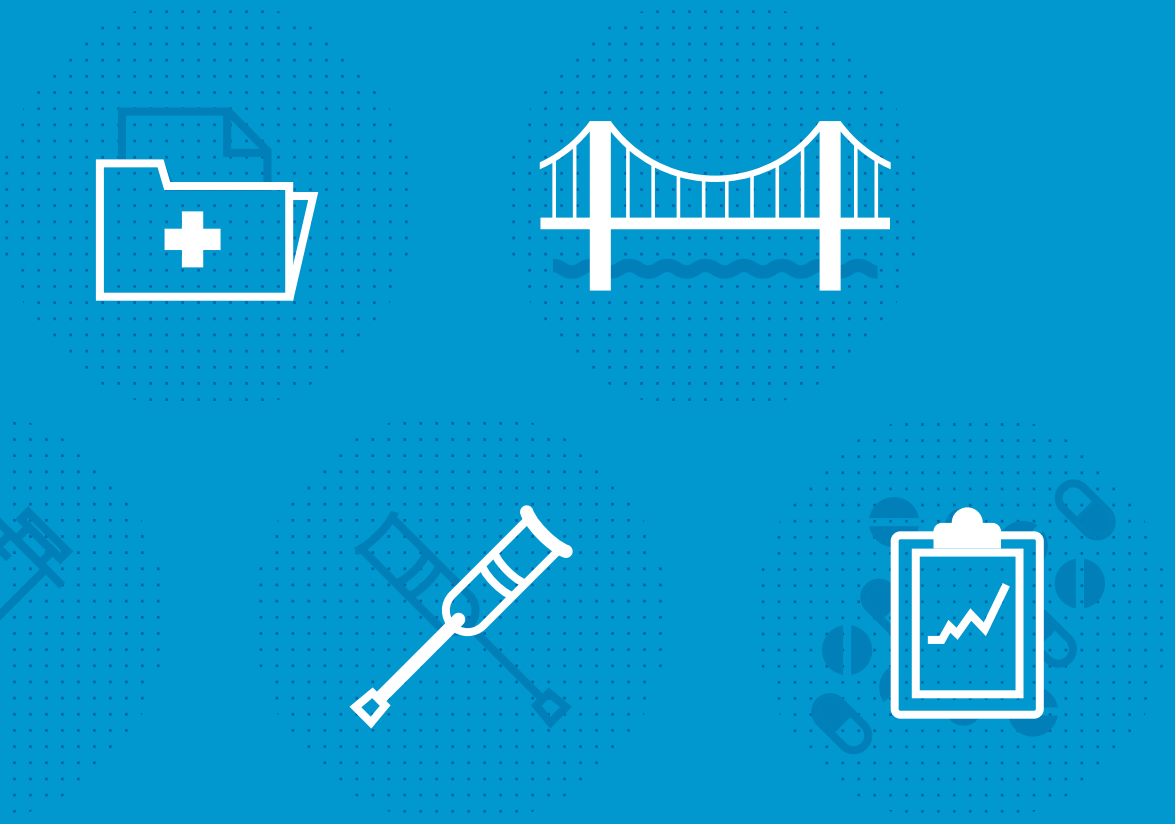
ALLEGIS GROUP

People. Service. Performance.

Benefit Guide for Contract Employees

January 1, 2015 – December 31, 2015



Enroll Online at www.AllegisMarketplace.com

To: All Individuals Eligible to Participate in the Allegis Group Contract Employee Health and Welfare Plan

Under health care reform, individuals eligible to participate in an employer-sponsored group health plan are entitled to receive a summary of benefits and coverage (also known as an SBC), which provides a general description about the benefits and out-of-pocket costs associated with the plan. The SBCs for the Bronze*, Silver* and Gold* Aetna plans are found on the next several pages of this guide.

In the event of any inconsistency between the SBC and the plan document, the information set forth in the plan document will control.

If you have any questions or would like additional information, please feel free to contact the Allegis Benefits Call Center at 1-866-886-9798.

**DISCLAIMER: Plan names distinguish only deductible levels and do not correspond to, or are not equivalent to, medical plans available through public exchanges.*

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.HealthReformPlanSBC.com** or by calling **1-855-873-9409**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Calendar Year, Network: Individual **$5,500** / Family **$11,000**. Out–of–Network: Individual **$11,000** / Family **$22,000**. Does not apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Network: Individual **$6,450** / Family **$12,900**. Out–of–Network: Individual **$12,900** / Family **$25,800**.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.aetna.com** or call 1-855-873-9409 for a list of network **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	40% coinsurance after $20 copay/visit	50% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	40% coinsurance after $40 copay/visit	50% coinsurance	——————none——————
	Other practitioner office visit	40% coinsurance after $40 copay/visit	50% coinsurance	Coverage is limited to 12 visits per calendar year for Chiropractic care.
	Preventive care /screening /immunization	No charge	20% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	40% coinsurance after $65 copay/visit	50% coinsurance	Pre-authorization may be required.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	After deductible, copay/prescription: $20 (retail), $40 (mail order)	After deductible, 50% coinsurance after copay/prescription: $20 (retail)	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Your cost will be higher for choosing Brand over Generics. Includes contraceptive drugs and devices obtainable from a pharmacy, oral fertility drugs. No charge for formulary generic FDA-approved women's contraceptives in-network. Precertification required for growth hormones. Precertification required with 90 day Transition of Care. Step therapy required with 90 day Transition of Care
	Preferred brand drugs	After deductible, copay/prescription: $40 (retail), $80 (mail order)	After deductible, 50% coinsurance after copay/prescription: $40 (retail)	
	Non-preferred brand drugs	After deductible, copay/prescription: $70 (retail), $140 (mail order)	After deductible, 50% coinsurance after copay/prescription: $70 (retail)	
	Specialty drugs	After deductible: 40% coinsurance/ prescription	After deductible: 50% coinsurance/ prescription	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	50% coinsurance	——————none——————
	Physician/surgeon fees	40% coinsurance	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	40% coinsurance	40% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	40% coinsurance after $150 copay/trip	40% coinsurance after $150 copay/trip	No coverage for non-emergency transport.
	Urgent care	40% coinsurance	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance after $500 copay/stay	50% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fee	40% coinsurance	50% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	40% coinsurance after $40 copay/visit	50% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	40% coinsurance after $500 copay/stay	50% coinsurance	Pre-authorization required for out-of-network care.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
	Substance use disorder outpatient services	40% coinsurance after $40 copay/visit	50% coinsurance	————————none————————
	Substance use disorder inpatient services	40% coinsurance after $500 copay/stay	50% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	No charge	50% coinsurance	————————none————————
	Delivery and all inpatient services	40% coinsurance after $500 copay/stay	50% coinsurance	Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.
If you need help recovering or have other special health needs	Home health care	40% coinsurance after $40 copay/visit	50% coinsurance	Coverage is limited to 60 visits per calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	40% coinsurance after $40 copay/visit	50% coinsurance	Coverage is limited to 20 visits per calendar year for Physical, Occupational, and Speech Therapy combined.
	Habilitation services	40% coinsurance after $40 copay/visit	50% coinsurance	Coverage is limited to children up to age 19 for Autism.
	Skilled nursing care	40% coinsurance after $500 copay/stay	50% coinsurance	Coverage is limited to 30 days per calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	40% coinsurance	50% coinsurance	————————none————————
	Hospice service	40% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Eye exam	No charge	20% coinsurance	Coverage is limited to 1 routine eye exam per 12 months.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care - Coverage is limited to 12 visits per calendar year.
- Hearing aids - Coverage is limited to 1 hearing aid to a maximum of $1,400 per ear per 36 months for children up to age 19.
- Infertility treatment - Benefit limitations may apply
- Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per 12 months.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-873-9409. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. If your group health plan is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration att 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**. You may also contact the Maryland Insurance Administration, (410) 468-2090, **www.mdinsurance.state.md.us**.

