A Guide to Your Benefits

September 1, 2020 – August 31, 2021

APEX Systems

Benefit Guide for Contract Employees

Contents

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 40 for more details.

Welcome to Your Benefits

Welcome to your 2020 – 2021 benefits guide! Apex values your contributions as an employee and recognizes that benefits are an essential part of your total compensation package. We're pleased to offer a comprehensive, high quality benefits program designed to meet your needs as well as the needs of your family.

Only you can determine which benefits are best for you and your dependents. Information found within this guide and in the benefits portal is there to assist you in making informed health and welfare plan decisions.

Our plans:

- Provide competitive and comprehensive benefit options that allow you to design a plan based on your individual needs
- Consider individual needs and the needs of covered family members
- Help to prepare for long-term financial security for you and your family
- Offer a variety of coverage options

The steps below will help you through the enrollment process:

- Verify your address
- If you are covering a dependent, please make sure the name is listed as it is on the dependent's Social Security Card
- Make sure you have Social Security numbers for each of your dependents

In accordance with health care reform laws, if you choose to cover any dependents, you must provide supporting documents (e.g., birth certificate, marriage certificate, domestic partner certification. legal guardianship paperwork, etc.) for each of your dependents before your coverage will be approved. Please send the supporting documents to **hrenrollment@apexsystems.com**.

Upon receipt, the Benefits team will review your documents. If there are any questions regarding your supporting documents, a member of the Benefits team will contact you. If you do not hear from the Benefits team, your transaction will be approved and you will see the deduction on your payroll check. Non-receipt of dependent verification documentation will result in loss of benefits for your dependents and you will not be allowed to enroll them until the Company's next Open Enrollment cycle.

Eligibility

Regular full-time employees working a minimum of 30 hours or more per week, spouses, domestic partners, and children up to age 26 who meet certain criteria are eligible. Find information about domestic partner coverage on the Benefits site on the intranet or contact the Contractor Care Team at 866-612-2739 with questions.

Getting Started

Benefits for You and Your Family

The Company is dedicated to providing a comprehensive and competitive benefits package for you and your family. Having the resources and programs available to help you have a work/life balance is important to our organization.

Our benefit plans have been intentionally designed to provide you a full range of coverage and protection for your short and long-term needs. We offer our employees medical, dental, and vision insurance focused on prevention along with additional services to help employees get back on track in the event of an illness or injury. You also have the opportunity to purchase accident insurance and critical illness insurance as your individual circumstances dictate. Please read the information provided in this guide carefully. For full details about your plans, please refer to the summary plan descriptions available online at **www.BenefitSolver.com**.

When to Enroll

You must enroll in benefits within your first 30 days of employment or during Open Enrollment.

The Enrollment Process: How to Enroll through BenefitSolver

BenefitSolver manages our benefits enrollment. BenefitSolver has a website available at **www.BenefitSolver.com** for you to view and manage your benefits 24 hours a day, 7 days a week. HR enrollment will email your login information and instructions about how to enroll.

Access the BenefitSolver site (using Microsoft Internet Explorer 5.01 or higher) by doing the following:

- Go to **https://www.BenefitSolver.com**.
- Click “Register”, then do the following:
- Enter your Social Security number
- Enter your Date of Birth
- Enter the Company code: APEXBEN
- You will be asked to create a UserID and Password.
- Login using your UserID and Password.
- You will come to a “start here” page which will navigate you through your election.

At the end of the enrollment process, you will be asked to review and confirm your elections by clicking approve. **If you DO NOT receive a confirmation number, then your election is not complete**.

MyChoice App

The MyChoice app provides you access to your benefits when and where you need it. Log in to your Benefits portal account and click on the MyChoice Mobile App icon.

You will enter your cell phone number and the link for the app will be texted to you. Enter your unique access code when prompted.

Available on iOS and Android.

The Summary Plan Description (SPD) booklets are also available on the BenefitSolver website.

After you have made your changes and/or elections, you will not be able to change them until the next Annual Open Enrollment period unless you have a qualified change in status.

You have the following enrollment options:

- Aetna Fixed Indemnity Medical Plan
- UHC Minimum Essential Coverage (MEC) Plan
- UHC Major Medical PPO Plan
  - Coverage Participation and Effective Date: You will have the option to participate in the UnitedHealthcare Major Medical Plan options after your one-month orientation period. Coverage will be effective the first of the month following the orientation period plus 54 days of employment.
- Dental
- Vision (through VSP Vision Care, Inc.)
- Unum Accident Plan
- Unum Critical Illness Plan
- Life/Disability (If you are electing outside of your first 30 days of employment, evidence of insurability is required.)
- Transit Account
- Identity Theft Protection
- Pet Insurance

Changing Coverage During the Year

After you are enrolled, you can only make changes to, enroll, or terminate participation in the plan if you have a qualified change in status. Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next Open Enrollment period (Open Enrollment is normally held in August of each year, with a September 1 effective date).

All qualified changes must be completed within 30 days of the effective date of the event. For example, if you married on August 1, you must submit the necessary paperwork and make the change in the BenefitSolver system on or before August 31. Non-receipt of the supporting documentation and completion of the change in the BenefitSolver system will result in denial of the change and you cannot make the change until the next Open Enrollment period.

Proof of Dependent Status

If you are covering a dependent in one of the UnitedHealthcare Plans, you are required to provide proof of dependent status. You are required to provide:

- Full name(s) and Social Security number(s) of dependent(s)
- Proof of dependent status (birth certificate, marriage certificate, domestic partner certification and/or tax return)

You can scan and email dependent verification documents to **hrenrollment@apexsystems.com**. Your dependent will not be covered until we are in receipt of the verification documents. Non-receipt of dependent verification documents within 30 days of the effective date of coverage will result in loss of coverage for your dependents. In accordance with IRS guidelines regarding qualified life events, you will not be able to add your dependents until Open Enrollment. Please see section titled "Changing Coverage during the Year." You can also load your supporting documents using the BenefitSolver message center. Send an email to Cassandra Murray at: **clmurray@apexsystems.com**. Upon receipt of your email, she will send you a message through the secure BenefitSolver website.

Qualified changes in status include:

- Marriage
- Divorce
- Legal separation
- Domestic partnership status change
- Birth or adoption of a child
- Change in child's dependent status
- Death of spouse, domestic partner, child, or other qualified dependent
- Permanent change in residence outside of the plan coverage area due to an employment transfer for you, your spouse or domestic partner
- Employee turns age 26 and loses coverage on parent's plan
- Commencement or termination of adoption proceedings
- Change in spouse's or domestic partner's benefits or employment status
- Employee's hours reduced to an average of less than 30 hours a week
- Employee purchased coverage on a public exchange or marketplace

What kind of supporting documentation do you need?

You must provide documentation to support your election change by documenting the change-of-status event that you base your election change. The documentation must show the date of the event. Some examples of appropriate documentation are:

CHANGE-OF-STATUS EVENT	EXAMPLE DOCUMENTATION
Marriage	Marriage certificate or Affidavit of Marriage.
Domestic Partnership	Copy of the Declaration or Certificate of Domestic Partnership.
Divorce	A copy of your finalized divorce decree.
Birth or adoption of a child	Birth Certificate (the hospital certificate may be used temporarily to add the child until the Birth Certificate is obtained). In the case of an adoption copies of the adoption papers.
Change in spouse's or domestic partner's benefits or employment status	A copy of new benefits effective date (certificate of credible coverage or letter from the carrier) or change of employment status supported by offer letter or termination paperwork.
Death of a Spouse, Domestic Partner or Dependent	Copy of the Death Certificate.
Permanent change in residence outside of the plan coverage area due to an employment transfer for you, your spouse or domestic partner	Copy of letter from the employer showing change of employment requiring location outside of the coverage area (i.e. moving out the country).
A judgment, decree or court order	A copy of the judgment, decree or court order.
Employee turns age 26 and loses coverage on parent's coverage	Letter from the employee's parent's plan showing plan employee has lost coverage.
Employee's hours are reduced to an average of less than 30 hours per week	Documentation that employee's hours have been reduced to less than 30 hours.
Employee has purchased coverage on a public exchange or marketplace	Documentation of the new plan in employee's name showing carrier name, effective date of coverage and policy number.

Non-receipt of the appropriate paperwork to support your qualified life event will result in denial of coverage and you will have to wait until Open Enrollment to make a change.

When Coverage Ends

Aetna Plan

For the Aetna plan, coverage ends eight days after your last payroll deduction. For example, if you have a deduction on Friday, September 18, 2020, coverage will end Saturday, September 26, 2020. Please see below:

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
13	14	15	16	17	18 FINAL PAYROLL DEDUCTION	19 DAY 1 COVERED
20 DAY 2 COVERED	21 DAY 3 COVERED	22 DAY 4 COVERED	23 DAY 5 COVERED	24 DAY 6 COVERED	25 DAY 7 COVERED	26 DAY 8 COVERAGE ENDS

UHC Medical, Dental, and Vision Plans

For the UHC medical, dental, and vision plans, coverage ends at the end of the month. For example, if your employment terminates on Wednesday, September 23, 2020, you will have coverage until Wednesday, September 30, 2020 (end of the month). Please see below:

UHC Plan Calendar Example

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
13 ACTIVE	14 ACTIVE	15 ACTIVE	15 ACTIVE	15 ACTIVE	15 ACTIVE	15 ACTIVE
20 ACTIVE	21 ACTIVE	22 ACTIVE	23 Termination Date	24 TERMED	25 TERMED	26 TERMED
27 TERMED	28 TERMED	29 TERMED	30 UHC Medical, Dental, and Vision Coverage Ends			

Medical and Prescription Drug Coverage

Aetna Fixed Indemnity Plan

The Company offers you and your family the option of enrolling in the **Fixed Indemnity Medical Plan** through **Aetna**. This plan is a reimbursement plan. You may be required to pay for services rendered first and receive reimbursement from Aetna or your physician's office may have you assign payment to the physician. **This plan is NOT Affordable Care Act (ACA) compliant. You may be subject to taxes and penalties under ACA.**

Employees in the state of NEW HAMPSHIRE are not eligible to enroll in this plan.

