ALLEGIS GROUP

2022 BENEFIT GUIDE *for* EXTERNAL EMPLOYEES

Aerotek · TEKsystems · Allegis Global Solutions · Major, Lindsey & Africa · MarketSource · Actalent · Aston Carter

The Coverage You Need, the Options You Want. **Enroll Online at www.AllegisMarketplace.com**

PEOPLE. SERVICE. PERFORMANCE.

That is what Allegis Group and our operating companies are all about. One way we recognize our employees' contributions is by offering an extensive benefits package. The Allegis Group benefit program gives access to plans that help you protect the health and security of you and your family.

We realize benefit needs vary from person to person, so we provide a range of plans that let you choose the level of coverage and the combination of benefits you want and need. And, we know the benefits and health insurance marketplace is more confusing than ever. So, we offer our employees The Allegis Marketplace—a one-stop online shopping experience where you can easily compare plans and enroll in coverage. This guide highlights the benefits available to you and explains how to enroll. In this guide, you will find:

YOUR EMPLOYEE BENEFITS-AT-A-GLANCE

WHO IS ELIGIBLE AND HOW TO ENROLL

SUMMARIES OF EACH BENEFIT PLAN

HOW TO LEARN MORE ABOUT EACH PLAN

IMPORTANT INFORMATION ABOUT THE BENEFITS AVAILABLE THROUGH ALLEGIS GROUP

This guide provides a general description of the benefits available to you through Allegis Group. More detailed information about our benefits, including certain legal notices, our plan documents and summary plan descriptions, is also available.

ACCESSING LEGAL NOTICES, PLAN DOCUMENTS AND SUMMARY PLAN DESCRIPTIONS

Important information about your legal rights under the Allegis Group programs can be found online at the Allegis Group benefits website. Our Plan Documents and Summary Plan Descriptions are available in the Documents section of the Resource Center.

SUMMARIES OF BENEFITS AND COVERAGE

Copies of the Summaries of Benefits and Coverage (SBCs) for each of the medical plan options are also available at the Allegis Group Benefits website. As an employee, the medical benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. SBCs help you make an informed choice regarding your medical coverage by summarizing important information about the plan options in a standard format. In doing so, SBCs are designed to help you compare across options.

RIGHT TO FREE PAPER COPIES

You have the right to request a free paper copy of any of the documents described above. You can request these documents by calling the Benefits Service Center at 1-866-886-9798, Monday through Friday 8am to 6pm ET, or sending an email to AskBenefits@allegisgroup.com.

THE ALLEGIS MARKETPLACE IS A ONE-STOP ONLINE SHOPPING EXPERIENCE FOR YOUR BENEFITS.

WE'VE GOT YOU COVERED!

The Allegis Marketplace is a one-stop online shopping experience where you can easily compare plans, rates and coverage options, and enroll in plans.

The Allegis Marketplace provides you with a wide variety of plan options that can be combined together or purchased by themselves so you can build a plan that is right for you and your budget, including:

- A choice of two BlueCross BlueShield Medical Plans
- Hospital Cost Protection Plans
- Critical Illness Protection
- Accident Protection
- Health Savings Account (HSA)
- Dental
- Vision
- Life Insurance and Accidental Death and Dismemberment (AD&D) for you and your family
- Short and Long Term Disability Coverage
- Health Advocacy Services and Health Cost Estimator+™ if you elect either of the two Medical Plans
- Employee Assistance Program (EAP) at no cost to you

ADVANTAGES OF PURCHASING YOUR BENEFITS THROUGH THE ALLEGIS MARKETPLACE

The advantages of purchasing your benefits through the Allegis Marketplace include:

- Savings by paying for your medical, dental and vision premiums with pre-tax dollars
- Convenient premium payment through payroll deduction
- Access to BlueCross BlueShield's national network of preferred providers
- Enhanced customer service through trained Benefits Advisors 1-866-886-9798
- Easy online enrollment at www.AllegisMarketplace.com
- Tax-advantaged savings if you open a Health Savings Account *(High-Deductible Comprehensive Medical Plan only)*
- Potential savings available on individual coverage under the BlueCross BlueShield High-Deductible Comprehensive Medical Plan for those that qualify

BENEFITS AT A GLANCE *for* EXTERNAL EMPLOYEES

MEDICAL & PRESCRIPTION

CAREFIRST BLUECROSS BLUESHIELD | www.CareFirst.com | 1-855-444-3122 | 1-800-241-3371 (CVS Caremark)

Choice of two plans in the National BlueCross and BlueShield PPO network, the Basic Medical plan and the High Deductible Comprehensive Medical plan. Both plans pay 100% for most in-network preventive care services, not subjected to the deductible and offer prescription drug coverage through CVS Caremark. The Basic Medical plan pays 100% of in-network basic services. There is no coverage for major services, specialty medications or out-of-network services. The High Deductible Comprehensive Medical plan pays 80% for most in-network services after the deductible is met and is compatible with the Health Savings Account (HSA).

HEALTH SAVINGS ACCOUNT (HSA)

OPTUM BANK | www.OptumBank.com | 1-844-326-7967

The Health Savings Account (HSA) is a tax-advantage savings account that allows you to put aside pre-tax income to pay for current or future medical expenses. To be eligible to open an HSA, you must be covered by the High Deductible Comprehensive Medical plan.

HOSPITAL COST PROTECTION

SYMETRA | www.Symetra.com | 1-800-497-3699

The Hospital Cost Protection plan pays a daily cash benefit for medical services such as hospitalization, major diagnostic testing, emergency room visits and more, up to the annual maximum. It is designed to be used in combination with your medical plan but coverage can be purchased separately. There are three options available: the Advantage plan pays a maximum benefit of $40,000 per covered person per year; the Advantage Plus plan pays a maximum benefit of $65,000 per covered person per year; and the Advantage Premium plan pays a maximum benefit of $120,000 per covered person per year.

CRITICAL ILLNESS PROTECTION

SYMETRA | www.Symetra.com | 1-800-497-3699

The Critical Illness Protection plan provides a cash benefit if you or a covered family member is diagnosed for the first time with a covered serious medical condition. It is designed to be used in combination with your medical plan but coverage can be purchased separately. There are two options available: $10,000 or $20,000 lump sum benefit.

ACCIDENT PROTECTION

SYMETRA | www.Symetra.com | 1-800-497-3699

The Accident Protection plan pays for medical services related to an accidental injury not incurred at work. The plan pays up to $10,000 per year and will be paid directly to you regardless of any other insurance you have. It is designed to be used in combination with your medical plan but coverage can be purchased separately.

HEALTH COST ESTIMATOR+™

HEALTH ADVOCATE | www.HealthAdvocate.com | 1-866-799-2728 | answers@HealthAdvocate.com

A tool that allows you to compare prices and other information for medical procedures by provider in your area to help you be a more educated health care consumer. Allegis Group pays 100% of the premium and you are automatically enrolled when you enroll a Medical Plan.

HEALTH ADVOCATE SERVICES

HEALTH ADVOCATE | www.HealthAdvocate.com | 1-866-799-2728 | answers@HealthAdvocate.com

Access to a personal Health Advocate, typically a registered nurse, supported by a team of physicians and administrative experts, who will help handle health care and insurance related issues. Allegis Group pays 100% of the premium and you are automatically enrolled when you enroll in a Medical Plan.

EMPLOYEE ASSISTANCE PROGRAM (EAP) & WORK/LIFE PROGRAM

HEALTH ADVOCATE | www.HealthAdvocate.com | 1-866-799-2728 | answers@HealthAdvocate.com

Access to confidential counseling for emotional, legal, financial and other personal issues. Allegis Group pays 100% of the premium and you are automatically enrolled at hire.

DENTAL

METLIFE | www.MetLife.com | 1-800-942-0854

The dental plan provides an option to visit in and out of network providers. The plan pays 100% for preventive and diagnostic careand 50%-80% for other services. The deductible is $50 per person.

VISION

VSP | www.VSP.com | 1-800-877-7195

The vision plan provides an option to visit in and out of network providers. The plan provides eye exams every 12 months and lenses, frames or contacts every 24 months. There are additional interim benefits for lenses and frames.

LIFE INSURANCE

RELIANCE STANDARD LIFE | www.RelianceStandard.com | 1-800-351-7500

The Allegis Group Life Insurance plans let you choose coverage for yourself, your spouse/domestic partner, and dependent children under age 26.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

RELIANCE STANDARD LIFE | www.RelianceStandard.com | 1-800-351-7500

Accidental Death and Dismemberment (AD&D) insurance covers you if you die or suffer serious injury as a result of an accident. You may buy AD&D coverage of up to $500,000 in $10,000 increments. You may also buy family AD&D coverage. For your Spouse/Domestic Partner, the benefit is 60% of your benefit; for dependent children, the benefit is 15% of your benefit.

FMLA

ALLEGIS GROUP | 1-866-886-9798 | Leave_Disability@allegisgroup.com

The company provides Family and Medical Leaves of Absence without pay to eligible employees. Qualified individuals must have worked for the company for at least 12 months in the last seven (7) years, and must also have worked at least 1,250 hours during the 12 months immediately preceding the request. Qualified individuals may be eligible to take up to 12 weeks of unpaid Family and Medical Leave within a rolling 12-month period.

SHORT TERM DISABILITY (STD)

METLIFE | www.MetLife.com | 1-800-438-6388

Short Term Disability is a voluntary benefit that pay benefits if you cannot work due to a sickness or injury that is not work related. The weekly STD benefit is 60% of your pre-disability weekly pay up to a maximum benefit of $600 a week. The cost of coverage is based on your age and weekly benefit amount.

LONG TERM DISABILITY (LTD)

METLIFE | www.MetLife.com | 1-800-438-6388

Long Term Disability is a voluntary benefit that pay benefits if total disability lasts more than 90 days. The monthly LTD benefit is 60% of your pre-disability monthly base pay to a maximum monthly benefit of $5,000.

TRANSPORTATION BENEFITS

OPTUM BANK | www.OptumBank.com | 1-844-326-7967

Transportation Benefits from Optum Bank allow you to use pre-tax payroll dollars to pay for qualified parking and transit expenses.

EMPLOYEE DISCOUNT PROGRAM

ABENITY | www.Abenity.com

Through Abenity, Allegis Group offers an extensive collection of discounts, created internally and from select vendors.

AUTO & HOME INSURANCE

FARMERS | 1-800-438-6381

Auto & Home is a voluntary group benefit program offering special group rates and policy discounts for personal insurance coverage needs.

401(K) PLAN

PRINCIPAL | www.Principal.com | 1-800-547-7754

Save up to $19,500 of your income for the calendar year. There are a wide range of investment options.

ALL EMPLOYEES WORKING AT LEAST 20 HOURS A WEEK ARE ELIGIBLE FOR BENEFITS.

ELIGIBILITY

All employee's working at least 20 hours a week are eligible for benefits. The following individuals are also eligible:

SPOUSE

A spouse is an individual who is recognized as the Employee's spouse under applicable state law, excluding, however, a common law spouse.

DOMESTIC PARTNER

Same-sex and opposite-sex couples who have registered with any state or local government agency authorized by state or local law to perform such registrations. In other words, you must have filed with the authorized agency and the agency must maintain a record of your domestic partnership.

A civil union partner is neither a spouse nor a domestic partner, unless otherwise registered on a state or local government agency's domestic partnership registry.

Allegis Group may request documentation of relationships, including marriage certificates, domestic partner registry certificates, and birth certificates. Any requirements for proof of relationship for domestic partnerships are also applied to marriages. For example, domestic partner registry certificates are recognized as fully equivalent to marriage certificates.

If you are adding a dependent with a last name that is different than yours, you will be required to provide proof of relationship, such as a birth certificate or adoption certificate.

CHILD

A child who is under the age of 26 or is permanently and totally disabled *(and meets the eligibility requirements described below)*; and is related to you in one of the following ways:

- You or your spouse's or domestic partner's child by birth or legal adoption;
- Under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration, and who resides with, and is the dependent of you or your spouse or domestic partner;
- A child who is the subject of a Medical Child Support Order or a Qualified Medical Support Order that creates or recognizes the right of the child to receive benefits under a parent's health insurance coverage;
- A grandchild who is in the court-ordered custody, and who resides with, and is the dependent of you or your spouse or domestic partner.

Children whose relationship to you is not listed above, including, but not limited to, grandchildren (except as provided above), foster children or children whose only relationship is one of legal guardianship (except as provided above) are not eligible, even though the child may live with you and be dependent upon you for support.

Employee contributions for health care coverage are generally taken on a pre-tax basis. However, according to federal law, employee benefit contributions for domestic partners who are not tax dependents as defined by the Internal Revenue Code, and children of domestic partners who are not tax dependents of the employee as defined by the Internal Revenue Code cannot be provided tax-free.

