cyberThink

Employee Benefits Guide

Unleash your best self: Unlock our Benefits!

2023-24

cyberThink

Questions, Problems or Concerns

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- **For claims assistance** call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- If you require further assistance contact AssuredPartners. cyberThink has partnered with AssuredPartners as our benefits administrator for expert assistance with benefit related questions, plan procedures, life events and claim issues.
- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.

Important Contact Information

Carrier	Group #	Web / Email	Phone
Medical and Prescription Cigna	0614032	www.cigna.com	1-800-997-1654
Health Savings Account Cigna		www.hsabank.com	1-800-357-6246
Dental Cigna	0614032	www.cigna.com	1-800-997-1654
Vision Cigna	0614032	www.cigna.com	1-800-997-1654
Flexible Spending Accounts Paylocity	T22689	https://bat.paylocity.com/	1-800-631-3539
Voluntary Life Insurance New York Life		www.newyorklife.com	1-800-225-5695
Short-Term Disability **Long-Term Disability** New York Life		www.newyorklife.com	1-800-225-5695
Voluntary Accident Insurance **Voluntary Critical Illness Insurance** **Voluntary Hospital Indemnity Insurance** Cigna		www.cigna.com	1-800-997-1654
Employee Assistance Program (EAP) New York Life		www.newyorklife.com	1-800-225-5695
Transportation Benefits Paylocity	T22689	https://bat.paylocity.com/	1-800-631-3539
401(k) Retirement Plan Nationwide		nationwide.com/realtirement	1-800-772-2182
AssuredPartners Benefits Helpline Monday-Friday, 8 am - 5:30 pm ET		cyberThink@AssuredPartners.com	1-888-896-8013 (phone) 410-229-8356 (fax)

Welcome to your Employee Benefits!

cyberThink is pleased to offer a wide range of benefits to its employees and their families. These company sponsored benefits are an important part of a total compensation package. They represent both a valuable asset to our employees and to their families, and demonstrate an investment by cyberThink in our employees. We are proud of our benefits program and are committed to continuously improving the plans that make up our offerings.

This guide was created to answer some of the questions you may have about your benefits. Please read it carefully along with any supplemental materials you receive.

If you have any benefits related questions or concerns, please do not hesitate to call the Employee Benefits Helpline.

Employee Benefits Helpline

1-888-896-8013

cyberThink@AssuredPartners.com

What's Inside

PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). cyberThink reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

Build a Strong Relationship with Your Primary Care Physician

Most doctors went into the practice of medicine so that they could build strong emotional bonds with patients and guide them through health challenges.

Here are 3 tips to building a strong relationship with a new primary care physician, or improving the bond with your current one:

1. **Know what's important to you in a physician.**

   If you're looking for a new doctor, be sure this is someone with whom you will have good interpersonal chemistry, that they're committed to your well-being, and that their office is well organized.

2. **Get your doctor familiar with your health history.**

   Help your doctors to get to know you better by collecting your medical records, writing down your family's health history, and sharing this information with every new physician you meet.

3. **Ask the right questions to build rapport and get on the road to better health.**

   To maximize the time you have together, write down your health questions for your physician beforehand.

Medical Coverage

cyberThink is proud to offer you a choice between four different medical plans. Coverage under all plans includes comprehensive medical care and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle.

Option 1: Open Access Plus Premier

Option 2: Open Access Plus Choice

The first two Open Access Plus plans are Preferred Provider Organizations, or PPO's for short. These plans offer you the freedom to receive care from any provider—in or out of your network.

- ✓ Copays for most services, lower deductible to fulfill
- ✓ Does not require Primary Care Physician (PCP) or specialist referrals
- ✓ Offers out-of-network coverage (although at greater cost to you)

These plans offer first dollar copays for office visits and prescription drugs, while larger medical expenses contribute towards your deductible and coinsurance.

Option 3: Open Access Plus In-Network Only

The Open Access Plus In-Network Only Plan is a Point of Service plan, or a POS for short.

- ✓ Does not require Primary Care Physician (PCP) or specialist referrals
- ✓ In-Network coverage only

Under the In-Network Only Plan, you have 100% coverage for most types of preventative care and have coverage for a variety of specialist visits.

Option 4: HSA Open Access Plus In-Network Only

The HSA Open Access Plus In-Network Only Plan is a High Deductible Health Plan, or a HDHP for short. This plan functions like a Health Maintenance Organization (HMO), but features a lower monthly premium in exchange for a higher deductible.

- ✓ Higher deductible to fulfill before plan pays coinsurance
- ✓ Eligible to use Health Savings Account (more info on page 9)
- ✓ In-Network coverage only

As with a PPO, both you and your family can see any health care provider in the UnitedHealthcare network, including specialists, without a referral. You are not required to choose a primary care physician.