AETNA FIXED INDEMNITY PLAN	
INPATIENT HOSPITAL STAY – DAILY BENEFIT (INCLUDES MATERNITY)	
Plan pays per day in a private or semi-private room	$650
Plan pays per day in Intensive Care Unit (ICU)	$1,300
Maximum number of days per stay	Unlimited
Maximum number of stays per coverage year	2 stays
INPATIENT HOSPITAL STAY – LUMP-SUM BENEFIT (INCLUDES MATERNITY)	
Plan pays per initial day of an inpatient stay	$900
Maximum number of days per coverage year	2 stays
INPATIENT SURGICAL PROCEDURE	
Plan pays per day on which a surgical procedure is performed	$550
Maximum number of days per coverage year	2 days
INPATIENT ACCIDENT – ADDITIONAL BENEFIT	
Plan pays per initial day for an accident	$400
Maximum number of days per coverage year	2 days
EMERGENCY ROOM	
Plan pays per day on which an emergency room visit occurs	$375
Maximum number of days per coverage year	2 days
OUTPATIENT SURGICAL PROCEDURE	
Plan pays per day on which a surgical procedure is performed	$550
Maximum number of days per coverage year	2 days
OUTPATIENT DOCTOR'S OFFICE VISITS (INCLUDES DOCTOR'S SERVICES IN THE OFFICE, HOME, WALK-IN CLINIC OR URGENT CARE CLINIC)	
Plan pays per day on which doctor's services are provided	$80
Maximum number of days per coverage year	7 days
OUTPATIENT LABORATORY AND X-RAY SERVICES	
Plan pays per day on which lab or x-ray services are provided	$110
Maximum number of days per coverage year	3 days
PRESCRIPTION DRUGS, EQUIPMENT, AND SUPPLIES	
Plan pays per day on which a prescription drug, equipment or supply is obtained	$55
Maximum number of days per coverage year	12 days

NOTE: If you get a prescription filled, you will need to make sure the prescription is filled as outlined on the back of your prescription benefit card. This is a discount program so you will receive the discounted drug price and submit a claim to Aetna for reimbursement. The plan will reimburse you up to $55 a day with a maximum of 12 days per plan year.

AETNA FIXED INDEMNITY PLAN WEEKLY COSTS	
Employee Only	$23.53
Employee + Spouse/ Domestic Partner	$52.30
Employee + Child	$52.30
Employee + Children	$75.31
Family	$75.31

Note: Any missed premium payments can be made directly to Aetna. The Company cannot collect a missed premium payment. Contractor Care can provide you with more information on submitting a missed premium payment.

Members can lower their medical expenses by seeing a participating provider in the **Aetna Open Choice® PPO** network.

To locate a participating provider, call toll-free 1-888-772-9682 or visit:

https://www.aetna.com/individuals-families/find-a-doctor.html

Example of how the plan works

You go to an Aetna in-network doctor on Monday and it costs $90 with Aetna's discounted pricing. You will need to pay the entire $90 and Aetna will reimburse you $80 or you can assign the benefits over to the doctor. If you assign the benefits to the doctor you will only have to pay the portion not covered by Aetna which, in this example, would be $10.

Aetna Fixed Indemnity Benefits Plan Exclusions and Limitations

This plan has exclusions and limitations. Refer to the actual policy and booklet certificate to determine which services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, the plan may contain exceptions to this list based on state mandates or the plan design purchased.

- All medical or hospital services not specifically covered in, or which are limited or excluded in, the plan documents
- Cosmetic surgery, including breast reduction
- Custodial care
- Experimental and investigational procedures
- Infertility services, including, but not limited to, donor egg retrieval, artificial insemination and advanced reproductive technologies, and reversal of sterilization
- Non-medically necessary services or supplies

No benefit is paid for or in connection with the following stays or visits or services:

- Those received outside the United States
- Those for education, special education, or job training, whether or not given in a facility that also provides medical or psychiatric treatment

The Aetna Fixed Indemnity Plan is not COBRA eligible nor is it ACA compliant. You will be required to verify dependent status directly with Aetna once a claim is processed.

UnitedHealthcare Medical Plan

You will have the option to participate in the **UnitedHealthcare (UHC)** Major Medical Plan options after your one-month orientation period. Coverage will be effective the first of the month following the orientation period plus 54 days of employment. **In the state of Massachusetts, the PPO 80 plans are considered compliant coverage.**

	UHC PPO 60		UHC PPO 70		UHC PPO 80	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE						
Individual	$3,250	$6,500	$2,000	$4,000	$750	$1,500
Family	$6,500	$13,000	$4,000	$8,000	$1,500	$3,000
OUT-OF-POCKET MAXIMUM						
Individual	$6,350	$12,500	$6,350	$12,500	$4,000	$5,000
Family	$12,700	$25,000	$12,700	$25,000	$8,000	$10,000
	YOU PAY		YOU PAY		YOU PAY	
OFFICE VISITS						
Primary	30%	50%	30%	50%	$25 copay	30%
Specialist					$50 copay	
Virtual Visits	30%	50%	30%	50%	$15 copay	30%
Inpatient	30%	50%	30%	50%	20%	30%
Emergency Room	30%	50%	30%	50%	$200 copay	$200 copay
Preventive Services	$0	Not covered	$0	Not covered	$0	Not covered
PRESCRIPTION DRUGS						
Prescription Drug Deductible	Included with medical deductible		$100		$100	
RETAIL RX (UP TO 30-DAY SUPPLY)						
Generic	30%*		$10*		$10*	
Brand Preferred	30%*		$30*		$30*	
Brand Non-Preferred	30%*		$50*		$50*	
MAIL ORDER RX (UP TO 90-DAY SUPPLY)						
Generic	30%*		$25*		$25*	
Brand Preferred	30%*		$75*		$75*	
Brand Non-Preferred	30%*		$125*		$125*	

* After deductible

The PPO 60 and 70 plans are not considered credible coverage in the state of Massachusetts.

In accordance with the Affordable Care Act, rates are based on your hourly wage.

UHC PPO 60 WEEKLY RATES				
HOURLY RATE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE/ DOMESTIC PARTNER	EMPLOYEE + CHILD(REN)	FAMILY
$8.50 – $10.99	$24.93	$206.17	$184.30	$387.91
$11.00 – $13.49	$32.27	$215.41	$193.57	$397.16
$13.50 – $15.99	$39.60	$224.41	$202.57	$406.16
$16.00 – $18.49	$46.94	$233.67	$211.82	$415.41
$18.50 – $20.99	$54.27	$242.67	$220.82	$424.41
$21.00 – $23.75	$61.61	$251.92	$230.07	$433.67
$23.76 – $26.49	$69.71	$261.94	$240.10	$443.69
$26.50 – $29.49	$77.75	$271.97	$250.12	$453.72
$29.50 – $32.22	$86.55	$283.03	$261.17	$464.77
$32.23>	$94.56	$293.05	$271.20	$474.79

UHC PPO 70 WEEKLY RATES				
HOURLY RATE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE/ DOMESTIC PARTNER	EMPLOYEE + CHILD(REN)	FAMILY
All Rates	$131.11	$320.83	$296.92	$518.01

UHC PPO 80 WEEKLY RATES				
HOURLY RATE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE/ DOMESTIC PARTNER	EMPLOYEE + CHILD(REN)	FAMILY
All Rates	$156.04	$374.15	$347.00	$600.89

REHIRES

If you are off an assignment for less than 13 weeks, you can continue your coverage without a gap in coverage by requesting the missed deductions be withheld from your paycheck upon return to work. If you do not initiate the request there will be a lap in coverage.

Please contact Contractor Care at 866-612-2739 if you have any questions.

UnitedHealthcare Preventive Minimum Essential Coverage (MEC) Plan

UnitedHealthcare offers an additional plan which provides an affordable option covering preventive services. This plan covers in-network services only. Preventive services covered at 100% include:

- Annual physical/OB/GYN check-ups
- Mammograms
- Immunizations
- Colorectal cancer screenings
  (Coverage should be verified before services are rendered.)
- Women's preventive contraceptives
- Well-child care
- Other preventive tests/screens included in the Affordable Care Act

UHC MEC PLAN WEEKLY COSTS	
Employee Only	$14.30
Employee + Spouse/ Domestic Partner	$30.44
Employee + Child(ren)	$28.36
Family	$47.04

This plan DOES NOT cover any chronic conditions or sick visits.

This plan does not provide minimum value coverage so it is NOT ACA COMPLIANT. You may be subject to taxes and penalties under ACA.

Log into www.myuhc.com to:

- View your claims
- Access claim forms
- Print an ID card
- Locate a pharmacy for the MEC plan only
- Look up your benefits
- Find a doctor, vision care, or mental health resources
- View an online statement
- Estimate health care costs
- Find out about extra programs and discounts

Resources Available to You If You Choose UHC

UHC Premium Physicians

The UnitedHealth Premium program gives you peace of mind when selecting a doctor. Physicians in the program meet both high quality and cost-efficient standards, so you know you'll get quality care that's also affordable. When doctors practice evidence-based medicine and follow medical society and national industry standards, there are likely to be fewer complications and repeat procedures. So by choosing a doctor from the UnitedHealth Premium program's wide network of physicians, you will lower the cost of your own care.

Take care of yourself by starting with the right doctor.

At **www.myuhc.com**, look for the UnitedHealth Premium program symbols:

Premium Care Physician.

The physician meets the UnitedHealth Premium program quality and cost-efficient care criteria.

Quality Care Physician.

The physician meets the UnitedHealth Premium program quality care criteria but does not meet the program's cost-efficient care criteria or is not evaluated for cost-efficient care.

Not Evaluated for Premium Care.

The physician's specialty is not evaluated in the UnitedHealth Premium program, the physician does not have enough claims data for program evaluation, or the physician's program evaluation is in process.

Does Not Meet Premium Quality Criteria.

The physician does not meet the UnitedHealth Premium program quality criteria so the physician is not eligible for a Premium designation.

Advocate4Me™

Experts to support you and your family

When you have questions about your health care, get answers quickly and reliably from UnitedHealthcare's Advocate4Me.

The Advocate4Me program connects you with a personal Advocate who helps you navigate the health care system to get the information and support you and your family need. Your Advocate consults with a team of experts who specialize in such areas as clinical medicine, behavioral health, wellness, pharmaceuticals and cost management.

Advocates help make things simpler for you by:

- Explaining your benefits and claims,
- Helping you find a doctor, and
- Estimating treatment costs

Advocates are also able to support families of children with special health care needs. A dedicated advisor is assigned to the family to provide continuity of service and help navigate the health care system by consulting with clinical staff, providers, social support and research experts to offer personalized information and assistance to the family.

Health resources and tools are accessible online and Advocate4Me Advocates are available by phone, email or secure chat on **www.myuhc.com**. Call the member phone number listed on your health plan ID card or email **advocate4me@uhc.com**.