If you and your spouse both work for Allegis Group and its operating companies, each family member—you, your spouse, and your eligible children—can be covered only once for medical, dental and vision. One of you can enroll in a plan and cover all eligible children, and the other can waive coverage, or you can both enroll. Children cannot be covered by each parent separately.

DISABLED CHILDREN

Coverage may be available for your disabled child who is over age 26, provided the child is financially dependent on you, is unmarried and was enrolled in the plan prior to attaining age 26. If you have an over age disabled dependent child, documentation of the disability may be required to continue coverage under the Plan.

Enrolling an individual that is not eligible for Allegis Group's plans is a fraudulent act and could result in disciplinary action up to and including termination.

WHEN BENEFITS BEGIN

Your benefit coverage begins on the first of the month following or coinciding with your date of hire *(your "Effective Date")* if you are on active service. Active service means you are doing your regular duties in the usual manner on a scheduled work day at one of the places of business where you normally work or where your work sends you. Coverage for your dependents begins when yours does, unless you add them to your coverage later. You have until the last day of the month in which your coverage is effective to enroll for benefits and you will be responsible for all missed premiums.

	EXAMPLE 1	EXAMPLE 2
DATE OF HIRE	**March 4, 2022**	**August 1, 2022**
DATE COVERAGE BEGINS	**April 1, 2022**	**August 1, 2022**
ENROLL BY DATE	**Midnight, April 30, 2022**	**Midnight, August 31, 2022**

Please keep in mind, you pay for benefits through weekly payroll deductions and if you miss deductions, payment will automatically be made up with double deductions. Please see the "Paying for Your Benefits" section of the guide for more detailed information.

WWW.ALLEGISMARKETPLACE.COM HELPS YOU TO CHOOSE BENEFITS THAT WILL WORK BEST FOR YOU AND YOUR FAMILY.

HOW TO ENROLL

Enroll Online at www.AllegisMarketplace.com, an online benefits service that puts benefits information and enrollment at your fingertips 24 hours a day, seven days a week. www.AllegisMarketplace.com lets you look at your personal benefits record, including current coverage, dependents, and costs. You can also find details about all the available plans, so you can choose benefits that will work best for you and your family. In addition:

- You ***do not*** have to fill out a paper enrollment form.
- www.AllegisMarketplace.com is private, secure, and accessible from any computer, anywhere, anytime.
- You can enroll online and print a confirmation.
- You can print a Temporary Benefit Confirmation to present to your providers in the event you have not received your ID cards.
- You can access www.AllegisMarketplace.com after the enrollment period whenever you have questions about your benefits.

If you do not have web access, please contact the Benefits Service Center at 1-866-886-9798 for a paper application. You may fax your enrollment form and all other forms to the Benefits Service Center at 410-785-1637. If you have questions, you may contact the Benefits Service Center at 1-866-886-9798 and speak with a Benefits Advisor.

LOGGING ON TO WWW.ALLEGISMARKETPLACE.COM

KELLY provides administrative services for your benefit plans. In addition, the KELLY Total Benefits Solution (KTBSonline) provides you an integrated technology solution and resource to access your benefits information any time throughout the year.

FIRST TIME USERS

- Go to www.AllegisMarketplace.com. *We recommend using the most recent version of Internet Explorer, Firefox, Safari or Chrome.*
- When prompted, enter your Last Name, Date of Birth, social security number and complete the reCAPTCHA.
- To confirm registration, you will be asked to verify your personal information. If the information is not correct please call the Benefits Center at 1-866-886-9798.
- Follow the directions provided on the site to complete your registration and setup your online account.
- Once registration is complete, click the green *Enroll Now* button to proceed to your Open Enrollment Elections. Follow the directions provided on the site to complete your Open Enrollment Elections.

RETURNING USERS

- Go to www.AllegisMarketplace.com. *We recommend using the most recent version of Internet Explorer, Firefox, Safari or Chrome.*
- Enter your Username and Password in the Login box on the right of your screen. Click *Login*.
- Click the green *Enroll Now* button to proceed to your Open Enrollment Elections. Follow the directions provided on the site to complete your Open Enrollment Elections.

LOGIN HELP/REGISTER FEATURES

Forgot Password

The link will provide you with either the option to enter the email address that is currently on file for your account or the option to enter your date of birth and social security number. Either option will allow for the login information to be sent to your current email address on file.

Register

- If you don't have an email address on file, click *Register Now*.
- When prompted, enter your Last Name, Date of Birth, and your Social Security Number. For security purposes you will also be asked to type a randomly generated security code. Click *Continue*.
- You will be asked to enter your previously saved security question as you have already been identified as having a login for your account. Click *Continue*.
- If at this point, you do not know your security answer, please contact Tech Support at 1-844-221-1600.
- At this time you may update your username, password and/or security question.

THE ENROLLMENT PROCESS

Once you log in, just follow these steps:

1. REVIEW YOUR PERSONAL INFORMATION

- Demographic *(if you need to make changes, you may do so at this screen. If you need to change a field you do not have access to, please contact the Benefits Service Center at* 1-866-886-9798*).*
- Employment information *(if this information is incorrect, please contact the Benefits Service Center at* 1-866-886-9798*).*
- Dependent Review *(to add or remove a dependent, you should do so from this screen).* **Please note, adding a dependent here does not enroll them in benefits. You must add them to each plan you wish to enroll them in.**

2. REVIEW ALL BENEFIT OPTIONS

3. ELECT YOUR BENEFITS OR WAIVE THOSE YOU DO NOT WISH TO ELECT

When doing so, choose your coverage level (Employee, Employee & Spouse/Domestic Partner, Employee & Children, Family) or waive coverage. If you choose coverage other than employee only, you must add your other covered members to the plan.

- Medical
- Health Savings Account (HSA) contributions – *if eligible*
  - Elect to open an HSA or elect to waive it. *(You should only waive it if you are waiving medical coverage. If you waive the HSA, no company contributions will be received.)*
  - If you elect to open an HSA, your contribution maximums are based on the coverage level you choose for your medical plan *(Employee, Employee & Spouse/Domestic Partner, Employee & Children, Family).*
  - Enter your annual Health Savings Account contribution amount.
  - Read the HSA Adoption Agreement and Investment Options info and select "I Accept" or I Decline" Please note, if you select "I Decline" your HSA will not be opened.
- Hospital Cost Protection Plans
- Critical Illness Protection
- Accident Protection
- Dental
- Vision
- Life Insurance *(if you enroll outside your eligibility period or increase your existing coverage, you are subject to approval)*
- AD&D
- Short Term Disability (STD)
- Long Term Disability (LTD)

4. REVIEW THE ENROLLMENT USER ACKNOWLEDGMENT TO COMPLETE THE PROCESS

5. PRINT YOUR ONLINE ENROLLMENT ELECTION FORM

We recommend you keep a copy for your records.

6. PLEASE VERIFY AND UPDATE YOUR EMAIL ADDRESS

TAKING THE TIME TO DESIGNATE OR UPDATE YOUR BENEFICIARIES CAN ELIMINATE MANY CHALLENGES FOR YOUR FAMILY.

BENEFICIARIES

Many people overlook and underestimate the importance of designating a beneficiary. In many cases, people don't designate a beneficiary at all, and in other cases, the information is outdated. Taking the time to designate or update your beneficiaries today can eliminate many challenges for your family in the event of your death.

HOW TO DESIGNATE OR UPDATE YOUR BENEFICIARIES

The following benefits require a beneficiary. Below are step-by-step instructions on how to check and update your beneficiaries.

Life Insurance and AD&D

» Log on to www.AllegisMarketplace.com.

» Click on the *My Benefits & Personal Information* tab at the top of the page.

» Under the Benefits Section on the left side of the page, click *Beneficiaries*.

401(k)

» Log on to www.principal.com.

» Click on *Overview*.

» Click on *Beneficiaries*.

» Click on *Add or Edit Beneficiaries*.

Health Savings Account (HSA)

» Log on to www.OptumBank.com.

» Click on *Manage Profile* at the bottom of the page.

» Click on *Beneficiary Designation* to complete your beneficiary information.

FOR QUESTIONS ABOUT BENEFITS OR ENROLLMENT, CALL THE BENEFITS SERVICE CENTER AT **1-866-886-9798**.

BENEFIT IDENTIFICATION (ID) CARDS

Your medical and hospital cost protection plan ID cards will arrive at your home approximately three weeks from the time your enrollment is received by the carrier. You will not receive ID cards for the critical illness, accident, dental and vision plans, as Symetra, MetLife and VSP do not require you to have an ID card for these plans. You may print a Temporary Benefit Confirmation if you have not received your medical ID card or if you would prefer to have your dental and vision information on hand when you visit your provider. To print your Temporary Benefit Confirmation, log on to the Allegis Benefits website and select the *My Benefits & Personal Information* tab at the top of the Homepage. Under the Benefits section, select *Temporary Benefits Confirmation*.

IF YOU DO NOT ENROLL

If you do not enroll during your initial eligibility period, (generally 30 days from your Effective Date), you cannot enroll or make changes to your coverage under the following plans until the next Open Enrollment period, unless you have a qualifying status change (described later in the guide): medical/prescription, hospital cost protection plans, critical illness protection, accident protection, dental and vision. You may enroll for short-term disability, long-term disability, life and/or AD&D insurance at any time, but you must complete the Evidence of Insurability (EOI) questionnaire if you do not elect during your initial eligibility period.

IF YOU DO NOT HAVE WEB ACCESS

If you do not have web access, you may complete a paper enrollment. To obtain a paper enrollment form, please contact the Benefits Service Center at 1-866-886-9798. You may fax your completed forms to the Benefits Department at 410-785-1637, inter-office the forms to: Allegis Group Benefits Department, Mail Stop- AG-29, or mail them to: Allegis Group Benefits Department, 7320 Parkway Drive, Hanover, MD 21076.

FOR QUESTIONS ABOUT PAYING FOR YOUR BENEFITS, CALL THE BENEFITS SERVICE CENTER AT **1-866-886-9798**.

PAYING FOR YOUR BENEFITS

Under Section 125 of the Internal Revenue Code, you may not change or cancel pre-tax benefits unless you incur a qualifying status change, described later in this guide.

Your contributions to your Health Savings Account (if applicable), and your premiums for Medical/Prescription, Hospital Cost Protection Plans, Critical Illness, Accident, Dental, and Vision coverage will be deducted from your paycheck on a pre-tax basis. Participation in these plans reduces your taxable income and may affect other compensation-based benefits such as life, disability, and Social Security. However, according to federal law, premiums for a Domestic Partner and his/her respective child(ren) cannot be paid on a pre-tax basis unless the Domestic Partner or child qualifies as your dependent as defined under the Internal Revenue Code.

In addition, if you are covering Domestic Partners and their children who do not qualify as your tax dependents as defined under the Internal Revenue Code, you will also be required to pay income taxes on the value of any contributions we made as the employer towards coverage for your non-federally recognized Domestic Partners and their children. State-specific withholding rules may also apply.

401(k) contributions are made on a pre-tax basis (unless you elect to make after-tax Roth 401(k) contributions). Deductions for Voluntary Life and AD&D insurance are made post-tax.

You pay for benefits through weekly payroll deductions. Please keep in mind that weekly payroll deductions begin the first full week of benefit coverage. If you enroll in benefits but wait until the latter part of the month in which your coverage first becomes effective, your benefits will still begin on the first of the month and you will be responsible for all missed premiums via double deductions in subsequent weeks. You must pay for your benefits every week, regardless of how often you use them.

Once you are enrolled if you miss any premium deductions it will generate an arrears balance. This balance will be deducted in full from your next available payroll check. You can call the benefits department to see if a payment plan option is available to you.

Your election remains in place for the year unless you experience a qualifying event.

You are still responsible for paying for your benefits even if you are out on a leave of absence (for example, FMLA, Short Term Disability, Worker Compensation, etc.). Please call the Benefit Service Center at 1-866-886-9798 to discuss paying for your benefits during this time.

PERSONALIZED COVERAGE THAT WORKS FOR YOU...

Allegis Group offers a variety of plans that you can choose separately or combine to create coverage that works for you. Our comprehensive benefits program features:

- **Two Medical Plans**—Provide access to the National BlueCross and BlueShield network of providers. Choose either the Basic option or the High Deductible Comprehensive option.
- **Three Hospital Cost Protection Plans**—Supplemental plans that pay you cash for covered hospital services.
- **Critical Illness Protection**—Provides cash benefits in the event that you or a family member is diagnosed for the first time with a covered serious medical condition.
- **Accident Protection**—Provides cash benefits for medical services related to a covered accidental injury not incurred at work.
- **Health Savings Account (HSA)**—Available in conjunction with the High Deductible Comprehensive Medical Plan option, a tax-advantaged savings account that allows you to put aside pre-tax income for eligible medical expenses.
- **Dental, Vision, Disability and Life Insurance Plans**— Provides you with the coverage you need at the price you can afford.

