APEX Systems | APEX LIFE SCIENCES

2018-2019

Plan Effective: **September 1, 2018** through **August 31, 2019**

CONTRACT EMPLOYEE BENEFITS GUIDE

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This document outlines benefits for Contract Employees of Apex Systems and Apex Life Sciences, herein referred to as the "Company."

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.

Most answers to your benefits questions will be found in this guide. However, if there are specific plan questions related to covering a condition or exclusions, the Summary Plan Description (SPD) booklet is a great source. The SPD can be found online at www.benefitsolver.com.

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 Healthcare Reform laws, if you choose to cover any dependents, you must provide supporting documents (e.g., birth certificate, marriage certificate, 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.

We want to encourage you to continue to be an advocate of your health. Our lifestyle choices have the greatest correlation to our well-being. When we shop for healthy foods and seek out ways to increase our physical activity, we reduce our risks for a number of diseases including diabetes and heart disease. Your enthusiasm and feedback motivate us to deliver a benefit design that helps you meet your personal health goals.

We look forward to working with you to ensure that the enrollment process is seamless. Again, please do not hesitate to contact our **Contractor Care Team** at **866-612-2739** if you have questions or concerns.

Sincerely,

Your Benefits Team

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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.

Who is Eligible?

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. Find information about domestic partner coverage on the Benefits site on the intranet or contact **Contractor Care** at **866-612-2739** with questions.

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:

1. Go to https://www.benefitsolver.com.
2. Click “Register”, then do the following:
    a. Enter your Social Security number
    b. Enter your Date of Birth
    c. Enter the Company code: **ASLSBEN**
3. You will be asked to create a UserID and Password.
4. Login using your UserID and Password.
5. You will come to a “start here” page which will navigate you through your election.
6. **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.**

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 United Healthcare 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.
    - **Proof of Dependent Status:** If you are covering a dependent in one of the United Healthcare 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, 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.
- **Dental**
- **NEW! 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).

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, 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.
Registration of Domestic Partner	Copy of the Declaration of Domestic Partnership accepted by the Secretary of the State.
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 of 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 plan	Letter from the employee's parent's plan showing 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 7, 2018**, coverage will end **Saturday, September 15, 2018**. Please see below:

Aetna Plan Coverage Termination Calendar Example

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
2	3	4	5	6	7 Final Payroll Deduction	8
9 Day 1 Covered	10 Day 2 Covered	11 Day 3 Covered	12 Day 4 Covered	13 Day 5 Covered	14 Day 6 Covered	15 Day 7 Coverage Ends

UHC Medical Plans, Dental, and Vision

For the UHC medical plans, dental, and vision, coverage ends at the end of the month. For example, if your employment terminates on **Tuesday, September 25, 2018**, you will have coverage until **Sunday, September 30, 2018** (end of the month). Please see below:

UHC Medical Plans, Dental, and Vision Coverage Termination Calendar Example

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
16 ACTIVE	17 ACTIVE	18 ACTIVE	19 ACTIVE	20 ACTIVE	21 ACTIVE	22 ACTIVE
23 ACTIVE	24 ACTIVE	25 Termination Date	26 TERMED	27 TERMED	28 TERMED	29 TERMED
30 UHC Medical, Dental, and Vision Coverage Ends						

Medical and Prescription Drug Coverage | Back to CONTENTS

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 Medical Plan Overview

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 days
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 COST ANALYSIS	
Cost per EE/Week	$23.53
EE + Spouse	**$52.30**
EE + Child	$52.30
EE + Children	**$75.31**
Family	$75.31

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

- **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.**

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.

United Healthcare Preventive Minimum Essential Coverage (MEC) Plan

United Healthcare 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
- Women's preventive contraceptives
- Well-child care
- Other preventive tests/screens included in the Affordable Care Act

UHC MEC MEDICAL RATES	
Employee Only	$14.30
Employee + Spouse	**$30.44**
Employee + Child(ren)	$28.36
Family	**$47.04**

Login to 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 healthcare costs
- Find out about extra programs and discounts

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.