Additionally, a consumer assistance program can help you file your **appeal**. Contact: Maryland Office of the Attorney General, Health Education and Advocacy Unit, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202, (877) 261-8807, **http://www.oag.state.md.us/Consumer/HEAU.htm**

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-855-873-9409.

如果需要中文的帮助，请拨打这个号码 1-855-873-9409.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-873-9409.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-873-9409.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $2,190
- **Patient pays:** $5,350

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$5,200
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$5,350**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $50
- **Patient pays:** $5,350

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$5,270
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$5,350**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.HealthReformPlanSBC.com** or by calling **1-855-873-9409**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Calendar Year, In-Network: Individual **$4,000** / Family **$8,000**. Out–of–Network: Individual **$8,000** / Family **$16,000**. Does not apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. In-Network: Individual **$6,450** / Family **$12,900**. Out–of–Network: Individual **$12,900** / Family **$25,800**.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.aetna.com** or call 1-855-873-9409 for a list of in-network **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	40% coinsurance after $20 copay/visit	50% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	40% coinsurance after $40 copay/visit	50% coinsurance	——————none——————
	Other practitioner office visit	40% coinsurance after $40 copay/visit	50% coinsurance	Coverage is limited to 12 visits per calendar year for Chiropractic care.
	Preventive care /screening /immunization	No charge	50% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	40% coinsurance after $65 copay/visit	50% coinsurance	Pre-authorization may be required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	After deductible, copay/prescription: $20 (retail), After deductible: $40 (mail order)	After deductible, 50% coinsurance after copay/prescription: $20 (retail)	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Your cost will be higher for choosing Brand over Generics. Includes contraceptive drugs and devices obtainable from a pharmacy, oral fertility drugs. No charge for formulary generic FDA-approved women's contraceptives in-network. Precertification required with 90 day Transition of Care. Precertification required for growth hormones.
	Preferred brand drugs	After deductible, copay/prescription: $40 (retail), After deductible: $80 (mail order)	After deductible, 50% coinsurance after copay/prescription: $40 (retail)	
	Non-preferred brand drugs	After deductible, copay/prescription: $70 (retail), After deductible: $140 (mail order)	After deductible, 50% coinsurance after copay/prescription: $70 (retail)	
	Specialty drugs	After deductible: 40% coinsurance/ prescription	After deductible: 50% coinsurance/ prescription	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% after $40 copay/visit	50% coinsurance	——————none——————
	Physician/surgeon fees	40% coinsurance	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	40% coinsurance	40% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	40% coinsurance, after $150 copay	40% coinsurance, after $150 copay	No coverage for non-emergency transport.
	Urgent care	40% coinsurance	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance after $500 copay/stay	50% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fee	40% coinsurance	50% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	40% coinsurance after $40 copay/visit	50% coinsurance	————————none————————
	Mental/Behavioral health inpatient services	40% coinsurance after $500 copay/stay	50% coinsurance	Pre-authorization required for out-of-network care.
	Substance use disorder outpatient services	40% coinsurance after $40 copay/visit	50% coinsurance	————————none————————
	Substance use disorder inpatient services	40% coinsurance after $500 copay/stay	50% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	No charge	50% coinsurance	————————none————————
	Delivery and all inpatient services	40% coinsurance after $500 copay/stay	50% coinsurance	Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.
If you need help recovering or have other special health needs	Home health care	40% coinsurance after $40 copay/visit	50% coinsurance	Coverage is limited to 60 visits per calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	40% coinsurance after $40 copay/visit	50% coinsurance	Coverage is limited to 20 visits per calendar year for Physical, Occupational, and Speech Therapy combined.
	Habilitation services	40% coinsurance after $40 copay/visit	50% coinsurance	Coverage is limited to children up to age 19 for Autism.
	Skilled nursing care	40% coinsurance after $500 copay/stay	50% coinsurance	Coverage is limited to 30 days per calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	40% coinsurance	50% coinsurance	————————none————————
	Hospice service	40% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Eye exam	No charge	20% coinsurance	Coverage is limited to 1 routine eye exam per 12 months.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
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Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. If your group health plan is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration att 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**. You may also contact the Maryland Insurance Administration, (410) 468-2090, **www.mdinsurance.state.md.us**.

Additionally, a consumer assistance program can help you file your **appeal**. Contact: Maryland Office of the Attorney General, Health Education and Advocacy Unit, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202, (877) 261-8807, **http://www.oag.state.md.us/Consumer/HEAU.htm**

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Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-873-9409.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $2,900
- **Patient pays:** $4,640

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$4,000
Copays	$490
Coinsurance	$0
Limits or exclusions	$150
Total	**$4,640**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $890
- **Patient pays:** $4,510

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$4,000
Copays	$260
Coinsurance	$170
Limits or exclusions	$80
Total	**$4,510**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.HealthReformPlanSBC.com** or by calling **1-855-873-9409**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Calendar Year, Network: Individual **$2,000** / Family **$4,000**. Out–of–Network: Individual **$4,000** / Family **$8,000**. Does not apply to preventive care in-network.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Network: Individual **$6,450** / Family **$12,900**. Out–of–Network: Individual **$12,900** / Family **$25,800**.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.aetna.com** or call 1-855-873-9409 for a list of network **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	40% coinsurance after $20 copay/visit	50% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	40% coinsurance after $40 copay/visit	50% coinsurance	——————none——————
	Other practitioner office visit	40% coinsurance after $40 copay/visit	50% coinsurance	Coverage is limited to 12 visits per calendar year for Chiropractic care.
	Preventive care /screening /immunization	No charge	20% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	40% coinsurance after $65 copay/visit	50% coinsurance	Pre-authorization may be required.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	After deductible, copay/prescription: $20 (retail), $40 (mail order)	After deductible, 50% coinsurance after copay/prescription: $20 (retail)	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Your cost will be higher for choosing Brand over Generics. Includes contraceptive drugs and devices obtainable from a pharmacy, oral fertility drugs. Precertification required with 90 day Transition of Care. Precertification required for growth hormones. No charge for formulary generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs	After deductible, copay/prescription: $40 (retail), $80 (mail order)	After deductible, 50% coinsurance after copay/prescription: $40 (retail)	
	Non-preferred brand drugs	After deductible, copay/prescription: $70 (retail), $140 (mail order)	After deductible, 50% coinsurance after copay/prescription: $70 (retail)	
	Specialty drugs	After deductible: 40% coinsurance/ prescription	After deductible: 50% coinsurance/ prescription	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	50% coinsurance	——————none——————
	Physician/surgeon fees	40% coinsurance	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	40% coinsurance	40% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	40% coinsurance after $150 copay/trip	40% coinsurance after $150 copay/trip	No coverage for non-emergency transport.
	Urgent care	40% coinsurance	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance after $500 copay/stay	50% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fee	40% coinsurance	50% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	40% coinsurance after $40 copay/visit	50% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	40% coinsurance after $500 copay/stay	50% coinsurance	Pre-authorization required for out-of-network care.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
	Substance use disorder outpatient services	40% coinsurance after $40 copay/visit	50% coinsurance	————————none————————
	Substance use disorder inpatient services	40% coinsurance after $500 copay/stay	50% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	No charge	50% coinsurance	————————none————————
	Delivery and all inpatient services	40% coinsurance after $500 copay/stay	50% coinsurance	Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.
If you need help recovering or have other special health needs	Home health care	40% coinsurance after $40 copay/visit	50% coinsurance	Coverage is limited to 60 visits per calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	40% coinsurance after $40 copay/visit	50% coinsurance	Coverage is limited to 20 visits per calendar year for Physical, Occupational, and Speech Therapy combined.
	Habilitation services	40% coinsurance after $40 copay/visit	50% coinsurance	Coverage is limited to children up to age 19 for Autism.
	Skilled nursing care	40% coinsurance after $500 copay/stay	50% coinsurance	Coverage is limited to 30 days per calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	40% coinsurance	50% coinsurance	————————none————————
	Hospice service	40% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Eye exam	No charge	20% coinsurance	Coverage is limited to 1 routine eye exam per 12 months.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care - Coverage is limited to 12 visits per calendar year
- Hearing aids - Coverage is limited to 1 hearing aid to a maximum of $1,400 per ear per 36 months for children up to age 19.
- Infertility treatment - Benefit limitations may apply.
- Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per 12 months.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-873-9409. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. If your group health plan is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration att 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**. You may also contact the Maryland Insurance Administration, (410) 468-2090, **www.mdinsurance.state.md.us**.