MEDICAL COVERAGE

Since everyone's health care needs are different, we offer a variety of plans so you can customize your own coverage. By enrolling in a BlueCross BlueShield Medical Plan, you can have medical and prescription coverage and access to BlueCross BlueShield's national network of providers.

To learn more about how to personalize your medical coverage, call a Benefits Advisor at 1-866-886-9798, Monday through Friday, 8 am–6 pm EST or visit www.AllegisMarketplace.com.

HOW TO BUILD PERSONALIZED MEDICAL COVERAGE

I NEED...	Basic Medical Plan	High Deductible Comprehensive Plan	Hospital Cost Protection	Critical Illness Protection	Accident Protection
A budget friendly, basic medical plan with no up-front deductible and no copays, without hospitalization coverage	✓				
A comprehensive medical plan with no annual or lifetime limits		✓			
A budget friendly, basic medical plan with no up-front deductible AND additional cash reimbursement for hospitalization expenses	✓		✓	✓	✓
A comprehensive medical plan with no annual or lifetime limits AND additional cash reimbursement for out-of-pocket expenses *(like deductibles)*		✓	✓	✓	✓
Options to provide me with cash reimbursements even though I have coverage elsewhere *(through an exchange, spouse's plan, parental coverage, etc.)*			✓	✓	✓

YOU HAVE A CHOICE OF TWO MEDICAL PLANS THAT GIVE YOU ACCESS TO THE BLUECROSS BLUESHIELD NETWORK OF PROVIDERS.

BLUECROSS BLUESHIELD MEDICAL PLANS

You have a choice of two plans—the Basic Medical Plan and the High Deductible Comprehensive Medical Plan. Both give you access to the BlueCross BlueShield nationwide network of providers and prescription drug coverage through CVS/caremark.

The High Deductible Comprehensive Medical Plan allows you to choose to go in-network or out-of-network for care. Using in-network providers will cost you less. If you use a doctor outside the network (a "non-preferred provider"), your costs will usually be higher. If you live in an area with no network providers, benefits will be paid at the in-network levels, but network discounts will not apply. Percentages of remaining charges you pay are based on *Negotiated Charges* in-network and *Recognized Charges* out-of-network. A provider outside the network may require that you pay more than the Recognized Charge, and this additional amount would be your responsibility. For a network provider near you, visit www.AllegisMarketplace.com for a direct link to the BlueCross BlueShield website or go to www.BCBS.com.

Below are some highlights of the BlueCross BlueShield medical plans. For a full description of covered services and exclusions, please see the Evidence of Coverage document available online at www.AllegisMarketplace.com. For additional information or questions, contact a Benefits Advisor at 1-866-886-9798.

Since the High Deductible Comprehensive Medical Plan is affordable under the Affordable Care Act (ACA), you will not qualify for a tax credit or subsidy if you purchase health insurance through Federal or State run exchanges.

COORDINATION OF BENEFITS

IRS regulations specify you (and your spouse/domestic partner, if you have family coverage and wish to contribute to an HSA) generally cannot have any other health coverage if you are enrolled in the High Deductible Comprehensive Medical Plan. However, you can have additional insurance that provides benefits for the following items:

- Liabilities incurred under workers' compensation laws, tort liabilities, or liabilities related to ownership or use of property;
- A specific disease or illness;
- A fixed amount per day (or other period) of hospitalization.

You can also have coverage (whether provided through insurance or otherwise) for the following items:

- Accidents
- Disability
- Dental care
- Vision care
- Long-term care

BLUECROSS BLUESHIELD BASIC MEDICAL PLAN SUMMARY

BENEFITS	IN-NETWORK
CALENDAR YEAR DEDUCTIBLE	
Individual *(medical and prescription combined)*	$0
Family *(medical and prescription combined)*	$0
CALENDAR YEAR OUT OF POCKET MAXIMUM	
Individual	$0
Family	$0
LIFETIME MAXIMUM BENEFIT	None
PREVENTIVE CARE	
Well Child Care *(including exams/immunizations)*	$0
Routine Physical Exam *(including routine GYN)*	$0
Breast Cancer Screening	$0
Pap Test	$0
Prostate and Colorectal Cancer Screening	$0
OFFICE VISITS FOR ILLNESS *(physician and specialist)*	$0
OUTPATIENT LAB WORK	Covered at 100%
X-RAY/DIAGNOSTIC IMAGING *(e.g. MRI)*	Not covered
EMERGENCY CARE & URGENT CARE	
Urgent Care Center	$0
Emergency Room *(facility services)*	Not covered
Emergency Room *(physician services)*	Not covered
Ambulance *(if medically necessary)*	Not covered
HOSPITALIZATION	
Inpatient/Outpatient Facility Services	Not covered
Outpatient Physician Services	Not covered
Inpatient Physician Services	Not covered
MATERNITY	
Preventive Prenatal/Postnatal Office Visits	$0
Delivery/Facility Services; Nursery Care of Newborn	Not covered
MENTAL HEALTH & SUBSTANCE ABUSE	
Inpatient/Outpatient Facility Services	Not covered
Outpatient Physician Services	Not covered
Inpatient Physician Services	Not covered
PRESCRIPTION DRUGS	
Tier 1: Generic	$0
Tier 2: Preferred Brand	$0
Tier 3: Non-Preferred Brand	100% of Allowed Wholesale Price
Tier 4: Preferred Specialty	Not covered
Tier 5: Non Preferred Specialty	Not covered

This summary is for descriptive purposes only. It is not an agreement or contract. Further information can be found in the applicable plan documents. The content of this chart is for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern.

The Basic Medical Plan does not provide the minimum creditable coverage that adults who file taxes in Massachusetts need to have in order to avoid penalties. Employees residing in Massachusetts who select the Basic Medical Plan may be subject to penalties.

For more information, including how services are covered when you use out-of-network providers, or to learn more about how to personalize your medical coverage, visit www.AllegisMarketplace.com or call a Benefits Advisor at 1-866-886-9798, Monday through Friday, 8 am–6 pm EST.

BLUECROSS BLUESHIELD HIGH DEDUCTIBLE COMPREHENSIVE MEDICAL PLAN SUMMARY

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE		
Individual *(medical and prescription combined)*	$5,000	$10,000
Family *(medical and prescription combined)*	$10,000	$20,000
CALENDAR YEAR OUT OF POCKET MAXIMUM		
Individual	$6,550	$13,100
Family	$13,100	$26,200
LIFETIME MAXIMUM BENEFIT	None	None
PREVENTIVE CARE		
Well Child Care *(including exams/immunizations)*	$0	50% of AB
Routine Physical Exam *(including routine GYN)*	$0	100%*, then 50% of AB
Breast Cancer Screening	$0	50% of AB
Pap Test	$0	100%*, then 50% of AB
Prostate and Colorectal Cancer Screening	$0	100%*, then 50% of AB
OFFICE VISITS FOR ILLNESS *(physician and specialist)*	100%*, then $40 copay per visit	100%*, then 50% of AB
OUTPATIENT LAB WORK	100%*, then $40 copay per visit	100%*, then 50% of AB
X-RAY/DIAGNOSTIC IMAGING *(e.g. MRI)*	100%*, then $40 copay per visit	100%*, then 50% of AB
EMERGENCY CARE & URGENT CARE		
Urgent Care Center	100%*, then $50 copay per visit	100%*, then $50 copay per visit
Emergency Room *(facility services)*	100%*, then $250 copay per visit	100%*, then $250 copay per visit
Emergency Room *(physician services)*	No charge after deductible	No charge after in-network deductible
Ambulance *(if medically necessary)*	100%*, then 20% of AB	100%*, then 20% of AB
HOSPITALIZATION		
Inpatient/Outpatient Facility Services	100%*, then 20% of AB	100%*, then 50% of AB
Outpatient Physician Services	100%*, then $40 copay per visit	100%*, then 50% of AB
Inpatient Physician Services	100%*, then 20% of AB	100%*, then 50% of AB
MATERNITY		
Preventive Prenatal/Postnatal Office Visits	$0	100%*, then 50% of AB
Delivery/Facility Services; Nursery Care of Newborn	100%*, then 20% of AB	100%*, then 50% of AB
MENTAL HEALTH & SUBSTANCE ABUSE		
Inpatient/Outpatient Facility Services	100%*, then 20% of AB	100%*, then 50% of AB
Outpatient Physician Services	100%*, then $40 copay per visit	100%*, then 50% of AB
Inpatient Physician Services	100%*, then 20% of AB	100%*, then 50% of AB
PRESCRIPTION DRUGS		
Tier 1: Generic	100% until deductible is met, then $15 copay	
Tier 2: Preferred Brand	100% until deductible is met, then $35 copay	
Tier 3: Non-Preferred Brand	100% until deductible is met, then $60 copay	
Tier 4: Preferred Specialty	100% until deductible is met, then $35 copay	
Tier 5: Non Preferred Specialty	100% until deductible is met, then $60 copay	

*AB=Allowed Benefit. *Until Deductible is met.*
This summary is for descriptive purposes only. It is not an agreement or contract. Further information can be found in the applicable plan documents.
The content of this chart is for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern.

For more information, including how services are covered when you use out-of-network providers, or to learn more about how to personalize your medical coverage, visit www.AllegisMarketplace.com or call a Benefits Advisor at 1-866-886-9798, Monday through Friday, 8 am–6 pm EST.

YOUR BENEFIT INCLUDES A MANDATORY GENERIC REQUIREMENT TO HELP MANAGE THE COST OF PRESCRIPTION DRUGS.

MANDATORY GENERIC REQUIREMENT

Your prescription benefit includes a mandatory generic drug requirement, which allows for substitution of brand-name drugs with generic drugs as a way to help you manage the costs associated with prescription drugs.

WHAT YOU NEED TO KNOW ABOUT GENERIC DRUGS

Making informed choices about utilizing generic drugs, when available, can help save you money. Generic drugs are equally safe and effective as brand-name drugs, but cost significantly less. The U.S. Food and Drug Administration defines a generic drug to be identical to a brand-name drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use.

WHAT YOU NEED TO KNOW ABOUT MANDATORY GENERIC DRUG SUBSTITUTION

If you receive a prescription for a brand-name drug, it will be substituted with a generic equivalent. If no generic equivalent exists, the brand-name drug will be dispensed. In both cases, you are only responsible for the applicable copayment or coinsurance.

You or your physician may request a brand-name drug when a generic equivalent is available, but you will have to pay the applicable copayment or coinsurance, plus the price difference between the brand-name drug and the generic drug, unless your physician proves medical necessity for the brand-name drug.

If your physician writes "brand only" or "dispense as written" on a prescription, it does not qualify as medical necessity. In this case, the pharmacist will be required to dispense the brand-name drug and you will still have to pay the cost differential when a generic equivalent is available.

We encourage you to talk to your provider to consider changing your prescription from a brand-name drug to a generic option.

If your provider indicates that there is a medical necessity for you to remain on the brand-name drug rather than an available generic, your provider may submit a brand exception request. If the brand exception request is approved, you are only responsible for the applicable copayment or coinsurance for the brand-name drug. To obtain the brand exception request form, log in to *My Account* at **www.CareFirst.com/myaccount** and click on *Drug & Pharmacy Resources* under Quick Links and then click on *My Drug Forms* or call CareFirst Pharmacy Services at **1-800-241-3371**.

Please note, Preferred and Non-Preferred Specialty prescriptions are not covered under the Basic Medical Plan.

FILLING PRESCRIPTIONS

Allegis Group has a partnership with CVS/caremark and through that partnership is able to negotiate better rates on maintenance drugs for our employees. This will require you to fill prescriptions for certain medications at a CVS pharmacy or by mail order, as explained below.

If you fill prescriptions of maintenance drugs at a pharmacy other than CVS (such as Rite Aid, Walgreens, etc.), our plan will not cover the cost, meaning the prescription cost will not be at the discounted CVS price nor will the amount you pay count toward your deductible.

THROUGH A PARTICIPATING RETAIL PHARMACY

For non-maintenance drugs, you can choose to have your prescriptions filled at any in-network pharmacy. A non-maintenance drug is a drug you do not take on a regular, ongoing basis (such as antibiotics). CVS/caremark, has a wide network of participating pharmacies throughout the country. To locate participating pharmacies including CVS and other in-network pharmacies (e.g., Walmart, Target, and Walgreens), visit **www.AllegisMarketplace.com** for a direct link to the CVS/caremark website through **www.CareFirst.com**, or call **1-800-241-3371**.

THROUGH MAIL ORDER

You can choose to have your ***non-maintenance medications*** filled through the CVS mail order program. You must either fill your prescription for ***maintenance medications*** through a local retail CVS pharmacy or through the CVS mail order program. A maintenance medication is a medication that is prescribed for long-term conditions and are taken on a regular, recurring basis. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma, and diabetes.