United Healthcare Medical Plan Overview

You will have the option to participate in the United Healthcare 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 MEDICAL PLAN						
Plan Highlights	**PPO 60**		**PPO 70**		**PPO 80**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible						
Single	$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 Max						
Single	$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
Office Visit						
Primary	70%	50%	70%	50%	$25	30%
Specialist					$50	
Coinsurance	70%	50%	70%	50%	80%	70%
Virtual Visit	70%	50%	70%	50%	$15	30%
Inpatient Copay	70%	50%	70%	50%	80%	70%
Emergency Room	70%	50%	70%	50%	$200	$200
Preventive Service	100%	N/A	100%	N/A	100%	N/A
PRESCRIPTION DRUGS						
Deductible Obligations ▶	*Subject to deductible **first**, then:*		*$100 deductible **first**, then:*		*$100 deductible **first**, then:*	
Type	**Retail**	**Mail**	**Retail**	**Mail**	**Retail**	**Mail**
Generic	70%		$10	$25	$10	$25
Brand Preferred	70%		$30	$75	$30	$75
Brand Non-Preferred	70%		$50	$125	$50	$125

- **The PPO 60 Plan is not considered credible coverage in the state of Massachusetts.**
- **In accordance with the Affordable Care Act, rates are based on your hourly wage.**

UHC Weekly Rates per PPO Plan

PPO 60 WEEKLY RATES				
Hourly Rate	**Employee**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
$8.50 – 10.99	$27.69	$185.08	$165.46	$348.23
$11.00 - $13.49	$36.00	$193.38	$173.77	$356.54
$13.50 - $15.99	$44.08	$201.46	$181.85	$364.62
$16.00 - $18.49	$52.38	$209.77	$190.15	$372.92
$18.50 - $20.99	$60.46	$217.85	$198.23	$381.00
$21.00 - $23.75	$68.77	$226.15	$206.54	$389.31
$23.76 - $26.49	$77.77	$235.15	$215.54	$398.31
$26.50 - $29.49	$86.77	$244.15	$224.54	$407.31
$29.50 - $32.22	$96.69	$254.08	$234.46	$417.23
$32.23>	$105.69	$263.08	$243.46	$426.23

PPO 70 WEEKLY RATES				
Hourly Rate	**Employee**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
$8.50 - 10.99	$117.69	$288.00	$266.54	$465.00
$11.00 - $13.49	$117.69	$288.00	$266.54	$465.00
$13.50 - $15.99	$117.69	$288.00	$266.54	$465.00
$16.00 - $18.49	$117.69	$288.00	$266.54	$465.00
$18.50 - $20.99	$117.69	$288.00	$266.54	$465.00
$21.00 - $23.75	$117.69	$288.00	$266.54	$465.00
$23.76 - $26.49	$117.69	$288.00	$266.54	$465.00
$26.50 - $29.49	$117.69	$288.00	$266.54	$465.00
$29.50 - $32.22	$117.69	$288.00	$266.54	$465.00
$32.23>	$117.69	$288.00	$266.54	$465.00

PPO 80 WEEKLY RATES				
Hourly Rate	**Employee**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
$8.50 - 10.99	$140.08	$335.86	$311.49	$539.40
$11.00 - $13.49	$140.08	$335.86	$311.49	$539.40
$13.50 - $15.99	$140.08	$335.86	$311.49	$539.40
$16.00 - $18.49	$140.08	$335.86	$311.49	$539.40
$18.50 - $20.99	$140.08	$335.86	$311.49	$539.40
$21.00 - $23.75	$140.08	$335.86	$311.49	$539.40
$23.76 - $26.49	$140.08	$335.86	$311.49	$539.40
$26.50 - $29.49	$140.08	$335.86	$311.49	$539.40
$29.50 - $32.22	$140.08	$335.86	$311.49	$539.40
$32.23>	$140.08	$335.86	$311.49	$539.40

REHIRES

If you are off an assignment for less than 30 days, 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.

PROOF OF DEPENDENT STATUS

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

- Full names and social security numbers of dependents
- Proof of dependent status (birth certificate , marriage certificate and/or tax return)

You can upload your documents to Benefitsolver using the message center in Benefitsolver to create a secure email.

Send an email to **Keisha Washington** at:

kwashington@apexsystems.com

Upon receipt of your email, she will send you a message through the secure Benefitsolver website.

You can also 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.

