2026 OPEN ENROLLMENT

Consultants
Employee Benefits Guide

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Important Disclaimer

The information in this guide is provided for illustrative purposes only to help you make informed decisions about your benefits. For complete details on coverage, exclusions, and limitations, please refer to your official plan documents or summary plan descriptions.

Each insurance provider follows specific medical protocols based on established and evidence-based treatment standards. In the event of any discrepancy between this guide and the official plan documents, the plan documents and the insurer's medical guidelines will take precedence.

It is your responsibility to review the actual plan materials before making any coverage or treatment decisions. For questions or further assistance, please refer to the plan contact information listed at the back of this guide.

Welcome to Your Benefits

We're proud to offer a comprehensive benefits package designed to support your health, well-being, and financial security. These benefits are a valuable part of your total compensation and are here to help you and your family thrive—both at work and at home.

Use this Benefits Guide as a helpful resource to explore your options, understand your coverage, and make the most of the programs available to you.

What's Inside

Common Eligibility Questions

What Is Open Enrollment?

Open Enrollment is the designated time each year when you can review and make changes to your benefit elections for the upcoming plan year. Outside of this period, changes are only allowed if you experience a Qualifying Life Event.

Who Is Eligible for Coverage?

All employees scheduled to work 30 hours or more per week are eligible to participate in the benefits program.

- Benefits you elect now will become effective as follows: If hired on the 1st, 2nd or 3rd day of the month, benefits are effective on your date of hire.
- If hired on the 4th or later day of the month, benefits are effective on the 1st of the following month.
- If you are electing your benefits during the annual enrollment period, your benefits will become effective on January 1, 2026.

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 individuals who live together and share a common domestic life but are not married.
- **Your children and/or children od 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 you are responsible for 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.** They may continue on the plan past the age of 26 as long as the disabled status is certified and approved by the plan.

When Can I Enroll?

You have 30 days from the date you become eligible to enroll in your benefits. If you don't enroll within that window, you'll need to wait until the next Open Enrollment period, unless you experience a Qualifying Life Event.

What Is a Qualifying Life Event?

While benefit elections can typically only be changed during the annual Open Enrollment period, certain Qualifying Life Events (QLEs) allow you to make changes outside of that window—as long as you notify your employer within the required timeframe.

Coverage Effective Dates: For most QLEs, coverage begins on the first day of the month following the event. For birth or adoption, coverage begins on the date of birth or adoption.

Coverage may be added when there is a:

- Birth/Adoption (or placement for adoption)
- Change in employment 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 Report a Qualifying Life Event (QLE)?

You are responsible for reporting a QLE when a change occurs during the plan year. In most cases, you must notify Human Resources within 30 days of the QLE.

Important: Failure to report a QLE within the required timeframe may may affect you or your dependent's eligibility for continued coverage under COBRA and/or result in personal liability for medical expenses incurred.

Paying for Your Coverage

We pay the 75% portion of the employee's medical premium. We pay 100% of the dental and vision premium of the employee's and dependent's coverage. The premium you pay will be taken on a pre-tax basis unless you elect otherwise. Please note that the IRS requires that premiums for Domestic Partners and their children who are not your tax dependents be taken on a post-tax basis. We are required to add the company's portion of the cost of coverage for non-tax dependents to your taxable income.

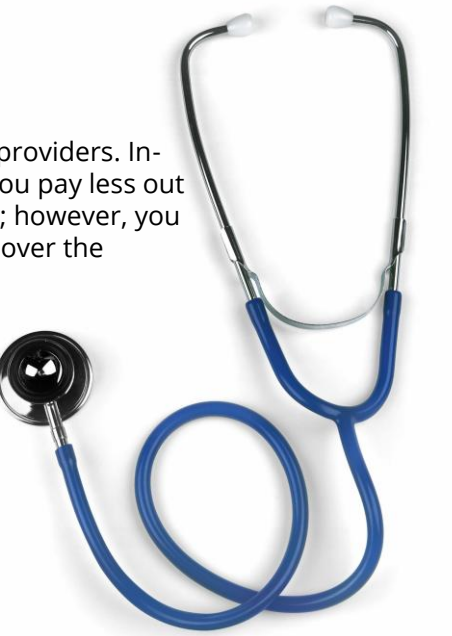
Per Pay Period Contributions for Bundled Coverage

Enrollment in the medical, dental, and vision plans are bundled; you cannot enroll in one without the others. And you must be enrolled for spouses and/or children to be enrolled.

