DCS
DYNAMIC COMPUTING
SERVICES CORPORATION

# CONSULTANTS EMPLOYEE BENEFIT GUIDE

## January 1, 2024 - December 31, 2024

The information in this guide is presented for illustrative purposes to assist you in making a coverage decision. Your plan booklet will have a detailed list of coverage and exclusions. In addition, every insurer has medical protocols they adhere to based on accepted and proven medical treatment standards. In case of discrepancy between this guide and the actual plan documents, the actual plan documents and insurers' medical standards will prevail. It is your responsibility to check actual plan documents before making a coverage or treatment decision. Please see the plan contacts listed in this guide for information.

# Welcome to Your Benefits

We are pleased to offer a comprehensive benefits program to our valued employees. These benefits available to you represent a significant component of your compensation package. We hope these benefits help you maintain a healthy work-life balance and meet the needs of you and your family. Please use this Benefits Guide as a resource to help you identify the benefits that are right for you, and to make the most of them.

## What's Inside

# Common Eligibility Questions

## Who Is Covered?

All eligible employees scheduled to work 30 or more hours per week are eligible for benefits.

Benefits you elect now will become effective as follows:

- If hired on the 1st, 2nd or 3rd of a month, benefits are effective on date of hire.
- If hired on the 4th or after of a month, benefits are effective on the first day of the following month.

If you are electing your benefits during annual open enrollment, your benefits are effective on January 1.

The following members of your family are also eligible.

- **Your spouse.** Defined as an individual to whom you are legally married.
- **Your domestic partner.** Defined as two adults who live together and share a common domestic life but are not married.
- **Your children and/or children of your domestic partner under the age of 26.** Including:
  - Biological children and/or stepchildren
  - Legally adopted children, including children placed with you for adoption
  - Children for which you are responsible under a qualified medical support order or court-order (whether the child resides with you or not)
  - Any child in your court-appointed legal custody
- **Your disabled children over the age of 26** may continue beyond age 26 as long as the disabled status is certified and approved by the plan, and they were insured by the same plan prior to age 26.

## When Can I Enroll?

Return your enrollment forms as soon as possible, and no later than 30 days after your hire date. After 30 days, you won't be able to make changes until the next open enrollment, unless you experience a qualifying life event.

## What Is Open Enrollment?

Open enrollment is the period of time in which you can make changes to your benefits elections for the upcoming plan year, unless you experience a qualifying life event at another point in the year.

## What Is a Qualifying Life Event?

While you are generally only allowed to change your benefits elections during the open enrollment period each year, certain Qualifying Life Events (QLE) provide an exception when timely notification is provided.

**Coverage may be added when there is a:**

- Birth/Adoption (or placement for adoption)
- Employment change resulting in loss of other coverage
- Marriage
- Qualified Medical Child Support Order
- Loss of Medicaid or CHIP coverage

**Coverage may be dropped when there is a:**

- Divorce or legal separation
- Death of a covered dependent
- Dependent child reaches the limiting age
- Change in employment resulting in a gain of other coverage
- FMLA-related Leave
- Gain of Medicare, Medicaid or CHIP coverage

## How Long Do I Have to Notify Human Resources of a QLE?

You are responsible to update your dependent status during the year. Under most circumstances, such notice must be made within 30 days of the status change. Failure to do this in a timely manner may impact dependent eligibility for health care continuation under COBRA and may also result in you incurring liability for medical expenses for non-eligible dependents. Coverage will start the first of the month following the QLE, unless for birth or adoption, which starts on the day of birth or adoption.

# Paying for Your Coverage

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 $.18 on each dollar payroll deducted. Your savings could be more depending on your federal income tax bracket. If you want deductions to be made with after-tax wages, please contact Human Resources right away.

## Per Pay Period Payroll Deductions for Medical Plan

Below are your payroll deductions.

| Family Tier | Your Cost Per Pay Period (24 per year) |
|---|---|
| **Employee Only** | $134.15 |
| **Employee & Spouse** | $724.43 |
| **Employee, Spouse and Children** | $1,207.36 |
| **Employee & Children** | $617.08 |

# Making the Most of Your Medical Plan

Helping you and your family members stay healthy and use your benefits to their best advantage is our goal in offering our medical plan. Here are some things to remember.