Virtual Visits

United Healthcare 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, 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:

- Load the United Healthcare "Health4Me" app to your Smart Phone or tablet.
- Once you set up Virtual Visits on your mobile device, load your debit or credit card information, which will be used to pay the copayment. You will also enter information on the pharmacy you use, in the event the physician has to send in a prescription for you. If you have a medical Flexible Spending Account card, you can enter that card number to pay for your copayment.
- Access the system and have a real time visit with a physician then pay the applicable copayment.

Virtual Visits gives you the convenience of seeing a physician without leaving the comforts of your home or office. Virtual Visits are only available to those enrolled in the PPO60, PPO70, or PPO80 United Healthcare Medical Plans.

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.

The Aetna Fixed Indemnity Plan is not a COBRA eligible plan.

Health Advocacy Service

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, 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.

Personal Health Support

Navigating the maze of health and health care can be challenging. We are pleased to offer your access to United Healthcare'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 United Healthcare, 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.healthy-pregnancy.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

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.

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.

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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.

NEED A DENTIST?

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 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.

SERVICES	COVERAGE
Preventive Services	Exams, Cleanings, Bitewing X-Rays, Fluoride, and Sealants
Coverage Level	100%
Deductible	Applies to basic and major services only
Individual	$50
Family Maximum	$150
Basic Services	Stainless Steel Crowns, Composite Resin, Silver Fillings, Endodontics
Coverage Level	80%
Major Services	Gold Crowns, Prosthetic Coverage
Coverage Level	50%
Annual Maximum	$1,000

Your Weekly Cost for Dental Coverage

Employee	Employee + Spouse	Employee + Child	Employee + Family
$7.54	$15.07	$15.07	$26.85

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**

NEW! VSP Vision Insurance | Back to CONTENTS

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 *Average savings of 20 -25% on other lens enhancements*	$150-$175
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

Your Weekly Cost for Vision Coverage

Employee Only	EMPLOYEE + Spouse	Employee + Child(ren)	Employee + Family
$1.42	$2.85	$4.58	$4.58

Additional Insurance | Back to CONTENTS

Accident Insurance

Unum's Accident Insurance can pay 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.

Advantages of the plan:

- Coverage is available to eligible employees age 17 to 80 (to age 64 in CA) who are actively at work.*
- You can buy coverage for your spouse and dependent children.
- There are no health questions to answer. If you apply, you automatically receive the base plan.
- Base plan is guaranteed renewable for life and covers a wide variety of injuries and accident-related expenses such as hospitalization, physical therapy, emergency-room treatment, doctor's office visits, fractures and dislocations, transportation, lodging and more.
- Benefits are paid for accidents that occur on or off the job.
- You own the policy so you can keep this coverage if you leave the company or retire. Unum will bill you directly.
- This plan includes convenient payroll deduction, so you don't have to remember to write a check for your premiums.
- Coverage becomes effective on the first day of the month in which payroll deductions begin.

Additional coverage option:

- You can purchase a Sickness Hospital Confinement Benefit to add additional coverage. This rider pays the insured employee, spouse, or child a daily benefit if he or she is in the hospital for a covered illness. Amount is $100 per day for employee and spouse, $75 for children. In Florida, the amount is $300 per day for employee and spouse and $225 per day for children. In North Carolina, the amount is $200 per day for employee and spouse and $150 per day for children. This rider is available to family members who are covered by the base plan.

In VT, insured individuals must be covered by comprehensive health insurance before applying for accident insurance. The policy is non-cancelable in MA.

**Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations, or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence.*

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage. Spouses and dependents must live in the U.S. to receive coverage.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to policy form L-21762 or contact your Unum representative.

This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. The expected benefit ratio for this policy is 50%. This ratio is the portion of future premiums which the company expects to return as benefits, when averaged over all people with this policy. IMPORTANT NOTICE: THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

THIS IS A LIMITED POLICY

Underwritten by: Provident Life and Accident Insurance Company, Chattanooga, Tennessee In New York, underwritten by: First Unum Life Insurance Company, New York, New York

Unum complies with state civil union and domestic partner laws when applicable. www.unum.com

Critical Illness Insurance

Unum's Group Critical Illness Insurance can help protect your finances from the expense of a serious health problem, such as a stroke or heart attack. Cancer coverage is also available. You choose a lump-sum benefit up to $50,000 that's paid directly to you at the first diagnosis of a covered condition. You can use the benefit any way you choose.