	Employee Contribution
Employee Only	$147.07
Employee & Spouse	$794.17
Employee & Family	$1.323.61
Employee & Children	$676.65

For the purposes of medical, dental, or vision enrollment, the term "spouse" is interchangeable with "domestic partner." If you are enrolling your Domestic Partner, however, you may need to sign a Domestic Partner Affidavit.

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 out of your pocket for care and can be balance billed, the excess over the allowed amount.

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 HSA-Qualified Medical Plan

The benefits below reflect the member's cost responsibility.

	In-Network Cannot balance bill	**Out-of-Network** Can balance bill
Network	Open Access Plus	Any Licensed Provider
Calendar Year Deductible Applies first unless otherwise noted	$3,000 individual $6,000 family aggregate; $3,400 individual on family coverage	$6,000 individual $12,000 family embedded
Coinsurance Carrier / Member	70% / 30%	50% / 50%
Calendar Year Out-of-Pocket Limit Includes deductible & coinsurance	$6,550 individual $13,100 family embedded	$13,100 individual $26,200 family embedded
Preventive Care	Covered in full	50%
Office Visits	30%	50%
Physical therapy Speech, hearing, and occupational therapy Chiropractic	20 visits per calendar year 20 visits per calendar year 12 visits per calendar year	Shared visit limits
Virtual Care	30%	50%
Lab & X-ray	30%	50%
Urgent Care Office Visit	30%	50%
Emergency Room	30%	30%
Prescription drugs	30%	30%

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

Preventive Services

Preventive Services Covered Under the Affordable Care Act

The Affordable Care Act (ACA) requires private health insurers to cover recommended preventive services without any patient cost-sharing, such as copays and 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. This requirement took effect for new plans sold or renewed on or after September 23, 2010.

Examples of Covered Benefits[1]

- 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?[1]

- 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[1]

Talk to a health care provider to know which covered preventive services are right for you — based on your age, gender, and health status.

[1] https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html 5.13.2025

Virtual Care

Your Cigna Virtual Care

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. Cigna's MDLIVE can be used in place of several face-to-face visits.

When Can I Talk to a Virtual Care Provider?

Illness can occur at anytime. But with constant access from virtual care providers, you don't have to wait for office hours to be seen. 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.

How do I Start?

Visit mycigna.com and click "talk to a doctor" to see your cost of care and start your visit. You can also start by using this QR code.

Cigna's MDLIVE Virtual Care

How can MDLIVE help?	Use it for:
Urgent Care *No scheduling needed*	Non-emergency medical conditions like sore throat, cold, flu, pink eye, etc.
Wellness Screening *Scheduled visit*	Preventive annual lab screening and review with primary care provider.
Routine Care *Scheduled visit*	Ongoing health conditions, requests for medication refills, lab tests, and any other questions and concerns.
Therapy *Scheduled visit*	Emotional and behavioral health concerns like anxiety, relationship issues, stress management, trauma, and more.
Psychiatry *Scheduled visit*	Behavioral conditions that require medication management including depression, bipolar, panic disorders, and more.
Dermatology *Secure messaging*	Rashes, acne treatment, hair, nails, and other skin conditions.

Making the Most of Your Medical Plan

Helping you and your family members stay healthy and making sure you use your benefits program to its best advantage is our goal in offering these programs. Here are a few things to keep in mind.