UnitedHealthcare Mobile Application

The UnitedHealthcare app is available as a free download from the Apple® iTunes® App Store® and the Android® Market. Get instant access to, find a physician near you, estimate treatment costs, check the status of a claim or get advice from a nurse.

Download the **UnitedHealthcare Mobile Application** to your smartphone and you'll be able to:

- Access and save ID cards to your phone
- Estimate costs of common procedures and conditions up front
- Find nearby providers, hospitals and quick care facilities
- Connect with helpful professionals 24/7
- Search pharmacies, claims, drug pricing and mail orders
- Check account balances and benefit amounts
- Collect, track and share past and current Personal Health Records
- View and manage claims
- Pay providers for out-of-pocket expenses

Need Help?

Find out more on the UnitedHealthcare App

Virtual Visits

UnitedHealthcare provides a network of virtual provider groups. This network offers video-based visits that allow participants in the medical plan to see and speak with a doctor using secure, online, real-time audio, and video technology via mobile phone, tablet, or computer 24 hours a day. Participants can obtain a diagnosis and any necessary prescriptions for minor medical needs including allergies, sinus and bladder infections, bronchitis and other conditions without leaving their home or office. You pay a portion of the cost for the virtual visit, subject to copays and out-of-pocket expenses based on your specific benefit plan.

Here's how Virtual Visits works:

- You load the UnitedHealthcare application (app) to your Smart Phone or tablet.
- When you set up Virtual Visits, you will:
- Load your debit or credit card information (which will be used to pay the copayment).
- Enter your pharmacy information (in the event the physician has to send in a prescription for you).
- You access the system and will have a real time visit with a physician and pay the applicable copayment.

You can use virtual visits to connect with a behavioral health professional to address Depression, Anxiety, ADD/ADHD, Addiction, Mental Health Disorders and Counseling.

For a behavioral health virtual visit go to **www.myuhc.com** and sign in or register. Click Find a Doctor > Mental Health Directory > People > Provider Type > Telemental Health Providers.

Virtual Visits gives you the convenience of seeing a physician without leaving the comforts of your home or office.

HealtheNotes

HealtheNotes (pronounced "healthy notes") are designed to provide you reminders about personalized care opportunities that may improve your health. We'll send them to you automatically when we have a message or recommendation we think would benefit you.

COBRA – Continuing Your Benefits

Discovery Benefits administer COBRA for the Company. As the administrator, Discovery Benefits is required to provide you with information regarding your rights under COBRA. When you are initially hired, you will receive a notice for you and your family's COBRA rights. This document is for information purpose only and no action is required by you.

Outreach

When you experience certain health events that require medical attention, or if the results of your health assessment reveal that you might need assistance, a Personal Health Support Nurse may be assigned to you and contact you by phone to provide you with access to information and resources that may help you better manage your health care needs and improve your quality of life.

Personal Health Support

Navigating the maze of health and health care can be challenging. We are pleased to offer your access to UnitedHealthcare's Personal Health Support programs give you access to services and clinical support across the range of health and wellness goals. From staying healthy and getting healthy to managing a chronic condition, there is a program or service to meet your unique health care needs. If you are with UnitedHealthcare, you have access to a wealth of Personal Health Support resources such as:

Healthy Pregnancy Program

This program can help soon-to-be-mothers through every stage of their pregnancy and delivery. We will share healthy-baby tips, and keep you informed by phone and newsletter. Call the number on the back of your health plan ID card and select the prompts to "speak to a nurse." Also, visit **www.healthypregnancy.com** to learn more.

myNurseLine℠

When you have a health concern, it can be difficult and time-consuming to find the information you need. One toll-free number connects you with a registered nurse who will take the time to understand what is going on with your health and provide personalized information that is right for you. And this is all available 24 hours a day, seven days a week. You can also choose from more than 1,100 health and well-being topics, with 600 messages available in Spanish. Services are available in 140 languages and for callers with hearing impairments. Call the number on the back of your health plan ID card to access myNurseLine.

Treatment Decision Support

If you are considering treatment decisions for a specific condition, Treatment Decision Support (TDS) is available to help you make informed decisions. TDS can help you select the treatment option that best meets your needs.

Call the number on the back of your health plan ID card and select the prompts to "speak to a nurse" to learn more. Supported conditions include:

- Musculoskeletal
- Back Pain
- Hip Replacement
- Knee Replacement
- Choose a physician and hospital for your treatment.
- Prepare you for your upcoming treatment and for a successful recovery.
- Men's Health
- Benign Prostate Disease
- Prostate Cancer
- Women's Health
- Benign Uterine Conditions, Hysterectomy
- Breast Cancer
- Heart Disease
- Coronary Disease, Coronary Artery Bypass
- Graft and Angioplasty

Dental Insurance

The Company offers two distinct PPO networks in the dental plan through **Delta Dental**. Although you may select any licensed dentist, you will receive the most value from your plan if you seek treatment from either a **Delta Dental PPO** or a **Delta Dental Premier** provider. The plan year for the dental plan is January 1st through December 31st.

The chart below is a brief outline of the plan. Please refer to the summary plan description available online at **www.BenefitSolver.com** for complete plan details.

Delta Dental Plan Specifics

SERVICES	DELTA DENTAL PPO	DELTA DENTAL PREMIER
	IN-NETWORK	IN-NETWORK
DEDUCTIBLE (APPLIES TO BASIC AND MAJOR SERVICES ONLY)		
Individual	$50	$50
Family Maximum	$150	$150
	YOU PAY	YOU PAY
PREVENTIVE SERVICES		
Exams, Cleanings, Bitewing X-Rays, Fluoride, and Sealants	$0	$0
BASIC SERVICES		
Stainless Steel Crowns, Composite Resin, Silver Fillings, and Endodontics	20%	20%
MAJOR SERVICES		
Gold Crowns, Prosthetic Coverage	50%	50%
ANNUAL MAXIMUM		
Maximum Amount	$1,000	$1,000

Your Weekly Cost for Dental Coverage

DELTA DENTAL PLANS WEEKLY COSTS	
Employee Only	$7.54
Employee + Spouse/ Domestic Partner	$15.07
Employee + Child	$15.07
Family	$26.85

To find locations where the Delta Dental PPO network is available, visit **www.deltadentalva.com** and click on the “Find a Dentist” link to check dentist participation and find plan details.

The MaxOver™ Benefit Program

MaxOver™ is Delta Dental's Benefit Maximum carryover program. Under this program, you have the opportunity to roll over a portion of your annual Benefit Maximum for future years. If you satisfy the below requirements, you can carry over up to $250 of your annual maximum to add to next year's maximum:

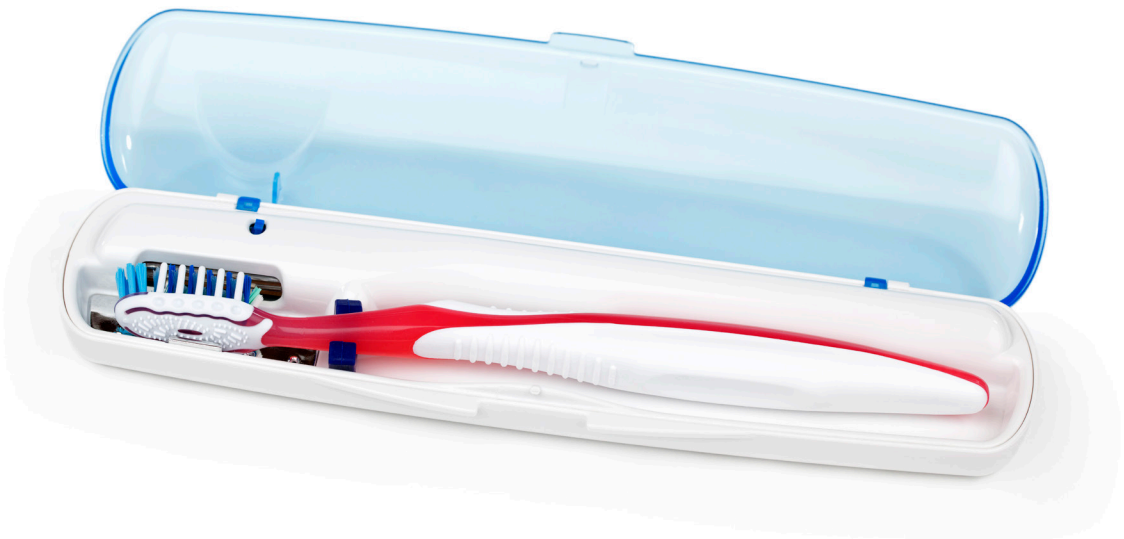
- Have at least one preventive exam during the Benefit Period
- Have at least one cleaning during the Benefit Period
- Claims paid during the Benefit Period must be less than the MaxOver claims threshold.
- Once met, the MaxOver amount of $250 will be carried forward for use at a future date. That means the level of coverage to which you have access can actually increase over time. So, when you need a procedure that costs more than the plan's annual maximum, the funds in the MaxOver account can help meet the difference.

MaxOver™ Benefits

MaxOver™ benefits are determined three months after the end of the group benefit period. Members who have qualified for a deposit into their MaxOver™ account or have a MaxOver™ account balance will receive a report showing details. The Company will also receive a group level report.

HOW DOES MAXOVER™ WORK?	
Benefit Allowance	$1,000
Claims Submitted	$500
MaxOver™ Amount added to next benefit period	Benefit Allowance – Claims Submitted = MaxOver™ Amount $1,000 – $500 = $500 ($250 in carryover)
Total Annual Maximum Benefit for the next benefit period	Benefit Allowance + Carryover = Total $1,000 + $250 = $1,250

The above illustration applies to the Comprehensive Dental Plan.



VSP Vision Insurance

The Company offers a vision plan from VSP Vision Care, Inc., which covers eye exams, prescription lenses and frames, or contact lenses in lieu of lenses and frames for you and your eligible family members. Although you may select any licensed provider, you receive the highest level of benefits when you see a network provider.

To learn more about VSP Vision Plan or to find a provider visit their website at **www.vsp.com**.