What is covered?

Covered conditions:

- Heart attack
- Blindness
- Major organ failure
- End-stage renal (kidney) failure
- Occupational HIV
- Coronary artery bypass surgery (pays 25% of lump-sum benefit)
- Benign brain tumor

Covered conditions with time limitations:

- Stroke (evidence of persistent neurological deficits confirmed at least 30 days after the event)
- Coma (resulting from severe injury lasting 14 consecutive days or more)
- Permanent paralysis (complete and permanent loss of the use of two or more limbs for a continuous 90 days as a result of a covered accident)

You may choose to select this benefit for an additional premium:

- Cancer
- Carcinoma in situ* (pays 25% of the lump-sum benefit)

Please refer to the policy for complete details about these covered conditions.

Advantages of the plan

- Coverage is available to eligible employees who are actively at work.**
- You can buy coverage for your spouse ages 17 to 64 with purchase of employee coverage.1 Benefit amount is from $5,000 to $30,000 in $1,000 increments.
- All eligible dependent children ages newborn until their 26th birthday, regardless of marital or student status, are automatically covered at 25% of the employee benefit amount at no additional cost. Eligible children are covered for the same conditions as the employee and the following specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. Diagnosis must occur after the child's coverage effective date.
- You can use this coverage more than once. If you receive a full benefit payout for a covered illness, your coverage can be continued for the remaining covered conditions. The diagnosis of a new covered illness must occur at least 90 days after the most recent diagnosis. Each condition is payable once per lifetime.
- You get affordable rates when you buy this coverage through your employer, and the premiums are conveniently deducted from your paycheck.
- Coverage is portable. You may take the coverage with you if you leave the company or retire, without having to answer new health questions. Unum will bill you directly.
- Coverage becomes effective on the first day of the month in which payroll deductions begin.
- Wellness Benefit — based on the plan selected by your employer, this benefit can pay $100 per calendar year per insured individual if a covered health screening test is performed, including blood tests, stress tests, colonoscopies, and mammograms. A full list of covered tests will be provided in your certificate.

Termination Provisions

If you choose to cancel your coverage under the policy, your coverage ends at 12:00 midnight on the first of the month following the date you provide notification to your employer. Otherwise, your coverage under the policy ends on the earliest of the following:

- Date this policy is cancelled
- Date you are no longer in an eligible group
- Date your eligible group is no longer covered
- Date of your death
- Last day of the period for which you made any required contributions
- Last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness. Coverage on your dependent children ends on the earliest of the date your coverage under the policy ends or the date a dependent child no longer meets the definition of dependent children. Unum will provide coverage for a payable claim that occurs while you are covered under this policy.

**Carcinoma in situ is defined as cancer that involves only cells in the tissue in which it began and that has not spread to nearby tissues.*

***Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations, or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence. 1 Employees and spouses may be covered under a policy or the Spouse Rider, but not both.*

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage. Spouses and dependents must live in the U.S. to receive coverage.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to policy form CI-1, or contact your Unum representative.

THIS IS A LIMITED POLICY

Underwritten by: Unum Life Insurance Company of America, Portland, Maine Unum complies with state civil union and domestic partner laws when applicable.

Critical Illness – Rates and Cost Information

Wellness benefit premium is in addition to base premium.

Sample Critical Illness Premiums (Non-Tobacco)

	BENEFIT AMOUNT	WEEKLY COST
Employee (age 40)	$5,000	$1.49
	$10,000	$3.06
	$15,000	$4.58
	$20,000	$6.11
	$25,000	$7.62

Calculating Your Monthly Critical Illness Cost

1. Find your age and rate in either the "Without Cancer" or "With Cancer" charts (listed below).
2. Choose your coverage amount.
3. Calculate using the following formula:
    a. Benefit Amount / 1,000* x Rate = Monthly Cost
    b. Monthly rate multiplied by 12 divided by 52

**The rates listed are per $1,000.*

Spouse issue ages are 17 through 64. Dependent Children issue ages are newborn up to their 26th birthday or to the maximum coverage age defined in the policy.