Additionally, a consumer assistance program can help you file your **appeal**. Contact: Maryland Office of the Attorney General, Health Education and Advocacy Unit, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202, (877) 261-8807, **http://www.oag.state.md.us/Consumer/HEAU.htm**

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-855-873-9409.

如果需要中文的帮助，请拨打这个号码 1-855-873-9409.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-873-9409.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-873-9409.

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(normal delivery)

- **Amount owed to providers:** $7,540
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Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
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Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$520
Coinsurance	$770
Limits or exclusions	$150
Total	**$3,440**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,270
- **Patient pays:** $3,130

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Copays	$680
Coinsurance	$370
Limits or exclusions	$80
Total	**$3,130**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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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 for 2015 and explains how to enroll. In this guide, you will find:

- Your 2015 Benefits-at-a-Glance;
- Who is eligible and how to enroll;
- Summaries of each benefit plan; and
- Phone numbers and websites where you can obtain more information about each plan.

Need Assistance?

Contact the Benefits Service Center at 1-866-886-9798 to speak with a Benefits Advisor.

We may refer in this guide to "ACA" or "PPACA" and both are abbreviations for the official name of the law commonly referred to as the federal healthcare reform law. "ACA" stands for the Affordable Care Act and "PPACA" stands for the Patient Protection and Affordable Care Act, which is the longer name used to refer to the law. We also refer to your "Individual Mandate" obligation. By this we mean your obligation under the ACA to have Minimum Essential Coverage (which can simply mean an employer group medical plan) or to pay a penalty on your tax return for not carrying such coverage.

Table of Contents

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:
    - ACA-compliant Aetna Preferred Provider Organization (PPO) Medical Plans which provide Minimum Essential Coverage and allow you to meet your Individual Mandate
    - Aetna Bridge Plans – supplemental fixed indemnity plans (Not Minimum Essential Coverage under the ACA)
    - Critical Illness Insurance (Not Minimum Essential Coverage under the ACA)
    - Accident Insurance (Not Minimum Essential Coverage under the ACA)
    - Hospital Indemnity Plan (Not Minimum Essential Coverage under the ACA)
    - Major Expense Protection Plan (MEPP) (Not Minimum Essential Coverage under the ACA)
    - New! Health Savings Account (HSA) (must enroll) in an Aetna PPO Medical Plan in order to elect the HSA through Allegis
- Access to other types of coverage, including dental, vision, life and accidental death & dismemberment (AD&D) insurance, health advocacy, and, new this year, a Health Savings Account (HSA).

The Allegis Marketplace Features:

- Savings through an exclusive group rate
- Potential savings on the cost of coverage by paying your premiums on a pre-tax basis
- Access to benefits advisors and personalized customer service
- Payment through convenient payroll deduction
- Easy online enrollment
- Access to Aetna's nationwide network of providers, who discount their services for Aetna participants

Your Allegis Group Benefits At-A-Glance

Type of Coverage	Benefits for 2015
Medical– Comprehensive Preferred Provider Organization (PPO) plans *(with prescription drug benefit)*[1]	▸ 3 PPO plan options: Bronze*[1], Silver*[1], and Gold* ▸ **All three plans allow you to meet your Individual Mandate under the ACA** ▸ All Aetna Minimum Essential Coverage (MEC) plans have a $6,350 annual out-of-pocket maximum for individual coverage only. The out-of-pocket maximum for Employee & Partner, Employee & Children and Family is $12,700. Out-of-pocket maximum amounts include any deductibles, copays and coinsurance amounts you pay but do not include any premiums or out-of-network costs you pay. The annual out-of-pocket maximum amounts shown here apply only to in-network services. ▸ Underwritten by Aetna ▸ Aetna's nationwide network of providers ▸ Plans pay 60% of most in-network services after calendar year deductible is met ▸ You pay a $20 copay for regular office visits and a $40 copay for Specialist office visits ▸ You pay $20 copay for generic prescription drugs in-network **DISCLAIMER: Plan names distinguish only deductible levels and do not correspond to, or are not equivalent to, medical plans available through public exchanges.* *[1]This health plan, alone, does not meet Minimum Creditable Coverage standards that are effective January 1, 2011 as part of the Massachusetts Health Care Reform Law. If you purchase this health plan only, you will not satisfy the statutory requirement that you have health insurance meeting these standards.*

Type of Coverage	Benefits for 2015
Aetna Bridge Plans—supplemental fixed indemnity plans	▸ 3 plan options: Basic, Enhanced, and Premium ▸ Underwritten by Aetna ▸ Aetna Bridge Plans include discounts available through Aetna PPO Network providers ▸ Pays fixed-dollar cash benefits when you incur expenses for covered events, such as certain doctor visits, hospital stays, prescriptions, and other medical services—all without a deductible ▸ **Not Minimum Essential Coverage under the ACA (designed to supplement a comprehensive medical plan)**
Critical Illness Insurance[1]	▸ 2 plan options: $10,000 or $20,000 lump sum benefits ▸ Provides cash benefits if you or a covered family member is diagnosed for the first time with a covered serious medical condition ▸ Underwritten by Symetra Life Insurance Company ▸ **Not Minimum Essential Coverage under the ACA (designed to supplement a comprehensive medical plan)**
Accident Insurance[1]	▸ 2 plan options: Benefits up to $3,500 or $10,000 per year ▸ Plan pays cash for medical services related to an accidental injury not incurred at work ▸ Cash benefits paid directly to you regardless of any other insurance you have ▸ Underwritten by Symetra Life Insurance Company ▸ **Not Minimum Essential Coverage under the ACA (designed to supplement a comprehensive medical plan)**
Hospital Indemnity Plan[1]	▸ Provides direct cash payment to you for inpatient hospitalization ▸ Includes a Prescription Drug Discount Program ▸ Underwritten by Symetra Life Insurance Company ▸ **Not Minimum Essential Coverage under the ACA (designed to supplement a comprehensive medical plan)**
Major Expense Protection Plan (MEPP)[1]	▸ Provides direct cash payment to you for emergency room and inpatient hospital benefits, including substance abuse and mental health ▸ Underwritten by Symetra Life Insurance Company ▸ **Not Minimum Essential Coverage under the ACA (designed to supplement a comprehensive medical plan)**
Health Savings Account (HSA)[4]	▸ A tax-advantaged savings account that allows you to put aside pre-tax income for eligible medical expenses ▸ Tax free earnings on your savings ▸ Provided through Wells Fargo ▸ You keep your account even if you change jobs or retire ▸ To be eligible, you must elect an Aetna PPO Medical plan offered by Allegis
Dental[1]	**MetLife Dental:** ▸ Pays 100% for preventive and diagnostic care ▸ Pays 50% to 80% for other services ▸ Deductible $50 per person
Vision[1]	**Vision Service Plan (VSP):** ▸ In and out-of-network option (eye exam every 12 months, lenses/frames/ contacts every 24 months) ▸ Interim Benefits for lenses and frames
Short Term Disability[2]	**The Hartford:** ▸ Plan pays 60% of pre-disability weekly pay up to a maximum benefit of $600 per week ▸ Benefits begin on the 8th day of total disability and are paid for up to 13 weeks ▸ Weekly premiums are based on age and weekly benefit amount