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 in order to get the most accurate estimate. Keep in mind that services performed in a hospital will be comprised of a hospital charge, a physician charge, as well as charges from other attending providers, such as anesthesiologists or radiologists, which may not be included in the estimate.

Make Sure You 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 out of 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 what you want to talk about with your doctor

If you need a medication, you could save money by asking your doctor if there are generics or 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 ER. 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.

Get Your Prescriptions via Mail Order

For medications you use long-term, you'll reduce hassle and could reduce cost if you order prescriptions through a subscription service. Utilizing 90-day supplies and mail order could decrease dispensing fees.

Review your Explanation of Benefits (EOB)

Make sure your care is properly billed. If you have any questions, contact your insurance carrier or your benefit advocate (located at the back 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 a co-pay or meet your deductible to get these services at no charge. Preventive care covers services such as:

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

How to Use Your Medical Plan

Your General Guide to Cost Shares

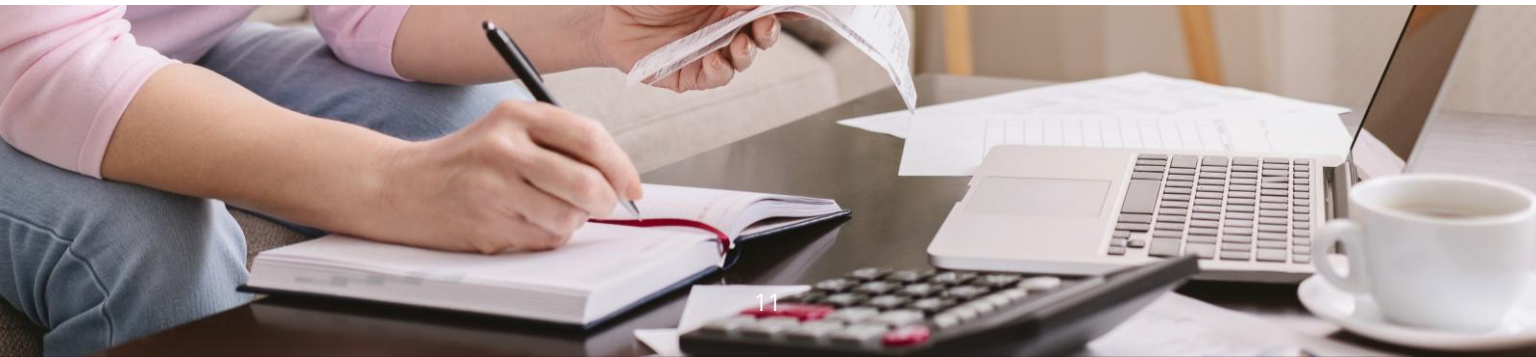
There are several types of cost-sharing within the plan. Becoming familiar with how these cost-shares work will help you understand and appreciate the benefits and eliminate surprises with your bills. Here is a quick outline of the cost sharing mechanisms and how they work together in general.

	In-Network You use an In-Network Provider	Out-of-Network You DON'T use an In-Network Provider
Deductible	The deductible is 100% your responsibility. You pay towards the deductible amount each calendar year as you accrue covered charges.	The deductible is 100% your responsibility. You pay towards the deductible amount each calendar year as you accrue covered charges.
Coinsurance	Coinsurance is the percentage of shared member and plan responsibility. You only pay coinsurance up to your out-of-pocket maximum.	Coinsurance is the percentage of shared member and plan responsibility. Your non-network coinsurance responsibility is higher than your network percentage.
Out-of-Pocket Maximum	Once your out-of-pocket maximum is met, the plan pays 100% of covered charges for the rest of the calendar year.	Once your out-of-pocket maximum is met, the plan pays 100% of covered charges for the rest of the calendar year.
Balance Billing	There is no balance billing when using network providers.	You will be billed for amounts over the allowable carrier expense ("balance billing") in addition to applicable coinsurance and copays when you see a non-network provider.