Without Cancer Monthly Rates per $1,000

ISSUE AGES	NON-TOBACCO	TOBACCO
< 25	$0.26	$0.34
25 - 29	$0.26	$0.39
30 - 34	$0.39	$0.59
35 - 39	$0.50	$0.86
40 - 44	$0.71	$1.26
45 - 49	$0.98	$1.73
50 - 54	$1.30	$2.26
55 - 59	$1.75	$2.93
60 - 64	$2.44	$3.89
65 - 69	$3.32	$4.81
70+	$4.33	$5.78

With Cancer Monthly Rates per $1,000

ISSUE AGES	NON-TOBACCO	TOBACCO
< 25	$0.42	$0.60
25 - 29	$0.48	$0.74
30 - 34	$0.71	$1.13
35 - 39	$0.98	$1.64
40 - 44	$1.39	$2.40
45 - 49	$1.94	$3.40
50 - 54	$2.63	$4.62
55 - 59	$3.58	$6.13
60 - 64	$4.90	$7.88
65 - 69	$6.38	$9.54
70+	$8.01	$10.81

Wellness Benefit – Monthly Benefit per $25

EMPLOYEE + CHILDREN	$0.80
SPOUSE	$0.80

Coverage Amount $100 - Unum will pay the Wellness Benefit once per insured per calendar year.
NOTE: The inclusion of rate information would make this advertisement an invitation to contract. Therefore, limitations, exclusions, and renewability provisions must be disclosed.

Disability Income Benefits | Back to CONTENTS

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.

PLEASE NOTE…

Disability coverage protects your income while you are recuperating from an accident, giving birth or illness. Pre-existing conditions are not covered. To avoid answering medical questions, you should enroll within your first 30 days of employment.

What is disability?

"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.

Short-Term Disability Rates

Age	Current Rate/Fee *Rate per $100 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 $100 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 salary divided by 12 months	$40,000/12
Monthly earnings	$3,333.33
Monthly benefit divided by the rate of $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

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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 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.

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

**Spousal/Domestic Partner Life coverage ends at age 70.*

***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

Life Insurance Rates

Age	Employee Rates	Spouse 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 INSURANCE 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 $1,000	$40,000/$1,000
Amount of salary calculated	$40.00
Salary amount multiplied by age band rate	$40.00 x **$0.08**
Monthly Rate	$3.20
Monthly rate multiplied by 12 divided by 52	$3.20*12/52
Weekly Deduction ▶	**$0.74**

Transit Account | Back to CONTENTS

A **transit account** allows you to deposit up to **$260** 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.

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.

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.

401(k) Plan | Back to CONTENTS

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 **(2018: $18,500 or $24,500 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 | Back to CONTENTS

In 2014, 17.6 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 Privacy Armor 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.

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

Pet Insurance | Back to CONTENTS

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.

Employee Notices | Back to 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 below for more details, and be sure to give this notice to your Medicare-eligible dependents covered under the Apex Systems, LLC group health plans.

Important Notice from Apex Systems, LLC About Your Prescription Drug Coverage and Medicare - CREDITABLE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Apex Systems, LLC 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. Apex Systems, LLC. has determined that the prescription drug coverage offered by the Apex Systems, LLC Employee Benefits 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.

QUESTIONS

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 Apex Systems, LLC coverage may or may not be affected. See the Contact listed below for an explanation of your plan benefits including the prescription drug coverage.
- If you do decide to join a Medicare drug plan and drop your current Apex Systems, LLC coverage, be aware that you and your dependents may or may not be able to get this coverage back.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

- Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Apex Systems, LLC 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 (teletypewriter) 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 users should call **1-800-325-0778**.

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

DATE:	10/03/2017
SENDER:	Apex Systems, LLC
CONTACT-POSITION/OFFICE:	Janet Turner-Ezell, Director, Benefits
ADDRESS:	5020 Sadler Place, Glen Allen, VA 23060
PHONE NUMBER:	866-612-2739

WOMEN'S HEALTH AND CANCER RIGHTS ACT

This communication is to provide notice as required under the federal Women's Health and Cancer Rights Act, effective October 21, 1998. Please review this information carefully.