Type of Coverage	Benefits for 2015
Long Term Disability[2]	**MetLife:** ▸ 2 plan options – "five year" option or "to age 65" option ▸ Plan pays 60% of pre-disability monthly base pay after 90 days of disability ▸ Maximum monthly benefit is $5,000 ▸ Weekly premiums are based on age, monthly earnings, and plan option
Life Insurance[2]	**Reliance Standard Life:** ▸ Employee Life – You can purchase up to $150,000; cost is based on age and level of coverage ▸ Spouse Life – You can purchase up to $30,000; cost is based on age and level of coverage ▸ Child Life – You can purchase up to $10,000; cost is based on level of coverage
Accidental Death & Dismemberment (AD&D)[2]	**Reliance Standard Life:** ▸ Provides a benefit in the event of death or dismemberment ▸ Employee AD&D – You can purchase up to $500,000 ▸ Family AD&D – Spouse's benefit is 60% of employee's, dependent children's benefit is 15% of employee's
401(k) Plan[3] **Traditional 401(k) plan, Roth 401(k) plan**	**Wells Fargo** ▸ Save up to $18,000 of your income for 2015 ▸ Wide range of investment options ▸ You can contribute to the 401(k) plan via pre-tax contributions or to the Roth via post-tax contributions
529 College Savings Plan[3]	**Alliance Capital** ▸ Build a tax-favored savings account for college expenses ▸ Wide range of investment options
Auto and Home Insurance[3]	**MetLife** ▸ Buy MetLife auto, renters, boat, and personal liability coverage ▸ Special group rates and policy discounts
Health Advocacy, EAP + Work Life Benefits	***Health Proponent, powered by Health Advocate*** ***Health Advocacy*** ▸ Access to a Personal Health Advocate, typically a registered nurse, supported by a team of physicians and administrative experts, who will help in handling health care and insurance related issues ▸ You, your spouse, children, parents and the parents of your spouse are eligible to use this service ***EAP + Work Life Benefits*** ▸ Confidential counseling for emotional, legal, financial, and other personal issues
Transportation Benefits	**ConnectYourCare** ▸ Allows you to use pre-tax payroll dollars to pay for qualified parking and transit expenses
Employee Discount Program	**Allegis Group, Inc/Abenity** ▸ 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.

[1] You may elect or change these benefits during the annual Open Enrollment period or anytime during the year with a qualifying status change.
[2] You may elect or change these benefits anytime during the year with medical underwriting requirements.
[3] You may elect or change these benefits anytime during the year once you meet eligibility, without restriction.
[4] You may elect to open an HSA through Allegis during the annual Open Enrollment period or anytime during the year with a qualifying status change provided you elect an Aetna PPO Medical plan offered by Allegis, but you may change your contribution level to your HSA at any time during the year.

Eligibility

Generally, if you are an active employee working at least 20 hours a week, you are eligible for benefits. The following individuals are also eligible:

- **A spouse:** (1) a person who is legally recognized as the Employee's spouse pursuant to a legally recognized ceremony, or (2) a same-sex partner who either: (a) is legally recognized as the Employee's partner pursuant to a state-sanctioned legal union between two individuals of the same-sex, which affords the same or substantially similar rights to the parties thereto as those imposed by an opposite sex marriage; or (b) provided the employee resides in a state that does not permit same-sex legal unions as described above, meets Allegis's definition of a same-sex Domestic Partner and completes an Affidavit of Domestic Partnership. For more information about Allegis's definition of Domestic Partnership and/or a copy of Allegis's Affidavit of Domestic Partnership, please contact the Human Resources Department.
- **A child who:**

  A. Is under the age of 26 or is permanently and totally disabled (and meets the eligibility requirements described below); and

  B. Is related to you in one of the following ways:

  1. You or your spouse's or same-sex domestic partner's child by birth or legal adoption;
  2. 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 same-sex domestic partner;
  3. 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;
  4. A grandchild who is in the court-ordered custody, and who resides with, and is the dependent of you or your spouse or same-sex 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.

Please note, Allegis Group Contract Employee Health and Welfare Plan does not recognize common law marriage.

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 and same-sex civil union couples who are not dependents as defined in the Internal Revenue Code, and children of domestic partners and same-sex civil union couples who are not dependents of the employee as defined in the Internal Revenue Code, cannot be taken pre-tax.

If you and your spouse or same-sex domestic partner both work for Allegis Group and its operating companies, each family member—you, your spouse or same-sex domestic partner, 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 to 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's plans is a fraudulent act and could result in disciplinary action up to and including termination.

When Benefits Begin

If you are a new hire, your benefit coverage begins on the first of the month following 60 days of employment (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 you are effective to enroll for benefits and you will be responsible for all missed premiums.

Example:
Hired 6/4/15
Benefit Coverage Begins 9/1/15
Must Enroll By: 12 Midnight ET, 9/30/15

You can access the website and enroll in benefits at any time from your date of hire through the end of the month you become eligible. Your benefits are always effective the first of the month following sixty days of employment. If you wait until the end of your eligibility month to enroll, your benefits will still be effective on the first and you will be responsible for the entire month's premiums. For example, if you were hired on July 7th your benefits would be effective October 1st . You could enroll at any time from your hire date until October 31st.

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.

How to Enroll

Enroll Online at AllegisMarketplace.com. AllegisMarketplace.com is an online benefits service that puts benefits information and enrollment at your fingertips 24 hours a day, seven days a week. **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.
- **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 **AllegisMarketplace.com** after the enrollment period whenever you have questions about your benefits.

If you do not have web access, please contact your local office for a paper application. You may fax your enrollment form and all other forms to the Benefits Department at 410-540-7549. 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 AllegisMarketplace.com

First Time AllegisMarketplace.com Users

- Go to **www.AllegisMarketplace.com**. (We strongly recommend the most recent version of Internet Explorer or Firefox).
- Click on the "**Register Now**" link located on the right-hand side of your screen.
- 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 that will be presented when the page loads. Select Next.
- Follow the directions provided on the site to complete your registration and setup your online account.

Returning AllegisMarketplace.com Users

- Go to **www.AllegisMarketplace.com**. (We strongly recommend the most recent version of Internet Explorer or Firefox).
- You will see a "**Login**" on the right of your screen where you can enter your Username and Password. Enter your Username and Password and then select **Login**. Please note: If you have forgotten your username and/or password, click on "**Login Help**" link.