Medical Plan Comparison

	Option 1: **OAP Premier** In-Network, You Pay:	*Option 2:* **OAP Choice** In-Network, You Pay:	*Option 3:* **OAP In-Net** In-Network, You Pay:	*Option 4:* **HSA In-Net** In-Network, You Pay:
Deductible (Individual / Family)	**$0 / $0**	**$1,500 / $3,000**	**$500 / $1,000**	**$2,500 / $5,000**
HSA Eligible?	No	No	No	
Out-Of-Pocket Max (Ind / Family)	$1,000 / $2,000	$3,000 / $6,000	$1,500 / $3,000	$6,450 / $12,900*
Preventive Services Well-Child Care Adult Physical Examination Breast Cancer Screening Pap Test	No charge	No charge	No charge	No charge
Office Visits Primary Care Physician Specialist	 $15 copay $25 copay	 $25 copay $50 copay	 $25 copay $50 copay	 Deductible, then 30% Deductible, then 30%
Laboratory Services Independent Lab Outpatient Facility Advanced Imaging	 No charge No charge No charge	 No charge No charge Deductible, then 10%	 Deductible, then 20% Deductible, then 20% Deductible, then 20%	 Deductible, then 30% Deductible, then 30% Deductible, then 30%
Emergency Services Emergency Room Urgent Care Facility Ambulance	 $100 copay $50 copay No charge	 $100 copay $75 copay Deductible, then 10%	 $100 copay $50 copay Deductible, then 20%	 Deductible, then 30% Deductible, then 30% Deductible, then 30%
Inpatient Care Hospital Facility Services Hospital Physician's Visit	 $250 copay No charge	 Deductible, then 10% Deductible, then 10%	 Deductible, then 20% Deductible, then 20%	 Deductible, then 30% Deductible, then 30%
Outpatient Care Outpatient Facility Services Outpatient Professtional Services Outpatient Therapy Services	 $50 copay No charge $25 copay	 Deductible, then 10% Deductible, then 10% $50 copay	 Deductible, then 20% Deductible, then 20% $50 copay	 Deductible, then 30% Deductible, then 30% Deductible, then 30%
Skilled Nursing Facility	No charge	Deductible, then 10%	Deductible, then 20%	Deductible, then 30%
Durable Medical Equipment	No charge	Deductible, then 10%	Deductible, then 20%	Deductible, then 30%
	Out-of-Network, You Pay:	**Out-of-Network, You Pay:**	**Out-of-Network, You Pay:**	**Out-of-Network, You Pay:**
Deductible (Individual / Family)	$1,000 / $2,000	$3,000 / $6,000	No coverage	No coverage
Out-Of-Pocket Max (Ind / Family)	$2,000 / $4,000	$6,000 / $12,000		
Coinsurance for Most Services	Deductible, then 20%	Deductible, then 30%		

**The Choice HSA Out-of-Pocket Maximum for each individual within a family cannot exceed $6,850 per year for covered services.*

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Prescription Coverage

Your prescription drug benefit is part of your Medical plan and is based on a three-tier drug system. Copayment and/or coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned as one of the three tiers. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to www.cigna.com or by emailing AssuredPartners at cyberThink@AssuredPartners.com.

Medicare Part D

The prescription drug benefit is creditable coverage. Medicare-eligible participants need not enroll in a separate Medicare D drug plan.

Rx Mail Order Program

Save time and money by filling maintenance drugs through the mail order program. The Mail Order Program benefits members who are on long-term medications for chronic conditions such as diabetes, high cholesterol, high blood pressure, depression or asthma. By utilizing the Mail Order Program, you can receive a 90-day supply of medication for the equivalent of 2.5 retail copayments. That's a savings of half a copayment for every 90-day supply.

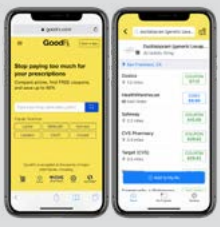
	Option 1: **OAP Premier**	*Option 2:* **OAP Choice**	*Option 3:* **OAP In-Net**	*Option 4:* **Choice HSA**
Prescription Deductible	None	None	None	**Combined w/ Med**
Retail - per 30-day supply				Deductible, then:
Tier 1: Generic	$10 copay	$15 copay	$15 copay	No charge
Tier 2: Preferred Brand	$25 copay	$30 copay	$40 copay	No charge
Tier 3: Non-Preferred Brand	$40 copay	$60 copay	$70 copay	No charge
Mail Order - per 90-day supply				Deductible, then:
Tier 1: Generic	$25 copay	$38 copay	$38 copay	No charge
Tier 2: Preferred Brand	$63 copay	$75 copay	$100 copay	No charge
Tier 3: Non-Preferred Brand	$100 copay	$150 copay	$175 copay	No charge

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Save money with Generic Drugs

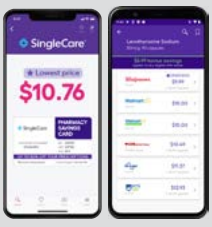
Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. That's because they're held to the same federal standards for safety and performance as the brand names. Because they're not branded, generics can sell for 30 percent to 80 percent less than their brand-name equivalents.

Mobile Apps for Prescription Coupons



GoodRx

Regardless of which plan you decide to enroll in, we encourage you to download and use the GoodRx Mobile App to help you save on your prescription drug costs. GoodRx doesn't sell the medications, they will tell you where you can get the best deal on them. GoodRx will show you prices, coupons, discounts and savings tips for your prescription at pharmacies near you.



SingleCare

SingleCare is a prescription savings card that provides discounts on 10,000+ Rx drugs for a sign-up price of $0. It's always 100% free to use the card. Whether you're insured, underinsured, or uninsured, you qualify for a reduced rate on pharmacy prescriptions with SingleCare, and our accurate drug pricing tool helps you find discounts on thousands of FDA-approved medications.

Health Savings Accounts

Only HSA Open Access Plus Choice In-Network Only Participants are Eligible

If you enroll in the HSA Open Access Plus Choice In-Network Only Plan, you are eligible to open and use a Health Savings Account (HSA). An HSA is a financial account that you can use to accumulate tax-free funds to pay for qualified health care expenses, as defined by the IRS. The account is similar to a traditional savings account with a debit card. The money in the account is owned by you and is fully portable. Funds can accumulate over time and roll over each year. If you use the funds for qualified health care expenses, you will pay no taxes. If you use the money for other expenses, you will pay a tax and a penalty fee.