As a Plan participant or beneficiary of the Apex Systems, LLC Health Plan, if you or a covered dependent elects breast reconstruction in connection to a mastectomy, coverage will also be provided for:

- reconstruction of the breast on which the mastectomy was performed
- surgery and reconstruction of the other breast to produce symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage will be provided after consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

This notice is provided to you for informational purposes, no action is required on your part.

Please keep this information with your other group health plan documents. If you have any questions regarding this notice, please contact Member Services at the number found on your Medical ID Card.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA (Health Insurance Portability and Accountability Act of 1996) SPECIAL ENROLLMENT RIGHTS

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

LOSS OF OTHER COVERAGE

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment **30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates their employment. If you notify your employer within **30 days** of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

MARRIAGE, BIRTH, or ADOPTION

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

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within **30 days** from the date of your marriage.

MEDICAID or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

PREMIUM ASSISTANCE UNDER MEDICAID and the CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are 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 are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within **60 days** of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. Contact your State for more information on eligibility.

In this column **"Alabama to Missouri"**

ALABAMA – Medicaid
- Website: www.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:
- Website: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARIZONA (not available)

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

CALIFORNIA – Medicaid (not available)

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+: www.colorado.gov/HCPF/Child-Health-Plan-Plus
- CHP+ Customer Service: 1-800-359-1991 / State Relay 711

CONNECTICUT (not available)

DELAWARE (not available)

DISTRICT OF COLUMBIA (not available)

In this column **"Montana to Wyoming"**

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

NEBRASKA – Medicaid
- Website: http://www.ACCESSNebraska.ne.gov
- Phone: (855) 632-7633
- Lincoln: (402) 473-7000
- Omaha: (402) 595-1178

NEVADA – Medicaid
- Medicaid Website: http://dwss.nv.gov/
- Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
- Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
- Phone: 603-271-5218

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 MEXICO (not available)

NEW YORK – Medicaid
- Website: http://www.nyhealth.gov/health_care/medicaid/
- Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
- Website: https://dma.ncdhhs.gov/
- Phone: 919-855-4100

NORTH DAKOTA – Medicaid
- Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
- Phone: 1-844-854-4825

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

GEORGIA – Medicaid
- Website: http://dch.georgia.gov/medicaid
  - *Click on Health Insurance Premium Payment (HIPP)*
- Phone: 404-656-4507

HAWAII (not available)

IDAHO (not available)

ILLINOIS (not available)

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
- Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
- Phone: 1-888-346-9562

KANSAS – Medicaid
- Website: http://www.kdheks.gov/hcf/
- Phone: 1-785-296-3512

KENTUCKY – Medicaid
- Website: http://chfs.ky.gov/dms/default.htm
- Phone: 1-800-635-2570

LOUISIANA – Medicaid
- Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
- Phone: 1-888-695-2447

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

OHIO (not available)

OKLAHOMA – Medicaid and CHIP
- Website: http://www.insureoklahoma.org
- Phone: 1-888-365-3742

OREGON – Medicaid
- Website (1): http://healthcare.oregon.gov/Pages/index.aspx
- Website (2): http://www.oregonhealthcare.gov/index-es.html
- Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
- Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
- Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
- Website: http://www.eohhs.ri.gov/
- Phone: 855-697-4347

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

SOUTH DAKOTA – Medicaid
- Website: http://dss.sd.gov
- Phone: 1-888-828-0059

TENNESSEE (not available)

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

MARYLAND (not available)	**VIRGINIA – Medicaid and CHIP** • Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm • Medicaid Phone: 1-800-432-5924 • CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm • CHIP Phone: 1-855-242-8282
MASSACHUSETTS – Medicaid and CHIP • Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ • Phone: 1-800-862-4840	**WASHINGTON – Medicaid** • Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program • Phone: 1-800-562-3022 ext. 15473
MICHIGAN (not available)	**WEST VIRGINIA – Medicaid** • Website: http://mywvhipp.com/ • Phone: 1-855-MyWVHIPP (1-855-699-8447)
MINNESOTA – Medicaid • Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp • Phone: 1-800-657-3739	**WISCONSIN – Medicaid** • Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf • Phone: 1-800-362-3002
MISSISSIPPI (not available)	**WYOMING – Medicaid** • Website: https://wyequalitycare.acs-inc.com/ • Phone: 307-777-7531
MISSOURI – Medicaid • Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm • Phone: 573-751-2005	

To see if any other states have added a premium assistance program since **August 2017**, or for more information on special enrollment rights, contact either:

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

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

PAPERWORK REDUCTION ACT STATEMENT

According to the **Paperwork Reduction Act of 1995** (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

NOTICE OF HIPAA PRIVACY PRACTICES (effective 9/1/2017)

Your Information. Your Rights. Our Responsibilities.

| Back to CONTENTS

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choice

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services

Our Uses and Disclosure

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

We will never market or sell your information.