VSP Vision Insurance Plan Specifics

SERVICE	COVERAGE	COPAYMENT
Well Vision Exam	Eyes and overall wellness	$10
Prescription Glasses	$130 allowance for a wide selection of frames	$10
	$150 allowance for featured frame brands	
	20% savings on the amount over your allowance	
	$70 Costco frame allowance	
Lenses	Standard progressive lenses	$0
	Premium progressive lenses	$95-$105
	Custom progressive lenses	$150-$175
	Average savings of 20-25% on other lens enhancements	
Contact Lenses (instead of glasses)	$130 allowance for contacts – copay doesn't apply (fitting and evaluation)	Up to $60
Diabetic Eye Care Plus Program	Services related to Diabetic eye disease, glaucoma and age related macular degeneration.	$20
EXTRA SAVINGS		
Glasses and Sunglasses	Extra $20 to spend on featured frame brands. Go to **vsp.com/specialoffers** for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.	–
Retinal Screening	No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.	–
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.	–

Your Weekly Cost for Vision Coverage

VSP PLAN WEEKLY COSTS	
Employee Only	$1.42
Employee + Spouse/ Domestic Partner	$2.85
Employee + Child(ren)	$4.58
Family	$4.58

Additional Insurance

Accident Insurance

Unum's Accident insurance can pay lump-sum benefits based on the injury you receive and the treatment you need, including emergency-room care and related surgery. The benefit can help offset the out-of-pocket expenses that medical insurance does not pay, including deductibles and copays. A Be Well option can pay an annual benefit for preventive care.

How does it work?

Accident insurance can pay a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. And it includes a range of serious events.

Why is this coverage so valuable?

- It can help you with out-of-pocket costs that your medical plan doesn't cover, like copays and deductibles.
- You're guaranteed base coverage, without answering health questions.
- The cost is conveniently deducted from your paycheck.
- You can keep your coverage if you change jobs or retire. You'll be billed directly.

The list of covered injuries includes:

- Broken bones
- Burns
- Torn ligaments
- Lacerations
- Eye injuries
- Ruptured discs
- Concussion
- Coma due to a covered injury

Some covered expenses may include:

- Emergency-room treatment
- Outpatient surgery facility visits
- Doctor office visit
- Hospitalization (including short stays)
- Occupational therapy
- Speech therapy
- Chiropractic visit
- Physical therapy
- X-rays
- Prescription Drugs

WHO CAN GET COVERAGE?

You	If you're actively at work*
Your spouse	Can get coverage as long as you have purchased coverage for yourself.
Your children	Dependent children from birth until their 26th birthday, regardless of marital or student status.

HOW MUCH DOES IT COST?

YOUR MONTHLY PREMIUM	PLAN 1
You	$10.49
You and your spouse	$18.84
Your and your children	$25.59
Family	$33.94

*Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. Spouses and dependent children must reside in the United States to receive coverage.

Active employment: You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 30 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff or leave of absence on the date that insurance would otherwise become effective. New employees have a 0 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date. If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at **https://www.medicare.gov/Pubs/pdf/02110-medicare-medigap-guide.pdf**.

Be Well Benefit

Every year, each family member who has Accident coverage can also receive $50 for getting a covered Be Well Benefit screening test, such as:

- Annual exams by a physician include sports physicals,well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

ACCIDENT INSURANCE COVERAGE EXAMPLES	
Plan Type	24-hour coverage
Portability	Included
Wellness Benefit	$50 wellness benefit can be added
Sickness Hospital Confinement Rider	Not available
Emergency Medical Treatment	ER: $150 Dr's Office: $75 Urgent Care: $75
X-ray	$50
Medical Imagine (MRI, MR, CT, CAT, EEG)	$200
Hospital Admission	$1,000
Hospital Confinement / Per day	$200 up to 365 days
Intensive Care Admission	$1,500
Intensive Care / Per day	$400 up to 15 days
Follow-up Treatment	$75, 2x per accident
Ambulance	Ground: $400 Air: $1,500
Outpatient Surgery	$300
Dislocations	Up to $6,750
Fractures	Up to $9,000
Burns	Up to $10,000
Eye Injury	$200
Lacerations	Up to $1,000
Medical Imaging	X-rays or ultrasound: $50 Bone Scan, CAT, CT, EEG, MR, MRA, or MRI: $75
Emergency Dental Repair	Crown: $300 Extraction: $100 Chip or filling repair: $75
Therapy	$25 per up to 15 visits (physical, occupational, speech or chiropractor)
Accidental Death	Employee: $50,000 Spouse: $25,000 Child: $12,500
Accidental Death (Common Carrier)	Employee: $100,000 Spouse: $50,000 Child: $25,000
Paralysis	Uniplegia: $12,500 Hemiplegia/Paraplegia: $25,000 Triplegia: $37,500 Quadriplegia: $50,000

Critical Illness Insurance

Unum's Critical Illness insurance can help protect your finances from the impact of a serious health problem, such as a stroke, heart attack, or cancer diagnosis. You choose a lump-sum benefit amount that's payable directly to you upon diagnosis of a covered condition. You can use the benefit any way you choose.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like copays and deductibles.
- You can use this coverage more than once.
- Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The reoccurrence benefit pays 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.

What's covered?

Critical Illnesses:

- Coronary artery disease (major pays 50% of benefit, minor pays 10% of benefit)
- Heart attack
- Major organ failure requiring transplant
- End-stage renal (kidney) failure
- Stroke

Additional Critical Illnesses for Children (50% of the Employee's benefit amount):

- Down Syndrome
- Cerebral Palsy
- Cystic Fibrosis
- Spina Bifida
- Cleft lip or palate

Cancer Conditions:

- Invasive cancer (including all Breast Cancer) – 100%
- Non-invasive cancer – 25%
- Skin cancer – $500

Supplemental Critical Illnesses:

- Infectious disease (25% of benefit)
- Occupational Human Immunodeficiency Virus (HIV) or Hepatitis
- Coma
- Loss of hearing
- Loss of sight
- Loss of speech
- Permanent paralysis
- Benign brain tumor

Be Well Benefit

Every year, each family member who has Critical Illness coverage can also receive $100 for getting a covered Be Well Benefit screening test, such as:

- Annual exams by a physician include sports physicals, well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Screenings for cholesterol and diabetes
- Immunizations including HPV, MMR, tetanus, influenza

CRITICAL ILLNESS COVERAGE INFORMATION	
Employee Coverage Options	$10,000, $20,000, $30,000, $40,0000 or $50,000
Guarantee Issue	Employee: $50,000 Spouse: 50% of employee Child: 50% of employee Coverage is guarantee issue for late entrants and/or increases
Family Coverage Options	Spouse –50% of employee Child –automatically covered at 50% of employee benefit
Wellness Benefit	$100
Portability	Included
X-ray	$50
What Triggers Benefit?	Diagnosis of covered condition (must occur after effective date)
Pre-existing Condition Exclusion	12/12 (applies to late entrants and future increases only). No pre-ex for employees who enroll when first eligible.
Re-occurrence Benefit	100% -Unlimited reoccurrence on all conditions that can reoccur except skin cancer. Diagnosis must be separated by 6 months
Invasive Cancer (%)	100%
Non-invasive Cancer (%)	25%
Skin Cancer Note: All breast cancer diagnosis are paid at 100% of face value.	$500
Heart Attack (%)	100%
Stroke (%)	100%
Major Organ Failure (%)	100%
Coronary artery disease	50% (major); 10% (minor)
End stage renal (kidney) failure	100%

Why Should I Buy Coverage Now?

It's more affordable when you buy it through your employer and the premiums are conveniently deducted from your paycheck.

- If you apply during your initial enrollment, you can get coverage without a health exam or medical questions.
- Coverage is portable. You may take the coverage with you if you leave the company or retire. You'll be billed at home.

WHO CAN GET COVERAGE?	
You	Choose from $10,000 to $50,000 of coverage in increments of $10,000 with no medical questions if you apply during this enrollment.
Your spouse	Spouses can get 50% of the employee coverage amount as long as you have purchased coverage for yourself.
Your children	Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. The diagnosis must occur after the child's coverage effective date.

Active employment: Active employment: You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 30 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff or leave of absence on the date that insurance would otherwise become effective. New employees have a 0 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.

If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at **https://www.medicare.gov/Pubs/pdf/02110-medicare-medigap-guide.pdf**.

Please refer to the certificate for complete definitions about these covered conditions. Coverage may vary by state. See exclusions and limitations.

Transit Account

The transit account allows you to deposit up to $270 of pre-tax dollars each month into a fund for you to draw from in order to pay for the following transportation options: transit passes, tokens, fare cards, vouchers, etc., when riding on mass transit, or when riding with someone in the business of transporting people for hire (it must be in a vehicle that seats six or more adults, excluding the driver). By paying for your daily commute with pre-tax dollars you save money by reducing your taxable income. This account is administered by **Discovery Benefits**.

SPECIAL INSTRUCTIONS FOR "WMATA" USERS

From the commuter page of your consumer portal, click the "New Order" button to place a transit or parking order. Then select "WMATA" from the transit authority drop-down and complete the remaining steps to place and verify your order. For more information on the Transit Account please visit **www.DiscoveryBenefits.com**.

Other important elements of the Company's transit account plan include the following:

- Employees can change their elections monthly.
- Unused amounts can be carried over from year to year. However, any unused funds in your transit account at the time your employment terminates will be forfeited.
- Contributions are available for use (via your Benefits Access card) once the payroll deduction has been posted to your account, up to the monthly IRS limit.
- Participants must use their Benefit Access Card to pay for transit expenses; manual claim submission is not permitted.
- You can enroll at any time, not just during Open Enrollment.
- There are no reimbursements or refunds given with this account.

You have until the end of the plan year (August 31) to utilize the money you have contributed to the transit account. Any unused money in your transit account at the end of the plan year rolls over to the next plan year as long as you remain an active employee, but your maximum allowable election amount for the year will be reduced by any amount you roll over.

If you want to change your election amount you will need to do so during Open Enrollment. Otherwise, your election will continue.

Disability Income Benefits

The Company knows how hard you work to help make this company a success and to provide for your families; that is why we offer plans to help protect your financial security in the event of an accident, illness or even death. CIGNA is the provider of this coverage.

What Is Disability?

Disability coverage protects your income while you are recuperating from an accident, giving birth or illness. To avoid answering medical questions, you should enroll within your first 30 days of employment. If you enroll after 30 days you may require evidence of insurability.

“Disability” or “Disabled” means that, due to sickness or accidental injury, you: (1) Are receiving appropriate care and treatment and complying with the requirements of such treatment; and (2) Are unable to earn more than 80% of pre-disability earnings at your own occupation.

Short-Term Disability covers up to 60% of your weekly earnings to a maximum of $1,000 per week, whichever is less.

Long-Term Disability covers up to 60% of your monthly salary to a maximum of $5,000 per month, whichever is less.

Rates are based on your age and may increase as you enter a new age bracket.

If you elect the coverage, you will also need to designate beneficiaries (primary and contingent). A contingent beneficiary is the person who will receive the death benefit proceeds from your coverage in the event your primary beneficiary is also deceased.