The Enrollment Process

Once you log in, just follow these steps:

1. Review your personal information.
   a. 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 your local office)
   b. Employment information (if this information is incorrect, please contact your local office)
   c. Dependent Review. If you need 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 your current benefits and details of your 2015 options.
3. Elect your 2015 benefits or waive those you do not wish to elect. When doing so, choose your coverage level (Employee, Employee & Partner, Employee & Children, Family) or waive coverage. If you choose coverage other than employee only, you must add your dependents to the plan.
   a. Medical

   **The PPO medical plans offered here will help you meet your Individual Mandate under the Affordable Care Act (ACA).*

   b. Bridge Plans
   c. Critical Illness Insurance
   d. Accident Insurance
   e. Hospital Indemnity Plan
   f. Major Expense Protection Plan (MEPP)
   g. Dental
   h. Vision
   i. Life Insurance (if you enroll outside of your eligibility period or increase your existing coverage you will be subject to approval by Reliance)
   j. AD&D
   k. Short Term Disability (STD)
   l. Long Term Disability (LTD)
4. Review all of your elections and continue through the enrollment process.
5. Elect your deductions for the benefits you have selected to be auto-deducted from your paycheck on a pre- or post-tax basis (please note, life insurance and disability are always deducted on a post-tax basis). To learn more about the advantages of pre-tax deductions, see page 37 or visit **AllegisMarketplace.com**.
6. Review the Online Enrollment User Acknowledgment and complete the online enrollment process.
7. Print your online Enrollment Election form and keep this copy for your records.

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

Below is a list of the benefits that need a beneficiary as well as 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.
- Click "Change Beneficiary Designations".

401(k)

- Log on to **www.wellsfargo.com/allegisgroup**.
- Click on "My Profile".
- Click on "Beneficiary Maintenance".

Benefit Identification (ID) Cards

Your medical and bridge plan ID cards will arrive at your home approximately 3 weeks from the time your enrollment is received at Aetna. You will not receive ID cards for the critical illness, accident, hospital indemnity, major expense protection plan, 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 **AllegisMarketplace.com** and select the "My Benefits & Personal Information" tab at the top of the Homepage. Under the Benefits Information Column, select "Print Temporary Benefit Confirmation". Select the benefits you would like to print a temporary confirmation for and select "Retrieve ID Cards".

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, or unless you have a qualifying status change (described later in this guide): medical/ prescription, bridge plans, critical illness, accident insurance, hospital indemnity, major expense 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.

Remember that you must meet your Individual Mandate under the Affordable Care Act (ACA) or pay an IRS tax. Enroll in one of the three medical PPO plans offered by Allegis to ensure you meet your Individual Mandate and avoid the IRS tax.

If You Do Not Have Web Access

If you do not have access to **AllegisMarketplace.com**, you may complete a paper enrollment to enroll in your benefits. To obtain a paper enrollment form, please contact your local office. You may fax your completed forms to the Benefits Department at 410-540-7549, inter-office the forms to; Allegis Group Benefits Department, Mail Stop- AG-29 OR mail them to: Allegis Group Benefits Department, 7312 Parkway Drive, Hanover, MD 21076.

Paying for Your Benefits

You pay for your benefits through weekly payroll deductions. Your premiums for your medical, bridge plans, critical illness, accident, hospital indemnity, major expense protection plan, dental, and vision coverage will be deducted from your paycheck on a pre-tax or post-tax basis, depending on the option you choose. However, according to federal law, premiums for a domestic partner or same-sex civil union couple and his/her respective child(ren) cannot be paid on a pre-tax basis unless the domestic partner or partner within a same-sex civil union couple or child qualifies as your dependent as defined under the Internal Revenue Code.

Under Section 125 of the Internal Revenue Code, if you choose pre-tax contributions, you may not change or cancel your benefits unless you incur a qualifying status change, described later in this guide. If you choose post-tax contributions you may cancel your benefits at any time during the year without restriction, but you cannot change your benefits (i.e., adding/ removing dependents) unless you experience a qualifying status change.

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

Pre-Tax Contributions

Pre-tax contributions save you money because you are taxed on less income.

In the example below, the employee contributes $1,200 in healthcare premiums. He saves $360 when he makes those contributions on a pre-tax basis.

	Post-tax Premiums	Pre-tax Premiums
Annual Income	$50,000	$50,000
Pre-tax Premiums	$0	($1,200)
Taxable Income	$50,000	$48,800
Estimated taxes (30%)	($15,000)	($14,640)
After-tax Premiums	($1,200)	$0
Net Take-home pay	$33,800	$34,160
Take-home pay increases	$0	**$360**

Please keep in mind:

- Weekly payroll deductions begin the first full week of benefit coverage.
- If you wait until the latter part of the month in which you become eligible to enroll, your benefits will still begin on the first of the month in which you become eligible and you will be responsible for all missed premiums.
- Missed deductions will be made up with double deductions in subsequent weeks.
- You must pay for your benefits every week, regardless of how often you use them.
- **You medical weekly premium may change if you experience a change in age or geographical location during the plan year.**

If You Have Questions

If you have questions about your benefit choices or the enrollment process, contact your local office or a Benefits Advisor by contacting the Benefits Service Center at 1-866-886-9798, Monday through Friday 8am to 6pm ET, or send an email to AskBenefits@allegisgroup.com. Phone numbers and web addresses for the various benefit plan providers are found on the back of this guide.

Build a Plan that Works for You!

Allegis offers a wide variety of plans for every situation and budget. You can select as little or much coverage as you need to build a plan that's right for you. Below are examples of some common situations and the plans that were built for them. Remember these plans can work alone or together! Details about each of these plans can be found on the next several pages of this guide.

Need help deciding which plan or combinations of plans is right for you? Talk with a Benefits Advisor at 1-866-886-9798—Monday–Friday, 8 am–6 pm EST.

How to Build a Medical Plan...
that fits your needs and budget!

I need...	Medical PPO Plans	Bridge Plan	Critical Illness Insurance	Hospital Indemnity Plan	Major Expense Protection Plan	Accident Insurance
A traditional & comprehensive benefits package	✓	✓	✓	✓	✓	✓
Coverage that meets my Individual Mandate under the ACA - But I don't want to pay a high out of pocket deductible	✓	✓				
Coverage that meets my Individual Mandate under the ACA - to avoid the IRS tax	✓					
A less expensive way to help pay for some of my medical costs (I'm not concerned about the IRS tax for not having coverage that meets the Individual Mandate under the ACA)		✓			✓	✓
Options to help me save money even though I have coverage elsewhere (through a spouse's plan, parent, etc.)		✓	**ADD ANY OF THESE PLANS** to help you save on out of pocket costs			

**DISCLAIMER: Plan names distinguish only deductible levels and do not correspond to, or are not equivalent to, medical plans available through public exchanges.*

Medical Preferred Provider Organization (PPO) Plans

Allegis Group offers contract employees three (PPO) medical plans. The plans are from Aetna Life Insurance Company. All of the plans offer access to Aetna's nationwide network of providers. Referrals are not required.

Three comprehensive plan options are available to you—Bronze*, Silver*, and Gold*. They primarily differ in the weekly premium amount you pay for coverage and the calendar year deductible.

As with most PPO plans, you can choose your own doctors, and you can choose to go in-network or out-of-network for care. Using in-network providers will costs you less. For a network provider near you, visit **AllegisMarketplace.com** for a direct link to the Aetna website or go to **www.aetna.com**.

If you use a doctor outside the network (a "non-preferred provider"), your costs will usually be higher, as shown in the following chart. 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.

Good News! We've got you covered!

All three of the Comprehensive PPO Plans—Bronze*, Silver*, and Gold*—will allow you to meet your Individual Mandate under the Affordable Care Act (ACA). So, if you enroll in any of them, you will avoid the IRS tax for not having ACA-compliant coverage.

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 full description of covered services and exclusions, please see the Certificate and Booklet Summary of Coverage (SOC) available online at **www.AllegisMarketplace.com**.

