DCS

DYNAMIC COMPUTING SERVICES CORPORATION

EMPLOYEE BENEFIT GUIDE - CONSULTANTS
JANUARY 1, 2022 - DECEMBER 31, 2022

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 about these benefits.

- 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. If there is any inconsistency between any statement in this guide and the relevant plan document or summary plan description, the plan document or summary plan description will override the information in this guide.

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

Eligibility

Employee

All full-time Consultants 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 by a Qualified Medical Child Support Order.
- Any dependent child who is 26 or older who is incapable of self-support because of a physical or mental disability and was covered on this plan prior to age 26.

When can you enroll?

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

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

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, notify the VP Office Operations and complete the necessary forms within 30 days of the event. For more information, refer to your benefit booklets.

Cost Sharing

Benefit Costs

DCS pays the majority of the cost to insure our employees. Employees pay the 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 the VP Office Operations right away.

Medical	Your cost per pay period (24 per year)
Employee only	$107.02
Employee + Spouse	$577.91
Employee + Spouse + Child(ren)	$963.18
Employee + Child(ren)	$492.28

Staying Healthy

Medical Benefits Overview

The information below is a summary of medical coverage only. Please see VP Office Operations 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	$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 per calendar year)	You pay 30% after deductible	You pay 50% after deductible
Mental Health	You pay 30% after deductible	You pay 50% after deductible
Preventive Care	Specific preventive services are covered in full, deductible waived. *For a current list of covered services for adults, women and children visit https://www.uspreventiveservicestaskforce.org*	
Lab, Diagnostic Testing/Imaging	You pay 30% after deductible	You pay 50% after deductible
Outpatient Rehab		
Physical & Occupational Therapy (20 visits per calendar year)	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

- **Balance billing** may apply if the provider is not a contracted Cigna Open Access Plus PPO provider. You 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, with the exception of the government-required preventive services.

Health Savings Accounts (HSA)

Banking Partner: Health Equity
This is a brief overview only. Please review full information about Health Savings Accounts before opening an account. Visit www.healthequity.com/learn/hsa.

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 Cigna Medical Plan is a qualified HDHP.
- Who 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.
- Who cannot be claimed as a dependent on someone else's tax return.
- Who is not enrolled on Medicare, Medicaid, Tricare or any other non-qualified medical plan, including having access to spouse's Flex Health Care Spending Account funds.

HDHP Enrollment	2022 Calendar Year HSA Contribution Maximum *
Individual	**$3,650**
Family	**$7,300**

* **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 from all sources cannot exceed the maximum contribution for which you are qualified based on the chart above.

Still Have Questions?

We encourage employees to become familiar with your benefits. If you need assistance, please use the following contact information to speak directly with a benefits professional. In general, Employee Benefit Support is available Monday through Friday, 8:00 a.m. to 5:00 p.m. Pacific Standard Time.

Benefit	Carrier	Customer Service Information	
Employee Benefit Support	AHT Insurance	Benefit Support: Phone: Email:	Matt Sackman 206.336.2939 matt.sackman@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

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.

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, 2021. 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: 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 (855-692-7447)	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki; Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
CALIFORNIA – Medicaid	**KANSAS – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322; Email: hipp@dhcs.ca.gov	Website: https://www.kancare.ks.gov/ 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 Health Insurance Buy-In Program (HIBI): 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: https://www.mass.gov/info-details/masshealth-premium-assistance-pa 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/other-insurance.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/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
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

OMB Control Number 1210-0137 (expires 1/31/2023). To see if any other states have added a premium assistance program since July 31, 2021, 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

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.

Common Terms 1

HEALTH

Affordable Care Act (ACA)
Health reform legislation that was passed in 2010. It was designed to increase the affordability of health insurance and lower the uninsured rate in the United States. Also referred to as Obamacare.

Allowed Amount
The maximum amount that a plan will pay for a service, including any amount that the patient is responsible for paying.

Balance Billing
When a provider bills you the difference between the provider's charge and the plan's allowed amount, typically this occurs when you use out-of-network providers.

Coinsurance
After you pay the deductible, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. Your plan pays 70% coinsurance and you are responsible for paying the remaining 30%, after you have paid the deductible each year.

Deductible

A deductible is your first dollar responsibility for health care expenses every year before the plan will begin to pay benefits, with the exception of the Federally required preventive care services.