How You Save With an HSA

As an HSA user, you will save in several ways:

- HSA contributions are not taxed
- You earn tax-free interest on HSA balances
- HSA funds used for qualified medical expenses are not taxed

HSA Funds Remain Yours to Grow

With an HSA, you own the account and all contributions. Unlike flexible spending accounts (FSAs), the entire HSA balance rolls over each year and remains yours even if you change health plans, retire or leave the company.

You Can Win With an HSA

Regardless of your personal medical situation, an HSA can empower you to maximize savings while building a reserve for the future.

Use your HSA for qualified medical expenses

HSA funds can be used for a variety of qualified medical, dental and vision expenses; for yourself, your spouse, and your qualified dependents. Eligible expenses include:

- Birth control
- Chiropractor
- Contact lenses
- Dental treatment
- Prescription eyeglasses
- Hearing aids
- Physical exams
- Prescriptions
- Stop-smoking programs
- Surgery (non-cosmetic)
- Therapy
- Over-the-Counter drugs
- Menstrual care products
- Personal Protective Equipment
- and more...

2024 HSA Annual Contribution Limits

$4,150 for individual coverage

$8,300 for all other coverage tiers

You can choose to contribute to your HSA on a before-tax basis, up to the IRS annual maximums. If you are or will be age 55 or over during the calendar year, you may also make a "catch-up" HSA contribution of an additional $1,000 each year.

Note: As a taxpayer, it is your responsibility to ensure that your HSA contributions do not exceed the maximum possible for your specific tax situation. Please consult your attorney, CPA or tax adviser about your specific tax situation before deferring monies to your Health Savings Account. The benefits of an HSA, who is qualified to have an HSA, etc. can be found in IRS Publication 969, beginning on page 2. https://www.irs.gov/pub/irs-pdf/p969.pdf

Dental Coverage

Option 1: High Dental PPO Plan

Option 2: Low Dental PPO Plan

The Cigna Dental PPO Plans offer you flexibility to see the provider of your choice each time you seek dental care.

Option 3: Dental HMO Plan

As a third option you can enroll in the Dental HMO Plan that offers in-network coverage only and requires designating a primary care provider when enrolling. Find a Cigna network dentist online at www.cigna.com or by calling 1-800-997-1654.

Total Cigna DPPO Options **Network includes Advantage and Cigna DPPO dental networks.**	*Option 1:* **High PPO Plan**	*Option 2:* **Low PPO Plan**
Calendar Year Maximum (Class I, II, III Expenses)	**$1,500**	**$1,000**
Calendar Year Deductible Per Individual / Per Family	$50 / $100	$50 / $100
Class I Expenses - Preventive & Diagnostic Care Oral Exams, Cleanings, Routine X-Rays, Fluoride Application	No charge, deductible waived	No charge, deductible waived
Class II Expenses - Basic Restorative Care Fillings, Simple Extractions, Anesthetics, Root Canal Therapy, Repairs	Deductible, then 20%	Deductible, then 20%
Class III Expenses - Major Restorative Care Crowns, Inlays, Onlays, Dentures, Bridges, Crowns	Deductible, then 50%	Deductible, then 50%
Class IV Expenses - Orthodontia Coverage for Eligible Children Only Lifetime Maximum	Deductible, then 50% $1,500	Deductible, then 50% $1,000

These summaries are not complete and are for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Fee Schedule - In-Network Only **Members must designate a primary care provider when enrolling.**	*Option 3:* **HMO Plan**
Adult cleaning (2/calendar year) - Additional cleanings	$0 $45
Child cleaning (2/calendar year) - Additional cleanings	$0 $35
Periodic oral evaluation	$0
Comprehensive oral evaluation	$0
Fluoride application (2/cal. year) - Additional applications	$0 $15
X-rays – (bitewings) 2 films	$0
X-rays – panoramic film	$0
Amalgam filling (silver colored) – 2 surfaces	$0
Composite filling (tooth – colored) – 1 surface, Anterior	$0
Molar root canal (excluding final restoration)	$250
Comprehensive orthodontic treatment of the adolescent dentition – Banding	$400
Crown – porcelain fused to high noble metal	$185

Vision Coverage

Cigna Vision Plan

To find a Cigna vision provider log into myCigna.com, under "Coverage", select the Vision page. Click on Visit Cigna Vision. Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision – serviced by Eye Med Directory.

	In-Network Plan Coverage	In-Network Member Cost	Out-of-Network Reimbursement
Exam and Professional Services:			
Frequency: once per 12 month			
Eye Exam	100% after $5 Copay	$5 Copay	Up to $45 Allowance
Retinal Screening	$0	Up to $39	Not Covered
Standard Eyeglass Lenses Allowances:			
Frequency: one pair per 12 month			
Lenses:	Copay: $10		Following Allowance:
Single / Bifocal / Trifocal / Lenticular	100%	$10 Copay	$32 / $55 / $65 / $80
Lens Enhancements / Options:			
Oversize lenses	100%	$0	Not Covered
Rose #1 and #2 Solid Tints	100%	$0	Not Covered
Polycarbonate Lenses <19 years of age	100%	$0	Not Covered
Standard Polycarbonate Lenses	$0	$40	Not Covered
Standard Progressives	$0	$65	Not Covered
Plastic Dye Tints	$0	$15	Not Covered
Photochromic – Glass or Plastic	$0	$75	Not Covered
Standard Scratch Coating	$0	$15	Not Covered
Standard Ultraviolet (UV) Coating	$0	$15	Not Covered
Standard Anti-Reflective (AR) Coating	$0	$45	Not Covered
Hi-Index Lenses	$0	20% off retail	Not Covered
All other lens options, including Premium Tiers	$0	20% off retail	
Contact Lenses Retail Allowance:			
Frequency: one pair or single purchase per 12 mo			
Elective	100% up to $150 Retail Allowance	Balance over $150 Allowance	Up to $120 Allowance
Therapeutic	100%	$0	Up to $210 Allowance
Frame Retail Allowance	100% up to $150	20% off balance over	Up to $83 Allowance
Frequency: one per 12 month	Retail Allowance	$150 Allowance	