When you see an in-network provider, the provider's bill is discounted, making both your share and the plan's share of the cost are based on the discounted rate. This allows the plan to pay a higher share of the cost. Payment to in-network providers is made at the in-network benefits level. This saves you money and keeps the program costs down.

When you use a out-of-network provider, your benefits will be paid at a lower level based on the allowable charge for the service. Any excess between the billed charge and the plan's allowable charge may be billed to you, in addition to your higher coinsurance responsibility. This is commonly referred to as "balance billing."

	In-Network	Out-of-Network
Your provider bills:	$100	$100
Insurance allows:	$80	$80
Plan's coinsurance 70% / 50%	$56	$40
Your coinsurance 30% / 50%	$24	$40
In-Network provider bills you:	$24	
Balance billed amount:		$20
Out-of-Network provider bills you:		$60



Health Savings Account

Your HealthEquity Health Savings Account Plan
Visit https://www.healthequity.com/learn/hsa before opening an account.

What Is an HSA?
When you're choosing a health plan, there are many factors that affect your decision. If you want an option with flexibility, a high level of choice and tax-advantaged savings, a Qualified High Deductible Health Plan (QHDHP) with a Health Savings Account (HSA) might be the right choice for you. HSAs are a great way to save money and efficiently pay for medical expenses. HSAs are tax-advantaged savings accounts that go with QHDHPs.

To have an HSA and make contributions to the account, you must meet several basic qualifications. Here's what you need to know to start saving with an HSA. 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)
- Have no other medical health insurance plan
- Cannot be claimed as a dependent on someone else's tax return
- Are not enrolled in Medicare

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 and the money in it belongs to you.

IRS Annual Maximum Contribution to an HSA
The annual max includes all contributions. Your contribution limit is determined by your enrollment in the QHDHP. If you are enrolled as single, you have the single HSA contribution limit. If you are enrolled with family coverage, you'll have the higher family maximum limit.

	Single	Family (2 or more)
2026 HSA Max	$4,400	$8,750

Age 55 or older	HSA Catch-Up Contributions
2026	$1,000

Health Savings Account

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

If your medical expenses are generally limited to routine or preventive care, you may want to consider an QHDHP. An HSA is also a tool you can use to make additional voluntary contributions to accelerate the accumulation of funds for future or retiree medical expenses. A QHDHP plan also offers protection from unexpected accidents or illnesses at a lower premium cost.

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 catastrophic in-network limit. Once you hit this in-network limit of expenses in a calendar year, your medical in-network services are 100% covered and you will not incur additional out-of-pocket in-network covered medical expenses including doctor visits co-pays and prescriptions.

What Can I Use the Funds in My HSA For?

Your HSA can be used to pay for "qualified medical expenses," as 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 Medicare enrolled you can use the account to purchase any health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are Medicare enrolled.

For the complete list of IRS-allowable expenses, you can request a copy of IRS Publication 502 by calling 1-800-829-3676 or visit the IRS website at www.irs.gov and select "Forms and Publications." Please note, however, 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 and, if you are under 65 years old, an additional 20 percent 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 Plan?

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

Can I Contribute to Both an HSA and an FSA?

An FSA counts as "other health coverage," according to IRS Publication 969. So, a general-purpose health FSA will not be compatible with an HSA. And it's important to note that if your spouse elects an FSA that's not compatible with an HSA, your ability to contribute to an HSA goes out the window, as you're technically considered covered under that FSA (whether your spouse adds you as a dependent to the plan or not).

If your employer or your 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 your FSA. And who doesn't want more tax-free spending on qualified medical expenses?

Dependent Care FSA is always available to you.

Dental

Good dental care supports your overall health. Like your medical plan, your dental plan provides a national network of dentists. In-network providers have agreed to accept a reduced rate for their services, so you will pay less out of your pocket for care. You have the freedom to use out-of-network providers; however, you will pay more out of your pocket for care and can be balance billed, the excess over the allowed amount.

