EMPLOYEE BENEFIT GUIDE

Consultants

January 1, 2018 - December 31, 2018

DCS
DYNAMIC COMPUTING SERVICES CORPORATION

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WELCOME TO YOUR BENEFITS!

This handbook is intended to assist you and your family in understanding and accessing your benefits. We know that occasionally you may need additional information or further explanation about the contents of this booklet. You are welcome to contact any member of Human Resources at your convenience. This booklet will cover information regarding the following:

- Medical Insurance
- Understanding Health Savings Accounts

Please note, this document is presented as a matter of information and is not intended to constitute a promise or contractual commitment by the company. The company reserves the right to unilaterally change or terminate any or all of the programs discussed herein, as well as all of its benefit plans and programs, at any time and without prior notice. Also, modifications may be necessary to comply with applicable legal requirements. In the event of any inconsistency between a statement contained in this document and the relevant plan document or summary plan description, the plan document or summary plan description will control this document.

If you have questions about your benefits or if you need assistance with claims resolution, we have a dedicated Employee Benefit Support service provided by AHT Insurance. Your Employee Benefit Support is available to provide confidential assistance for you and your covered family members. Please see the contact page at the end of this guide.

ELIGIBILITY

Employee

All full-time employees scheduled to work 30 hours or more per week are eligible for benefits. Coverage will begin the first day of the month following or coinciding with 60 days of employment.

Dependents

You may cover your eligible dependents, which include the following:

- Your legal spouse
- Your children up to the age of 26 (includes step children living at your address and/or for whom you have financial responsibility)
- Any dependent child who is incapable of self-support because of a physical or mental disability

When can you enroll?

You can sign up for benefits at any of the following times:

- After completing initial eligibility period
- During the annual open enrollment period
- Within 30 days of a qualified life event

If you do not enroll at the above times, you must wait for the next annual open enrollment period.

Qualified Life Event Changes

You may make changes to your healthcare and insurance benefits choices once a year during the Open Enrollment period. All benefits you select will be effective until our next renewal, unless you have a "qualified change in status" or leave employment. Because many of your benefits are available on a pre-tax basis, the IRS requires you to have a qualified change in status in order to make changes to your benefit elections during the year.

- Marriage
- Divorce or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your work status that affects your benefits
- Change in residence or work site that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

If you have a qualified life event, you must notify Human Resources and complete the necessary forms within 30 days of the event. For more information, refer to your benefits booklets.

COST SHARING

Benefit Costs

Below is reflected what your per pay period deduction will be. DCS will cover the remainder of the monthly premium in accordance with the ACA. You pay for 100% of your dependents medical costs.

Costs below reflect your premiums per pay period (24 per year).

Medical	Your cost
Employee only	$75.77
Employee + Spouse	$409.16
Employee + Spouse + Child(ren)	$681.93
Employee + Child(ren)	$348.54

STAYING HEALTHY

Medical Benefits Overview

The information below is a high-level overview of medical coverage only. Please see Human Resources for plan summaries detailing coverage information, limitations, and exclusions. Any deductibles, copays, and coinsurance percentages shown in the chart below are amounts for which you are responsible. **Medical benefits apply after the calendar-year deductible is met unless otherwise noted.**

	Cigna	
Provider Network	**Cigna Open Access Plus**	**Out-of-Network**
Calendar Year Deductible	$3,000 per individual $6,000 per family	$6,000 per individual $12,000 per family
Calendar Year Out-of-Pocket Limit (Includes Deductible & Coinsurance)	$6,550 per individual $13,100 per family	$13,100 per individual $26,200 per family
Hospital Inpatient & Outpatient	70%/ 30%	50% / 50%
Office Visits		
Office Visit	30% after deductible	50% after deductible
Chiropractic (12 visits PCY)	30% after deductible	50% after deductible
Mental Health	30% after deductible	50% after deductible
Preventive Care		
Office Visit, Screenings, Immunizations	Covered in full	50% after deductible
Lab & X-Ray		
Diagnostic Testing	30% after deductible	50% after deductible
Imaging (CT, PET Scans, MRIs)	30% after deductible	50% after deductible
Rehabilitation		
Outpatient Physical/Occupational Therapy (20 visits PCY)	30% after deductible	50% after deductible
Prescription Drugs		
Retail Pharmacy, 30 day supply	30% after deductible	Not available
Mail Order, 90 day supply	30% after deductible	Not available
Emergency Room	30% after deductible	

- **PCY:** Per Calendar Year
- **Balance billing** may apply if a provider is not contracted. Members are responsible for amounts in excess of the allowable charge.
- **Aggregate:** Your health plan will not begin paying for health care expenses for anyone in your family until the entire family deductible has been met.