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Reasons why you should consider Vision Coverage

Having vision benefits can be incredibly useful in various situations, as they help individuals manage their eye health and reduce the financial burden of routine eye care, prescription eyewear, and potential eye-related medical issues. Here are some examples of when having vision benefits would be beneficial:

- **Routine Eye Exams:** Vision benefits cover the cost of regular eye exams, which are crucial for detecting and managing eye conditions like refractive errors as well as monitoring overall eye health.
- **Prescription Glasses:** If you require corrective eyeglasses to improve your vision, our Cigna plan can significantly offset the cost of frames, lenses, and lens enhancements.
- **Contact Lenses:** Whether you use daily, bi-weekly, or monthly contact lenses, vision benefits can help cover the costs of both the lenses and related professional fittings.
- **Screen-related Eye Strain:** With increased screen time from computers, smartphones, and other digital devices, having vision benefits can support the cost of specialized lenses or treatments to reduce digital eye strain.

Flexible Spending Accounts

Eligibility Based on Medical Plan Election

Flexible Spending Accounts (FSA's) offer another way to save money on health care and dependent care expenses. You may submit expenses incurred by any of your dependents, whether or not they are covered by the insurance plans you have through your employer. Employees need not be enrolled in either medical plan to participate in FSAs.

If you enroll, you fund the accounts via a payroll deduction each pay period. Money that you contribute to your FSAs is not subject to social security taxes, federal, and in most cases, state income taxes.

Flexible Spending Account Options		Contribution Limit
Medical FSA	**Federal regulations do not allow participation in an HSA and this type of account.** Eligible health care expenses include many of the out-of-pocket expenses you pay to maintain your health and well-being. These include deductibles and coinsurance expenses not covered by your medical plan, expenses for glasses or contact lenses, and more. For the 2023-2024 plan you will be able to rollover up to $610.	**$3,200 per year**
Dependent Care FSA	**Available to all eligible employees.** You may use pre-tax dollars from your DCFSA to pay expenses for care when the services enable you and your spouse to work outside of the home. These include expenses for the care of a dependent child, spouse or elderly parent inside your home. Also included are baby-sitters, nursery schools, and day care centers. Only the portion of expenses which enable you to remain employed are eligible. Educational expenses are not eligible.	**$5,000 per year** *(Or $2,500 if you are married and file a separate tax return.)*
Limited Purpose FSA	**Available only to those enrolled in an HSA eligible plan.** A Limited Purpose FSA is reserved for employees who are enrolled in a Health Savings Account. This account is to be used on eligible vision and dental expenses only.	**$3,200 per year**
Commuter Benefits	Commuter FSA Accounts reimburse you for travel and parking expenses related to your commute to work. cyberThink offers you two types to enroll in: transit and parking. A transit account reimburses you for expenses like bus, ferry, subway, and vanpooling passes. Tolls and gas are not eligible expenses. A parking account reimburses you for your parking expenses including metered, garage, and lot parking.	**Transit: $315 per month** **Parking: $315 per month**

The FSA Plan Year is is January 1 until December 31. FSA Open Enrollment is held annually in November.

"Use it or lose it" FSA Rollover Provision - HCFSAs only

cyberThink has elected to participate in the FSA rollover provision, allowing employees to rollover up to $610 of unused 2023-24 HCFSA funds to 2024-25. The rollover amount of $610 will not impact the max election limit for 2024-25. The rollover provision applies to participants that enroll in the HCFSA plan for both the 2023-24 and 2024-25 plan years. You are still encouraged to consider your expenses carefully before you decide how much to contribute to each Flexible Spending Account. As a reminder, your election will cover the period from September 1 through August 31. You should not contribute more than you are reasonably certain to use.

Voluntary Life and AD&D Insurance

Affordable Life Insurance Coverage

You may elect life insurance coverage for yourself, your spouse and your dependent children – all at an affordable group rate provided by New York Life. Elect coverage up to the Guaranteed Issue during the initial enrollment period and you will not be required to answer health questions to qualify for coverage. Amounts over the Guaranteed Issue amount will require Evidence of Insurability (EOI).

Employee Voluntary Life/AD&D Insurance

Benefit Amount: increments of $25,000 up to $500,000
Guarantee Issue: $150,000

Spousal Voluntary Life/AD&D Insurance

Benefit Amount: increments of $5,000 up to $100,000
Guarantee Issue: $50,000

Dependent Child Voluntary Life/AD&D Insurance

Benefit Amount: increments of $2,000 up to $10,000
Guarantee Issue: $10,000

Portability Options for Basic & Voluntary Life

Portability is available when an Insured Person's employment terminates for a reason other than sickness or injury or retirement at the Social Security Normal Retirement Age (SSNRA). The Insured Person's coverage must be enforce for at least 12 months in a row just prior to the date employment ends.