Aetna Navigator® Member Website

If you enroll in any of the Aetna PPO medical plans, you have access to the Aetna Navigator member website. When you sign up and use it, you can easily:

- **Find in-network doctors** who accept your plan.
- **See what you owe.** Look up claims to see how much the plan paid and what you may have to pay.
- **Know your plan.** Check who is covered by your plan and what it covers.
- **Get valuable information.** See which doctors and hospitals have met extra standards for quality and efficiency.
- **Know costs before you go.** See cost estimates before you make an appointment for an office visit, test or procedure.
- **Get healthier.** Take a health assessment to learn about your health and how to lower your risks.

Visit AllegisMarketplace.com for a direct link to the Aetna Navigator Member Website or go to www.aetna.com to learn more. For the mobile app, visit www.aetna.com/mobile.

**DISCLAIMER: Plan names distinguish only deductible levels and do not correspond to, or are not equivalent to, medical plans available through public exchanges.*

Are PPO benefits coordinated with benefits from other plans?

Yes, as comprehensive major medical plans, the Aetna PPO Plans are designed to supplement other comprehensive medical plans such as a spouse's medical plan. Together, the two types of plans can provide very robust benefits.

PPO Covered Services

The following chart highlights commonly covered services under the three Aetna medical insurance plans. For a full description of covered services and exclusions, please see the Summary of Benefits and Coverage (SBC) and the Certificate and Booklet Summary of Coverage (SOC) available online at **www.AllegisMarketplace.com**.

Plan Features	Bronze*[1]		Silver* [1]		Gold*	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$5,500 Individual $11,000 Family	$11,000 Individual $22,000 Family	$4,000 Individual $8,000 Family	$8,000 Individual $16,000 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family
Member Coinsurance	40%	50%	40%	50%	40%	50%
Payment Limit/ Out-of-Pocket Maximum	$6,450 Individual $12,900 Family	$12,900 Individual $25,800 Family	$6,450 Individual $12,900 Family	$12,900 Individual $25,800 Family	$6,450 Individual $12,900 Family	$12,900 Individual $25,800 Family
Preventive Care	Covered at 100%	Covered at 20%	Covered at 100%	Covered at 20%	Covered at 100%	Covered at 20%
Office Visit to Non-Specialist	You pay 40% after $20 copay; after deductible	You pay 50%; after deductible	You pay 40% after $20 copay; after deductible	You pay 50%; after deductible	You pay 40% after $20 copay; after deductible	You pay 50%; after deductible
Specialist Office Visit	You pay 40% after $40 copay; after deductible	You pay 50%; after deductible	You pay 40% after $40 copay; after deductible	You pay 50%; after deductible	You pay 40% after $40 copay; after deductible	You pay 50%; after deductible
Emergency Care	You pay 40%; after deductible	You pay 40%; after deductible	You pay 40%; after deductible	You pay 40%; after deductible	You pay 40%; after deductible	You pay 40%; after deductible
Hospital	You pay 40% after $500 per admission copay; after deductible	You pay 50%; after deductible	You pay 40% after $500 per admission copay; after deductible	You pay 50%; after deductible	You pay 40% after $500 per admission copay; after deductible	You pay 50%; after deductible

The above are high-level examples of plan benefits. See the Aetna Plan Design and Benefits grids for Aetna PPO Bronze*, Silver* and Gold* plans for full plan details including Exclusions and Limitations. The documents will be available on www.AllegisMarketplace.com.

For more information on the Bronze*, Silver*, or Gold* Medical Plans, including the weekly premiums, contact your local office or a Benefits Advisor at 1-866-886-9798.

**DISCLAIMER: Plan names distinguish only deductible levels and do not correspond to, or are not equivalent to, medical plans available through public exchanges.*

[1]This health plan, alone, does not meet Minimum Creditable Coverage standards that are effective January 1, 2011 as part of the Massachusetts Health Care Reform Law. If you purchase this health plan only, you will not satisfy the statutory requirement that you have health insurance meeting these standards.

Prescription Benefits

The three medical PPO (Bronze*, Silver*, and Gold*) options include prescription coverage. You can get prescription medications at a pharmacy (Retail) or through mail order (Aetna Rx Home Delivery). Copays below apply only after the medical plan deductible is satisfied.

Retail

If you get a prescription at a retail pharmacy, your copay will be based on whether you use an in-network or out-of-network pharmacy, and the type of drug, as shown below:

Bronze*, Silver*, Gold* Retail Pharmacy — 30-day supply		
	In-Network	Out-of-Network
Generic	$20 copay after deductible	$20 copay after deductible, plus 50% of the submitted cost
Formulary brand-name	$40 copay after deductible	$40 copay after deductible, plus 50% of the submitted cost
Non-formulary brand-name	$70 copay after deductible	$70 copay after deductible, plus 50% of the submitted cost

The above are high-level examples of plan benefits. See the Aetna Plan Design and Benefits grids for Aetna PPO Bronze*, Silver*, and Gold* plans for full plan details including Exclusions and Limitations. The documents will be available on www.aetna.com.

Mail Order – Aetna Rx Home Delivery®

Aetna Rx Home Delivery is Aetna's mail order prescription drug service for maintenance medications (prescription medications used to treat chronic conditions or diseases).

Aetna Rx Home Delivery offers you:

- **Cost Savings** – You can receive up to a three-month supply for only two copays.
- **Convenience** — Quick, confidential shipping of your maintenance medications right to your home, place of work or any other location of your choice. Standard delivery is free. Overnight requests can be shipped for an additional cost.
- **Ease of Use** — A simple, two-step process makes ordering your maintenance medications easy. Refills can be ordered by mail, phone, online, or by fax.
- **Quality Service** — Registered pharmacists check orders for accuracy and are available 24 hours a day, 7 days a week in case of emergency.

Your copays for medications you receive through Aetna Rx Home Delivery are shown below.

Bronze*, Silver*, Gold* Aetna Rx Home Delivery® (Mail Order) — 31–90 day supply		
	In-Network	Out-of-Network
Generic	$40 copay after deductible	Not applicable
Formulary brand-name	$80 copay after deductible	Not applicable
Non-formulary brand-name	$140 copay after deductible	Not applicable

The above are high-level examples of plan benefits. See the Aetna Plan Design and Benefits grids for Aetna PPO Bronze*, Silver*, and Gold* plans for full plan details including Exclusions and Limitations. The documents will be available on www.AllegisMarketplace.com.

In accordance with applicable law and our pharmacy policies, Aetna Rx Home Delivery can only dispense the brand name version of certain medications, unless your doctor specifically prescribes the generic alternative by name.

For additional information about Aetna Rx Home Delivery, please log into **www.AllegisMarketplace.com** and view the Aetna Rx Home Delivery Information and Order Form located under the Important Form Downloads section. For questions about your pharmacy benefit, please call the Member Services number on your member ID card.

**DISCLAIMER: Plan names distinguish only deductible levels and do not correspond to, or are not equivalent to, medical plans available through public exchanges.*

To Use Your Prescription benefits:

If you use an in-network pharmacy, just show your ID card and pay the appropriate copay.

If you use an out-of-network pharmacy, you may have to pay for your prescription out of pocket and submit your receipt to Aetna for reimbursement (unless the pharmacy submits the claim for you). Once you meet the annual deductible, Aetna will reimburse you according to the plan.

Prescriptions do apply toward your out-of-pocket maximum expense limit.

Walk-In/Retail Health Care Clinics

As a feature of the Medical PPO Plans, you may have a Doctor Office Visit performed in a Walk-In or Retail Health Care Clinic for a $20 copay, whereas if the service is performed in your doctor's office you would pay a $20 copay.