UNDERSTANDING HEALTH SAVINGS ACCOUNTS

Carrier **Health Equity**

What is an HSA?

HSAs are a great way to save money and efficiently pay for medical expenses. HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHPs).

HSA money can be used tax-free when paying for qualified medical expenses, helping you pay your HDHP medical plan's larger deductible. At the end of the year, you keep any unspent money in your HSA. This rolled over money can grow with tax-deferred investment earnings, and, if it is used to pay for qualified medical expenses, then the money will continue to be tax-free. Your HSA and the money in it belongs to you—not your employer or insurance company.

An HSA can be a tremendous asset as you save for and pay medical bills because it gives you tax advantages, more control over your own spending and the ability to save for future expenses.

HSA Advantages

- Security – Your HSA can provide a savings buffer for unexpected or high medical bills.
- Affordability – In most cases, you can lower your monthly health insurance premiums when you switch to health insurance coverage with a higher deductible, and these HDHPs can be paired with an HSA.
- Flexibility – You can use your HSA to pay for current medical expenses, including your deductible and expenses that your insurance may not cover, or you can save your funds for future medical expenses.
- Savings – You can save the money in your HSA for future medical expenses, all while your account grows through tax-deferred investment earnings.
- Tax Savings – An HSA provides you with triple tax savings:
    1. Tax deductions when you contribute to your account
    2. Tax-free earnings through investment
    3. Tax-free withdrawals for qualified medical expenses

- Control – You make the decisions regarding:
    - How much money you will put in the account
    - When to make contributions to the account
    - Whether to save the funds for future expenses or pay current medical expenses
    - How to invest the money in the account
- Portability – Accounts are completely portable, meaning you can keep your HSA even if you:
    - Change jobs
    - Change your medical coverage
    - Become unemployed
    - Move to another state
- Ownership – Funds remain in the account from year to year, just like an IRA. There are no “use it or lose it” rules for HSAs, making it a great way to save money for future medical expenses.

UNDERSTANDING HEALTH SAVINGS ACCOUNTS

HSA Eligibility

To have an HSA and make contributions to the account, you must meet several basic qualifications. Here's what you need to know to start saving with an HSA.

- HSA Eligibility – In order to qualify for an HSA, you must be an adult who meets the following qualifications:
  - Have coverage under an HSA-qualified, high deductible health plan (HDHP)
  - Have no other health insurance plan (this exclusion does not apply to certain other types of insurance, such as dental, vision, disability or long-term care coverage)
  - Cannot be claimed as a dependent on someone else's tax return
  - Are not enrolled in Medicare

HSAs must be used with an HDHP. To qualify as an HDHP, a health plan must satisfy requirements for the minimum annual deductible and the maximum out-of-pocket expenses.

Annual Contribution Maximum

	2018
Individual:	$3,450
Family:	$6,900

HSA owners 55 and older can contribute an extra $1,000

- Who can contribute - Contributions to your HSA can be made by anyone, including you, your employer or a family member; the combined contributions of you and your employer (and anyone else making contributions to your HSA) can not exceed the HSA maximum contribution limit.

This is a brief explanation of HSAs. Please see Human Resources for more details or visit www.hsacenter.com.

LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

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

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

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

If you would like more information on WHCRA benefits, please contact HR.