If you participate in the United Healthcare PPO plan, you can access your claims payment and information via www.myuhc.com.

Your Health Information

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we will tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we have shared information	• You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to ***200 Independence Avenue, S.W., Washington, D.C. 20201***, calling **1-877-696-6775**, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosure

We typically use or share your health information in the following ways:

Help manage the health care treatment you receive	We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Notice of Availability of HIPAA Privacy Practices

TO:	Participants in the Apex Systems, LLC Group Health Plan
FROM:	Janet Ezell, Benefits Team
SUBJECT:	RE: Availability of Notice of Privacy Practices
MESSAGE:	Apex Systems, LLC Employee Benefits Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Janet Ezell, 866-923-2739.

Continuation Coverage Under COBRA

This notice applies to everyone with healthcare coverage under the Plan. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage.
For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies,
- Your spouse's hours of employment are reduced,
- Your spouse's employment ends for any reason other than his or her gross misconduct,
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both), or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

- **Contractor Care, 866-612-2739, 5020 Sadler Place, Glen Allen, VA 23060**

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- ***Disability extension of 18-month period of COBRA continuation coverage***
  - If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.
- ***Second qualifying event extension of 18-month period of continuation coverage***
  - If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the **Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan)** through what is called a **"special enrollment period."** Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

- **Contractor Care, 866-612-2739, 5020 Sadler Place, Glen Allen, VA 23060**

Notice of Reasonable Alternative Standard for Health-Contingent Wellness Program

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Contractor Care at 866-612-2739, and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires **5-31-2020**)

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 Contractor Care at 866-612-2739.

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.

PLEASE PRINT THE FORM ON THE FOLLOWING PAGE IF YOU DECIDE TO COMPLETE AN APPLICATION FOR COVERAGE IN THE MARKETPLACE.

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
5020 Sadler Place		866-612-2739
7. City	8. State	9. ZIP Code
Glen Allen	VA	23060
10. Who can we contact about employee health coverage at this job?		
Contractor Care Team		
11. Phone number (if different from above)		12. Email address
866-612-2739		contractorcare@apexsystems.com

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

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

☐ ALL EMPLOYEES. Eligible employees are:

☐ SOME EMPLOYEES. Eligible employees are:

☐ With respect to dependents:

☐ We do offer coverage. Eligible dependents are:

☐ We **DO NOT** offer coverage. Eligible dependents are:

☐ 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, www.HealthCare.gov will guide you through the process. If you need additional assistance, please contact Contractor Care at 866-612-2739.

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.

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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?
  - ANSWER: _____ (MM/DD/YYYY)

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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.

- How much would the employee have to pay in premiums for this plan?
  - ANSWER: $_____
  - 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.)
- How much would the employee have to pay in premiums for this plan?
  - ANSWER: $_____
  - How often?
    - ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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* 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)

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General

What plans are offered through the Company?

- **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 United Healthcare 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.
    - **Proof of Dependent Status:** If you are covering a dependent in one of the United Healthcare 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, 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.
- **Dental**
- **NEW! 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**

What are my medical plan options?

You are eligible to participate in the Aetna Fixed Indemnity Medical Plan or the United Healthcare MEC (Minimum Essential Coverage) plans within your first 30 days of employment. After your one month orientation period plus 54 days of employment, you can enroll in one of the United Healthcare Major Medical PPO plans.

How does Healthcare 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, 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.

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.

What is a pre-existing condition and how does coverage differ between healthcare and disability?

Pre-existing conditions are those conditions for which the insured person received diagnosis, care or treatment (to include prescription drugs) within 90 days before that person enrolled in the plan. The healthcare and disability plans differ when considering coverage for pre-existing conditions.

