EMPLOYEE BENEFIT GUIDE

Consultants

January 1, 2019 - December 31, 2019

DCS
DYNAMIC COMPUTING SERVICES CORPORATION

WELCOME TO YOUR BENEFITS!

This guide 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. This guide will cover information regarding the following:

- Medical Insurance
- Health Savings Accounts

Please note, this guide does not constitute a promise or contractual commitment by the company. The company reserves the right to unilaterally change or terminate any or all of our benefit 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 in this guide 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, including stepchildren, adopted children and foster children living at your address and/or for whom you have financial responsibility, and any children required to be covered under a Qualified Medical Child Support Order.
- 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. Benefits you select will be effective until our next renewal, unless you have a "qualified change in status" or leave employment. Because 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

DCS pays the majority of the cost to insure our employees. Employees pay the full cost to insure dependents.

Our Flex Plan allows your payroll deductions to be made with pre-tax income, saving you a minimum of $.22 on each dollar that is payroll deducted. If you want deductions to be made with after-tax wages, please contact Human Resources right away.

Medical	Your cost per pay period (24 per year)
Employee only	$83.36
Employee + Spouse	$450.13
Employee + Spouse + Child(ren)	$750.21
Employee + Child(ren)	$383.43

STAYING HEALTHY

Medical Benefits Overview

The information below is a summary 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 are available after the calendar year deductible has been paid unless otherwise noted.**

	Cigna	
Provider Network	**Cigna Open Access Plus Preferred Providers**	**Any Other Licensed Provider**
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
Office Visits		
Office Visit	You pay 30% after deductible	You pay 50% after deductible
Chiropractic (12 visits PCY)	You pay 30% after deductible	You pay 50% after deductible
Mental Health	You pay 30% after deductible	You pay 50% after deductible
Preventive Care		
Office Visit, Screenings, Immunizations	Covered in full, deductible waived	You pay 50% after deductible
Lab & X-Ray		
Diagnostic Testing	You pay 30% after deductible	You pay 50% after deductible
Imaging (CT, PET Scans, MRIs)	You pay 30% after deductible	You pay 50% after deductible
Rehabilitation		
Outpatient Physical/Occupational Therapy (20 visits PCY)	You pay 30% after deductible	You pay 50% after deductible
Prescription Drugs		
Retail Pharmacy, 30 day supply	You pay 30% after deductible	Not covered
Mail Order, 90 day supply	You pay 30% after deductible	Not covered
Emergency Room	30% after deductible	
Hospital Inpatient / Outpatient	You pay 30% after deductible	You pay 50% 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.
- **Calendar Year Deductible:** Your health plan will not begin paying for health care expenses for anyone in your family until the entire family deductible has been paid.

UNDERSTANDING HEALTH SAVINGS ACCOUNTS (HSA)

Banking Partner: Health Equity

What is an HSA?

An HSA is a tax-advantaged savings account into which you can deposit funds only if you are enrolled on a qualified high deductible health plan. Our Medical Plan is a qualified high deductible health plan. Your Health Savings Account is completely separate from the medical plan.

HSA funds can be used tax-free to pay for qualified medical expenses. At the end of each year, you keep any unspent funds that remain in your HSA. This money can grow with tax-deferred investment earnings, and if used to pay for qualified medical expenses the money will continue to be tax-free. Your HSA and the money in it belongs to you—not your employer or insurance company.

HSA Eligibility

To set aside funds in a Health Savings Account, you must be an adult who:

- Has coverage only under an HSA-qualified, high deductible health plan (HDHP). Our Planis a qualified HDHP.
- Has no other medical insurance plan that is not also a qualified high deductible plan. However, you can have 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.
- Is not enrolled on Medicare, Medicaid, Tricare or any other non-qualified medical plan, including access to a Full Flex Health Care Spending Account.

HDHP Enrollment	2019 Calendar Year HSA Contribution Maximum *
Individual	$3,500
Family	$7,000

*** HSA accountholders 55 or over** can contribute an extra $1,000 per calendar year until they are on Medicare. This amount is in addition to the Contribution Maximum shown above.

Who can contribute? Contributions to your HSA can be made by anyone. The combined contributions cannot exceed the maximum contribution for which you are qualified (extra $1000 if 55 or over).

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, AHT 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: Phone: Email:	Genae Gillespie 206.336.0410 ggillespie@ahtins.com
Medical	Cigna	Group Number: Customer Service: Network: Website:	0607507 866.494.2111 Open Access Plus www.cigna.com
Health Savings Account	Health Equity	Customer Service: Website:	866.346.5800 www.healthequity.com
DCS	Human Resources	Debbie Pangburn Email:	800.345.1275 debbie@dcshq.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

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

- **Loss of Other Coverage**
  If you are declining coverage 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).

  Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

- **Marriage, Birth or Adoption**
  If you have a new dependent as a result of a 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, or placement for adoption.

  Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

- **Medicaid or CHIP**
  If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

  Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

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 July 31, 2018. 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: https://chfs.ky.gov
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.in.gov/fssa/hip/
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/hawk-i
Phone: 1-800-257-8563

NEW HAMPSHIRE – Medicaid

Website: http://www.dhhs.nh.gov/oii/documents/hippapp/
Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999

NEW JERSEY – Medicaid and CHIP

Website:
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

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

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: 1-800-862-4840

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-
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://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

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:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
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: 855-697-4347

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-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

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

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To see if any other states have added a premium assistance program since July 31, 2018, 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