Your Cigna Dental Plan

The benefits below reflect the member's cost responsibility.

Network	In-Network Cannot balance bill	Out-of-Network Can balance bill
Network Name	Total Cigna DPPO	Any licensed provider of your choice
Calendar Year Deductible Waived for Class 1 services	$50 individual $150 family	$50 individual $150 family
Calendar Year Benefit Maximum	$1,500 per member	
Class 1 – Preventive Care Exam, cleanings, routine x-rays	0%	0%
Class 2 – Basic Treatment Fillings, periodontics, oral surgery	20%	20%
Class 3 – Major Treatment Crowns, dentures, bridges	50%	50%

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

Helpful Tips

If you plan to enter a course of treatment with an anticipated cost of $300 or more or any Class 3 treatment, please ask your provider to submit a pre-treatment estimate.

A pre-treatment estimate gives your carrier the chance to review what the claim may look like before you've received the services and incurred charges. Upon review, they'll send both you and your dentist an estimate of what will be covered by the plan.

This allows you to:

- Preview what services will/won't be covered,
- See in advance what your anticipated costs will be, and
- Negotiate a payment arrangement with your provider.

Vision

Keep your vision clear and your eyes in good health with regular eye exams. You'll save money by visiting in-network providers. Like your medical plan, your vision plan provides a national network of vision providers. In-network providers have agreed to accept a reduced rate for their services, so you will pay less out of your pocket for care. You have the freedom to use out-of-network providers; however, you will pay more out of your pocket for care and can be balance billed, the excess over the allowed amount.

Your Cigna/EyeMed Vision Plan

Network	In-Network	Out-of-Network Reimbursements
Network Name	EyeMed	Any licensed provider of your choice
Plan Copays		
Eye Exam	$10 copay	
Hardware (lenses and frames)	$25 copay	
Benefit Frequency		
Eye Exam	Once per calendar year	
Lenses	Once per calendar year	
Frames	Once every two calendar years	
Contacts (in lieu of lenses & frames)	Once per calendar years	
Benefits		
Eye Exam	Covered in full	Up to $45
Frames	$250 allowance	Up to $120
Lenses		
Single	Covered in full	Up to $32
Lined Bifocals	Covered in full	Up to $55
Lined Trifocals	Covered in full	Up to $65
Standard Progressives	$65 copay	No benefit
Elective Contacts (in lieu of lenses and frames)	$250 allowance, including fitting and evaluation	Up to $176, including fitting and evaluation

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 The Baldwin Group. 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	Carrier	Customer Service Information	
General Benefits Support	The Baldwin Group	Benefits Support: Phone: Email:	Shannon Kyzar 206.501.3347 shannon.kyzar@baldwin.com
Medical Dental Vision	Cigna	Group Number: Customer Service: Network: Website:	0607507 888.482.7342 Open Access Plus www.my.cigna.com
Telemedicine Virtual Care	MDLIVE	Customer Service: Website:	800.400.6354 www.MDLIVE.com
Health Savings Account (HSA)	HealthEquity	Customer Service: Website:	866.346.5800 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 a carrier 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 carrier's allowed amount, typically when you use out-of-network providers.

Coinsurance
After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 80% coinsurance, you are responsible for paying your coinsurance share, 20% of the cost.

Copay
A set fee you pay whenever you use a particular health care service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

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.

Deductible – Individual vs Family
An individual deductible is a deductible that applies to only one person on the policy. For example, if your individual deductible is $1,000, the plan will begin covering your expenses after you have paid $1,000 out-of-pocket for your own medical costs. This amount does not include any of your other family members' medical bills.

A family deductible, on the other hand, applies to the total costs incurred by all members on the policy. For example, if your family deductible is $3,000, the policy will begin covering your family's health care expenses after you have spent $3,000 out-of-pocket for family members' medical costs.