This person has the option to continue all or part of his or her insurance enforce when employment ends without Evidence of Insurability. To continue insurance, application and the first premium payment must be made within the time period specified in the policy. Coverage can continue until the earlier of the date the master policy terminates or up to 36 Months.

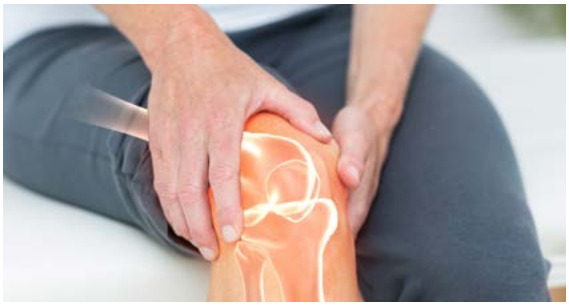
For information on Portability, please contact cyberThink's Benefits Helpline.

Reasons you may want to consider Voluntary Life Insurance

People might consider purchasing voluntary life insurance for a variety of reasons depending on their individual financial, personal, and family situations. Here's a list of common reasons:

- **Higher Coverage:** If the company-paid Basic Life policy doesn't provide sufficient coverage to meet your family's financial needs in the event of your death, you might opt for voluntary coverage to bridge the gap.
- **Debt Coverage:** To cover outstanding debts such as mortgages, loans, and credit card balances.
- **Childcare and Education Expenses:** Parents might purchase supplemental life insurance to cover future education costs.
- **Charitable Giving:** Individuals who wish to leave a charitable legacy might purchase voluntary life insurance to provide a future donation to a chosen charitable organization.

Voluntary Short-Term Disability



To ensure your income will continue if you are unable to work due to a disability that extends for more than 7 consecutive days, cyberThink offers short-term disability (STD) through the New York Life. Benefits are payable for a non-occupational injury or illness that keep you from performing the normal duties of your job. If a medical condition is job-related, it is considered Workers' Compensation rather than STD.

Benefits Start After: 7 days

Benefit Amount: 60% of basic earnings up to $2,000 / week

Benefit Duration: 25 weeks

Voluntary Long-Term Disability

Long-Term Disability (LTD) insurance helps replace a portion of your income if you are disabled for an extended period of time. Eligibility for long-term benefits are generally defined as, due to sickness or accidental injury which you are receiving appropriate care and treatment; are complying with your treatment requirements and unable to earn more than 80% of your predisability earnings.

Benefits Start After: 180 days

Benefit Amount: 50% of predisability monthly earnings up to $10,000 / month

Benefit Duration: The later of your SSNRA* or the Maximum Benefit Period.

**SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date.*

Reasons you may want to consider Voluntary Disability Insurance

Disability insurance is designed to provide income replacement if you're unable to work due to a illness, injury, or medical condition. Here are common reasons why someone might consider purchasing short- or long-term disability insurance:

Short-Term Disability

- **Income Replacement:** Helps replace a portion of your income when you're unable to work due to a covered medical condition.
- **Non-Work-Related Injuries/Illnesses:** Unlike workers' compensation, short-term disability insurance covers injuries or illnesses that occur outside of the workplace.

Long-Term Disability

- **Protection for Chronic Conditions:** Chronic illnesses or medical conditions that require prolonged recovery periods can cause significant financial strain.
- **Serious Injuries:** If you suffer a severe injury that leaves you disabled for an extended duration.

Pre-Existing Condition Limitations

The carrier will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before your most recent effective date of insurance.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after you are covered for at least 12 months after your most recent effective date of insurance, or the effective date of any added or increased benefits.

How to Enroll

AssuredPartners

Open Enrollment Period

cyberThink's annual enrollment period will be held **August 18 through August 31, 2023**.

Log on to the enrollment site to review the benefits being offered, make any plan changes, or update dependent and/or beneficiary information.

Newly Hired/Eligible Employees

New hires and newly elligible employees must complete online enrollment within 45 days of your date of hire. Employee elected coverage will begin following 60 days of employment.

Have social security numbers and birth dates for all dependents and beneficiaries available prior to logging on.

Enrolling In Your Benefits

Please review this guide to gain a full understanding of the plans being offered. Be sure to go online to review your current benefits and make any changes for the upcoming plan year.

https://access.paylocity.com

Enter your Company ID, Username and Password then click Login.

(If you do not remember your Username or Password, click on the Help button, then click on Forgot Company ID, Forgot Username or Forgot Password as applicable.)

Paylocity Company ID: 119875

After Logging In...

- Navigate to **HR & Payroll > bswift Benefits**
- In the Welcome screen, click on **Start Your Enrollment**. Verify your Employee Information and Family Information and click **Continue** after each screen (after you check "I agree" at the bottom).
- From the Enrollment Screen, click either the "I don't want this benefit (waive)" button or the "View Plan Options" button for each of the benefits where a selection is required.
- Choose beneficiary or beneficiaries for each of the benefits listed where applicable.
- Review and Confirm your elections for accuracy, then click on **Complete Enrollment**. The screen will say "Your enrollment is complete!" and give you the option to View or Print your Confirmation Statement, as well as provide instructions on how to upload required dependent verification documents (e.g. Marriage Certificate or Birth Certificates).

Ensure that the pop-up blocker in your browser is disabled in order to use the site properly.

If you need assistance, contact cyberThink at **shilpa@cyberthink.com** or AssuredPartners at **cyberThink@AssuredPartners.com**.