To learn more about CIGNA, visit their website at **www.cigna.com**.

NOTE: Pre-existing conditions are not covered under the disability plan. A pre-existing condition is considered any condition for which you have received diagnosis, care, or treatment (to include prescription drugs) within 90 days before you are enrolled in the plan.

For the disability plan, pregnancy is considered a pre-existing condition.

*STD is not available in RI and PR.

*Employees in the states of CA, NJ, NY, and HI are automatically enrolled into a state mandated STD policy through CIGNA, contributed to through your payroll taxes. You can choose to enroll in The Company’s voluntary Short-Term Disability policy to receive the full 60% benefit if the state mandated policy is less.

Thinking of Having a Baby?

Be sure you are enrolled in Short-Term Disability!

Short-Term Disability Rates

AGE	CURRENT RATE/FEE RATE PER $10 OF PAY
< 24	$0.21
25 – 29	$0.22
30 – 34	$0.22
35 – 39	$0.20
40 – 44	$0.22
45 – 49	$0.28
50 – 54	$0.33
55 – 59	$0.40
60 – 64	$0.48
65 – 69	$0.48
70+	$0.48

SHORT-TERM DISABILITY PREMIUM CALCULATION EXAMPLE

This shows the calculations to determine the weekly deduction for a 30-year-old employee with an annual salary of $40,000.

Annual salary divided by 52 weeks	$40,000/52
Weekly earnings	$769.23
Weekly benefit amount covered (60% of weekly earnings)	$461.54
Weekly benefit amount divided by $10 weekly benefit	$46.15
Weekly benefit multiplied by age rate	$46.15 x $0.22
Monthly rate	$10.15
Monthly rate multiplied by 12 divided by 52	$10.15*12/52
Weekly Deduction	**$2.34**

Long-Term Disability Rates

Long-Term Disability provides 60% of your take home income after the end of the elimination period of 90 days or the end of the Short-Term Disability Maximum Benefit Period Rates based on monthly covered payroll.

AGE	CURRENT RATE/FEE RATE PER $10 OF PAY
< 34	$0.15
35 – 39	$0.24
40 – 44	$0.36
45 – 49	$0.49
50 – 54	$0.71
55 – 59	$0.92
60+	$0.99

LONG-TERM DISABILITY PREMIUM CALCULATION EXAMPLE

This shows the calculations to determine the weekly deduction for a 30-year-old employee with an annual salary of $40,000.

Annual payroll divided by 12 months	$40,000/12
Monthly earnings	$3,333.33
Monthly benefit divided by the rate per $100 of pay	$33.33
Multiplied by age band rate ($0.15)	$33.33 x $0.15
Monthly rate	$5.00
Monthly rate multiplied by 12 divided by 52	$5.00*12/52
Weekly Deduction	**$1.15**

Voluntary Life/Accidental Death and Dismemberment Insurance

Often we plan for vacations, retirement, and our children's education; as unpleasant as it may be, very seldom do we plan for family's financial protection in the event of our death. We offer you the opportunity to provide some financial protection to your family in the event of your death via our Voluntary Life/AD&D Insurance through CIGNA Life Insurance Company. You can purchase coverage on yourself as well as your spouse/domestic partner and child or children. Please note you must elect coverage for yourself in order to elect coverage for your spouse, domestic partner and/or dependents.

You are eligible to enroll in this plan during your first 30 days of employment up to the guarantee issue amount* without answering medical questions. If you are eligible for an amount above the guarantee issue amount you will have to answer medical questions and coverage will not go into effect until it is approved by CIGNA.

If you do not elect coverage during your first 30 days of employment, you will be considered a late entrant and will be subject to medical underwriting.

To learn more about CIGNA visit their website at **www.cigna.com**. Rates are listed at **www.BenefitSolver.com**.

VOLUNTARY LIFE & AD&D	
For You	Increments of $10,000 to a maximum of $500,000
For Your Spouse/Domestic Partner	Increments of $10,000 to a maximum of $250,000 (Maximum of 50% of Employee Life Amount)
For Your Dependent Children	$5,000 or $10,000
For Your Dependent Children ages 15 days – 6 months	$500

GUARANTEE ISSUE	
For You	5 times employee salary up to a maximum of $200,000
For Your Spouse/Domestic Partner*	50% of employee's benefit amount up to $20,000
For Your Dependent Children	$5,000 or $10,000
For Your Dependent Children ages 15 days – 6 months	$500

AD&D RATES

AGE	EMPLOYEE RATES	SPOUSE/ DOMESTIC PARTNER RATES
<25	$0.04	$0.03
25 – 29	$0.05	$0.04
30 – 34	$0.06	$0.06
35 – 39	$0.07	$0.07
40 – 44	$0.08	$0.09
45 – 49	$0.12	$0.12
50 – 54	$0.20	$0.20
55 – 59	$0.36	$0.31
60 – 64	$0.50	$0.54
65 – 69	$0.96	$0.94
70+	$1.56	–
AD&D	$0.02	$0.02
Children	–	$0.12
AD&D Children	–	$0.02

LIFE PREMIUM CALCULATION

This shows the calculations to determine the weekly deduction for a 30-year-old employee with an annual salary of $40,000.

Annual payroll divided by $1,000	$40,000/$1,000
Amount of salary calculated	$40.00
Salary amount multiplied by age band rate	$40.00 x $0.06
Monthly rate	$2.40
Monthly rate multiplied by 12 divided by 52	$2.40*12/52
Weekly deduction	$0.55

Resources Available to You If You Choose Cigna

Health Advocacy

Available at no cost to you as part of your Cigna benefits!

Welcome to a value-add service designed to help you, and your family, navigate the health care landscape – one turn at a time. Let us help you – your spouse, domestic partner, dependents, parents and parents-in-law – get the answers you need. Access the help you need 24 hours a day, seven days a week at 866-799-2725.

Don't know where to turn? We point the way.

- Find the right health care professionals based on your needs
- Schedule appointments; arrange for medical tests or special treatments
- Answer questions about diagnoses, test results, treatments, and medications

Want to maximize your benefit dollars? We can help you save.

- Find options for non-covered and alternative health services
- Receive information about generic drug options
- Address questions and concerns related to your medical bills

Need eldercare or special needs services? We're there for you.

- Find in-home care, adult day care, group homes, assisted living, and long-term care.
- Coordinate care among multiple providers.

Additional Benefits

Please review your employee handbook or visit the intranet page on the HR intranet site for information about other policies and benefits including:

- Family Medical Leave Act (FMLA)
- Americans with Disabilities Act (ADA)
- COBRA – Continuing Your Insurance Coverage
- Wireless Service Discounts
- BJ's Membership Discounts

401(k) Plan

The Contract Employee 401(k) Retirement Savings Plan allows eligible employees to set aside up to 75% of pre-tax earnings up to the IRS limit (2020: $19,500 or $26,000 if age 50+) annually for investment in retirement funds. Eligibility begins immediately, however you will be given an opportunity to enroll within your first thirty (30) days of employment.

After you have worked one year, you will be eligible for the company match of 50% of the first 1% and an additional 25% of the next 5% you contribute. The maximum match is $1,000. The match will be deposited in January of the year following the calendar year in which you are eligible for a match, provided you are employed on December 31st of the year in which you are eligible.

You will receive enrollment information from Fidelity via regular mail. You can also access information at **www.netbenefits.com**.

Identity Theft Protection

In 2018, 14.4 million people were identity theft victims. Identity theft occurs when someone obtains your personal identifying information without your permission to commit fraud or other crimes.

Enjoy peace of mind and financial reassurance when you enroll in InfoArmor's PrivacyArmor® Plus.

PrivacyArmor® Plus provides:

- Identity and credit monitoring
- Annual credit report and monthly credit score tracking
- Threshold monitoring
- Social media reputation monitoring
- Digital wallet storage and monitoring
- Full-Service Identity Restoration
- $1,000,000 Identity Theft Insurance Policy
- A Digital Exposure Report

To enroll in PrivacyArmor Plus, simply click the link on the BenefitSolver website. The cost is $9.95 per month for single coverage or $17.95 per month for family coverage. You will be billed directly for this coverage.

Pet Insurance

Figo Pet Insurance frees you from financial stress when choosing the best available veterinary care for your pet. The pet insurance plans offered through Figo cover the unexpected illnesses and injuries of your dog or cat. You can visit any licensed veterinary practice, emergency hospital or specialist.

There are three levels of coverage offered by Figo, each of which cover many core services, including:

- Veterinary Exams
- Emergency & Hospitalization
- Surgeries
- Prescription Medications
- Chronic Conditions
- Diagnostic Testing
- …and many more!

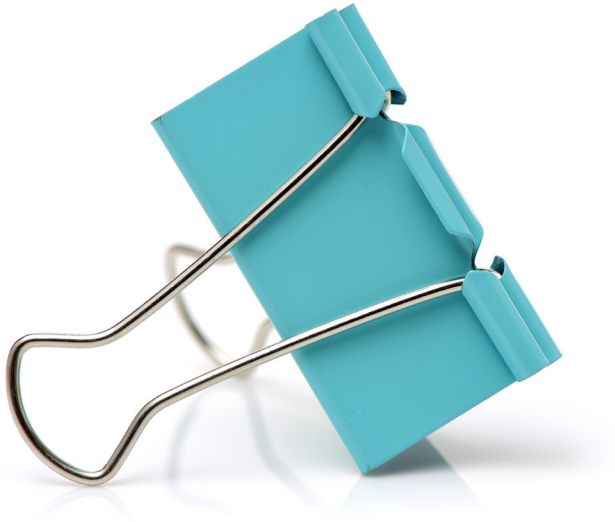
With three flexible plans you can customize both your reimbursement percentage and annual deductible. Plans are designed to be straightforward and simple, meaning you spend less time choosing and more time with your pet.

Although premiums vary by type of pet and by state, typically premiums average less than $1.50 per day, meaning you can enjoy the peace of mind in knowing your pet will always receive the care they deserve.

Figo also offers cutting-edge technology to manage your pet's health through smartphone and tablet apps. Through Figo's Pet Cloud, you are able to setup reminders for care, process claims and also manage pet records.

To view additional information and setup coverage, please visit **www.Figopetinsurance.com**.

You will be billed directly for this coverage. Payroll deductions are not available.



Frequently Asked Questions

General

How does Health Care Reform affect the plan?

The Patient Protection and Affordable Care Act (PPACA) is the health care reform bill signed into law on March 23, 2010. Several provisions affected the limited medical plans offered by the Company.