Embedded Deductible
A family deductible limit that has an individual deductible limit per member. This is common to traditional copay-based PPO plans.

Health Maintenance Organization (HMO)
HMOs cover services performed solely by providers in a network. This tends to be a low-cost system but is more restrictive than other plans. HMOs do not have out-of-network benefits.

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

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

Out-of-Network Provider
A provider without a contract with your insurance plan. You'll generally pay more to see this type of provider.

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, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

Terms to Know

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.

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

Preferred Provider Organization (PPO)
Plans that allow members to use any health care professional without a referral. Staying in-network means smaller copays 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 a person keep or reclaim skills and functioning for daily living 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 medicine or group of patient to diagnose, prevent, or treat certain conditions.

Summary of Benefits and Coverage (SBC)
The SBC is a document 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 easy comparisons of different options when selecting new coverage.

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 one severe enough to require emergency room care.

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

PRESCRIPTIONS

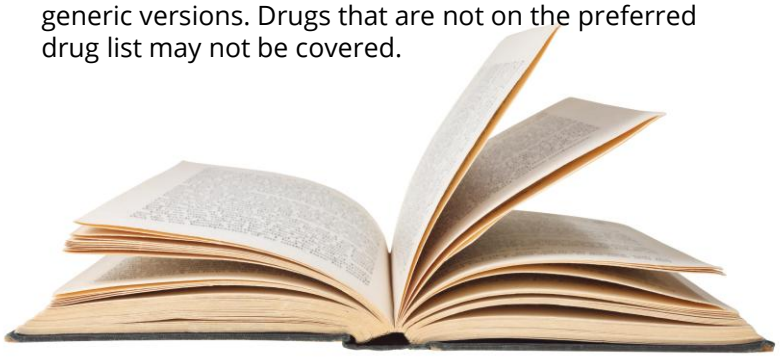
Brand Name
Prescription drugs marketed with a specific brand name by the vendor that manufactures it, usually the vendor which develops and patents it. You generally pay a higher copay for brand name drugs.

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.

Non-Preferred Brand Drug
A drug that is neither generic nor on the plan's preferred (or "formulary") list.

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

Preferred Drugs (Formulary)
Each health plan has a list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.



COBRA

Group Health Care Plans and COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances, such as any of the following:

- Voluntary or involuntary job loss
- Reduction in the hours worked
- Transition between jobs
- Death
- Divorce
- Other life events

Covered Employers

Employers with 20 or more employees are usually required to offer COBRA coverage and to notify their employees of the availability of such coverage.

Covered Employees

A covered employee under COBRA includes anyone who is covered under a group health plan by virtue of an employment relationship with the employer. However, employees that are eligible for the plan are not considered covered employees unless they are enrolled in the plan on the date of the qualifying event.

Eligibility for COBRA Benefits

A group health plan is required to offer COBRA continuation coverage only to qualified beneficiaries after a qualifying event has occurred. A **group health plan** is any arrangement that an employer establishes or maintains to provide employees or their families with medical care, whether it is provided through insurance, by a health maintenance organization, out of the employer's assets, or through any other means. **Medical care** includes, but is not limited to:

- Inpatient and outpatient hospital care
- Physician care
- Surgery and other major medical benefits
- Prescription drugs
- Dental and vision care

Qualifying Events

Qualifying events are certain events that would cause an individual to lose health coverage. The type of qualifying event will determine who the qualified beneficiaries are and the amount of time that a plan must offer the health coverage to them under COBRA. A plan, at its discretion, may provide longer periods of continuation coverage.