Eligibility

Full-time employees with a regular schedule of **30 hours per week** are eligible for the benefits described in this guide, unless otherwise stated.

When Benefits Become Effective

Coverage for most benefit plans are effective following 60 days of employment. Part-time, seasonal, temporary, internship, and contracted employees are not eligible to participate.

Eligible Dependents

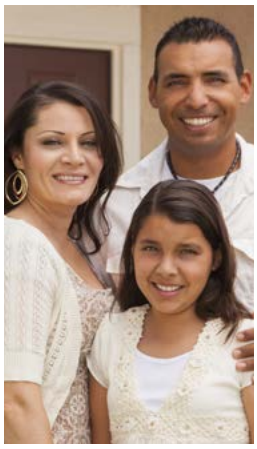
Your dependents are eligible to participate in cyberThink's benefit plans. Your eligible dependents include*:

- A spouse to whom you are legally married.
- A domestic partner.
- A dependent child under age 26. Coverage will terminate at the end of the month of the dependent's 26th birthday. Coverage may be extended past the age of 26 for disabled dependents. Dependent children include natural, adopted children, and stepchildren.

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

**Additional carrier conditions may apply and may vary by state.*

For all benefits you must enroll within 30 days from your date of hire by going to https://access.paylocity.com.



Pre-Tax Benefits: Section 125

cyberThink's benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, vision and flexible spending account coverage on a pre-tax basis. When you use pretax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS' definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election, or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.

You must notify your Benefit Administrator, or visit the bswift Benefits website to create a life event, within 30 days from the life event status change in order to make a change in your benefit selections.

Benefit Changes

The benefit elections you make during open enrollment or as a new hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of health, dental, vision and flexible spending accounts, you will be deemed to have a life event status change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer;
- a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility.

In order to be permitted to make a change of election relating to your health, dental or vision coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right;
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, at its discretion, under applicable law and the plan provisions.

Benefit Changes *continued...*

Event	Action Required	Results If Action Not Taken
New Hire:	Make elections within 30 days of hire date. Documentation is required.	You and your dependents are not eligible until the next annual Open Enrollment.
Marriage:	Your new spouse must be added to your elections within 30 days of the marriage date. A copy of the marriage certificate must be presented.	Your spouse is not eligible until the next annual Open Enrollment period.
Divorce:	The former spouse must be removed within 30 days of the divorce. Proof of the divorce will be required. A copy of the divorce decree must be presented.	Benefits are not available for the divorced spouse and will be recouped if paid erroneously.
Birth or adoption of a child:	The new dependent must be enrolled in your elections within 30 days of the birth and adoption, even if you already have family coverage. A copy of the birth certificate, footprints, or hospital discharge papers must be presented. Once you receive the child's Social Security Number, be sure to contact your HR Department to update your child's insurance information record.	The new dependent will not be covered on your health insurance until the next annual Open Enrollment period.
Death of a spouse or dependent:	Remove the dependent from your elections within 30 days from the date of death. Death certificate must be presented.	You could pay a higher premium than required and you may be overpaying for coverage.
Your spouse gains or loses employment that provides health benefits:	Add or drop health benefits from your elections within 30 days of the event date. A letter from the employer or insurance company must be presented.	You need to wait until the next annual Open Enrollment period to make any change.
Loss of coverage with a spouse:	Change your elections within 30 days from the loss of coverage. A letter from the employer must be provided.	You will be unable to enroll in the benefits until the next annual Open Enrollment period.
Changing from full-time to part-time employment (without benefits) or from part-time to full-time (with benefits):	Change your elections within 30 days from the employment status change in order to receive COBRA information or to enroll in benefits as a full-time employee. Documentation from the employer must be provided.	Benefits may not be available to you or your dependents if you wait to enroll in COBRA. Full-time employees will have to wait until the annual Open Enrollment period.

If you Experience a Life Event Status Change

Log onto **https://access.paylocity.com** to add or drop dependents from your coverage if you experience a life event status change. Your user-name and password will be the same as you used during open enrollment. Click on "Life Events" and a series of easy-to-follow instructions will lead you through the enrollment process.

You must update your elections within 30 days of your life event status change or you will not be able to make changes until the next annual open enrollment. If adding or removing dependents, you are required to submit specific documents to AssuredPartners. The change will be inactive until proper documentation is received and approved. For assistance processing life event status changes, you can or e-mail cyberThink@AssuredPartners.com.

Voluntary Benefits

The following Voluntary Benefits can complement existing medical coverage and help fill financial gaps caused by out-of-pocket expenses such as deductibles, co-payments, and non-covered medical services. Benefits are paid regardless of what is covered by medical insurance. Payments are made directly to you, to spend as you choose.

All three plans are portable (you can continue coverage if you leave the company) and two of the plans includes a wellness benefit.

Accident Insurance

Accident Insurance is designed to help covered individuals meet the out-of-pocket expenses and extra bills that can follow an accidental injury, whether minor or catastrophic. Lump sum benefits are paid directly to you based on the amount of coverage listed in the schedule of benefits. The coverage is guaranteed issue so no health questions are required.

Coverage for accidental injury, minor or catastrophic.

Below are some examples of covered accidents and the Benefit Amount that you will be paid:

Basic Accidental Death:
Loss of Life Acc. Death: $50,000
Automobile Acc. Death: $50,000

Emergency Care Treatment: $200

Physician Office Visit: $100
Includes urgent & virtual care

Hospital Admission: $1,000

Fractured Skull: $8,000 (Surgical)

Fractured Leg: $2,000 (Surgical)

Dislocated Ankle: $2,000 (Surgical)

Small Burns: $300

Large Laceration: $600

Coma: $10,000

Wellness Benefit: $75
Ex. General health exams, certain blood tests, mammography, and more.