Members can sign up for mail order four ways:

- Doctor Call-In: *You can tell your doctor to either call CVS/caremark's mail order program at* **1-800-378-5697** *(then press Option 3) or e-fax them the prescription at* **1-800-378-0323**. *If you need the medication quickly, the doctor call-in is the fastest method.*
- By Phone: *Call CVS Customer Care at* **1-800-241-3371** *(this is also the toll-free number for Pharmacy on the back of your CareFirst member ID card). A CVS/caremark representative will walk you through the full process to set up your mail order prescriptions. Once you provide the representative with the necessary information, CVS/caremark can contact your doctor directly regarding your prescription(s).*
- Mail: *If you already have a paper prescription from the doctor, you can mail it to CVS/caremark along with a completed Mail Service Order Form. You can access a Mail Order form through My Account, under My Coverage, Drug and Pharmacy Resources, My Drug Home, Order Prescriptions, then Forms for Print.*
- Online: *You can open an online account by going to* **www.CareFirst.com**. *Under Already a Member?, click on Register Now to create your account. Once registered, go to My Coverage, Drug and Pharmacy Resources, My Drug Home. You will then be able to submit the new prescription online. You will need the exact name of the medication, as well as your doctor's name. CVS will then contact your doctor for you to fill the prescription through mail order. If CVS is unable to reach your doctor after four attempts, they will reach out to you.*

MY CAREFIRST ACCOUNT

My CareFirst Account gives you online access to your Allegis Group health insurance information. Once you set up your secure, password-protected online account, you will be able to:

- View real-time information on your claims and out of pocket costs online.
- Check your deductible and out-of-pocket costs for your current and previous plan year.
- Review up to one year of medical claims—total charges, benefits paid, and costs for a specific date range.
- Select a drug and the prescribed dosage to find out the exact dollar amount you will pay at the particular pharmacy.
- View a side-by-side comparison of costs at local pharmacies.
- Find out potential savings of a generic drug.
- Plan for surgeries and other procedures by comparing outcomes and other quality measures for nearby hospitals.

HOW TO SET UP MY CAREFIRST ACCOUNT

- Go to www.AllegisMarketplace.com or www.CareFirst.com/myaccount. Click *Register*.
- Enter your Member ID, found on your BlueCross BlueShield member ID card. *(You may also use your Social Security number to register if you have provided it to CareFirst previously).*
- Enter your first name, last name and date of birth, relationship to policy holder, and your gender. Click *Continue* to set up your User ID and Password.

ACCESS AND MANAGE YOUR PRESCRIPTION DRUGS

- Go to www.CareFirst.com and log in. Click on *My Coverage, Drug and Pharmacy Resources, My Drug Home*.
- Once you open the online account, you will be able to view your prescription information and manage your prescriptions through the mail order program.
- Once you have accessed your online account, the website will provide instructions regarding the various tools you have available to manage your prescriptions.

HOW TO REDUCE MEDICATION COSTS

Here are simple steps you can take to help lower your prescription drug costs:

- Request generic prescriptions whenever available and be on the lookout for alternatives. New medicines become available often, so the price of your prescription may rise or fall as a result.
- Go to www.CareFirst.com/myaccount. In the prescription drug section of this helpful website, you can look up medicines using the online database. You can also use the price comparison tool to learn more about the costs associated with the medicines you may be taking.
- Talk with your doctor. Review the medicines you are taking with your physician and ask if there are more affordable alternatives that may be right for you.
- Use a participating pharmacy. There are more than 59,000 participating pharmacies nationwide that accept your prescription drug card. Choose one that is convenient, but remember to shop around. Some pharmacies charge more than others. Use CVS retail pharmacies or CVS mail order for all maintenance drugs.
- Do not forget your benefit card. Take your BlueCross BlueShield card to a participating pharmacy near you to help ensure you receive proper service.

MEDICAL & PRESCRIPTION PLAN PREMIUMS

COVERAGE LEVEL	EMPLOYEE	EMPLOYEE & SPOUSE/ DOMESTIC PARTNER	EMPLOYEE & CHILD(REN)	FAMILY
BASIC PLAN	$49.62	$89.92	$81.86	$138.28
HIGH DEDUCTIBLE PLAN	$103.09	$220.33	$169.41	$316.29

PPO TERMS YOU SHOULD KNOW

In-Network and Out-of-Network: In-network benefits provide the highest level of plan coverage. This means you have the most coverage at the lowest cost when you choose a doctor participating in the BlueCross BlueShield PPO network.

When you go to providers outside of the PPO network, you pay more of the cost of your healthcare in return for greater flexibility. However, you are responsible for 100% of additional amounts an out-of network provider may bill above the allowed benefit (AB).

Using the BlueCross BlueShield PPO Network: BlueCross BlueShield PPO Preferred Providers are doctors, hospitals, and other healthcare providers who have contracted with BlueCross BlueShield (BCBS). They have agreed to honor your membership card and bill BCBS directly for services rendered. You benefit by using network providers because your out-of-pocket costs are kept to a minimum. To find a PPO provider, visit www.BCBS.com, or call 1-800-810-2583.

Deductible: By law, deductibles under a CDHP plan work differently than under traditional PPO plans. Under a CDHP plan, you must incur the entire deductible in claims before the plan pays benefits. Once the deductible is met, CareFirst BlueCross BlueShield will begin to pay benefits at the coinsurance level for in-network services. The employee responsibility known as coinsurance.

Out-of-Pocket Maximum: Once you reach your out-of-pocket maximum BlueCross BlueShield will pay 100% of the allowed benefit for most covered services for the remainder of the year. After you have met your deductible, the coinsurance you pay for medical and prescription services counts toward your out-of-pocket maximum. The in-network out-of-pocket maximum includes deductible and co-insurance.

Coinsurance: Coinsurance is the amount you pay for most other services after you meet your deductible. It is a percentage of the BlueCross BlueShield discounted rate for the service.

Preventive Care: There is an old saying that, "an ounce of prevention is worth a pound of cure." That is why Allegis Group covers the cost of most preventive care at 100% and these expenses are not charged against your deductible. Eligible preventive care services include well-child visits, annual adult physicals and GYN visits including PAP smear, mammogram, and prostate cancer screening.

OTHER PPO FEATURES

No Referrals: BlueCross BlueShield's PPO coverage offers referral-free, self-directed choices. This means you will not need to select a Primary Care Physician (PCP) and you will have the peace of mind to receive healthcare when you need it, by a doctor with whom you are comfortable.

HEALTH SAVINGS ACCOUNT (HSA)

WHO CAN HAVE AN HSA?

To be eligible to open an HSA, you must be covered by a qualified high deductible health plan such as the Allegis Group BlueCross BlueShield High Deductible Comprehensive Medical Plan. You are not eligible if:

- You can be claimed as a tax dependent of another individual;
- You are currently enrolled in any Medicare coverage including parts A & B; or
- You have medical plan coverage other than a high deductible health plan, including secondary coverage under your spouse/domestic partner's plan. There cannot be coordination of benefits with another plan.
- You have coverage under a spouse or parent's Health Care Flexible Spending Account *(a Health Care FSA)*.

WHAT IS AN HSA?

An HSA is a tax-advantaged savings account that allows you to put aside pre-tax income, invest your savings, and use your tax-free savings for eligible medical expenses. Unlike other medical savings accounts, any money you do not use stays in your account.

An HSA helps you save for health care expenses over your lifetime. If you use the account to pay for eligible medical expenses, *(a list can be found at* www.irs.gov/pub/irs-pdf/p502.pdf*)*, you will not have to pay federal income taxes on your savings. You may choose to use the funds for ineligible expenses, but you will be taxed on the amount, and if you are under age 65, you will also be subject to an additional 20% tax penalty. *(Please note you may want to keep your receipts for IRS purposes)*.

In addition to being an excellent way to put money aside for current expenses, an HSA is a tax-free way to save for future expenses— such as the need to cover retiree health premiums *(excluding Medicare Supplement plans)* or to pay for uncovered healthcare expenses at some time in the future.

Your HSA is your personal account and is entirely portable. This means if you leave Allegis Group, you can take the account with you. Allegis Group has partnered with Optum to manage your Health Savings Account. Once you set up your HSA, you will receive a Welcome Package from Optum *(which will include your Healthcare Payment card)*, quarterly Health Savings Account statements and other information pertaining to your HSA.

You may contribute to your HSA through pre-tax payroll deductions or through post-tax contributions of your own *(you will set this up directly with Optum)*, up to the amount allowed by the IRS. If you choose to contribute through post-tax contributions, you will adjust your gross income when filing your income tax return the following year.

It is important to note although some expenses are eligible for reimbursement from your HSA, they may not count toward your annual deductible or annual out-of-pocket maximum (such as certain over-the-counter medications or long term care insurance premiums). For additional information about eligible and ineligible expenses, please refer to IRS Publication 502 www.irs.gov/pub/irs-pdf/p502.pdf.

HSA CONTRIBUTIONS

You determine how much you want to contribute to your HSA on an annual basis however you must contribute at least $260 per year *($5 per pay)*. You may contribute up to the following IRS maximums:

▸ HSA ANNUAL PRE-TAX CONTRIBUTIONS

COVERAGE LEVEL	EMPLOYEE	EMPLOYEE & SPOUSE/ DOMESTIC PARTNER	EMPLOYEE & CHILD(REN)	FAMILY
CONTRIBUTION	$3,650	$7,300	$7,300	$7,300

If you are age 55 or older, you are also eligible to make an additional contribution of $1,000 to your HSA by logging into your account at www.OptumBank.com. From the main dashboard page, click on *Make a Deposit* and follow the prompts to make a deposit from the bank account of your choosing. Call Optum customer service at 1-844-326-7967 if you have questions or need assistance.

STATES NOT RECOGNIZING THE TAX-FREE STATUS OF HSA CONTRIBUTIONS

While the pre-tax contributions to your HSA made through payroll always provide tax savings on the federal level, the following states do not currently recognize those contributions for state income tax purposes. Please note, this is the most current list at the time this guide was created.

- California
- New Jersey

HOW TO SET UP YOUR HSA

You will set up your HSA with Optum Bank via **www.AllegisMarketplace.com** at the time you enroll in the BlueCross BlueShield High Deductible Comprehensive Medical Plan. After enrolling in your medical benefits, you will be asked to enter an annual election amount you wish to contribute to your HSA. Once you complete this step, choose your other benefits and submit your enrollment, your information will be sent to Optum and your HSA will be established.

There is a $3.50 monthly administrative fee that will be deducted from your HSA, however the fee is waived when your account reaches a balance of $5,000 or more.

HSA CHANGES

You may change your HSA contributions at any time during the year by logging on to **www.AllegisMarketplace.com**. A voluntary HSA contribution change will take effect on the following week's paycheck.

ACCOUNT BALANCE

Depending on your health care expenses in a given year, you may not need to use all of the funds in your HSA. In this event, the remaining balance in your HSA will be available for your use in future years.

INTEREST AND EARNINGS ON YOUR ACCOUNT BALANCE

Initially, the contributions made by you through payroll are deposited into an FDIC Insured interest bearing account.

Once your account balance reaches a certain amount as determined by Optum, you may choose to invest your HSA savings in a variety of mutual funds. Please keep in mind mutual funds carry a certain level of risk and return. You should consult a financial advisor when making investment decisions.

Optum Bank will assesses account holders a fee of $1.50 per quarter for paper statements. *(The $1.50 fee covers the cost to produce and mail the statement)*. Please note, Optum Bank does provide electronic statements at no charge. We are encouraging account holders who still receive paper statements to switch their delivery preference to electronic delivery. Electronic delivery is a more secure method of providing statements, it supports environmental sustainability and, again, is provided at no charge to the account holder. It should be noted that Optum Bank automatically enrolls individuals in electronic statements if an email address is provided with their enrollment.

HOSPITAL COST PROTECTION

Hospital Cost Protection, offered by Symetra, are designed to supplement your medical plan, but can also be purchased on a stand-alone basis. The plans can also supplement other medical plans, such as a spouse's medical plan.

Hospital Cost Protection pays a fixed daily cash benefit directly to you to help you offset the cost of medical services such as hospitalization, major diagnostic testing, emergency room visits, and more, up to the shared and annual allowed maximums *(see details below)*. Coverage is "guaranteed issue", which means you cannot be denied coverage, regardless of current or prior personal or family health history. While the plans work well together, Hospital Cost Protection does not coordinate benefits with the medical plans and are purchased separately.

WHY ENROLL IN HOSPITAL COST PROTECTION?

» **First Dollar Benefits:** This plan pays cash benefits without making you satisfy a deductible first.

» **Enrollment Guaranteed:** No doctor exam required and you can't be turned down during open enrollment.

» **Easy to Use:** The plan pays regardless of any other insurance coverage you may have.