## Compare the Cost of Services

Did you know that hospitals are now required to post their fees for services? You can search the name of any hospital plus "price estimate" and locate their pricing for most services. Be sure to enter your health plan information to get the most accurate estimate. Keep in mind that services performed in a hospital will include a hospital charge, a physician charge and charges from other attending providers, such as anesthesiologists or radiologists, which may not be included in the estimate.

## Understand Your Plan

Keep those benefits documents you get when you sign up for your insurance plan handy. They can provide great info on what you'll pay for different types of services, and what the rules of your insurance plans are—like whether you need to choose an in-network primary care physician or if you need referrals to see a specialist. Following the rules will help you ensure that you get quality care at a significant savings.

## Stick with In-Network Providers

The lowest charges are for doctors and hospitals who participate in your insurance network. Check to make sure that the doctors who are treating you and your family are on your insurance plan.

## Plan Your Doctor Visits

To get the most from your doctor visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of things to talk about with your doctor

If you need a medication, you could save money by asking your doctor if there are generic alternatives for your specific medication.

## When to Use Urgent Care

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or Emergency Room. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

## Be Med Wise!

Always follow your doctor's and pharmacist's instructions when taking medications. You can worsen your condition(s) by not taking your medication or by skipping doses. If your medication is making you feel worse, contact your doctor.

## Prescriptions via Mail Order

For medications you use long-term, you'll reduce hassle and could reduce cost if you order prescriptions through the mail order system.

## Review your Explanation of Benefits (EOB)

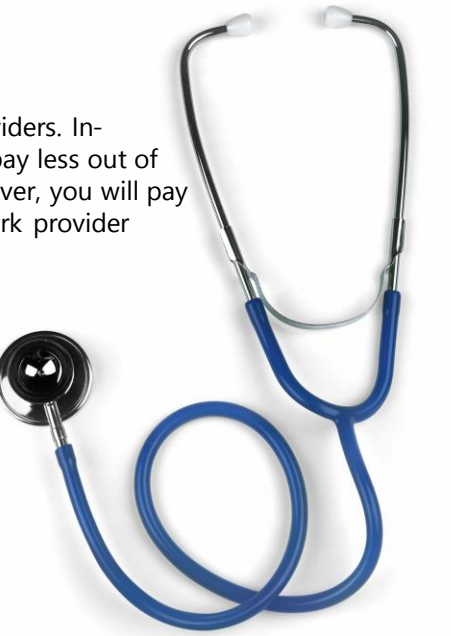
Make sure your care is properly billed. If you have any questions, contact your insurance carrier or your AHT benefit advocate (see contact page of this guide).

## Take Advantage of Free Preventive Services

Your medical plan pays 100% for in-network preventive care. You won't have to pay coinsurance or meet your deductible to get these services at no charge. Preventive care covers things like:

- Annual physical exams
- Well-child care
- OB/GYN annual exam
- Mammograms
- Colonoscopies
- Immunizations (including the flu shot)
- Birth Control

# Medical



Your medical plan provides a national network of doctors, hospitals and other providers. In-network providers have agreed to accept a reduced rate for their services, so you pay less out of your pocket for care. You have the freedom to use out-of-network providers; however, you will pay more of the cost of your care because you can be balance billed if an out-of-network provider charges more than the plan's allowed amount, which they often do.

**Take advantage of Preventive Care**

Your medical plan pays 100% for in-network preventive care. Preventive care covers services such as annual physical exams, routine pediatric care (to age 19), OB/GYN exam, mammogram and certain cancer screenings (such as colonoscopies) and some prescription medications.