Qualifying events occur in three major categories:

- **Employee.** A qualifying event affecting an employee may be:
  - Voluntary or involuntary termination of employment for reasons other than gross misconduct
  - Reduction in the number of hours of employment
- **Spouse.** A qualifying event affecting a spouse may be:
  - Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
  - Reduction in the hours worked by the covered employee
  - Covered employee becoming entitled to Medicare entitlement
  - Divorce or legal separation from the covered employee
  - Death of the covered employee
- **Dependent child.** A qualifying event affecting a dependent child may be:
  - The same events listed for spouse, above
  - Loss of dependent child status under the plan rules

Alternatives to COBRA

When an individual loses group health coverage, he or she may have health insurance options other than COBRA continuation. Loss of employer-sponsored group health insurance may create a "special enrollment period" allowing enrollment in a spouse's plan. Some individuals may also qualify for Medicaid. Since the Health Insurance Marketplace opened in January 2014, some individuals and families may find coverage that costs less than COBRA continuation coverage. Being offered COBRA continuation coverage will not limit a COBRA-qualified beneficiary's eligibility for coverage or for a tax credit through the Marketplace. If a person elects Marketplace coverage instead of COBRA continuation coverage, it is not possible to switch back to COBRA continuation. Information about the Health Insurance Marketplace is available from www.healthcare.gov.

For more information about your COBRA rights, please contact your HR department.

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.

Cigna Healthcare HSA (the "Plan") provides health benefits to eligible employees of Dynamic Computing Services Corporation ("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 , 2025 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 health care 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 health care provider, a health care 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 health care to you; or
- the past, present, or future payment for the provision of health care 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 health care 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 health care 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 Dynamic Computing Services Corporation). 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.

Legal Notices

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

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 Debbie Pangburn as its contact person for all issues regarding the Plan's privacy practices and your privacy rights at:

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

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 have an emergency medical condition and get 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 March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2
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: https://health.alaska.gov/dpa/Pages/default.aspx	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864; Member Services 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: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov); HIPP Phone: 1-888-346-9562
CALIFORNIA – Medicaid	KANSAS – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322; Fax: 916-440-5676; Email: hipp@dhcs.ca.gov	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 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/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
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.mymaineconnection.gov/benefits/s/?language=en_US 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 Phone: 1-800-699-9075
MASSACHUSETTS – Medicaid and CHIP	PENNSYLVANIA – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
MINNESOTA – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
MISSOURI – Medicaid	SOUTH CAROLINA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 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; Email: HHSHIPPProgram@mt.gov	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: 402-473-7000; Omaha: 402-595-1178	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
NEVADA – Medicaid	UTAH – Medicaid and CHIP
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov; Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
NEW HAMPSHIRE – Medicaid	VERMONT– Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont 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/; Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/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 and CHIP
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://dhhr.wv.gov/bms/; http://mywvhipp.com/ Medicaid Phone: 304-558-1700 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 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. To see if any other states have added a premium assistance program since March 17,2025, 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

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved OMB
No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace").To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings on your premium that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see **https://www.irs.gov/pub/irs-drop/rp-22-34.pdf** for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Health Insurance Marketplace Coverage Options and Your Health Coverage

When Can I Enroll in Health Insurance Coverage Through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800- 318-2596. TTY users can call 1-855-889-4325.

What About Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment- based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit **https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/** for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

Debbie Pangburn 800.345.1275 or 425.578.2200 x120

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.

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 or 425.578.2200 x120	
7. City	8. State	9. ZIP code
Maple Vallew	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	
Same	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:

  Employees who 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 to age 26.

  ☐ 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 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 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 has determined that the prescription drug coverage offered by The Cigna Healthcare 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 first become 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 coverage will not be affected. The entity providing the Disclosure Notice should insert an explanation of the prescription drug coverage plan provisions/options under the particular entity's plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current Dynamic Computing Services coverage, be aware that you and your dependents will be able to get this coverage back.

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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 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 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:	01/01/2026
Name of Entity/Sender:	Dynamic Computing Services
Contact-Position/Office:	Debbie Pangburn / VP of Office Operations
Address:	23849 225th Way SE #100 Maple Valley, WA 98038
Phone Number:	425-578-2200

CMS Form 10182-CC Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.