HOSPITAL COST PROTECTION OPTIONS

PLANS	ADVANTAGE		ADVANTAGE PLUS		ADVANTAGE PREMIUM	
ANNUAL BENEFIT MAX PER PERSON	$40,000		$65,000		$120,000	
SERVICES	**BENEFIT**	**MAX**	**BENEFIT**	**MAX**	**BENEFIT**	**MAX**
HOSPITAL ADMISSION *(3 admissions max)*	$2,000		$2,500		$3,000	
HOSPITAL STAY[1]						
Regular Room or Substance Abuse Facility	$1,200/day	✓	$2,500/day	✓	$3,000/day	✓
ICU	$2,400/day	✓	$5,000/day	✓	$6,000/day	✓
Mental Health	$600/day	✓	$1,250/day	✓	$1,500/day	✓
POST-HOSPITAL NURSING FACILITY[2]	$600/day	✓	$1,250/day	✓	$1,500/day	✓
OUTPATIENT DIAGNOSTICS						
X-Ray and Lab Class "A"	$300/day	✓	$300/day	✓	$350/day	✓
X-Ray and Lab Class "B"	$30/day	✓	$30/day	✓	$30/day	✓
EMERGENCY ROOM	$150/day	✓	$300/day	$900	$500/day	$1,500
SURGERY *(one benefit per day max)*						
Outpatient Doctor's Visit	$90		$85	✓	$90	✓
Outpatient Surgical Facility	$1,600	$3,000*	$1,250	✓	$1,600	✓
Inpatient Hospital	$2,500		$3,000	✓	$4,000	✓
SURGICAL ANESTHESIA	25%	$750	$300/day		$550/day	
DOCTOR OFFICE VISITS	$85/day	$680	$100/day	✓	$100/day	✓
OUTPATIENT SURGICAL FACILITY	$300/day	✓	$500/day	$1,000	$500/day	$1,500
AMBULANCE TRANSPORTATION						
Ground Transport	$750/day	5 days combined*	$1,000/day	5 days combined*	$1,000/day	5 days combined*
Air Transport	$1,500/day		$2,000/day		$2,000/day	

✓ *These services count towards the plan's Shared Annual Benefit Maximum*

All benefits are per covered person per calendar year. *Calendar year maximum per person. 1) 500 days per lifetime maximum except that mental health facility stay is limited to 180 days lifetime maximum. 2) This benefit is paid only if following a covered hospital stay of at least 3 consecutive days and the insured is under age 65. This summary is for descriptive purposes only. It is not an agreement or contract. Further information can be found in the applicable contract.
Due to state regulations, Hospital Cost Protection is not available to employees who live in New Hampshire.
The content of this chart is for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern.

HOSPITAL COST PROTECTION PREMIUMS

COVERAGE LEVEL	EMPLOYEE	EMPLOYEE & SPOUSE/ DOMESTIC PARTNER	EMPLOYEE & CHILD(REN)	FAMILY
ADVANTAGE	$28.96	$61.71	$47.47	$85.92
ADVANTAGE PLUS	$39.60	$84.39	$64.92	$117.50
ADVANTAGE PREMIUM	$56.57	$120.56	$92.74	$167.85

CRITICAL ILLNESS PROTECTION PROVIDES A LUMP SUM PAYMENT UPON THE DIAGNOSIS OF A COVERED CONDITION.

CRITICAL ILLNESS PROTECTION

Critical Illness Protection, offered by Symetra, provides a lump sum payment upon the first diagnosis of a covered condition once coverage takes effect for the individual. Covered critical illness conditions are grouped into benefit categories. The benefit is payable once for a specific covered critical illness, up to 100% of the benefit amount payable for each category of covered critical illness. You may elect $10,000 or $20,000 worth of coverage for yourself and your spouse/domestic partner, and the benefit is always 100% of the lump sum benefit you enrolled for. Benefits for children are 25% of the adult benefit.

CATEGORY 1	CATEGORY 2*	CATEGORY 3*	CATEGORY 4
100% Invasive Cancer	**100%** Heart Attack Stroke	**100%** Coma or Paralysis due to accident Occupational HIV Infection Loss of Sight, Speech or Hearing Major Organ Failure End-Stage Renal Failure Severe Burn	**100%** Advanced Alzheimer's Disease Amyotrophic Lateral Sclerosis Motor Neuron Diseases Multiple Sclerosis Parkinson's Disease
25% Minor Cancer	**25%** Coronary Artery Disease Needing Surgery Angioplasty		

Category 2 benefits are limited for residents of New Hampshire due to state regulations. Category 3 benefits are limited for residents of Washington state, Montana and New Hampshire due to state regulations. Refer to the policy for more information. The content of this chart is for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern.

Critical Illness Protection can be purchased separately, or it can be purchased in combination with your medical plan, providing a lump sum cash benefit to help with out-of-pocket costs and unforeseen expenses. The benefits of Critical Illness Protection include:

- Helps you have money for deductibles, copays, lost income, experimental treatment, spousal income.
- Benefits are paid directly to you in addition to the major medical insurance you may already have in place.
- With this policy, each category condition is independent. For example, if you have a stroke while covered and a year later you are diagnosed with invasive cancer, you may get paid the full benefit amount twice. *Pre-existing conditions and other limitations apply.*
- Payroll deductions are taken pre-tax and paid benefits are not taxed *(except for domestic partners)*.

CRITICAL ILLNESS PROTECTION PLAN PREMIUMS

COVERAGE LEVEL	EMPLOYEE	EMPLOYEE & SPOUSE/ DOMESTIC PARTNER	EMPLOYEE & CHILD(REN)	FAMILY
$10,000 (OPTION 1)	$4.07	$8.13	$5.43	$9.50
$20,000 (OPTION 2)	$8.13	$16.28	$10.86	$18.99

ACCIDENT PROTECTION PAYS FOR MEDICAL SERVICES RELATED TO ACCIDENTAL INJURIES NOT INCURRED AT WORK.

ACCIDENT PROTECTION

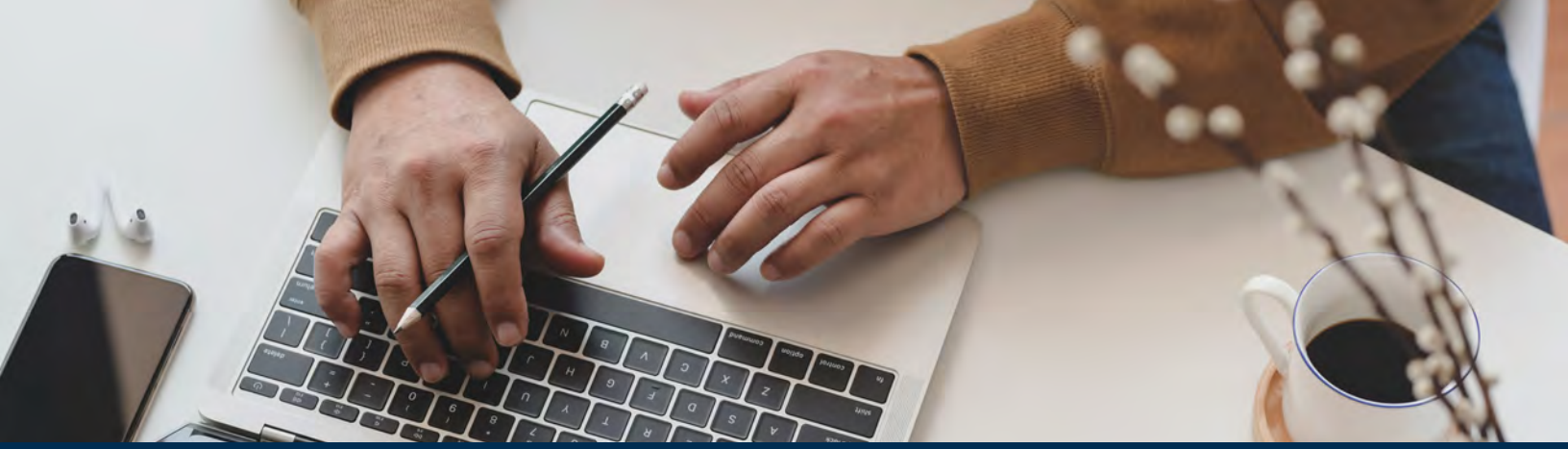
Accident Protection, offered by Symetra, pays for medical services related to an accidental injury not incurred at work *(up to three per calendar year per covered person)*. The plan covers any type of accident and pays your actual billed expenses up to the maximum plan benefit of $10,000 per year. Accident Protection can be purchased separately, or in combination with your medical plan, providing a lump sum cash benefit to help with out-of-pocket costs and unforeseen expenses.

Due to state regulations, Accident Protection is not available to employees who live in New Hampshire.

For more information on the plans, rates, and how to select what's best for you, visit the Allegis Group benefits website or contact a Benefits Advisor at 1-866-886-9798.

▸ ACCIDENT PROTECTION PLAN PREMIUMS

COVERAGE LEVEL	EMPLOYEE	EMPLOYEE & SPOUSE/ DOMESTIC PARTNER	EMPLOYEE & CHILD(REN)	FAMILY
$10,000 BENEFIT	$8.51	$18.14	$13.95	$25.26



HEALTH COST ESTIMATOR+™, A PRICING TRANSPARENCY SOLUTION, HELPS YOU SHOP AROUND FOR CARE.

HEALTH COST ESTIMATOR+™

Healthcare is an important purchase, and knowing how much you will pay before you get care can save you a lot of money. Health Cost Estimator+™, offered by Health Advocate, is a tool that allows you to compare prices for medical procedures by provider in your area to help you be a more educated healthcare consumer. Health Cost Estimator+™ not only provides you the ability to shop around and compare costs for medical procedures and services, but you can also review quality scores and patient reviews for hospitals, doctors and care centers—giving you the power to choose before you get care.

You can access Health Cost Estimator+™ by downloading the mobile app on your phone or tablet, visiting the Health Advocate member website, www.HealthAdvocate.com/members, or by calling a Personal Health Advocate at 1-866-799-2728.

Employees who participate in the Medical Plan are eligible to use the Health Cost Estimator +™ and Allegis Group will provide this benefit at no cost to you. You will be automatically enrolled when you enroll in the medical plan.

HEALTH ADVOCATE PROVIDES ONE-ON-ONE ASSISTANCE TO HELP NAVIGATE THE HEALTH CARE WORLD.

HEALTH ADVOCATE SERVICES

Health Advocate, the nation's leading health advocacy company, provides confidential, personalized, one-on-one assistance to you and eligible family members to help navigate many aspects of the health care world. You will have access to a Personal Health Advocate, typically a registered nurse, supported by a team of physicians and administrative experts, who will help in handling healthcare and insurance related issues. Eligible family members who can use Health Advocate include you, your spouse, your domestic partner, your children, children of domestic partners, your parents, and your spouse's parents.

TOP 10 REASONS TO CALL HEALTH ADVOCATE

- Finding the best doctors, hospitals, dentists, and other leading healthcare providers anywhere in the country. This includes locating providers in your health insurance plan's network.
- Scheduling appointments with providers including hard to reach specialists and critical care providers and arranging for specialized treatments and tests.
- Helping to resolve insurance claims and assisting with negotiating billing and payment arrangements, and related administrative issues.
- Working with our insurance companies to obtain appropriate approvals for needed services often fostering communications between physicians and insurance companies.
- Assisting with eldercare and related healthcare issues facing your parents and parents-in-law. They work with Medicare and other government insurance programs and help make arrangements following discharge from a hospital for in-home or needed institutional service.
- Answering questions about test results, treatment recommendations and medications recommended or prescribed by your physician.
- Obtaining unbiased health information to help make an informed decision.
- Assisting in the transfer of medical records, x-rays and lab results.
- Locating and researching the newest treatments for a medical condition.
- Assisting with finding qualified wellness programs, providers and services.

To utilize Health Advocate, simply call 1-866-799-2728 or email answers@HealthAdvocate.com. When you request service, you will be asked to complete a Medical Information Release Form. Please be assured Health Advocate will keep all information strictly confidential and will protect your privacy. For more information about the company and services, visit www.HealthAdvocate.com.

If eligible, you will be automatically enrolled. Allegis Group will provide this benefit at no cost to you.

THE EAP & WORK/LIFE PROGRAM IS DESIGNED TO HELP YOU LEAD A HAPPIER AND MORE PRODUCTIVE LIFE AT HOME AND AT WORK.

EAP & WORK/LIFE PROGRAM

WHAT IS THE EAP AND WORK/LIFE PROGRAM?

The Employee Assistance Program (EAP) and Work/Life program is designed to help you lead a happier and more productive life at home and at work. Balancing the needs of work, family and personal responsibilities isn't always easy. This program offers the right support at the right time.

WHAT DOES IT DO?

The EAP and Work/Life program provides a professional counselor or work life specialist to listen and;

- Help define the problem clearly,
- Assess the type of help needed, and
- Either provide the required help or make the most appropriate, cost-effective referral for you.