## Your Cigna Medical Plan

The benefits below show insured's cost responsibility.

| Benefits | In-Network *Cannot balance bill* | Out-of-Network *Can balance bill* |
|---|---|---|
| **Network of Providers** | **Cigna Open Access Plus Preferred Providers** | **Any Other Licensed Provider** |
| **Calendar Year Deductible**<br>Applies first unless otherwise noted | $3,000 individual<br>$6,000 family | $6,000 individual<br>$12,000 family |
| **Coinsurance**<br>Cigna/ Insured | 70% / 30% | 50% / 50% |
| **Calendar Year Out-of-Pocket Limit**<br>Includes deductible and coinsurance | $6,550 individual<br>$13,100 family | $13,100 individual<br>$26,200 family |
| **Preventive Care** | | |
| Office Visit, Screenings, Immunizations | Covered in full | 50% after Deductible |
| **Office Visits** | | |
| Office Visit and Virtual Visits | 30% after Deductible | 50% after Deductible |
| Mental Health | 30% after Deductible | 50% after Deductible |
| Chiropractic 12 Visits Per Calendar Year | 30% after Deductible | 50% after Deductible |
| **Outpatient Rehabilitation** | | |
| Physical / Occupational / Massage<br>20 Visits Per Calendar Year | 30% after Deductible | 50% after Deductible |
| **Lab & X-ray** | | |
| Diagnostic, Complex Imaging, CT, PET Scan, & MRI | 30% after Deductible | 50% after Deductible |
| **Urgent Care Office Visit** (free standing facility) | 30% after Deductible | 50% after Deductible |
| **Inpatient/Outpatient Hospital & Emergency Room** | 30% after Deductible | |

Balance Billing is when a provider bills you the difference between their charge and Cigna's allowed amount. This often occurs when you use out-of-network providers, and you are responsible to pay this extra charge.

# Prescriptions

## Your Cigna Prescription Plan

The benefits below show the member's cost responsibility.

Prescriptions can only be filled at a Cigna in-network pharmacy or through the mail order system. If you use a non-network pharmacy you will need to pay in full and submit a claim for reimbursement. Reimbursement is only available if costs were incurred at a non-network pharmacy as part of an Emergency Service, as defined by the plan.

| | Retail<br>Up to a 30-day supply | Mail Order<br>Up to a 90-day supply |
|---|---|---|
| **Generic Drugs** | 30% after Deductible | 30% after Deductible |
| **Preferred Brand Drugs** | 30% after Deductible | 30% after Deductible |
| **Non-Preferred Brand Drugs** | 30% after Deductible | 30% after Deductible |
| **Specialty Drugs- 30 day supply only** | 30% after Deductible | 30% after Deductible |

**Certain preventive care medications are covered at no cost to you as required by the Affordable Care Act. See details at www.healthcare.gov.**

## What Is a Formulary?

A drug formulary is a list of prescription drugs, both generic and brand name, used by practitioners to identify drugs that offer the greatest overall value. A committee of independent, actively practicing physicians and pharmacists maintain this formulary. The name of your formulary is Cigna Performance.

### Important Reminder

Formulary lists can change for several reasons such as a new generic drug comes onto the market, a drug is removed from the market, or new restrictions are added to a brand name drug. You can always check your plan's formulary list by logging into your Cigna online account or calling the number on your ID card.

### Helpful Tips

You can manage ongoing maintenance medications by signing up for Home Delivery (mail order prescriptions).

If you're considering mail order, make sure you request a 90-day supply prescription to send in with your initial request. Also make sure you have enough medication on hand to cover the initial processing time. After that, you can re-order online.

Some medications are subject to quantity limits or prior-approval. To review the formulary simply log into your account. If you haven't signed up yet, you can sign up with the information on your ID card.

# Preventive Services

## Preventive Services Covered Under the Affordable Care Act

The Affordable Care Act (ACA) requires health insurers to cover recommended preventive services without any patient cost-sharing, such as deductibles when receiving these services from a Preferred Provider. The ACA requires coverage of services with an "A" or "B" recommendation from the United States Preventive Services Task Force (USPSTF), an independent panel of clinicians and scientists.

## Examples of Covered Benefits

- Blood pressure, diabetes, and cholesterol tests
- Many cancer screenings, including mammograms and colonoscopies
- Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression, and reducing alcohol use
- Regular well-baby and well-child visits
- Routine vaccinations against diseases such as measles, polio, or meningitis
- Counseling, screening, and vaccines to ensure healthy pregnancies
- Flu shots and other vaccines

## Can I Ever Be Charged a Fee For Preventive Care?

- Out-of-network providers: These services are free only when delivered by a doctor or other provider in your plan's network. Your health plan may allow you to receive these services from an out-of-network provider but may charge you a fee.
- Office visit fees: Be aware that your plan can require you to pay some costs of the office visit if the preventive service is not the primary purpose of the visit.