- Dependent coverage up to age 26: Health plans now must offer coverage for children until the age of 26, unless the child has another offer of employer-based coverage or is covered through other insurance. Both married and unmarried children can qualify for this coverage.
- Wellness Visits: Covered with no copayment. You pay nothing!
- No pre-existing conditions: You can no longer be penalized for having a pre-existing condition
- No Limits: All lifetime maximum benefits have been removed from in-network benefits.

What happens if a Virtual Visit provider cannot resolve your issue? Are you charged?

Once you are seen by a treating virtual physician, you will receive a diagnosis and will be charged your copayment once the diagnosis and treatment notes are completed. If you are presenting with something that is clearly not appropriate for a virtual visit, you will be immediately redirected to a more appropriate site of care, there is no charge for a visit.

What if I change my mind about the benefits I enrolled in – can I change them after the enrollment period ends?

Each year you can elect, terminate, or change coverage during our Annual Open Enrollment. Outside of the Annual Enrollment, you must have a qualified change in status such as marriage, divorce, legal separation, domestic partnership status change, birth or adoption of a child, change in child's dependent status, death of a spouse, domestic partner, child or other qualified dependent, change in residence due to an employment transfer for you, your spouse or domestic partner, commencement or termination of adoption proceedings or change in spouse's or domestic partner's benefits or employment status. You must enroll within 30 days of the qualified change in status.

I will turn 26 years old soon and will have to get off of my parents' medical plan. What do I need to do?

Turning age 26 is considered a qualified life event. You have 30 days from your 26th birthday to enroll in one of the health care plans. You will need to log into BenefitSolver, click the dropdown box next to your name, and select "Qualified Life Event."

How do I change my beneficiary information?

Review your beneficiary information in your enrollment information on **www.BenefitSolver.com**. We encourage you to review your beneficiary information at least once a year.

Disability and Life Insurance

I live in a state that provides disability coverage; do I still need to elect Short-Term Disability?

It's important to look at what the state provides and what you will get from the Company's short-term disability plan. For example, if the state only provides a weekly benefit of $425 but based on your earnings, you would get up to $1,000 from Cigna's short-term disability plan, you need to determine if you can live on $425 a week.

Please note that if you are enrolled in Cigna's short-term disability plan, your benefit will be offset by what you are eligible to receive from the state disability plan.

If I get married or enter a domestic partnership, and need to increase my life insurance, how do I do it?

Simply log on to **www.BenefitSolver.com** to increase your coverage. Because your election will be outside of your enrollment period, you will have to answer medical questions. Coverage will be effective once Cigna reviews and approves the coverage. If you decide to elect spousal life coverage, you must have coverage on yourself in order to cover your spouse or domestic partner for dependent life coverage.

Additional Benefits

You are also eligible for:

- Banking discounts with Wachovia/Wells Fargo and Bank of America (Union and Virginia Credit Union for those who reside in Virginia only.)
  - – Simply visit your local branch and show them a copy of your Company paycheck stub.
- Discounts on your wireless phone service with Verizon Wireless, T-Mobile and AT&T.
  - – Simply visit your local store and show them a copy of your Company paycheck stub.
- Discounts on retail, entertainment, and travel.
  - – Visit the Discounts page on the Contract

Benefits on the Go — Mobile Apps

Now you can access your benefits on the go. Simply go to the Apple® App Store or Google Play™ and download these free apps:

- UnitedHealthcare – Health4Me® Mobile App
- Delta Dental of Virginia – Delta Dental Mobile App
- Discovery Benefits – Discovery Benefits Mobile App
- Cigna Disability – myCigna Mobile App
- Unum Accident and Critical Illness – Unum Mobile App
- Fidelity Investments – NetBenefits Mobile App
- InfoArmor – InfoArmor Mobile App
- Figo – Figo Mobile App
- BenefitSolver – MyChoice App

Required Notices

Company Name (the "Company")
Apex Systems. LLC
Employer Identification Number: 54-1773546

Effective Date
09/01/2020

Creditable Plan Name(s)
United Healthcare Plans

Plan Administrator
Janet Turner-Ezell
Director, Benefits
4400 Cox Road, Suite 200
Glen Allen, VA 23060
866-923-2739
eservices@apexsystems.com

HIPAA Privacy Official
Janet Turner-Ezell

HIPAA Special Enrollment Deadline
30 days

Members of Organized Health Care Arrangement
Apex Systems, LLC
Carriers of Apex Systems, LLC
Insurance Broker for Apex Systems, LLC

Women's Health and Cancer Rights Notice

The Company is required by law to provide you with the following 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). If you or a covered dependent are 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 lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Company Medical Plan.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description/Policy booklet or contact the Plan Administrator.

HIPAA Notice of Privacy Policy and Procedures

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice is provided to you on behalf of the Company about the Plan. It pertains only to health care coverage provided under the Plan. Please review it carefully.

The Company sponsors the United Healthcare Plans which include various benefits which constitute group health plans under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The United Healthcare Plan (the "Plan") has been established and maintained to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Company, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information 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.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic

information, collected from you or created or received by a health care provider, a healthcare clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

1. your past, present or future physical or mental health or condition;
2. the provision of health care to you; or
3. the past, present or future payment for the provision of health care to you.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Company HIPAA Privacy Officer.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

- **For Treatment:** We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.
- **For Payment:** We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your Healthcare provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or pre-certification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.
- **For Health Care Operations:** We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal Services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.
- **To Business Associates:** We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.
- **As Required by Law:** We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.
- **To Avert a Serious Threat to Health or Safety:** We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.
- **To Plan Sponsors:** For the purpose of administering the

Plan, we may disclose your protected health information to certain employees of the Company. 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 protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Organ and Tissue Donation:** If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans:** If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation:** We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks:** We may disclose your protected health information for public health actions. These actions generally include the following:
  - to prevent or control disease, injury, or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.
- **Health Oversight Activities:** We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement:** We may disclose your protected health information if asked to do so by a law enforcement official:
  - in response to a court order, subpoena, warrant, summons or similar process;
  - to identify or locate a suspect, fugitive, material witness, or missing person;
  - about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
  - about a death that we believe may be the result of criminal conduct;
  - about criminal conduct; and
  - in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors:** We may release protected health information to a coroner medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.
- **National Security and Intelligence Activities:** We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Inmates:** If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **Research:** We may disclose your protected health information to researchers when:
  1. the individual identifiers have been removed; or
  2. when an institutional review board or privacy board has:
     (a) reviewed the research proposal; and
     (b) established protocols to ensure the privacy of the requested information and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

- **Government Audits:** We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.
- **Disclosures to You:** When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.
- **Notification of a Breach:** We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

The following is a description of disclosures of your protected health information we are required to make.

- **Personal Representatives:** We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

  1. you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
  2. treating such person as your personal representative could endanger you; or
  3. in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

- **Spouses, Domestic Partners and Other Family Members:** With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse, domestic partner and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse, domestic partner and other family members and information on the denial of any Plan benefits to the employee's spouse, domestic partner and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.
- **Authorizations:** Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. 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 the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

- **Right to Inspect and Copy:** You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.
- **Right to Amend:** If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - is not part of the medical information kept by or for the Plan;
  - was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - is not part of the information that you would be permitted to inspect and copy; or
  - is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

- **Right to an Accounting of Disclosures:** You have the right to request an "accounting" of certain disclosures of

your protected health information. The accounting will not include.

1. disclosures for purposes of treatment, payment, or health care operations;
2. disclosures made to you;
3. disclosures made pursuant to your authorization;
4. disclosures made to friends or family in your presence or because of an emergency;
5. disclosures for national security purposes; and
6. disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years and may not include dates prior to your request. Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. If we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us

  1. what information you want to limit;
  2. whether you want to limit our use, disclosure, or both; and
  3. to whom you want the limits to apply—for example, disclosures to your spouse or domestic partner.

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

- **Right to a Paper Copy of This Notice:** You have the right to 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 agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

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 United States Department of Health and Human Services. To file a complaint with the Plan, write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

HIPAA Notice of Special Enrollment Rights for Medical Plan Coverage

Loss of Eligibility for Other Health Coverage

If you are declining medical plan enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Company medical plan, or switch health benefit options under 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 non-COBRA coverage). However, you must request enrollment within 30 days after the date your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).Loss of eligibility for coverage includes:

- Loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, spouse or domestic partner, termination of employment, reduction in the number of work hours of employment
- A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual, and
- In the case of an individual who has COBRA continuation coverage, at the time the COBRA continuation coverage is exhausted.

However, loss of eligibility for other coverage does not include a loss of coverage due to:

- The failure of the employee or dependent to pay premiums on a timely basis
- Voluntary disenrollment from a plan, or
- Termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

When coverage begins.

If you enroll yourself, your spouse, domestic partner and/or your eligible dependent child(ren) in a group health plan due to a loss of eligibility for coverage event described above, coverage under this plan will begin the first of the month following the date of election (not to exceed 30 days before the date the election is made).

Gaining a New Dependent

If you have a new dependent as a result of marriage, domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in a Company medical plan. However, you must request enrollment within 30 days after the marriage, domestic partnership, birth, adoption, or placement for adoption.

In addition, if you are not enrolled in the Company medical plan as an employee, you also must enroll in the plan when you enroll any of these dependents. And, if your spouse or domestic partner is not enrolled in the health plan, you may enroll him or her and any other eligible dependents in the plan when you enroll a child due to birth, adoption or placement for adoption.

When coverage begins.

In the case of marriage, coverage will begin on the day the election is made in the enrollment system as long as you notify the Company within 30 days of the event. In the case of birth, adoption or placement for adoption, coverage is retroactive to the date of birth, adoption or placement for adoption.

Loss or Gain of Eligibility for a State Children's Health Insurance Program (CHIP) or Medicaid

If you are eligible for, but not enrolled in medical coverage under this plan (or your dependent is eligible for, but not enrolled in, medical coverage under this plan), you (and your dependent) may enroll in a medical option, or switch medical options under this plan, if either of the following conditions are met:

- You (or your dependent) are covered under CHIP or Medicaid and such coverage is terminated as a result of loss of eligibility, and you request medical coverage under this plan not later than 60 days after the date of termination of such CHIP or Medicaid coverage, or
- You (or your dependent) become eligible for CHIP or Medicaid premium assistance subsidy with respect to medical coverage under this plan, and you request medical coverage under this plan not later than 60 days after the date you or your dependent is determined to be eligible for such premium assistance subsidy.

When coverage begins.

If you enroll yourself, your spouse, your domestic partner and / or your eligible dependent child(ren) in medical coverage under this plan due to a loss or gain of eligibility for a coverage event described above, coverage under this plan will begin the day after coverage is lost or the day after the event date. To request special enrollment or obtain more information, contact the plan administrator.