Your counselor can address:

- Stress, depression, anxiety
- Marital relationships, family/parenting issues
- Work conflicts
- Anger, grief and loss
- Drug and alcohol abuse

Work/Life Specialist can assist with:

- Eldercare, childcare, in-home care
- Legal, financial issues
- Summer camps
- Time management
- Parenting and Adoption
- Pet sitting

Simply call 1-866-799-2728 or visit online at www.HealthAdvocate.com/members to access EAP or Work/Life services. The EAP and Work/Life program is available to you, your spouse, your domestic partner, and dependent children at no cost to you.

HOW LONG DOES COVERAGE LAST?

Termination or Reduction in Hours

You, your spouse or domestic partner, and your dependent children remain eligible for the EAP and Work/Life program for 18 months after termination of your employment or a reduction in your hours of employment to below 20 hours a week. If you or a family member is determined by Social Security to be disabled and you notify Allegis Group in a timely fashion, all of your family may be covered by the EAP and Work/Life program for up to an additional 11 months of coverage, for a maximum of 29 months from your termination or reduction in hours. The disability must have started at some time before the 61st day after your termination of employment or reduction of hours and must last at least until the end of the original 18-month period that would have been available without the disability extension.

The disability extension is available only if you notify Allegis Group in writing of the Social Security Administration's determination of disability within 60 days after the latest of the date: (1) of the Social Security Administration's disability determination and (2) the end of the 18-month period after your termination of employment or reduction in hours.

If your family experiences a second qualifying event, your spouse or domestic partner, and dependent children, may be covered by the EAP and Work/Life Program for up to 36 months from your termination or reduction in hours, if Allegis Group is notified in writing *(as specified below)* about the second qualifying event.

This second qualifying event extension may be available to your spouse or domestic partner and any dependent child if, during the original 18-month period of continued coverage after your termination of employment or reduction in hours, you: (1) die; (2) get divorced or terminate your domestic partnership; or (3) if your child no longer qualifies as a dependent.

Your Death

Your spouse or domestic partner, and your dependent children, remain eligible for the EAP and Work/Life program for 36 months from your death if you die while working for Allegis Group at least 20 hours a week.

Divorce or Child Losing Dependent Status

If you experience a divorce or a termination of your domestic partnership, or a dependent child losing eligibility for coverage as a dependent child, you must notify Allegis Group in writing *(as specified below)* within 60 days after the later of the event. If timely notice is provided, then your former spouse or domestic partner, and child(ren), as applicable, will be entitled to extended coverage under the EAP and the Work/Life Program for 36 months from the event.

All notices required under this section must be made in writing to: Allegis Group, Inc. Benefits Service Center, 1 Kelly Way, Sparks, MD 21152. Tel: 1-866-886-9798 | Fax: 410-785-1637.

DENTAL BENEFITS

The MetLife dental plan covers preventive, basic, and major dental services and supplies. Generally, when you receive care from a MetLife participating dentist, your out-of-pocket expenses will be lower than if you receive services from a non-participating dentist. To find a participating dentist, visit www.MetLife.com/dental.

MYBENEFITS BY METLIFE

MyBenefits by MetLife is a secure, online portal that enables you to manage your MetLife dental benefits quickly and easily from your own desktop. At the MyBenefits website, what you need is in one place—so you can manage your dental benefits in less time than ever before. With MyBenefits, you can:

- View, manage and gain a better understanding of your dental benefits
- Review recent claims
- Elect to receive automatic e-mail alerts when there are updates to your dental claims
- Access information on oral health news
- Locate an in-network dentist

You also have access to:

- A home page with access to personalized information which highlights the benefits available to you, and gives you quick links to other valuable tools
- Special message boxes with timely benefits information
- A *My Account* section that gives you a quick snapshot of your benefit options and activities

You can access MyBenefits directly from the Allegis Group benefits website by selecting the *MyBenefits by MetLife* link located on the left side of your home page or go to www.MetLife.com/mybenefits. When you sign in to MyBenefits, enter *Allegis Group* in the box where it says *Enter Your Company Name*.

The following chart provides highlights of some covered services. For a full description of covered services and exclusions, please see the detailed plan description provided on the Allegis Group benefits website.

DENTAL BENEFITS SUMMARY

BENEFITS	IN-NETWORK*	OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE	**$50 per person**	**$50 per person**
ANNUAL MAXIMUM BENEFIT	**$1,000 per person**	**$1,000 per person**
TYPE A PREVENTIVE CARE SERVICES **Exams and Cleanings (once every 6 months)**	**Plan pays 100%* (No deductible)**	**Plan pays 100%** (No deductible)**
TYPE B BASIC RESTORATIVE SERVICES **X-rays, Fillings, Minor Oral Surgery**	**Plan pays 80%* after deductible**	**Plan pays 80%** after deductible**
TYPE C MAJOR RESTORATIVE SERVICES **Crowns, Bridgework, Dentures, Complex Oral Surgery**	**Plan pays 50%* after deductible**	**Plan pays 50%** after deductible**
TYPE D ORTHODONTIA	**Not covered**	**Not covered**

This summary is for descriptive purposes only. It is not an agreement or contract. Further information can be found in the applicable contract. Additional Type A, B & C information can be found in the MetLife Dental Plan Certificate of Insurance.

**In-network benefits are based on Negotiated Fees. Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.*

***Out of network benefits are based on R&C Fees. R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife. R&C charges are calculated at the 70th percentile.*

The content of this chart is for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern.

THE METLIFE DENTAL PLAN COVERS PREVENTIVE, BASIC, AND MAJOR DENTAL SERVICES AND SUPPLIES.

DENTAL PLAN PREMIUMS

COVERAGE LEVEL	EMPLOYEE	EMPLOYEE & SPOUSE/ DOMESTIC PARTNER	EMPLOYEE & CHILD(REN)	FAMILY
WEEKLY PREMIUM	$6.27	$14.36	$12.60	$16.23

For more information including how to find a participating dentist, visit www.MetLife.com/dental. You can also call MetLife at 1-800-942-0854 or contact the Benefits Service Center at 1-866-886-9798 to speak with a Benefits Advisor.

VISION BENEFITS

Vision care benefits are provided through Vision Service Plan, or VSP. Generally, when you receive care from a VSP participating provider, your out-of-pocket expenses will be lower than if you receive services from a non-participating provider. To find a VSP provider, go to www.VSP.com. Select *Members* and *Find a VSP Doctor* or, call VSP at 1-800-877-7195. When you make an appointment, indicate you are a VSP member. The provider will obtain the necessary approvals. If you use non-participating providers, you must pay for services and then submit a claim to VSP for reimbursement.

The following chart provides highlights of some covered services. For a full description of covered services and exclusions, please see the detailed plan description provided on the Allegis Group benefits website.

VISION BENEFITS SUMMARY

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
EYE EXAM *(once every 12 months)*	**$15 copay, then plan pays 100%**	**Plan pays up to $55**
FRAMES *(once every 24 months)*	**Plan pays 100% for select frames up to $150** **Plan pays 100% for featured frames up to $200**	**Plan pays up to $70**
LENSES *(once every 24 months)*	**Combined $15 copay for lenses and frames, then plan pays 100%**	
Single Vision		**Plan pays up to $50**
Bifocal *(lined)*		**Plan pays up to $75**
Trifocal *(lined)*		**Plan pays up to $100**
Lenticular		**Plan pays up to $125**
CONTACT LENSES *(once every 24 months)*		
Visually Necessary	**$15 copay, then plan pays 100%**	**Plan pays up to $210**
Elective	**$60 maximum copay, then plan pays up to $150**	**Plan pays up to $105**

**Frequency is based on your last date of service with any VSP plan. VSP will not cover eye exams more than once in a 12-month period, or contact lenses and eyeglasses/frames in the same 24-month period.*
The content of this chart is for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern.

INTERIM BENEFITS FOR FRAMES, LENSES & CONTACT LENSES

If your lens prescription changes before you are eligible for new lenses and those prescriptions meet at least one of the following criteria, lenses and frames will be replaced at a 12 month frequency:

- A new prescription differs from the original by at least a .50 diopter sphere or cylinder;
- An axis change of 15 degrees for more;
- A .5 prism diopter change in at least one eye.

VSP MEMBERS PORTAL

The VSP Members Portal offers features for you to use that make managing your VSP benefits and eye health simple.

- **View Your Benefits** provides a concise benefits overview and a member reference card that you may print and carry with you.
- **Find a VSP Doctor** assists you in finding a participating doctor and provides you information about VSP doctors.
- **Member Resources** guides you in using your VSP benefits; provides Frequently Asked Questions and much more.

Visit www.VSP.com and select *Members*. To access the Members Portal you will need to register by selecting *Log In/Registration* at the top of the page and select *Register Now*. If you have already registered simply select *Log In/Registration* and enter your username and password.

WITH VSP, YOU RECEIVE ACCESS TO GREAT EYE DOCTORS, QUALITY EYEWEAR & MORE AT LOW OUT-OF-POCKET COSTS.

VISION PLAN PREMIUMS

COVERAGE LEVEL	EMPLOYEE	EMPLOYEE & SPOUSE/ DOMESTIC PARTNER	EMPLOYEE & CHILD(REN)	FAMILY
WEEKLY PREMIUM	$1.69	$2.66	$2.71	$4.37

For more information including how to find a participating provider, visit www.VSP.com. You can also contact the Benefits Service Center at 1-866-886-9798 to speak with a Benefits Advisor.

YOU CANNOT CHANGE BENEFIT ELECTIONS DURING THE PLAN YEAR UNLESS YOU HAVE A QUALIFYING STATUS CHANGE.

CHANGING BENEFITS DURING THE PLAN YEAR

Once you enroll for medical/prescription, dental and vision benefits, you generally cannot change elections during the plan year unless you have a qualifying status change.

QUALIFYING STATUS CHANGES

- **Marriage:** You may add yourself, spouse, domestic partner, child(ren), children of domestic partners, and/or stepchild(ren), first of the month following the event.
- **Birth or adoption or placement for adoption of a child(ren):** You may add yourself, spouse, domestic partner, child(ren), children of domestic partners, and/or stepchild(ren), effective the date of event.
- **Divorce/Legal Separation:** You may cancel coverage for your spouse/domestic partner if enrolled in your employer's plan or you may add coverage for yourself and your children if enrolled in your spouse's plan, effective the first of the month following the event. **Only in states that recognize legal separation.*
- **You, your spouse, domestic partner, child(ren), or children of domestic partners loses other coverage:** You may add yourself, spouse, domestic partner, child(ren), and children of domestic partners, effective the first of the month coinciding with or following the event. **Canceling an individual health plan or COBRA plan is not ordinarily considered a qualifying change and does not allow you to add coverage with Allegis Group.*
- **You, your spouse, domestic partner, child(ren), or children of domestic partners gains other group coverage:** You may cancel coverage for yourself, spouse, domestic partner, child(ren), and/or children of domestic partners who gain coverage, effective the end of the week in which coverage is gained. **Purchasing an individual health plan is not considered a qualifying change and does not allow you to cancel your coverage with Allegis Group.*
- **Change in dependent's eligibility for benefits, such as ag:e** You may cancel coverage for your dependent, effective the end of the month following the event.
- **Change in work status, such as significant reduction in hours:** You may cancel coverage for yourself, spouse, domestic partner, child(ren), and/or children of domestic partners who gain coverage, effective the first of the month coinciding with or following the event.

You may be able to add coverage mid-year for yourself and/or your dependents (including your spouse) if you decline enrollment for yourself or your dependents because of other health insurance or group health plan coverage, and if you or your dependents subsequently lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). 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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Benefit Service Center at 1-866-886-9798 or via e-mail at askbenefits@allegisgroup.com.

You have 30 days from the date of the status change to change your benefits. However, if you or your dependent become eligible for a state premium subsidy for Medicaid or through a state Children's Health Insurance Program with respect to coverage under this plan, you have 60 days from the date of such eligibility determination to enroll in the plan. If you or your dependent decline to participate in the plan because you have Medicaid coverage or coverage under a state Children's Health Insurance Program and you later lose that coverage you have 60 days from the date of such loss of coverage to enroll in the plan.

You may make your change on www.AllegisMarketplace.com or submit a change form. In either case, you need to submit hard copy of proof of the change, such as a birth or marriage certificate. You can only make changes consistent with the status change. For example, if you add a child, you may change your medical plan coverage level (i.e. employee plus one or family), but you may not cancel your medical plan. Additionally, you may be able to drop your medical coverage during the year if your position changes and you have a significant reduction in hours. You will be required to certify that you will be enrolling in other medical coverage. Please contact a Benefits Advisor at 1-866-886-9798 for more information.

HSA CHANGES

You may change your HSA contributions at any time during the year by logging on to www.AllegisMarketplace.com. A voluntary HSA contribution change will take effect on the following week's paycheck.

WHEN COVERAGE ENDS

Medical/prescription, Hospital Cost Protection, Critical Illness Protection, Accident Protection, dental and vision coverage end at midnight on the Saturday following your last day of employment.

