EMPLOYEE BENEFIT GUIDE

Consultants

January 1, 2021 - December 31, 2021

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, includes 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 by 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. All benefits you select will be effective until our next renewal, unless you have a "qualified change in status" or leave employment. Because most 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

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	$94.73
Employee + Spouse	$511.43
Employee + Spouse + Child(ren)	$852.38
Employee + Child(ren)	$435.62

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	$6,550 per individual $13,100 per family	$13,100 per individual $26,200 per family
Office and Virtual 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 and Virtual Visits	ACA-list of covered services are overed in full, deductible waived	ACA list of covered services, 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. Please review full information about Health Savings Accounts at www.healthequity.com/learn/hsa before making a decision.

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 Regence Medical Plan H10 HDHP is 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	2021 Calendar Year HSA Contribution Maximum *
Individual	**$3,600**
Family	**$7,200**

* **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).

Medical Benefit Definitions

In-Network

Our plan gives 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.

Coinsurance

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.

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

The out-of-pocket maximum, 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 are separate in- and out-of-network annual out-of-pocket maximums.

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 are defined by the Affordable Care Act of 2010 and include:

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

There are limits and age ranges for certain preventive care 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, 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:	Joann Morgan 206.336.2978 jmorgan@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, 2019. 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+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus

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: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

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

IOWA – Medicaid

Website:
http://dhs.iowa.gov/Hawki
Phone: 1-800-257-8563

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

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

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:
https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.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://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://medicaid.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 and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.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, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
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

To see if any other states have added a premium assistance program since July 31, 2019, 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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact VP Office Operations, Dynamic Computing Services .

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
Dynamic Computing Services	91-1472534
5. Employer address	**6. Employer phone number**
23849 – 225th Way SE. #100	800.345.1275

7. City	8. State	9. ZIP code
Maple Valley	WA	98037

10. Who can we contact about employee health coverage at this job?	
VP Office Operations	
11. Phone number (if different from above)	**12. Email address**
	Debbie@dcshq.com

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Active employees regularly scheduled to work 30 or more hours per week.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouses, domestic partners, and children up to the age of 26 who are dependents of eligible employees as defined above. Please review the Dynamic Computing Services Medical Summary Plan Description for detailed specifications of eligible dependents of contact VP Office Operations.

☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process to find out if you can get a tax credit to lower your monthly premiums.

Legal Notices

Women's Health and Cancer Rights Act

Enrollment Notice

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.

Newborns' and Mother's 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.

Legal Notices

Notice of Privacy Practices

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our medical, dental and vision plans provide health benefits to eligible employees of Dynamic Computing Services ("we"), and their eligible dependents. The Plan creates, receives, uses, maintains, and discloses health information about Plan participants ("you"). The Plan has adopted policies to safeguard the privacy of your health information and comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This Notice is effective January 1, 2021 and remains in effect until we change or replace it.

This Notice describes how your protected health information (PHI) may be used or disclosed to carry out treatment, payment, or healthcare operations, or for any other purposes that are permitted or required by law. It also describes the Plan's responsibilities and your rights with respect to your PHI.

Generally, PHI is health information, including demographic information, collected from you or created or received by a healthcare provider, a healthcare clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

- your past, present, or future physical or mental health or condition;
- the provision of healthcare to you; or
- the past, present, or future payment for the provision of healthcare to you.

The Plan's Responsibilities

The Plan is required by law to:

- Ensure that health information that identifies you is kept private, except as such information is required or permitted to be disclosed by law;
- Describe the Plan's responsibilities and privacy practices with respect to your PHI;
- Abide by the terms of this Notice as currently in effect; and
- Inform you in the event of a breach of your unsecured PHI.

If you are covered by an insured health option under the Plan, you will also receive a separate notice from the insurance company or HMO.

How the Plan May Use and Disclose Your Information

The Plan and its business associates, which are service providers that assist us in administering the Plan or providing Plan services to you, use and disclose PHI in the ways described below. For purposes of this Notice, "the Plan" includes its business associates. We will not use or share your information other than as described in this Notice.

In order to administer your Plan coverage effectively, the Plan is permitted by law to use and disclose your PHI in certain ways without your authorization. The following list describes the ways that the Plan is legally allowed or required to use and disclose your PHI without your prior written authorization:

- **For treatment.** To ensure that you receive appropriate treatment and care, the Plan may use and disclose your PHI to coordinate care between the Plan and your provider. For example, we may disclose your PHI to healthcare providers for their treatment activities.

- **For payment.** To ensure that claims are paid accurately, and you receive the correct benefits, the Plan may use and disclose your PHI to determine plan eligibility and responsibility for coverage and benefits. For example, the Plan may use and disclose your PHI when it confers with other health plans to resolve a coordination of benefits issue. The Plan may also use your PHI for utilization review activities.

- **For healthcare operations.** To ensure quality and efficient plan operations, the Plan may use and disclose your PHI in several ways, including plan administration, quality assessment and improvement, vendor review and for health care fraud and abuse detection and compliance. The Plan is not allowed to use genetic information to decide whether to give you coverage or the price of that coverage.