Healthcare: Pre-existing conditions do not apply.

Disability: Pre-existing conditions are not covered under the disability plan. Pre-existing for disability applies to those who have not had the coverage item 365 days prior to entering the new plan. *Pregnancy is considered a pre-existing condition, so electing coverage in advance is important.*

Disability and Life Insurance

What happens if I don't enroll when I am first hired or during this Annual Enrollment period? What is the process?

You can elect short-term disability at any time; however you will be required to answer medical questions. Simply log onto www.benefitsolver.com to elect the coverage. Coverage is subject to approval by CIGNA and pre-existing conditions will apply.

How do pre-existing conditions apply to the Short Term Disability plan?

Any conditions you were treated for **three months prior** to joining the plan are considered pre-existing conditions, and the condition will not be covered for twelve months.

For example, you join the plan **September 1, 2018**. You went to the doctor on **July 15, 2018** and he said you need to have foot surgery on **October 31, 2018**. Your surgery will **not** be covered, as it is considered a pre-existing condition.

However, if you get in a car accident **September 3, 2018**, you will be covered because the injuries from the accident were not a pre-existing condition.

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 $1000 from Cigna's short term disability plan, you need to determine if you can live on $425 a week. Please note that if you elect 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 and need to increase my life insurance, how do I do it?

Simply log onto 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 for dependent life coverage.

Identity Theft Protection

How do I enroll in the Identity Theft Protection Plan?

Simply log on to www.benefitsolver.com and click on the Info Armor link. It will take you out to their website where you can enroll in the coverage and receive the company discounted pricing of **$9.95 per month for individuals** and **$17.95 for family coverage**.

Can the cost of this plan be payroll deducted?

No, you must set up direct payment with **Info Armor**.

Pet Insurance

How do I enroll in the Pet Insurance Plan?

Simply log on to www.benefitsolver.com and click on the FIGO link. It will take you out to their website where you can enroll in the coverage and receive the company discounted pricing.

Can the cost of this plan be payroll deducted?

No, you must set up direct payment with FIGO.

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 Employee Portal for more information.*

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:

- United Healthcare - Health4Me® Mobile App
- CVS Pharmacy – CVS 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

What can you do with these apps?

- Everything you can do on a computer or via the telephone.
- You can pull up a copy of your plan ID card on your phone — in the physician's office.
- Find a participating physician or pharmacy
- Check on your claim or initiate a 401(k) loan and so much more.

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Important Telephone Numbers and Websites

Benefit	Carrier	Website	Phone Number
Accident Insurance or Critical Illness Insurance	Unum	www.unum.com	800-635-5597 800-635-5597 (verify coverage)
Dental Insurance	Delta Dental	www.deltadentalva.com	800-237-6060
Transit Account	Discovery Benefits	www.discoverybenefits.com	866-451-3399
Medical Insurance (Fixed Indemnity)	Aetna	www.aetna.com	888-772-9682
Medical Insurance (PPO)	United Healthcare	www.uhc.com	866-633-2446
Medical Insurance (MEC)	Optum UHC (MEC only)	www.optum.com	800-788-4863
Pharmacy (Major Medical Plan)	Caremark/CVS	www.caremark.com	800-552-8159 800-364-6331 (verify coverage)
Vision Insurance	VSP Vision Care, Inc.	www.vsp.com	800-877-7195
Short Term (STD) and Long Term Disability (LTD)	Cigna	www.cigna.com	800-732-1603 800-362-4462 (claims reporting)
Health Advocacy	Cigna	www.cigna.com	866-799-2725
Identity Theft Protection	Info Armor	www.infoarmor.com/APEXCE	800-789-2720
Pet Insurance	Figo	www.figopetinsurance.com	844-493-4130

Contractor Care Department

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

The information in this guide should in no way be construed as a promise or guarantee of employment or benefit coverage. Pricing, underwriting, plan specifics, and all other product features are solely that of the Insurance Company and not The Company. If there is a conflict between the information in this guide and the actual plan document or policies, the documents or policies will always govern. Complete details about the benefits can be obtained by reviewing current plan descriptions, contracts, certificates, policies and plan documents available from the Contractor Care Team.