## Questions

Talk to your health care provider to know which covered preventive services are right for you — based on your age, gender, and health status or visit **www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html** for a complete list of preventive services available at no cost.

# Virtual Care

## Your Cigna Virtual Care Options

### What Is Virtual Care?

Virtual Care is a form of technology-based communication that allows a doctor and patient to communicate without being in the same physical space. Virtual Care can be used for **Primary Care, Behavioral Health, and Substance Abuse.** From everyday medical issues to managing problems that feel too big to face alone, Cigna's virtual care network is here to help.

### When Can I Talk to a Virtual Care Provider?

Illness can occur at anytime. You can talk to any board-certified providers any time by phone, video, or through the app–24 hours a day, 7 days a week, 365 days a year.

### Easy to Use

You can use virtual care as often as you need to. Each visit is processed as a health plan claim, and your costs count toward your deductible.

This is more than a nurse advice line. A doctor can diagnose, treat and prescribe medications. You will work with the virtual care doctor, not your regular doctor. With your permission, the virtual care doctor will share your treatment information with your regular doctor.

### Is Virtual Care a Substitute for In-Person Doctor's Visits?

No. A virtual appointment is good for a number of mild conditions but is not suitable for severe symptoms like a high fever or a debilitating cough.

| Virtual Care Cost | |
|---|---|
| MDLive | 30% after Deductible |
| Talkspace/Cigna Mental Health/Ginger | 30% after Deductible |
| Cigna Substance Abuse | 30% after Deductible |
| iPrevail | 30% after Deductible |
| Happify | 30% after Deductible |

| Cigna's Virtual Care Network | |
|---|---|
| MDLIVE | Board-certified doctors and pediatricians can diagnose, treat and prescribe most medications for **minor medical conditions** and **dermatology.**<br><br>Licensed counselors and psychiatrists can diagnose, treat and prescribe most medications for nonemergency behavioral conditions.<br><br>mycigna.com |
| talkspace<br>Cigna<br>ginger | Get specialized comprehensive **talk therapy, medication management,** and more from licensed prescriber with Talkspace,through a Cigna provider or with Ginger – all from the comfort of your home.<br><br>**talkspace.com/cigna**<br>**mycigna.com**<br>**ginger.com/cigna** |
| Cigna | If you or a loved one are struggling with **substance use**, it can affect everything. We're here to help you on the road to recovery with inpatient and outpatient services, online tools, behavioral coaches, and educational support.<br><br>**mycigna.com** |
| Prevail HEALTH | iPrevail offered through Cigna provides **on-demand coaching, personalized learning and caregiver support.** Complete an assessment, receive a program tailored to your needs, and get connected to a peer coach.<br><br>**mycigna.com** |
| happify | Happify offered through Cigna is a **self-directed program** with activities, science-based games and guided meditations, designed to help reduce anxiety, stress and boost overall health.<br><br>**mycigna.com** |

# Health Savings Account

Your Health Equity Health Savings Account Plan. Visit healthequity.com/learn/hsa before opening an account.

## What Is an HSA?

To open a Health Savings Account and make contributions to the account, you must meet several basic qualifications. In order to qualify for an HSA, you must be an adult who meets the following qualifications:

- Have coverage under an HSA-Qualified High Deductible Health Plan (QHDHP).
- The DCS medical plan is a qualified plan.
- Have no other medical health insurance plan
- Cannot be claimed as a dependent on someone else's tax return
- Are not enrolled in Medicare

## Annual Contribution Maximum

Your HSA contribution limit is defined by your enrollment in the qualified medical plan.

If you are enrolled as single on our medical plan, you are eligible for the Single HSA contribution limit.