- **Disclosures to the plan sponsor.** For the purpose of administration, the Plan may disclose PHI to certain employees of the Plan Sponsor. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

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Other Permitted Uses and Disclosures
Federal regulations allow us to use and disclose your PHI, without your authorization, for several additional purposes, in accordance with federal and state law:

- To a coroner or medical examiner;
- To cadaveric organ, eye or tissue donation programs;
- For research purposes, as long as certain privacy-related standards are satisfied;
  - Public health;
  - Reporting and notification of abuse, neglect or domestic violence;
  - Oversight activities of a health oversight agency;
  - Judicial and administrative proceedings;
  - Law enforcement;
  - To avert a serious threat to health or safety;
  - Specialized government functions (for example, military and veterans' activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations);
  - Workers' compensation or similar programs established by law that provide benefits for work-related injuries or illness; and
  - Other purposes required by law, provided that the use or disclosure is limited to the relevant requirements of such law.

Also, for health and safety, and when consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others.

Uses and Disclosures that You May Authorize
The following uses and disclosures will only be made with your written authorization:

- Uses and disclosures for marketing purposes;
- Uses and disclosures that constitute a sale of PHI;
- Most uses and disclosures of psychotherapy notes; and
- Other uses and disclosures not otherwise described in this Notice.

You may revoke your authorization in writing at any time by contacting us. (See "How to Contact Us" below.) Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon your written authorization and prior to receiving your revocation. We also may continue to use and disclose your PHI after revocation if the authorization was obtained as a condition of securing insurance and other law provides us with the right to contest a claim under the policy or the policy itself.

Finally, if applicable state law provides you greater rights or protections concerning your PHI, we will follow such laws.

Your Rights
You have certain rights regarding access to, and the use and disclosure of your PHI as described below. To exercise any of these rights, contact us. (See "How to Contact Us" below.) Specifically, you have the right to:

- **Inspect and copy.** You have the right to inspect your PHI. Any request for access to your health information should be sent to us in writing. (See "How to Contact Us" below.) If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request if the information can be readily produced in that form and format. If the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. We may deny your request in writing in certain, very limited circumstances. We may charge a reasonable, cost-based fee. If you are denied access, you may request that the denial be reviewed by submitting a written request to us.

- **Amend.** You have the right to request to amend your PHI if you think it is incorrect or incomplete. You must provide the request and your reason(s) for the request in writing to us. (See "How to Contact Us" below.) You will be notified in writing if your request is denied. If your request is denied, you have the right to submit a written statement disagreeing with the denial, which will be appended or linked to the health information in question.

- **Receive an accounting of disclosures.** You have the right to request a list of certain disclosures of your PHI that the Plan or our business associates have made. We will include all of the disclosures except for those about treatment, payment, health care operations and certain other disclosures (such as any you have asked us to make). Your request must be made in writing and state the time period of the request which may not be longer than six years prior to your request. The first request within a 12-month period will be

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provided to you free of charge, and any additional requests within this time period may be subject to a reasonable, cost-based fee. The Plan will notify you prior to charging a fee, and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Be notified of a breach.** You have the right to be notified in the event that the Plan (or a business associate) discovers a breach of unsecured PHI.

- **Personal representatives.** You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

- **Obtain a copy of this Notice.** You have a right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time, even if you have previously agreed to receive the Notice electronically.

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the U.S. Department of Health and Human Services. To file a complaint with the Plan, see "How to Contact Us" below. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with the Plan.

How to Contact Us
The Plan has designated Human Resources as its contact person for all issues regarding the Plan's privacy practices and your privacy rights at:

Dynamic Computing Services
23849-225th Way SE, #100
Maple Valley WA 98038
800.345.1275

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, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 1-678-564-1162 ext 2131
ALASKA – Medicaid	**INDIANA – 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	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: https://www.in.gov/medicaid/ Phone 1-800-457-4584
ARKANSAS – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (1-855-692-7447)	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563
CALIFORNIA – Medicaid	**KANSAS – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-916-440-5676	Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**KENTUCKY – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 / Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
FLORIDA – Medicaid	**LOUISIANA – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Children's Health Insurance Program

MAINE – Medicaid	OREGON – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MASSACHUSETTS – Medicaid and CHIP	PENNSYLVANIA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
MINNESOTA – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 1-401-462-0311 (Direct Rite Share Line)
MISSOURI – Medicaid	SOUTH CAROLINA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
MONTANA – Medicaid	SOUTH DAKOTA - Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEBRASKA – Medicaid	TEXAS – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEVADA – Medicaid	UTAH – Medicaid and CHIP
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NEW HAMPSHIRE – Medicaid	VERMONT– Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 1-603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NEW JERSEY – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
NEW YORK – Medicaid	WASHINGTON – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
NORTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://medicaid.ncdhhs.gov Phone: 1-919-855-4100	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
NORTH DAKOTA – Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
OKLAHOMA – Medicaid and CHIP	WYOMING – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, 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

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