	EXAMPLE 1	EXAMPLE 2
DATE EMPLOYMENT ENDS	**June 8, 2022**	**August 5, 2022**
DATE COVERAGE ENDS	**Midnight, June 11, 2022**	**Midnight, August 6, 2022**

COBRA information will be mailed to you when your coverage ends. Disability, life, AD&D, and all other coverage end on your last day of work. Your benefit coverage also ends when you are no longer eligible, when you stop paying premiums, or when the group plan ends, whichever comes first. Coverage for dependents ends when they are no longer eligible, when dependent coverage is no longer offered, or when your coverage ends. Please see the Eligibility section of this guide for information on eligible dependents.

COBRA eligible plans include medical/prescription, dental, vision, and EAP. Hospital Cost Protection Plans, Critical Illness Protection, and Accident Protection are not COBRA eligible plans. You may elect to continue these plans after your Allegis Group coverage ends. Please contact Symetra for instructions. Life, AD&D and disability insurance are also not COBRA eligible plans. However, you may elect to continue life and AD&D insurance for yourself and your dependents under the Portability and Conversion terms of the plan. You have 30 days to send your completed application to the Allegis Group Benefits Department. Please refer to the plan certificate, which can be located on www.AllegisMarketplace.com for more details.

REINSTATEMENTS

If you are rehired within 30 days from the date your employment ended, you have the option to have your medical/prescription, dental and vision coverage reinstated without a lapse in coverage. In order to do so, you must contact the Benefits Service Center at 1-866-886-9798. You will be reinstated with the same coverage and contributions you had prior to your employment ending. You will be responsible for any missed weekly premiums—payment will automatically be made up with double deductions. The request for reinstatement must be made within 30 days of your reinstatement date.

CONTINUATION OF HEALTH CARE COVERAGE

COBRA (Consolidated Omnibus Budget Reconciliation Act) provides for continuation of health care coverage for employees and covered dependents that lose their group coverage for a variety of reasons. It requires employers to offer the same medical coverage as is offered to active employees and their families. You and any eligible dependents covered at the time your Allegis Group medical coverage ends may elect to continue coverage, but you must pay the full *(employee plus company)* premium plus an additional administrative fee.

WHEN YOU CAN ELECT COBRA COVERAGE

You can continue medical coverage for yourself and your covered dependents for up to 18 months if your group coverage ends because:

- You separate from service with Allegis Group *(for reasons other than gross misconduct on your part)*.
- Your hours are reduced so that you are no longer eligible for the Allegis Group plan.

If you or a dependent are determined to be disabled *(for Social Security benefit purposes)* when the group coverage ends or within the first 60 days of COBRA coverage, coverage for that person may continue for up to a total of 29 months. Your spouse/domestic partner and covered children can elect to continue coverage for up to 36 months if their coverage ends due to:

- Your death.
- Divorce or legal separation.
- If a termination or reduction of hours occurs less than 18 months after the employee's Medicare entitlement 36 months of COBRA coverage is allowed from the date of the Medicare entitlement.

Your dependent children can also elect to continue medical plan coverage for up to 36 months when they no longer qualify as your dependents. You must notify your COBRA Administrator within 60 days of the qualifying event.

APPLYING FOR COBRA COVERAGE

When your coverage under the Allegis Group plan ends, you or your dependents have 60 days to elect continued coverage. If you lose coverage due to separation from service or a reduction in work hours, Allegis Group will automatically notify you of your COBRA rights.

In the case of a divorce, legal separation, or when a child no longer qualifies for dependent coverage, you, your spouse, or dependent child must notify Allegis Group within 60 days of the event. You then will be provided with information on your COBRA rights.

WHEN COBRA COVERAGE ENDS

Allegis Group has the right to end your COBRA coverage if:

- Allegis Group stops providing medical coverage for all employees.
- You do not pay your premium on time.
- You become covered by another group health plan.
- You become covered by Medicare.
- You extended COBRA coverage to 29 months due to disability, but are not longer considered disabled

MONTHLY COBRA PREMIUMS

COVERAGE LEVEL	EMPLOYEE	EMPLOYEE & SPOUSE/ DOMESTIC PARTNER	EMPLOYEE & CHILD(REN)	FAMILY
BASIC MEDICAL	$217.31	$393.74	$358.47	$605.53
HIGH DEDUCTIBLE MEDICAL	$526.30	$989.85	$761.12	$1,421.01
DENTAL	$27.71	$63.45	$57.70	$71.72
VISION	$7.48	$11.74	$11.97	$19.32

Please note, the Hospital Cost Protection, Critical Illness Protection and Accident Protection plans are not COBRA eligible. You may elect to continue these plans after your Allegis Group coverage ends. Please contact Symetra for instructions.

CHOOSE COVERAGE FOR YOURSELF, YOUR SPOUSE/DOMESTIC PARTNER, AND DEPENDENT CHILDREN UNDER AGE 26.

LIFE INSURANCE

The Allegis Group life insurance plans let you choose coverage for yourself, your spouse/domestic partner, and dependent children up to age 19 *(26 if full-time student)*. You may elect coverage for your spouse/domestic partner without buying coverage for yourself. However, in order to buy coverage for your child(ren), either you or your spouse/domestic partner must elect coverage. Coverage is portable—you may purchase an individual policy if your Allegis Group employment ends.

EMPLOYEE LIFE INSURANCE

Allegis Group provides eligible employees the option to purchase additional life in increments of $10,000 up to a maximum of $150,000. You may elect up to $150,000 if you enroll during your original eligibility period without completing a medical questionnaire and the insurance carrier approve you. This process is called providing evidence of insurability (EOI). You are required to complete the EOI process for any amount of coverage if you decide to enroll in this plan at any time following your original enrollment opportunity. If EOI is required, the coverage you elect under this plan will not become effective until it is approved by the insurance carrier.

LIFE INSURANCE FOR YOUR SPOUSE/DOMESTIC PARTNER

Eligible employees may elect coverage for their spouse or domestic partner in increments of $10,000 up to a maximum of $30,000. You may elect up to $30,000 if you enroll yourself and your spouse/domestic partner during your original eligibility period without completing a medical questionnaire and the insurance carrier approve you. This process is called providing evidence of insurability (EOI). You are required to complete the EOI process for any amount of coverage if you decide to enroll in this plan at any time following your original enrollment opportunity. If EOI is required, the coverage you elect under this plan will not become effective until it is approved by the insurance carrier. You are the beneficiary for your spouse/ domestic partner's coverage. On the date of application, your spouse/domestic partner must be under age 70. Insurance on a spouse/ domestic partner terminates at age 75.

LIFE INSURANCE FOR DEPENDENT CHILDREN

You may elect $2,500, $5,000, $7,500, or $10,000 for dependent children up to age 19 *(26 if full-time student)*. This benefit covers all of your eligible children. Coverage for children 14 days of age but less than six months is $1,000. Coverage for children age six months but less than 26 years is the elected amount. You are the beneficiary.

The cost of employee and spouse/domestic partner's term life insurance is based on age and the amount of coverage you select. The rates are the same for the employee and spouse's coverage. Weekly premium multipliers are shown on the following chart. When completing your new hire enrollment, you will be able to automatically calculate your weekly Life Insurance premiums.

WEEKLY RATES - EMPLOYEE AND SPOUSE/DOMESTIC PARTNER

YOUR AGE	EMPLOYEE/SPOUSE/DOMESTIC PARTNER*
0-24	$0.0120
25-29	$0.0120
30-34	$0.0145
35-39	$0.0210
40-44	$0.0298
45-49	$0.0556
50-54	$0.0900
55-59	$0.1394
60-64	$0.2545
65-69	$0.3743
70-74	$0.6074
74+	$0.6074

**The costs shown above are per $1,000 of life insurance coverage.*
Example: For an individual age 46 with $50,000 in life insurance, the weekly cost is $2.78 [$.0556 (weekly rate for age 46) times 50].

WEEKLY RATES - DEPENDENT CHILDREN

AMOUNT OF INSURANCE	AGE	DEPENDENT CHILD(REN) WEEKLY PREMIUM MULTIPLIER
$2,500*	6 months but less than 26 years	$0.0464
$5,000*	6 months but less than 26 years	$0.0348
$7,500*	6 months but less than 26 years	$0.0312
$10,000*	6 months but less than 26 years	$0.0293

** If 14 days but less than six months, benefit will be $1,000.*

The cost of life insurance for dependent children is based on the coverage level you choose, regardless of how many eligible children you have. Weekly premium multipliers are shown on the chart above.

Please note, life insurance is not a COBRA eligible plan. However, if your employment ends you may elect to continue Life Insurance for yourself and your dependents under the Portability and Conversion terms of the plan. You have 30 days to send your completed application to the Allegis Group benefits department.

Please refer to the plan certificate, which can be located on the Allegis Group benefits website for more details, or contact the Benefits Service Center at 1-866-886-9798 to speak with a Benefits Advisor.

AD&D PAYS A BENEFIT TO YOUR BENEFICIARY IF YOU DIE OR SUFFER SERIOUS INJURY AS A RESULT OF AN ACCIDENT.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Accidental Death and Dismemberment (AD&D) insurance covers you if you die or suffer serious injury as a result of an accident. You may buy AD&D coverage of up to $500,000 in $10,000 increments.

Benefits are paid to your beneficiary if you die, or to you if you suffer certain injuries as a result of an accident. AD&D benefits are paid in addition to your life insurance coverage if you die as a result of an accident. Proof of good health is not required.

You may choose employee-only coverage or family coverage (family includes coverage for yourself). If you choose family coverage, your spouse/domestic partner's benefit is 60% of yours and dependent children's benefit is 15% of yours. You are the beneficiary for your dependents' AD&D coverage.

The cost of AD&D coverage depends on the coverage level you choose, as shown on the chart below. When completing your new hire enrollment, you will be able to automatically calculate your weekly AD&D premiums.

▸ WEEKLY PREMIUMS

COVERAGE LEVEL	EMPLOYEE ONLY	FAMILY
COVERAGE AMOUNT	$0.090 per $10,000	$0.21 per $10,000

Example: for an individual who chooses family AD&D coverage of $50,000, the weekly cost is $1.05 [$.210 (weekly rate for family coverage) times 5].

Please note, AD&D Insurance is not a COBRA eligible plan. However, if your employment ends you may elect to continue AD&D Insurance for yourself.

ALLEGIS GROUP PROVIDES FAMILY AND MEDICAL LEAVES OF ABSENCE TO ELIGIBLE EMPLOYEES.

FAMILY AND MEDICAL LEAVE (FMLA)

Allegis Group provides Family and Medical Leaves of Absence without pay to eligible employees. Qualified individuals must have worked for Allegis Group for at least 12 months in the last seven years, and must also have worked at least 1,250 hours during the 12 months immediately preceding the request. Qualified individuals may be eligible to take up to 12 weeks of unpaid Family and Medical Leave within a rolling 12-month period for the following reasons:

- To care for the employee's child during the first 12 months following birth, adoption or foster care placement.
- To care for the employee's spouse/domestic partner, child, child of domestic partner, or parent with a serious health condition.
- For incapacity due to the employee's pregnancy or child birth.
- For the employee's own serious health condition.

Furthermore, qualified individuals may be eligible to take up to 26 weeks of unpaid Family and Medical Leave within a rolling 12- month period for the following reasons:

- To care for the employee's spouse/domestic partner, child, child of domestic partner, parent or next of kin who is a service member recovering from serious illness or injury sustained in the line of active duty.
- Due to a qualifying exigency arising because the employee's spouse/domestic partner, child or parent is on active duty or has been notified of an impending call to order to active duty in support of a contingency operation.

In addition to FMLA, employees may also be eligible for leave under a similar state law. For more detailed information, please see the Allegis Family and Medical Leave Policy. For information about the availability of state leave, please contact the Leave team at Leave_Disability@allegisgroup.com or by calling 1-866-886-9798.

SHORT TERM DISABILITY PROTECTS YOU FROM LOSS OF INCOME IF YOU CANNOT WORK DUE TO ILLNESS, INJURY, OR PREGNANCY.

SHORT TERM DISABILITY (STD) BENEFITS

Allegis Group offers a Short-Term Disability (STD) plan through MetLife that protects you against loss of income if you cannot work due to a sickness or injury that is not work related.

If you become totally disabled, your benefit will be 60% of your pre-disability weekly pay up to a maximum benefit of $600 a week. Benefits begin on the 8th day of total disability, and will be paid for up to 13 weeks.

If you enroll during your initial eligibility period, you will not be subject to approval by MetLife. Late enrollees are subject to approval by MetLife and medical questions will be required to be answered.

If you become disabled in the first 12 months after you enroll for STD coverage, benefits will not be paid for a disability caused by any medical condition for which you have been treated or diagnosed within the six months before joining the STD plan, including pregnancy.