If you are enrolled as a family of two or more on our medical plan, you are eligible for the higher Family HSA contribution limit.

| | **Single** | **Family** (2 or more) |
|---|---|---|
| 2024 Maximum | $4,150 | $8,300 |

| **Age 55 or older** | **HSA Catch-Up Contributions** |
|---|---|
| 2024 | Additional $1,000 |

## HSA Advantages

- Security and Savings: Your HSA can provide a savings buffer for unexpected or high medical bills.
- Flexibility: You can use your HSA to pay for current medical expenses, including your deductible and expenses that your insurance may not cover, or you can save your funds for future medical expenses.
- Tax Savings: An HSA provides you with triple tax savings:
  - Pre-tax pay deducted contributions to your account.
  - Tax-free earnings through interest & investments.
  - Tax-free withdrawals for qualified medical expenses.
- Control: You make the decision about your account: contributions (when and how), whether to save for future expenses or pay current expenses, and how to invest.
- Portability: Accounts are completely portable.
- Ownership: Your HSA funds always belong to you, regardless of your employment at DCS.

# Health Savings Account

## How Should I Decide If a QHDHP Is Right for Me?

If your medical expenses are generally routine or preventive care, you may want to consider an QHDHP. An HSA is a tool you can use to accumulate funds for future medical expenses. A QHDHP plan offers protection from unexpected major or catastrophic accidents or illnesses at a lower cost than traditional plans.

## What Is My Financial Risk If I Am Enrolled in a QHDHP Plan?

Your out-of-pocket expenses for covered medical services are limited to the Calendar Year Out of Pocket Maximum amounts shown in the Medical Benefit Summary. Note that there are two maximum limits in your medical plan, depending on whether you are using Cigna Access Plus providers or not. Once you pay the maximum in a calendar year, your covered medical services are paid by the plan for the balance of the calendar year.

## What Can I Use the Funds in My HSA For?

Your HSA can be used to pay for "qualified medical expenses," defined by IRS Code 213(d). These expenses include, but are not limited to medical plan deductibles, diagnostic services covered by your plan, long-term care insurance premiums, LASIK surgery and some nursing services.

When you become enrolled on Medicare you can use the HSA funds to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once enrolled on Medicare.

For the complete list of IRS-allowable expenses, you can get IRS Publication 502 by calling 1-800-829-3676 or visiting the IRS website at **www.irs.gov** and select "Forms and Publications." Please note: while health insurance premiums are listed as an allowable expense, they are not reimbursable from HSAs unless you are receiving Federal unemployment compensation.

## Can I Use My HSA to Pay for Non-Health Related Expenses?

You can, but it will be subject to income tax. If you are under 65 years old, you will pay an additional 20% tax penalty on the amount withdrawn.

## Can I Use My HSA to Pay for a Family Member's Medical Expenses If They Are Not on My Medical Plan?

Yes. You may use your HSA funds to cover eligible expenses of your spouse and/or other eligible tax dependent family members.

## Can I Contribute to Both an HSA and an FSA?

An FSA counts as "other health coverage," according to the IRS. So, a general-purpose health FSA will not be compatible with an HSA. It's important to note that if your spouse elects an FSA that's not compatible with an HSA, you cannot contribute to an HSA because you're technically considered covered under the spouse FSA (whether your spouse adds you as a dependent to the spouse's medical plan or not).

If your employer or spouse's employer offers either a limited-purpose health FSA (dental and vision expenses only) or a post-deductible health FSA (also referred to as an "HSA-compatible FSA"), start celebrating! It means you can have an HSA alongside this type of FSA.

Dependent Care FSA is always available to you whether you have an FSA or an HSA..

# Your Benefit Resources

Support is available Monday through Friday, 8:00am to 5:00pm Pacific Time. We encourage all 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.

