverage. Report the cost of employer- Sponsored health plan

Benefit Manager approves Forms 1095-C and 1094-C in ACA Administrator Vendor's system. File is transmitted to IRS and forms are generated and sent to employee addresses on file.

- After transmittal if the IRS identifies errors, benefit staff works conterminous with ACA Administrator to correct them.

Ongoing Task for ACA Administrator Vendor and Benefit Staff

- Continue to track employee hours and status
- Continue to track determination of eligibility for benefits
- Identify full time employees
- Track employer mandate requirements
- Report the cost of employer- Sponsored health plan
- Continue to track Filing deadlines
- Track SSN problems
- Filing deadlines
- COBRA ACA reporting
- Provide eligible employees with Conditional offers
- Prompt delivery of government mandated forms, Summary of Benefits and Coverage
- Deliver ACA required Communication
- Once a year after the prior year reporting is completed the vendor must set up the Configuration for the following year to authenticate all eligible plans for ACA eligible populations