Critical Illness Insurance

Critical Illness Insurance is designed to help you offset the financial effects of a catastrophic illness with a lump sum benefit if you are diagnosed with a covered critical illness. The benefit is based on the amount of coverage in effect on the date of diagnosis or the date treatment is received according to the terms and provisions of the policy.

You have the choice of electing coverage of $10,000 or $20,000.

Both amounts are Guaranteed Issue coverage. Your Spouse/Domestic Partner will be offered 50% and child(ren) will be offered 25% of your benefit amount.

Below are some examples of covered critical illnesses and the percent of your elected coverage that you will be paid (Initial Benefit / Recurrence):

Invasive Cancer: 100% / 100%

Skin Cancer: $250 / Not Available

Heart Attack: 100% / 100%

Stroke: 100% / 100%

Coronary Artery Disease: 25% / 25%

Parkinson's Disease: 25% / Not Avail.

Multiple Sclerosis: 25% / Not Avail.

Major Organ Failure: 100% / 100%

Wellness Benefit: $50
Ex. General health exams, certain blood tests, mammography, and more.

Hospital Indemnity Ins.

Hospital Indemnity insurance is designed to help provide financial protection by paying a benefit due to a hospitalization and, in some cases, for treatment received for an accident or sickness, even if that treatment occurs outside the hospital. You may use the benefit to meet the out-of-pocket expenses and extra bills that occur.

Coverage if you are hospitalized, and for some treatments.

Below are some examples of covered incidents and the Benefit Amount that you will be paid:

Hospital Admission: $1,000
No elimination period. Limited to 1 day, 1 benefit(s) every 365 days.

Hospital Chronic Condition Adm: $50
No elimination period. Limited to 1 day, 1 benefit(s) every 90 days.

Hospital Stay: $100 / day
No elimination period. Limited to 30 days, 1 benefit(s) every 90 days.

Hospital ICU Stay: $200 / day
No elimination period. Limited to 30 days, 1 benefit(s) every 90 days.

Hospital Observation Stay: $100 / day
24 hour elimination period. Limited to 72 hours.

For a full list of coverages for each plan and specific benefit information, please refer to the applicable insurance contract.

Voluntary Benefits *continued...*

Reasons you may want to consider Voluntary Benefits

ACCIDENTAL INJURY EXAMPLE: CHLOE

- Fell while playing soccer
- Suffered broken leg and dislocated wrist[1]

Chloe pays $5.43 per paycheck for the employee-only coverage

Expenses not covered by major medical insurance plan2	
Emergency room copay	$100
Deductible	$1,500
Surgery coinsurance	$2,650
Out-of-pocket costs	**$4,250**

Covered benefits paid by Accidental Injury plan	
Doctor's office visit	$100
Diagnostic exam (X-ray)	$75
Broken leg non- surgical	$1,000
Wrist dislocation surgical	$1,600
Physical therapy visits	$500
Benefits paid directly to Chloe	**$3,275**

1. This is an example used for illustrative purposes only and assumes injuries were the direct result of a covered accident. It's not an actual Cigna customer experience. Your actual costs and plan's actual benefit amounts may vary.
2. Refer to Benefit Summary for exclusions, limitations and premiums.

HOSPITAL CARE EXAMPLE: SUSAN

- 48 years old
- Hospitalization: Covered accident[1]

Susan pays $6.77[2] per paycheck for employee only coverage

Expenses not covered by traditional medical insurance plan	
Plan annual out of pocket	$3,000
Indirect expenses	$750
Total out of pocket:	**$3,750**

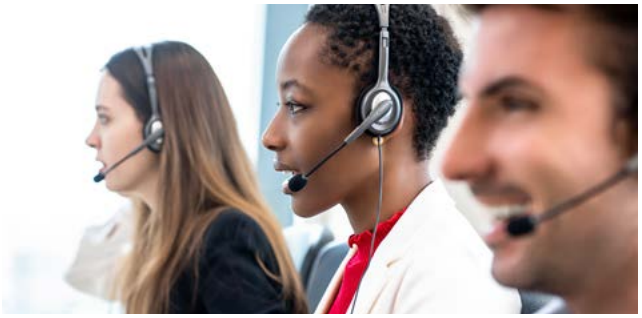
Covered benefits paid by Hospital Care plan[1]	
Hospital admission	$1,000
Hospital ICU stay (1 day)	$200
Hospital stay (3 days)	$300
Benefits paid directly to Susan	**$1,500**

1. This is an example used for illustrative purposes only. It's not an actual Cigna customer experience. Your plan's actual costs and benefit amounts may vary. Refer to your plan materials for the features of your specific plan. To receive benefits, the event must meet the terms and definitions of the policy. Waiting periods and frequency limitations may apply. Subject to all other plan exclusions and limitations.
2. Refer to benefit summary for exclusions, limitations and premiums. See Appendix C for more information.

Value-Added Employee Resources

The following benfits are provided by New York Life AT NO COST to you

Life: just when you think you've got it figured out, along comes a challenge. Whether your needs are big or small, New York Life's resources are there for you with their Employee Assistance, Wellness Support program, Financial Support, and Legal Resources. These benefits can help you and your family find solutions and restore your peace of mind.