The cost of coverage is based on your age and weekly benefit amount, as shown in the following chart. When completing your new hire enrollment, you will be able to automatically calculate your weekly STD premium.

▸ WEEKLY PREMIUMS

YOUR AGE	WEEKLY PREMIUM MULTIPLIER
UNDER 25	$0.089 per $10 of weekly benefit
25-29	$0.075 per $10 of weekly benefit
30-34	$0.075 per $10 of weekly benefit
35-39	$0.066 per $10 of weekly benefit
40-44	$0.069 per $10 of weekly benefit
45-49	$0.078 per $10 of weekly benefit
50-54	$0.098 per $10 of weekly benefit
55+	$0.117 per $10 of weekly benefit

Example: for an individual age 36 with $480 in weekly pay, the weekly benefit is $288 and the weekly cost to the employee is $3.51. The weekly STD benefit of $288 is based on 60% of the $480 weekly pay. Weekly premiums are calculated for every $10 of weekly benefit amount (i.e. $288/$10 = $28.80). Using the age of the employee (36) and the chart above, the premium multiplier in this example is $.066. When the $.066 is multiplied by $28.80, the employee arrives at his/her weekly premium of $1.90.

LONG TERM DISABILITY (LTD) BENEFITS

Allegis Group offers a Long Term Disability (LTD) plan through MetLife that pays benefits if total disability lasts more than 90 days.The monthly LTD benefit is 60% of your pre-disability monthly base pay, reduced by Social Security and other disability income benefits.

LTD benefits are not paid for more than 24 months for mental or nervous disabilities. Conditions existing within three months of your effective date of coverage are considered pre-existing and are not covered until you are continuously insured for 12 months.

The maximum monthly LTD benefit is $5,000. The minimum monthly LTD benefit is the greater of $100 or 10% of your monthly benefit before reductions for Social Security and other income benefits.

If you enroll during your initial eligibility period, you will not be subject to approval by MetLife. Late enrollees are subject to approval by MetLife and medical questions will be required to be answered. When you enroll, you can choose a five-year benefit period or a benefit period to age 65.

The cost of coverage is based on your age, monthly earnings, and benefit period you choose, as shown in the following chart. When completing your new hire enrollment, you will be able to automatically calculate your weekly LTD premium.

LONG TERM DISABILITY PREMIUMS

YOUR AGE	5 YEAR PLAN: PREMIUM MULTIPLIER	TO AGE 65 PLAN: PREMIUM MULTIPLIER
UNDER 25	$0.024 per $100 of monthly earnings	$0.035 per $100 of monthly earnings
25-29	$0.028 per $100 of monthly earnings	$0.043 per $100 of monthly earnings
30-34	$0.038 per $100 of monthly earnings	$0.062 per $100 of monthly earnings
35-39	$0.051 per $100 of monthly earnings	$0.090 per $100 of monthly earnings
40-44	$0.069 per $100 of monthly earnings	$0.120 per $100 of monthly earnings
45-49	$0.110 per $100 of monthly earnings	$0.194 per $100 of monthly earnings
50-54	$0.181 per $100 of monthly earnings	$0.272 per $100 of monthly earnings
55+	$0.309 per $100 of monthly earnings	$0.346 per $100 of monthly earnings

Example: for an individual age 36 with $3,000 in monthly earnings who chooses benefits to age 65, the monthly LTD benefit is $1,800 and the weekly premium cost to the employee is $3.00. The monthly LTD benefit of $1,800 is based on 60% of the $3,000 monthly pay. Monthly premiums are calculated for every $100 of monthly earnings (i.e., $3,000/$100 = 30). Using the age of the employee (36) and the chart above, the premium multiplier in this example is $0.090. When the $0.100 is multiplied by 30, the employee arrives at his/her weekly premium of $2.70.

Please note, the maximum insurable monthly earnings amount is $8,333.33 ($100,000 annually).

For information about the availability of state leave, please contact the Benefits Service Center at 1-866-886-9798 or via email at Leave_Disability@allegisgroup.com.

TRANSPORTATION BENEFITS ALLOW YOU TO USE PRE-TAX DOLLARS TO PAY FOR QUALIFIED PARKING & TRANSIT EXPENSES.

TRANSPORTATION BENEFITS

Transportation Benefits from Optum allow you to use pre-tax payroll dollars to pay for qualified parking and transit expenses.

HOW DO I PLACE MY ORDER?

You can place your order by selecting the Optum link located on the left side of yourAllegis Group benefits home page under the *HSA Tools & Resources* section. Once you arrive at the Optum Bank home page, you will then:

- Select *Account Holder* under *View Your Account*
- If it is your first time visiting the site, choose *Register for Site* to select your user name and password.
- From the *Accounts* section, select *Transportation Services* to be taken to the Transit and Parking Home Page.

You can elect to purchase for a specific transit authority. Each and every transit authority handles their passes differently. Some will reload an existing card or account, some will issue passes every month. Monthly passes are generally issued around the 20th or 21st of each month.

You can enroll in Transportation Benefits at anytime during the year. Orders must be placed by the 10th of each month for use the following month (example: orders placed by March 10th are for vouchers that can be used in April). The amount of your purchase, will be deducted from your paycheck on or around the 12th of the month.

Additional information regarding Transportation Benefits, including eligible and ineligible expenses, can be found in IRS publication 15B. You may also call Optum Bank at 1-800-243-5543.

ALLEGIS GROUP OFFERS AN EXTENSIVE COLLECTION OF DISCOUNTED PRODUCTS & SERVICES.

EMPLOYEE DISCOUNT PROGRAMS

Allegis Group offers access to over 100,000 discounts and provides employees with an elite collection of local and national discounts from thousands of hotels, restaurants, movie theaters, retailers, florists, car dealers, theme parks, national attractions, concerts, and events through Abenity.

Abenity provides more than $4,500 in available savings from vendors including Costco, Sam's Club, Sprint, Firestone, Papa Johns, DirecTV, T-Mobile, Dell, Target.com, Verizon Wireless, Overstock.com, Brooks Brothers, Gold's Gym, LA Fitness, Bally's Total Fitness and Hewlett Packard.

Offers are also available from over 150 national attractions and theme parks including the Walt Disney World® Resort, Universal Studios®, SeaWorld, Cirque du Soleil, and Six Flags! Discount offers are redeemable in-store through printable and mobile coupons, online, and over the phone. Join the Employee Discount Program.

Register online at www.AllegisBenefits.EmployeeDiscounts.com *using the registration code: AllegisWorkLife.*

FARMERS OFFERS SPECIAL GROUP RATES AND DISCOUNTS FOR PERSONAL INSURANCE COVERAGE NEEDS.

AUTO AND HOME INSURANCE

As part of the Allegis Group benefit program, Allegis Group is proud to introduce you to an opportunity to access discounted auto and home insurance from Farmers GroupSelect[SM].

Farmers GroupSelect provides you with access to insurance coverage for your personal insurance needs. Policies available include auto, condo, renter's, boat, personal excess liability, and more. Farmers GroupSelect offers special benefits and money-saving discounts including:

- Special group discounts
- Automated payment savings
- Good driver rewards
- Multi-policy discounts
- Multi-vehicle discounts
- 24/7 customer service
- ID protection services[1]
- and more!

For more information or to get your free no-obligation quotes today, visit www.AllegisBenefits.com or call Farmers GroupSelect at 1-800-438-6381.

[1]*Identity protection services are not available to auto customers in NC or NH nor with all policy forms. Identity protection services are available in NC homeowner's policies with the optional "Identity Theft Expense and Resolution Plus" endorsement for an additional premium.*

Program information provided by the following specific insurers seeking to obtain insurance business underwritten by Farmers Property and Casualty Insurance Company (a MA licensee) and certain of its affiliates: Economy Fire & Casualty Company, Economy Premier Assurance Company, Economy Preferred Insurance Company, Farmers Casualty Insurance Company, Farmers Direct Property and Casualty Insurance Company (CA Certificate of Authority: 6730; Warwick, RI), Farmers Group Property and Casualty Insurance Company (CA COA: 6393; Warwick, RI), or Farmers Lloyds Insurance Company of Texas, all with administrative home offices in Warwick, RI. Coverage, rates, discounts, and policy features vary by state and product and are available in most states to those who qualify. 3732186.1v3 © 2021 Farmers Insurance

ALLEGIS GROUP 401(K) PLAN

The Allegis Group 401(k) plan gives you an opportunity to build retirement savings. Here is how it works:

- Employee are eligible to participate and enroll in the 401(k) plan on the 1st of the month following 30 days of employment.
- When an employee becomes eligible for the 401K plan Principal establishes an account whether the employee contributes or not.
- You can contribute up to 100% of your eligible compensation up to the maximum permitted by the IRS. The dollar limit is $19,500 for 2022. *(Highly compensated employees may not be able to defer the statutory maximum.)*
- Deductions usually begin during the first full week of payroll.
- The plan offers a variety of different investment options, so you can tailor an investment strategy that suits your current situation and your future needs.
- The plan offers you two ways to save. You can make traditional 401(k) pre-tax contributions and lower your taxable income today or make Roth 401(k) post-tax contributions and your investments will grow tax-free.
- Employees age 50 or over may contribute an additional "catch-up contribution." The maximum catch-up contribution is $6,500 for 2022. This full amount can be contributed even if you are "highly compensated," as defined by the IRS. Employees must elect a deferral percentage to the catch-up contribution in order to have those deductions begin. Deductions will begin the first of the month following the deferral elections.
- The plan allows up to one loan at a time. The amount of the loan is limited to the lesser of one half of your vested account balance or $50,000. The minimum loan amount is $1,000. All loans must be repaid within five years (or 10 years if such loan is taken to purchase a primary residence). A $75 initiation fee for loans will be taken out of the proceeds of your loan.

For more information or to enroll, visit the Allegis Group benefits website for a direct link to the Principal website or go to www.Principal.com.

HOW TO MAKE CHANGES IN YOUR ACCOUNT

You can make changes to your account or investments at any time. You may change your contribution rate - increase, decrease, or stop contributions. You may also transfer your balance and future contributions to other plan investment options.

To make changes or for further information, simply log on to the Principal website at www.Principal.com. You may also call the Retirement Service Center at 1-800-547-7754. Representatives are available Monday through Friday, 8 am to 10 pm EST (7 am to 9 pm CST).

When you access your account online for the first time, you'll need your Social Security number and your date of birth in mm/dd/yyyy format. To enroll by telephone, you'll need your Social Security Number and your personal identification number, which is initially the last four digits of your Social Security Number.

BENEFITS ACKNOWLEDGMENT

PLEASE INITIAL EACH OF THE STATEMENTS BELOW TO ACKNOWLEDGE THE FOLLOWING:

_____ I understand that I have been given an offer of health care coverage, including medical coverage, by my employer. I have received the summary of the benefit plans that explains the offer of this coverage and understand that I am eligible to enroll in health care coverage following the applicable waiting period *(which is the first of the month coinciding with or following my hire date)*.

_____ I have received the notice titled "New Health Insurance Marketplace Coverage Options and Your Health Coverage." I understand that this notice indicates that my employer is offering me a medical plan that meets the requirements of Minimum Value *(as defined in the notice)* and is intended to be affordable based on my wages.

_____ I understand that if my employer offers me the Minimum Value coverage noted above and that coverage is affordable based on my wages that I am not eligible for a premium tax credit from any state or federal healthcare marketplaces. If I receive a premium tax credit I am not eligible for, I will need to refund the government for the credits. For more information on eligibility for premium tax credits, I can go to: www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Premium-Tax-Credit.

_____ I have received a Summary of Benefits and Coverage describing the medical benefits available to me. I understand that this Summary of Benefits and Coverage indicates that my employer is offering me a medical plan that meets the requirements of Minimum Value *(as defined in the Summary of Benefits and Coverage)*.

_____ I acknowledge the Benefits Guide I received is only a summary of the benefits. Complete descriptions of the plans are contained in the applicable plan documents. If there is any disagreement between the Benefits, Guide, this acknowledgment and the wording of the applicable contract or plan document, the contract or plan document will govern. Allegis Group, Inc. and its operating companies reserve the right to modify, amend, suspend, or terminate any plan in whole or in part, at any time.

_____ I understand that I may access more information about the medical benefits available to me at any time by visiting www.AllegisMarketplace.com or by calling 1-866-886-9798 to request a paper copy of relevant documents at any time free of charge.

_____ I acknowledge that if I choose to participate in the benefits for which I am eligible, I will need to visit www.AllegisMarketplace.com or complete the required paper enrollment forms to enroll.

THIS ACKNOWLEDGMENT DOES NOT CONSTITUTE A GUARANTEE OF EMPLOYMENT.

Please Note: If you enroll in benefits during the first month in which you are eligible to participate, your enrollment will be retroactive to the first of the month and you will be double deducted from your paycheck for any missed weekly premiums.

Printed Name of Employee: _____

Signature of Employee: _____ Date: _____