Walk-in Clinics and Retail Health Care Clinics are clinics that are either freestanding or located in retail stores, supermarkets or pharmacies. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. They are not alternatives for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital are considered walk-in clinics or retail health care clinics.

Some examples of walk-in/retail health care clinics are MinuteClinic (inside select CVS stores) and TakeCare Health (inside select Walgreens stores).

To determine whether a walk-in or health care clinic in your area is a participating provider, log in to Aetna Navigator (www.aetna.com) and click "Find a Doctor, Pharmacy or Facility" on the left. Enter the required information and your "provider category". Choose "Facilities". Or, call Aetna at 1-855-873-9409.

Discounts and Programs You Receive If Enrolled in Aetna Medical PPO Plans

Your enrollment in the Medical PPO plans includes special programs* and discounts** with a wealth of features. These programs include savings on products and educational materials geared toward particular health needs. Here are a few highlights:

Weight management discount program

You and your eligible family members can save on weight-loss programs and products from Jenny Craig®.

Hearing discount program

Receive a discount** on hearing exams and services with HearPO® at participating locations nationwide.

Aetna Natural Products and Services℠ program

Professional services**, such as acupuncture, chiropractic care, massage therapy and nutritional counselors offered at reduced rates.

Discounts on health-related products* including over-the-counter vitamins, herbal and nutritional supplements and natural products.

Fitness program

Discounted rates on memberships at participating health clubs contracted with GlobalFit™ as well as savings on home exercise equipment.

Aetna Vision℠ Discounts

Receive discounts** on eyewear, contact lenses, LASIK eye surgery and eye care accessories at participating optical centers such as Sears Optical®, LensCrafters®, Target Optical® and many Pearle Vision® locations.

Informed Health® Line

Provides health information from a registered nurse and instant online access to information**

To learn more about these programs and discounts once you are an Aetna member go to www.aetna.com, choose "Health Programs", then "See the Discounts". Follow the steps for each discount you want to use.

*These discount programs are rate-access programs and may be in addition to any plan benefits. Discount and other similar health programs offered hereunder are not insurance. Program features are not guaranteed under the plan contract and may be discontinued at any time. Program providers are solely responsible for the products and services provided hereunder. Aetna does not endorse any vendor, product or service associated with these programs. It is not necessary to be a member of an Aetna plan to access the program participating providers.

** Discounts are from the provider's usual fee for the service (retail price). These discount programs are not incurred benefits but provide access to discount programs maintained by Aetna Inc. and its affiliates.

Additional Supplemental Plan Options

Allegis offers several supplemental plans, which can be purchased in addition to a comprehensive medical plan, or on their own. Please remember that none of the supplemental plans by themselves will not satisfy your Individual Mandate under the ACA.

Aetna Bridge Plans

The Aetna Bridge Plans are supplemental fixed indemnity plans that are designed to work with the PPO Plans (described in the previous section) to provide more robust coverage. For example, if you enroll in one of the PPO plans, you will have to meet a deductible before the plan will cover certain services. And, for other services, you will need to pay a copay. If you enroll in a Bridge Plan in addition to a PPO Plan, the Bridge plan could cover some of the expenses you have to pay before you reach your PPO Plan deductible, and copays thereafter.

While the plans work well together, the Bridge Plans do not coordinate benefits with the Medical PPO plan and are purchased separately.

The Aetna Bridge Plan pays a fixed dollar amount whenever you receive a covered service—even if you haven't yet met your medical plan's deductible. You can use the cash benefit any way you want. Allegis Group offers three of these plan options (Basic, Enhanced, and Premium) through Aetna.

The Aetna Bridge Plans are designed to supplement the Aetna PPO plans or other comprehensive plans, such as spouse's medical plan. Together, the two types of plans can provide very robust benefits.

While the Aetna Bridge Plans work well when combined with a more traditional or comprehensive plan, they can also be purchased individually. Enrolling in any one of these plans does not require purchasing any additional coverage. *(Please note this plan does not meet Minimum Essential Coverage under the ACA and does not provide IRS penalty protection.)*

Please note: these plans are not available to employees who live in Hawaii, North Dakota and Washington State. These plans are not available to employees who live and work in New Hampshire.

Why enroll in a Bridge Plan?

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.

Affordable—Group rates that are typically less per week than the average cost of a couple's night out at the movies; pre-tax payroll deductions make it even better.

Which coverage options are right for you?

Contact the Benefits Service Center to speak with a Benefits Advisor 1-866-886-9798 or email AskBenefits@allegisgroup.com for help.

Three Aetna Bridge Plan options are available. The chart below shows how much each of the options pays for various services.

Service	Basic	Enhanced	Premium
Inpatient Hospital Stay—daily benefit *(Includes maternity)* Plan pays per day in a private or semi-private room Plan pays per day in Intensive Care Unit (ICU) Maximum number of stays per coverage year	$350 $700 2 stays	$500 $1,000 2 stays	$650 $1,300 2 stays
Inpatient Hospital Stay— lump-sum benefit *(Includes maternity)* Plan pays per initial day of an inpatient stay Maximum number of days per coverage year	$500 2 days	$700 2 days	$900 2 days
Inpatient surgical procedure Plan pays per day on which a surgical procedure is performed Maximum number of days per coverage year	$300 2 days	$450 2 days	$550 2 days
Inpatient Accident - additional benefit Plan pays per initial day of an inpatient stay for an accident Maximum number of days per coverage year	$200 2 days	$300 2 days	$400 2 days
Emergency room Plan pays per day on which an emergency room visit occurs Maximum number of days per coverage year	$175 2 days	$275 2 days	$375 2 days
Outpatient surgical procedure Plan pays per day on which a surgical procedure is performed Maximum number of days per coverage year	$300 2 days	$450 2 days	$550 2 days
Outpatient doctors' office visits *Includes doctors' service in the office, home, walk-in clinic, and urgent care clinic.* Plan pays per day on which doctors' services are provided Maximum number of days per coverage year	$60 5 days	$70 7 days	$80 7 days
Outpatient laboratory and x-ray services Plan pays per day on which lab or x-ray services are provided Maximum number of days per coverage year	$70 3 days	$90 3 days	$110 3 days
Prescription drugs, equipment and supplies Plan pays per day on which a prescription drug, equipment or supply is obtained Maximum number of days per coverage year	$30 12 days	$45 12 days	$55 12 days

How to use your Aetna Bridge Plans prescription benefit

The Bridge Plans prescription benefit is a discount reimbursement program. If the prescription being purchased is eligible for a discount and the pharmacy is in-network, the discount will be applied at the point-of-purchase and you will then pay your cost of the prescription.

In order to be reimbursed, you will need to submit a medical claim form and the prescription receipt (not the cash register receipt) to Aetna. Reimbursement is either $30, $45, or $55 per day, depending on the plan you purchase (see the benefit description on the previous page for details). You are allotted 12 days per coverage year that Aetna will reimburse prescriptions. For example, Bill fills a prescription on June 18th, therefore his allotted number of days per coverage year would change from 12 to 11. Then, a month later, Bill needed to fill three more prescriptions; his allotted number of days per coverage year would change from 11 to 10, as so on.

A. Present your Aetna identification (ID) card to the pharmacist.

B. Participating pharmacies will apply a discount.

C. You pay the amount charged by the pharmacy.

D. Submit a medical claim form to Aetna to receive your Bridge payment.

To find a participating pharmacy, call toll-free 1-855-873-9409 or visit www.aetna.com/docfind/custom/avp.