Summary of Material Modifications (SMM) for United Healthcare Plans (Sept. 2020)

This summary of material modifications (SMM) provides important updates about Plan provisions that are in your current summary plan descriptions (SPDs). This SMM is required under ERISA when plan provision(s) materially change. Until new SPDs are published, use this Summary of Material Modifications (SMM) in combination with your current SPDs.

Read on to learn what is changing for you.

Extension of Timeframes

In response to the COVID-19 outbreak, you will have additional time to comply with certain deadlines affecting HIPAA special enrollment periods, COBRA continuation coverage, claims for benefits, appeals of denied claims, and external review of certain claims.

The extension of timeframes is effective from March 1, 2020 (the start date of the COVID-19 "National Emergency") until 60 days after the announced end of the National Emergency. This time period is called the "outbreak period." As of 9/1/2020, the National Emergency end date has not yet been announced.

HIPAA Special Enrollment Periods

The "outbreak period" suspends the following special enrollment deadlines:

- The 30-day period to request special enrollment
- The 60-day special enrollment period for those who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs

However, you may report the event sooner if you prefer. Keep in mind that coverage is only retroactive in situations of a birth, adoption, or placement for adoption. Please review the applicable SPD for information on when coverage will be effective.

Example: Grace is eligible for but previously declined participation in the Plan. On Sept. 30, 2020, Grace gave birth and wants to enroll herself and the child in the Plan mid-year. Grace and her child qualify for HIPAA special enrollment in the Plan as early as the date of the child's birth. Assuming the National Emergency ends on January 31, the outbreak period would end 60 days later on March 31. Grace may exercise her HIPAA special enrollment rights and enroll herself and her child until 30 days after March 31, 2021, which is April 30, 2021. Coverage would be effective retroactive to September 30, 2020, provided that Grace pays the premiums for any period of coverage.

To request special enrollment or obtain more information, contact the Plan Administrator.

COBRA

The "outbreak period" suspends the following COBRA continuation coverage deadlines or payment due dates:

- The date for individuals to notify the Plan of a qualifying event (e.g., divorce, legal separation, dependent child

losing dependent status under the plan), second qualifying event or determination of disability under COBRA

- The 60-day election period for COBRA continuation coverage
- The date for making COBRA premium payments (typically 45 days for the initial premium and not later than 30 days after the first day of the period for which payment is being made for subsequent premiums)

Example: Marco participates in the Plan. He has a COBRA qualifying event when his hours are reduced, and he loses Plan eligibility. Marco is provided a COBRA election notice on November 1, 2020 and under COBRA normally must make an election for COBRA within 60 days. Assuming the National Emergency ends on January 30, 2021, the outbreak period would end 60 days later on March 31. Marco's deadline to elect COBRA continuation coverage is 60 days after March 31, 2021, which is May 30, 2020.

Note that any if you do not pay the premiums for your COBRA continuation coverage in a timely manner under the regular COBRA rules or under this "outbreak period" time extension, then your coverage may be suspended until you pay the premiums. This means that any claims you submit while your coverage is suspended may be denied and you may have to resubmit them once your coverage is reinstated after you pay all of the back premiums that you owe. If you have any questions, you should contact the vendor using the number on the back of your identification card or contact the Plan Administrator.

Note: The date by which the plan must provide a COBRA election notice to you has also been extended.

Internal Claims and Appeals Procedures

The "outbreak period" suspends the following ERISA claims and appeals deadlines:

- The date within which claimants may file a claim under the Plan's ERISA claims procedures
- The date within which claimants may file an appeal of an adverse benefit determination under the Plan's ERISA appeals procedures

Example: Addison is a participant in the Plan. On December 1, 2020, Addison received medical treatment for a condition covered under the Plan, but did not submit a claim until December 1, 2021. Under the Plan, claims must be submitted within 365 days of the date of service. This example assumes the National Emergency ends on January 31, 2021, with the outbreak period ending 60 days later on March 31, 2021. Addison's claims are timely because under the outbreak period extension, Addison's last day to submit a claim is 365 days after March 31, 2021, which is March 31, 2022.

Please review the applicable SPD, vendor benefit summary or contact the Plan Administrator for additional information.

External Review Process (Medical Plan Only)

The "outbreak period" suspends the following ERISA external review deadlines:

- The date within which claimants may file a request for an external review under the Plan (normally 4 months after the date you receive your denied internal appeal)
- The date within which claimants may file information to substantiate a request for external review if the initial request was not complete.

Example: Jerry's internal appeal for his medical claim was denied on December 1, 2020, based on medical judgement. Jerry normally would have 4 months (until April 1, 2021) to file an external claim. Assuming the National Emergency ends on January 31, 2021, the outbreak period would end 60 days later on April 1, 2021. Jerry's deadline to file for an external review of his denied claim is August 1, 2021.

Please review the applicable SPD, vendor benefit summary or contact the Plan Administrator for additional information.

Important Notice from the Company about Your Prescription Drug Coverage and Medicare

This notice has information about your current prescription drug coverage with the Company 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 prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug 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. The Company has determined that the prescription drug coverage offered by the Company's medical 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 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 Company medical coverage will not be affected. The Company coverage will be treated as the primary coverage and Medicare will be secondary.

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

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 the Company 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.

Starting with the end of the last month that you were eligible to join a Medicare drug plan but didn't join, 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, please contact the Plan Administrator.

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 the Company's medical plan 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). 1-800-772-1213 (TTY 1-800-325-0778).

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 http://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 http://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 January 31, 2020. Contact your State for more information on eligibility.

ALABAMA – MEDICAID

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – MEDICAID

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – MEDICAID

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – MEDICAID

Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-800-541-5555

COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA – MEDICAID

Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – MEDICAID

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

INDIANA – MEDICAID

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

KANSAS – MEDICAID

Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY – MEDICAID

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – MEDICAID

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – MEDICAID

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – MEDICAID AND CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – MEDICAID

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"]
Phone: 1-800-657-3739

MISSOURI – MEDICAID

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – MEDICAID

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – MEDICAID

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – MEDICAID

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – MEDICAID

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

NEW JERSEY – MEDICAID AND CHIP
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK – MEDICAID
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – MEDICAID
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – MEDICAID
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – MEDICAID AND CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – MEDICAID
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – MEDICAID
Website: https://www.dhs.pa.gov/providers/Providers/Pages/ Medical/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND – MEDICAID AND CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – MEDICAID
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - MEDICAID
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – MEDICAID
Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – MEDICAID AND CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– MEDICAID
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

VIRGINIA – MEDICAID AND CHIP
Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WASHINGTON – MEDICAID
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – MEDICAID
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – MEDICAID AND CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING – MEDICAID
Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since **January 31, 2020**, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149

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 the plan administrator.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
Apex Systems. LLC	54-1773546
5. Employer address	**6. Employer phone number**
4400 Cox Road, Suite 200	866-923-2739

7. City	8. State	9. ZIP code
Glen Allen	VA	23060

10. Who can we contact about employee health coverage at this job?	
Janet Turner-Ezell	
11. Phone number (if different from above)	**12. Email address**
Same as above	eservices@apexsystems.com

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

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

[X] All employees. Eligible employees are:

All regular full-time employees working 30 hours or more per week are eligible for benefits.

[ ] Some employees. Eligible employees are:

- With respect to dependents:

[X] We do offer coverage. Eligible dependents are:

Dependents eligible for benefits coverage include: Your legal spouse, member of civil unions and domestic partners; Your dependent children up to age 26, regardless of student or marital status; Your unmarried, disabled dependent children of any age (you may be required to provide proof of disability)

[ ] 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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

CITY AND COUNTY OF SAN FRANCISCO
CONTRACT MONITORING DIVISION
S.F. ADMINISTRATIVE CODE CHAPTERS 12B & 12C
DECLARATION: NONDISCRIMINATION IN CONTRACTS AND BENEFITS

(CMD-12B-101)

The Equal Benefits Ordinance prohibits the City and County of San Francisco from contracting with vendors that discriminate in the provision of benefits between employees with domestic partners and employees with spouses, and between the domestic partners and spouses of such employees.

- Domestic Partners are same-sex and opposite-sex couples registered with any state or local government agency authorized to perform such registrations.
- Domestic partnerships and marriages may only be verified to the same extent and in the same manner.
  For example, waiting periods to qualify for benefits must be the same for domestic partners and spouses.
  Domestic partner registry certificates must be recognized as fully equivalent to marriage certificates.

INSTRUCTIONS

STEP 1 Obtain a Vendor Number

☐ If you have already been issued a vendor number by the City & County of San Francisco, go to Step 2.

☐ To obtain a vendor number, contact Vendor File Support: vendor.file.support@sfgov.org or (415) 554-6702.

STEP 2 Complete this 12B & 12C Declaration: Nondiscrimination in Contracts and Benefits form (CMD-12B-101)

STEP 3 Obtain the necessary supporting documentation

☐ Most recent legal verification of employee count/firm structure, for example, a W-3 Form, DE 1 Form, DE 9 Form or an annual San Francisco Payroll Expense Tax Statement.
(Please redact confidential employee information.)

☐ A copy of a memorandum that has been distributed to your firm's employees detailing the firm's compliant nondiscrimination and domestic partner benefit policies. An example of a memorandum that includes all required confirmations is provided with this form and on the Contract Monitoring Division website.
Note: the memorandum is not a substitute for fully compliant incorporation of domestic partner language in all benefit policies. Please contact the Contract Monitoring Division prior to distribution of the memorandum if you have questions.