If you need escalated assistance, please reach out to your Employee Benefit Support team at AHT. Due to HIPAA Privacy, it may be necessary to obtain your written authorization in order to assist with certain issues. All calls are confidential and claim issues are monitored to resolution.

| Benefit | Company | Customer Service Information | |
|---|---|---|---|
| General Benefits Support | **AHT Insurance** | Benefits Support:<br>Phone:<br>Email: | Natalia Shavlovsky<br>206.895.1365<br>**Natalia.Shavlovsky@ahtins.com** |
| Medical | **Cigna** | Group Number:<br>Customer Service:<br>Network:<br>Website: | 0607507<br>888.482.7342<br>Open Access Plus PPO<br>**www.my.cigna.com** |
| Health Savings Account (HSA) | **Health Equity** | Customer Service:<br>Website: | 866.346.5800<br>**www.healthequity.com** |

**DCS : Debbie Pangburn**

**call 800.345.1275 or 425-578-2200 ext. 120 or email Debbie@dcshq.com**

# Terms to Know

## HEALTH

### Aggregate Deductible
The shared family deductible amount that applies when you enroll on a High Deductible Health Plan with one or more dependents. There is no individual deductible limit within the family deductible.

### Affordable Care Act (ACA)
Landmark health reform legislation 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 an insurer will consider to pay for a service, including any amount that the patient will be responsible for paying.

### Balance Billing
When a provider bills you the difference between the provider's charge and the insurer's allowed amount, typically 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%. For example, if the DCS plan pays 70% coinsurance, you are responsible for paying your coinsurance of 30..

### Deductible
A deductible is your first dollar responsibility for health care expenses every year before the plan will begin to pay benefits. The deductible is only charged once per year and typically applies to any service where coinsurance would otherwise apply. Please see your plan highlights and booklet for a full outline of when the deductible will apply to covered services.

### Out-of-Pocket Limit (Maximum)
The most you would pay from your own money for covered health care expenses in one plan year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible and coinsurance), the plan pays for all eligible expenses for the rest of the plan year.

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

### In-Network Providers
The providers, suppliers, and facilities your insurance plan
has contracted with to provide services.

### Out-of-Network Provider s
A providers without a contract with your medical plan. You generally pay more to see this type of provider.

### Out-of-Pocket Cost
A health care expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

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

### Preferred Provider Organization (PPO)
Plans that allow members to use any health care professional without a referral. Staying in-network means lower out of pocket cost 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.

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

# 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.

# Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

### What Is "Balance Billing" (Sometimes Called "Surprise Billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

### You Are Protected From Balance Billing For:

**Emergency Services**

If you receive emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

**Certain Services at an In-network Hospital or Ambulatory Surgical Center**

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

**You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.**

### When Balance Billing Isn't Allowed, You Also Have the Following Protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

Visit **https://www.federalregister.gov/** for more information about your rights under federal law.

# 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 1, 2023. Contact your State for more information on eligibility –

| ALABAMA – Medicaid | GEORGIA – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website:<br>https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: 1-678-564-1162, Press 2 |
| ALASKA – Medicaid | INDIANA – Medicaid |
| The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility: http://health.alaska.gov/dpa/Pages/default.aspx | Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.in.gov/fssa/hip Phone: 1-877-438-4479<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>Phone 1-800-457-4584 |
| ARKANSAS – Medicaid | IOWA – Medicaid and CHIP (Hawki) |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Medicaid Website: https://dhs.iowa.gov/ime/members<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website: http://dhs.iowa.gov/Hawki; Phone: 1-800-257-8563<br>HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp<br>HIPP Phone: 1-888-346-9562 |
| CALIFORNIA – Medicaid | KANSAS – Medicaid |
| Website: Health Insurance Premium Payment (HIPP) Program<br>http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322; Fax: 916-440-5676; Email: hipp@dhcs.ca.gov | Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-967-4660 |
| COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) | KENTUCKY – Medicaid |
| Health First Colorado Website: https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center:<br>1-800-221-3943/ State Relay 711<br>CHP+: https://hcpf.colorado.gov/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/ State Relay 711<br>Health Insurance Buy-In Program (HIBI) https://www.mycohibi.com<br>HIBI Customer Service: 1-855-692-6442 | Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website: https://www.chfs.ky.gov/agencies/dms |
| FLORIDA – Medicaid | LOUISIANA – Medicaid |
| Website:<br>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<br>Phone: 1-888-342-6207 (Medicaid hotline)<br>or 1-855-618-5488 (LaHIPP) |