Newborns' and Mothers' Health Protection Act

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

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM

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 January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – 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

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

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

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

FLORIDA – Medicaid

Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: http://dch.georgia.gov/medicaid
- Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.hip.in.gov
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid

Website:
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

NEW HAMPSHIRE – Medicaid

Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM

MAINE – Medicaid

Website:
http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003 / TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website:
http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx

Phone: 1-855-632-7633

NEVADA – Medicaid

Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov

TEXAS – Medicaid

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website:
Medicaid Phone: 1-800-432-5924
CHIP Website:
CHIP Phone: 1-855-242-8282

NORTH CAROLINA – Medicaid

Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website:
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website:
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/indexes.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm

Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: http://www.eohhs.ri.gov/
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

WASHINGTON – Medicaid

Website: http://www.hca.wa.gov/free-or-low-cost-health-
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website:
http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx

Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

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

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

BENEFIT DEFINITIONS

In-Network

Consider your health care options highlighted in this guide. Some plans give you the freedom to use any health care provider of your choice. However, when you use an in-network provider, the percentage you pay out-of-pocket will be based on a negotiated fee, which is usually lower than the actual charges. If you use a provider who is outside of the network, you may be responsible for paying the difference between the Reasonable and Customary (R&C) charges and what the provider charges. R&C charges are set by the insurance carrier and are the amounts that are generally considered reasonable based on what most providers charge for a particular service in a geographic area.

Copayments and Coinsurance

A copayment (copay) is the fixed dollar amount you pay for certain in-network services. In some cases, you may be responsible for coinsurance after copay is made.

Coinsurance is the percentage of covered expenses shared by the employee and the plan. In some cases, coinsurance is paid after the insured meets a deductible. For example, if you pay 20% of an in-network covered charge, the plan pays 80%.

Annual Deductible

Your annual deductible is the amount of money you must first pay out-of-pocket before your plan begins paying for services covered by coinsurance. Some services, such as office visits, require copays and do not apply to the deductible.

After you meet your deductible, the plan pays for a percentage of eligible expenses (coinsurance) until you meet your out-of-pocket maximum. If you receive services from an out-of-network provider, the plan pays a lower percentage of coinsurance. Refer to your health care plan summaries for more information.

Out-of-Pocket Maximum

Some plans feature an out-of-pocket maximum, which limits the amount of coinsurance you will pay for eligible health care expenses. Once you reach that maximum, the plan begins to pay 100% of eligible expenses. There may be separate in- and out-of-network annual out-of-pocket maximums. Generally, copays, R&C charges, and deductibles do not apply to your out-of-pocket maximum.

Preventive Care Services

Preventive care is covered in-network at 100% for those services that are generally linked to designated routine wellness exams and screenings. Examples of preventive care include:

- Annual routine physicals, immunizations
- Bone-density tests, cholesterol screening
- Mammograms, pap smears, pelvic exams, PSA exams
- Sigmoidoscopies, colonoscopies

There may be limits on how often you can receive preventive care treatments and services. You should ask your health care provider whether your visit is considered preventive or non-preventive care.

STILL HAVE QUESTIONS?

We encourage all of our employees and their families to become familiar with your benefits. If you do not find what you need, please use the following contact information to speak directly with a benefits professional that can better serve you. Employee Benefit Support is available Monday through Friday, 8:00 a.m. to 5:00 p.m. Pacific Standard Time.

All calls are confidential and monitored until resolution. Due to HIPAA Privacy, EBS may need to obtain your written authorization in order to assist with certain issues. If needed, an authorization form will be provided to you. You can always contact the providers directly as well.

Benefit	Carrier	Customer Service Information	
Employee Benefit Support	AHT Insurance	Benefit Support:	Quinn Chiotti
		Phone:	206.336.2991
		Email:	qchiotti@ahtins.com
		Benefit Support:	Joann Morgan
		Phone:	206.336.2978
		Email:	jmorgan@ahtins.com
Medical	Cigna	Group Number:	0607507
		Customer Service:	866.494.2111
		Network:	Open Access Plus
		Website:	www.cigna.com
Health Savings Account	Health Equity	Customer Service:	866.346.5800
		Website:	www.healthequity.com
DCS	Human Resources	Debbie Pangburn	800.345.1275
		Email:	debbie@dcshq.com

Washington, D.C. ● Seattle ● New York ● Chicago ● San Francisco

www.ahtins.com