STEP 4 Submit the 12B & 12C Declaration: Nondiscrimination in Contracts and Benefits form (CMD-12B-101) and all supporting documentation to:

☐ cmd.equalbenefits@sfgov.org *or*
Contract Monitoring Division, 30 Van Ness Avenue, Suite 200, San Francisco, CA 94102-6020

Section 1. Vendor Information

Name of Firm: _____

Name of Firm Contact Person: _____

Phone: _____ Ext.: _____

E-mail Address: _____

Vendor Number (if known): _____

Federal ID or Social Security Number: _____

Approximate Number of Employees in the U.S. (Do not count yourself): _____

DATE & TIME RECEIVED BY CMD
(FOR CMD USE ONLY)

Are any of your employees covered by a collective bargaining agreement or union trust fund? ☐ **YES** ☐ **NO**

Union name(s): _____

Section 2. Compliance Questions

Question 1. Nondiscrimination – Protected Classes

A. Does your firm agree it will not discriminate against its employees, applicants for employment, employees of the City, or members of the public on the basis of the fact or perception of a person's membership in the following categories? ☐ **YES** ☐ **NO**
***Please note**: a **YES** answer is required for compliance.*

Race, Color, Creed, Religion, National origin, Ancestry, Age, Sex, Sexual orientation, Gender identity (transgender status), Domestic Partner status, Marital status, Disability, AIDS/HIV status, Height, Weight

B. Does your firm agree to insert a similar nondiscrimination provision in any subcontract you enter into for the performance of a substantial portion of the contract you have with the City? ☐ **YES** ☐ **NO**
***Please note:** you must answer this question even if you do not intend to enter into any subcontracts, and a **YES** answer is required for compliance.*

Question 2. Nondiscrimination – Equal Benefits for Employees with Spouses and Employees with Domestic Partners, and for the Spouse or Domestic Partner of an Employee

*Questions 2A and 2B should be answered **YES** even if your employees pay some or all of the cost of spousal or domestic partner benefits.*

A. Does your firm provide or offer access to any employee benefits? ☐ **YES** ☐ **NO**
(If your firm does not have employees, answer ***NO***)

B. If you answered "Yes" to 2.A, are all of the benefits equally available to employees with domestic partners and employees with spouses? ☐ **YES** ☐ **NO**
(If your firm does not have employees, answer ***NO***)

***If you answered YES to either or both** Questions 2A and 2B, please continue to Question 2C.*
***If you answered NO to both** Questions 2A and 2B, please complete Section 3.*

C. Please check all benefits that apply to your answers above and list in the "Other" line any additional benefits not already specified. Note: some benefits are provided to employees because they have a spouse or domestic partner, such as bereavement leave; other benefits are provided directly to the spouse or domestic partner, such as dependent life insurance.

BENEFIT	Available to Employees	Available to/Affects Domestic Partners	Available to/Affects Spouses
Health Insurance	☐	☐	☐
Dental Insurance	☐	☐	☐
Vision Insurance	☐	☐	☐
Retirement (Pension, 401(k), IRA, etc.)	☐	☐	☐
Bereavement Leave	☐	☐	☐
Family Leave	☐	☐	☐
Parental Leave	☐	☐	☐
Employee Assistance Program	☐	☐	☐
Relocation and/or Travel	☐	☐	☐
Firm Discount, Facilities & Events	☐	☐	☐
Credit Union	☐	☐	☐
Child Care	☐	☐	☐
Dependent Life Insurance	☐	☐	☐
Short-Term/Long-Term Disability Insurance	☐	☐	☐
Accidental Death & Dismemberment Insurance	☐	☐	☐
Other (Please specify)	☐	☐	☐
Other (Please specify)	☐	☐	☐

Firm Name_____

D. Please **initial** all statements below that apply to your firm. ***Please note:*** *in addition, a* ***YES*** *answer is required for compliance.*

__ Domestic partners are defined as same-sex couples and opposite-sex couples registered with any state or local registry and verify their relationship in the same manner as spouses.	☐ **YES**	☐ **NO**
__ A memorandum detailing our firm's domestic partner policies has been distributed to employees.	☐ **YES**	☐ **NO**
__ The employee handbook includes domestic partner language wherever spouses are referenced.	☐ **YES**	☐ **NO**
__ The children of domestic partners are explicitly included in all policies that recognize stepchildren.	☐ **YES**	☐ **NO**
__ All insurance plans contain language that recognizes spouses and domestic partners equally.	☐ **YES**	☐ **NO**
__ All retirement, 401(k) and similar plans explicitly provide the same distribution choices for spousal and domestic partner or nonspousal beneficiaries.	☐ **YES**	☐ **NO**

Note: If you can't offer a benefit in a nondiscriminatory manner *because of reasons outside your control*, (e.g., there are no insurance providers in your area willing to offer domestic partner coverage) you may be eligible for Reasonable Measures compliance. To comply on this basis, you must agree to pay a cash equivalent, submit a completed Reasonable Measures Application Form (CMD-12B-102) with all necessary attachments, and have your application approved by the Contract Monitoring Division. For more information, see the Rules of Procedure or contact the Contract Monitoring Division.

COMPLIANCE AUDITS AND REQUIRED DOCUMENTATION

The City and County of San Francisco regularly audits firms to verify that the answers on this form are complete and accurate.
Please see the Chapter 12B Equal Benefits Documentation Guide for a detailed description of compliant documentation.

To be certified under Chapters 12B & 12C you must submit proper documentation confirming that your firm has already fully implemented equal benefits for employees with spouses and employees with domestic partners, and between the spouses and domestic partners of such employees. In addition to a compliant CMD-12B-101 Declaration, you must submit legal verification of your firm's employee count and a copy of your compliant memorandum to employees that explains your firm's nondiscrimination and domestic partner benefit policies. *Note: the memorandum is not a substitute for fully compliant incorporation of domestic partner language in your firm's benefit policies.* You may also be required to provide benefit documentation to verify that your firm does not discriminate in the provision of benefits. Such documentation may include your employee handbook and confirmations from your insurance, union and retirement documents. Failure to offer benefits in accordance with the San Francisco Chapter 12B Equal Benefits Ordinance may result in suspension of your firm's compliance status, financial penalties and/or the inability to contract with the City and County of San Francisco.

Section 3. Execute this CMD-12B-101 Declaration

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that I am authorized to bind this entity contractually.

Executed this _____day of _____in the year_____ , at _____, _____
(City) (State)

_____ _____
Signature Mailing Address

_____ _____
Name of Signatory (please print) City, State, Zip Code

_____
Title

- **Submit this form and supporting documentation to**: Contract Monitoring Division, 30 Van Ness Ave., Suite 200, San Francisco, CA 94102-6020, or to CMD.EqualBenefits@sfgov.org or to the City department that sent it to you if the department so requests.
- ✓ **Resource Materials** and additional copies of this form may be found at: www.sfgov.org/CMD.
- ✓ **For assistance,** please contact the Contract Monitoring Division at 415-581-2310.

CMD-12B-101 (4-15)

CITY AND COUNTY OF SAN FRANCISCO
HUMAN RIGHTS COMMISSION

AFFIDAVIT OF JURISDICTION
FOR CONTRACT-BY-CONTRACT COMPLIANCE
(HRC-12B-108)

Your company has applied to the San Francisco Human Rights Commission to be in compliance with the requirements of Chapter 12B of the San Francisco Administrative Code for the *purpose of entering into a specific contract*. This means that your company is unwilling to provide equal benefits to employees with spouses and employees with domestic partners throughout your operations in the United States. Instead, your company will only provide equal benefits at all its locations:

- in San Francisco;
- on property outside of San Francisco that is owned by the City or that the City has the right to occupy; and
- elsewhere in the United States where work relating to a City contract is being performed.

You must complete this form to document where in the United States your company will perform work related to the specific City contract at issue. ***This form must be completed prior to each award of a City contract*** so that the City may assess where work related to each contract is being performed.

Section 1. Vendor Information

Name of Company:_____

Name of Company Contact Person: _____

Phone: _____ Fax: _____

Vendor Number (if known): _____

Company Federal Identification Number: _____

DATE & TIME RECEIVED BY HRC
(FOR HRC USE ONLY)

Section 2. City Department Information

Contracting City Department: _____

City Department Contact Person: _____

Phone: _____ Fax: _____

Section 3. Contract Information

Contract Number: _____

You must attach to this form a description of the work to be performed for the City, as follows:

1. The section of the proposed City contract that describes the scope of work to be performed for the City; or
2. If such contract language has not yet been prepared, attach the description of the scope of work submitted with your company's bid proposal for this contract; or
3. If the contract was not bid, please prepare and attach a description of work to be performed under the contract. *Please be specific.*

✓ Check here to confirm that a description of the scope of work is attached: ☐

Section 4. Company Locations & Contract Activity

Please indicate whether your company has operations in the following locations and the *total number of employees** working at each:

In San Francisco (*regardless* of whether work on a City contract is being performed there).

Number of employees _____

On real property outside of San Francisco that is owned by the City or that the City has a right to occupy (*regardless* of whether work on a City contract is being performed there).

Number of employees _____

*E*lsewhere in the U.S. where work *is being performed* on the City contract.

Location: _____ Number of employees _____

Location: _____ Number of employees _____

Location: _____ Number of employees _____

(Attach Additional Sheet if Necessary)

> ***Note:*** Total number of employees includes ALL employees at the specified location, not only those employees working on the City contract.

Section 5. Executing the Document

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that I am authorized to bind this entity contractually.

Executed this _____ day of _____, in the year _____, at _____, _____.

(City) (State)

_____ _____

Signature Mailing Address

_____ _____

Name of Signatory (please print) City, State, Zip Code

_____

Title

- **Return this form to**: HRC, 25 Van Ness Ave., Suite 800, San Francisco, CA 94102-6033.
- ✓ **For assistance** please contact the Human Rights Commission at 415-252-2500.

HRC-12B-108 (12-01)

Contact Information

PLAN	PROVIDER	PHONE NUMBER	WEBSITE
Medical	Aetna	888-772-9682	www.aetna.com
	UnitedHealthcare	866-633-2446	www.uhc.com
	Optum UHC (MEC only)	800-788-4863	www.optum.com
Dental	Delta Dental Plan of VA	800-237-6060	www.deltadentalva.com
Vision	Vision Service Plan (VSP)	800-877-7195	www.vsp.com
Voluntary Life and AD&D Insurance	Cigna	800-362-4462	www.cigna.com
Short-Term Disability Insurance	Cigna	800-732-1603	www.cigna.com
Long-Term Disability Insurance	Cigna	800-362-4462	www.cigna.com
Accident Insurance or Critical Illness Insurance	Unum	800-635-5597 (verify coverage)	www.unum.com
Transit Account	Discovery Benefits	866-451-3399	www.discoverybenefits.com
Health Advocacy	Cigna	866-799-2725	www.cigna.com
401(k) Retirement Plan	Fidelity	800-291-4015	www.netbenefits.com
Identity Theft Protection	InfoArmor	800-789-2720	www.infoarmor.com/ApexCE
Pet Insurance	Figo	844-493-4130	www.figopetinsurance.com

Contractor Care Department

- Email: **contractorcare@apexsystems.com**
- Phone: 866-612-2739
- Hours of Operation: Monday through Friday
  8:00 AM to 8:00 PM EST

Notes

Notes

Notes

Benefit Guide for Contract Employees

About this Guide: This benefit summary provides selected highlights of the Apex Systems employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Apex Systems reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.