The deductible is only charged once per yearand typically applies to any service where coinsurance would otherwise apply. Please see your Summary of Benefits Coverage and Cigna booklet for a complete information.

Deductible– Individual vs Family
An individual deductible applies to only one person on the policy. For example, if your individual deductible is $3,000, the plan will begin covering your expenses after you have paid $3,000 for your own medical costs. This amount does not include any of your other family members' medical bills.

A family deductible applies to the total costs incurred by all family members. For example, if your family deductible is $6,000, the policy will begin covering your family's health care expenses after you have spent $6,000 out-of-pocket for all family members' medical costs.

Health Maintenance Organization (HMO)
HMOs cover services performed only by providers in a network. This tends to be a lower-cost healthcare delivery system and is more restrictive than other plans. HMOs do not have out-of-network benefits. The DCS Cigna medical plan is not an HMO.

Medically Necessary
A health service or supply required to prevent or treat an injury, illness, or symptoms that meet accepted standards of medicine.

Network & Out of Network Providers/PPO & nonPPO
Network/PPO: providers, suppliers and facilities your plan contracts with to provide services.
Out of Network/nonPPO: providers without contracts with your insurance plan. You'll generally pay more to see this type of provider.

Out-of-Pocket Limit (Maximum)
The most you will pay from your own funds for services covered by your plan each calendar year. This includes your deductible and coinsurance. Once you have paid the total out-of-pocket maximum in a year, the plan pays 100% of covered services for the balance of that year.

Common Terms 2

Preauthorization or Prior Authorization
A decision by your plan that a service or drug is medically necessary. Your plan may require pre-authorization for specific services before you receive them.

Physician Services
Services delivered by your physician to treat an illness or injury.

Preferred Provider Organization (PPO)
Plans that allow members to use any healthcare professional without a referral. Staying in-network means lower expenses to you and more coverage. If you go out-of-network, you'll have higher out-of-pocket costs and not all services may be covered.

Primary Care Physician (PCP)
A primary care physician (PCP) is considered your main doctor. Your PCP is responsible for dealing with the majority of your health care issues.

Provider
A physician, health care professional, or facility that is licensed and certified as required by state law.

Rehabilitation Services
Services that help keep or reclaim skills and functions required for daily living that are lost due to an illness or injury. Examples include occupational therapy, speech therapy, and select psychiatric services.

Specialist
A physician that focuses on a specific area of medicine to diagnose, prevent, or treat certain conditions.

Summary of Benefits and Coverage (SBC)
This is a summary providing simple and consistent information about health plan benefits and coverage. Its purpose is to help you better understand the coverage you have and to make comparisons of different options when selecting new coverage. This are provided separately from this guide.

Telemedicine or Virtual Visits
Telemedicine allows health care professionals to evaluate, diagnose and treat patients at a distance using telecommunications technology.

Usual, Customary and Reasonable (UCR)
The amount paid for a service in a geographic area based on what local providers typically charge.

Urgent Care
Care for a condition or injury serious enough that one would seek care right away, but not severe enough to require services in a hospital emergency room.

Waiting Period
The time that must pass before coverage becomes effective for an employee and his or her dependents.

PRESCRIPTIONS

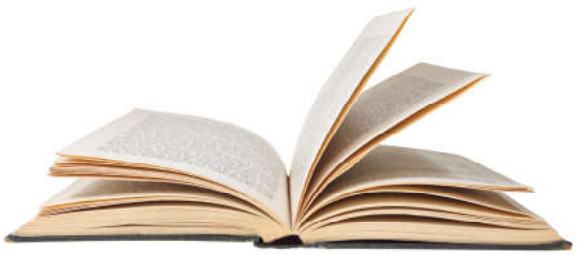
Brand Name Drugs
Prescription drugs marketed with a specific brand name by the vendor that manufactures it (usually the vendor who develops and patents it). Most brand name drugs cost more than generic drugs.

Generic Drug
A drug that has the same active ingredients as a brand name drug but sold under a different name. For example, Atorvastatin is the generic name a drug that has the same formula as Lipitor. Most generic drugs cost less than brand name drugs.

Specialty Drugs
Specialty drugs are powerful medications used to treat certain complex, chronic conditions like cancer, rheumatoid arthritis, and multiple sclerosis.

Formulary

Each health plan has a list of medicines that are preferred, based on an evaluation of effectiveness and cost. The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions.
Drugs that are not on the formulary are generally not covered.



AHT
INSURANCE
www.ahtins.com