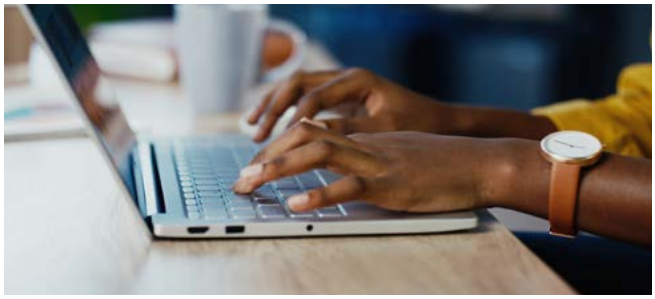
Employee Assistance Program (EAP)	**Are you feeling overwhelmed by the demands of balancing work and family life?** Maybe you have questions about a legal or financial concern. You and your family members now have access to various counseling services including legal, financial, and work-life balance assistance. All counseling calls are answered by a Master's or PhD-level counselor who will collect some general information and will discuss your needs. The EAP provides a maximum of ***three sessions, per issue, per year.***
GuidanceResources	**When you need information quickly to help handle life's challenges,** you can visit guidanceresources.com for resources and tools on topics such as health and wellness, legal regulations, family and relationships, work and education, money and investments, and home and auto. You will also have access to articles, podcasts, videos, slideshows, "Ask the Expert," and more.
Well-Being Coaching	Sometimes you may need help with personal challenges and physical issues that can be overwhelming. To help you achieve your goals, you will have **access to a certified coach** who will work with you, one on one, to address health and well-being issues such as burnout, time management and coping with stress. You have access to ***five sessions per year.*** All sessions are conducted telephonically.
FamilySource	Managing the everyday concerns of home, work and family can be difficult. To help resolve those concerns, you have **access to family care service specialists** that provide customized research, educational materials and prescreened referrals for childcare, adoption, elder care, education, and pet care.
FinancialConnect	Sometimes you may not know where to start when facing a stressful financial challenge or when you need financial planning expertise. With FinancialConnect® you and your family members have **unlimited access to a team of qualified experts** including Certified Public Accountants (CPAs) and other financial professionals to help guide you. In addition, on guidanceresources.com, you will have access to financial information on a wide range of topics including debt management, family budgeting, estate planning and tax planning as well as interactive tools and financial calculators.
LegalConnect	**If you are facing a difficult legal challenge and don't know where to start,** LegalConnect® can help. This program gives you access to unlimited phone consultations with a staff of attorneys who can provide guidance on issues such as divorce, adoption, estate planning, real estate, and identity theft. If needed, you can be referred to a local attorney for a ***free 30-minute consultation*** and a 25 percent reduction in fees thereafter.
EstateGuidance	This user-friendly online tool allows you and your family members to **write a last will and testament, a living will and documents outlining your wishes for final arrangements** quickly, easily and cost effectively. EstateGuidance® walks you through the entire process, guiding your choices with a series of questions and breaking down each step into easy-to-understand terms.

How to Access: Phone: (800) 344-9752 Website: guidanceresources.com Web ID: NYLGBS

Exclusive Employee Discounts

CDW Computer Centers

cyberThink, Inc. and CDW Computer Centers have come together to offer an Employee Purchase Program (EPP) for your personal computing purchases. CDW has extended our company's volume pricing for your personal purchases on any products CDW.com has to offer (more than 70,000 hardware, software, and electronics products).



You can place orders two ways: online and via telephone.

Online:

1. Go to the website www.cdw.com/epp
2. Enter our company's EPP Access Code: **7Y2JE8XB**
3. Fill out the required information to set up an online EPP E-Account.

Each time you go to CDW.com and shop, all you have to do is log on to your E-Account and you will receive cyberThink's special pricing.

By Phone:

1. Call your CDW Account Manager at 1-888-419-7208 and mention your cyberThink's name.
2. You will need to provide our EPP Access Code for proof of employment.

Enterprise Rent-A-Car

We are a member of the Enterprise Rent-A-Car Corporate Class Program. All cyberThink employees and subcontractors are eligible for discounted rates. To be connected to the closest Enterprise office and get rate quotes or reserve a vehicle, call 1-800-RENT-A-CAR and mention Corporate Account Number **24E7540**.

Verizon Wireless

Verizon Wireless offers you discounts on wireless products and services based on your employment with cyberThink. Visit this website for details:

https://www.verizonwireless.com/b2c/employee/eleuLanding.jsp

Plum Benefit, powered by TicketsatWork

We are proud to offer you exclusive discounts and special offers in travel and entertainment, and on must-have products and services that are important to you.

Company Code: ac0627034

Glossary of Terms

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren't complications of pregnancy.

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Grievance: A complaint that you communicate to your health insurer or plan.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.Out-of-Network Co-insurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-payment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network copayments.

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium: The amount that must be paid for your health insurance or plan. You and or your employer usually pay it yearly.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Annual Notices

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in the Company-sponsored health and welfare benefit plan are reminded that the Company's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Company asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Annual Notices *continued...*

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits.

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events 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.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

Health Insurance Marketplace

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families.

PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in cyberThink's medical plan, then PPACA may have little effect on you. cyberThink's medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by cyberThink, you will lose any contribution your employer makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis. (See https://www.healthcare.gov/have-job-based-coverage/).

If you are not eligible to enroll in cyberThink's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered though the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: healthcare.gov).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit healthcare.gov or call 800-318-2596.

cyberThink

Your Benefits Helpline: 888-896-8013 cyberThink@AssuredPartners.com