# Children's Health Insurance Program
## continued

| MAINE – Medicaid | OREGON – Medicaid |
|---|---|
| Enrollment Website:<br>https://www.mymaineconnection.gov/benefits/s/?language=en_US<br>Phone: 1-800-442-6003; TTY: Maine relay 711<br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-977-6740; TTY: Maine relay 711 | Website: http://healthcare.oregon.gov/Pages/index.aspx<br>http://www.oregonhealthcare.gov/index-es.html<br>Phone: 1-800-699-9075 |
| **MASSACHUSETTS – Medicaid and CHIP** | **PENNSYLVANIA – Medicaid** |
| Website: https://www.mass.gov/masshealth/pa<br>Phone: 1-800-862-4840<br>TTY: 711<br>Email: masspremassistance@accenture.com | Website:<br>https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) |
| **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/<br>Phone: 1-855-697-4347<br>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<br>Phone: 1-573-751-2005 | Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 |
| **MONTANA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084; Email: HHSHIPProgram@mt.gov | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |
| **NEBRASKA – Medicaid** | **TEXAS – Medicaid** |
| Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 1-402-473-7000; Omaha: 1-402-595-1178 | Website: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>Phone: 1-800-440-0493 |
| **NEVADA – Medicaid** | **UTAH – Medicaid and CHIP** |
| Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Medicaid Website: https://medicaid.utah.gov/<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 |
| **NEW HAMPSHIRE – Medicaid** | **VERMONT– Medicaid** |
| Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program; Phone: 1-603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345 ext 5218 | Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Health Access; 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/<br>Medicaid Phone: 1-609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 | Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **NEW YORK – Medicaid** | **WASHINGTON – Medicaid** |
| Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 | Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 |
| **NORTH CAROLINA – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 1-919-855-4100 | Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **NORTH DAKOTA – Medicaid** | **WISCONSIN – Medicaid and CHIP** |
| Website: https://www.hhs.nd.gov/healthcare<br>Phone: 1-844-854-4825 | Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 |
| **OKLAHOMA – Medicaid and CHIP** | **WYOMING – Medicaid** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website:<br>https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/; Phone: 1-800-251-1269 |

OMB Control Number 1210-0137 (expires 1/31/2026). To see if any other states have added a premium assistance program since July 31, 2023, 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

# New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

## 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

**Debbie Pangburn, 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.

# New Health Insurance Marketplace Coverage Options and Your Health Coverage

## 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 Corporation | 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? | | |
| Debbie Pangburn | | |
| 11. Phone number (if different from above) | 12. Email address | |
| 800.345.1275 | 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:

  full time employees who are regularly scheduled to work at least 30 hours per week

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:

  Legal spouse, domestic partner, and children.

  ☐ 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. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

# Creditable Coverage Disclosure Notice

## Important Notice from Dynamic Computing Services Corporation About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Dynamic Computing Services Corporation and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare drug prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Dynamic Computing Services Corporation has determined that the prescription drug coverage offered by the Dynamic Computing Services Corporation Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

## When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you are first eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

## What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Dynamic Computing services Corporation coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance that outlines prescription drug plan provisions and options that Medicare-eligible individuals may have available when becoming eligible for Medicare Part D at this website: **http://www.cms.hhs.gov/CreditableCoverage/.**

If you do decide to join a Medicare drug plan and drop your current Dynamic Computing Services Corporation coverage, be aware that you and your dependents will be able to get this coverage back as long as you are still an actively working employee.

**CMS Form 10182-CC Updated April 1, 2011**

# Creditable Coverage Disclosure Notice

## When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Dynamic Computing Services Corporation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

## For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Dynamic Computing Services Corporation changes. You also may request a copy of this notice at any time.

## For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember**: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

| | |
|---|---|
| Date: | Most recently distributed prior to October 14, 2023 |
| Name of Entity/Sender: | Dynamic Computing Services Corporation |
| Contact-Position/Office: | Debbie Pangburn, Vice President, Office Operations |
| Address: | 23849 225th Way SE, Suite 100, Maple Valley, WA 98038 |
| Phone Number: | 800.345.1275 or 425.578.2200 x 120 |

**CMS Form 10182-CC Updated April 1, 2011**


www.ahtins.com