Services to prevent illness are covered under the applicable benefit (Outpatient doctors' office visits or Outpatient laboratory and x-ray services) listed in this Benefit Summary, the same as services to treat illness.

Aetna Bridge Plans – Weekly Premiums			
Coverage Level	**Basic Plan**	**Enhanced Plan**	**Premium Plan**
Employee	$17.40	$23.34	$27.12
Employee & Partner	$38.44	$51.81	$60.31
Employee & Children	$34.23	$46.11	$53.67
Family	$55.28	$74.58	$86.87

Note – these premiums are for the Aetna Bridge Plans only; these do not include the PPO Medical Plans.

For more information on the Bridge Plans, contact the Benefits Service Center at 1-866-886-9798 to speak with a Benefits Advisor.

Critical Illness Insurance

Critical Illness Insurance pays you a fixed dollar amount if you or a covered family member is diagnosed for the first time with a serious illnesses or condition such as invasive cancer, heart attack, stroke, end-stage renal failure, major organ transplant, paralysis, and coma. The plan is "guaranteed issue" coverage, which means you cannot be denied coverage, regardless of current or prior personal or family health history. (Please note: while you cannot be denied for your prior personal or family history, you cannot obtain coverage for a specific covered critical illness if you have previously been diagnosed with that critical illness.) You may elect $10,000 (Option 1) or $20,000 (Option 2) worth of coverage for yourself and your spouse. Benefits for children are 25% of the adult benefit.

As with the Aetna Bridge Plans, critical illness insurance is intended to supplement a comprehensive medical plan. It provides a lump sum cash benefit for expenses that may not be covered by a traditional medical plan.

The benefits of critical illness insurance include:

- Helps you have money for deductibles, copays, lost income, experimental treatment, spousal income when using FMLA, etc.
- Benefits are paid directly to you **in addition** to the major medical insurance you may already have in place
- Benefits for the employee or spouse are always 100% of the lump sum benefit you enrolled for ($10,000 or $20,000); benefits for children are 25% of the adult benefit
- With this "first occurrence ever" policy, each condition is independent. So, if you have your first ever heart attack while covered and a year later you are diagnosed with invasive cancer, then you get paid the full benefit amount twice.
- Payroll deductions can be taken pre-tax and paid benefits are not taxed (except for domestic partners and same-sex civil unions).

Critical Illness Insurance – Weekly Premiums		
Coverage Level	**Option 1 – $10,000**	**Option 2 – $20,000**
Employee	$4.07	$8.13
Employee & Partner	$8.13	$16.28
Employee & Children	$5.43	$10.86
Family	$9.50	$18.99

Critical Illness Insurance can be purchased as a stand-alone plan or in addition to any one of the three comprehensive medical PPO plan options (Bronze*, Silver*, Gold*), Bridge Plans, Accident Insurance, Hospital Indemnity Plan and Major Expense Protection Plan.

For more information on Critical Illness Insurance, contact the Benefits Service Center at 1-866-886-9798 to speak with a Benefits Advisor.

**DISCLAIMER: Plan names distinguish only deductible levels and do not correspond to, or are not equivalent to, medical plans available through public exchanges.*

Accident Insurance

Accident Insurance is another option for supplementing a comprehensive medical plan. When accidents happen, out-of-pocket costs for things such as doctor visits, x-rays and physical therapy can add up fast. This plan can help.

You can choose from two options:

- Coverage of up to $3,500 per accident (Option 1), or
- Coverage of up to $10,000 per accident (Option 2)

The Accident Insurance plan covers any type of accidental injury not incurred at work (up to 3 per calendar year per covered person) and pays your actual billed expenses up to the maximum benefit for the option you purchased. As with the other supplementary plans available, this plan can help you meet your deductible or pay other expenses that are not covered by a comprehensive plan.

Example 1:
Ambulance service $800
Emergency room $1,525
Diagnostic testing (MRI) $750
Physician fees $300
Physical therapy $500
Total expenses $2,875
Benefits paid to insured = $2,875

Example 2:
Urgent Care $310
Lab tests $235
X-rays $280
Physician fees $120
Chiropractic services $390
Prescriptions (inpatient) $75
Total expenses $1,410
Benefits paid to insured= $1,410

Here are two examples of how benefits would be paid if Option 1—Up to $3,500 was elected.

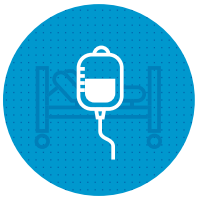
Premiums are based on the coverage level you choose and whether you cover yourself only or yourself and your dependents.

Accident Insurance – Weekly Premiums		
Coverage Level	**Option 1—Up to $3,500**	**Option 2—Up to $10,000**
Employee	$7.13	$8.51
Employee & Partner	$15.20	$18.14
Employee & Children	$11.69	$13.95
Family	$21.16	$25.26

Accident Insurance can be purchased as a stand-alone plan or in addition to any one of the three medical PPO plan options (Bronze*, Silver*, Gold*), Bridge Plans, Critical Illness Insurance, Hospital Indemnity Plan and Major Expense Protection Plan.

For more information on the Accident Insurance Plan, contact the Benefits Service Center at 1-866-886-9798 to speak with a Benefits Advisor.

**DISCLAIMER: Plan names distinguish only deductible levels and do not correspond to, or are not equivalent to, medical plans available through public exchanges.*



Hospital Indemnity Plan – Symetra

If you are hospitalized as an inpatient, the plan will pay you $1,000 in cash per admission, up to 3 admissions per covered person per calendar year. Each covered person will also receive a benefit for each day (24 hour period) hospitalized as illustrated by the chart below subject to all policy provisions.

The plan also includes a Pharmacy Discount Program at no additional cost. A discount from usual and customary drug charges will be given to you when prescriptions are purchased through an in-network pharmacy. This is not a prescription drug benefit but a discount program provided through ReStat (www.restat.com). Most national pharmacies are included in the ReStat network as are many regional and local pharmacies. You can verify participation by asking your pharmacy or checking on-line. **You should not attempt to use this discount program if you participate in the medical plan through Allegis or another medical plan with prescription drug coverage.**

This plan can be purchased as a stand-alone plan or in addition to any one of the three PPO medical plan options (Bronze*, Silver*, Gold*), Bridge Plans, Critical Illness, Accident Insurance and Major Expense Protection Plan.

Health advocacy services are also included at no additional cost.

Hospital Indemnity – Weekly Premiums	
Coverage Level	
Employee	$6.63
Employee & Partner	$13.05
Employee & Child	$13.05
Family	$18.82

Benefit	Coverage
Deductible	None
Copay	None
Lifetime Maximum	500 days lifetime maximum (except for Mental Health Facility Stay)
Hospital Admission	$1,000 per admission, per covered person, per calendar year
Hospital Stay[1] (regular room)	$300 per day, 30 days maximum per covered person, per calendar year
Hospital Stay[1] (ICU)	$600 per day, 30 days maximum per covered person, per calendar year
Hospital Stay[1] (Substance Abuse Facility)	$300 per day, 30 days maximum per covered person, per calendar year
Hospital Stay[2] (Mental Health Facility)	$300 per day, 30 days maximum per covered person, per calendar
Post Hospital Nursing Facility Stay[1,3]	$150 per day, 60 days maximum per confinement per covered person under the age of 65

This is a summary of benefits for illustration purposes only. Policy provisions govern. See policy for details, exclusions and limitations.
[1]500 days per lifetime maximum
[2]180 days per lifetime maximum
[3]Following a hospital stay of at least 3 days

**DISCLAIMER: Plan names distinguish only deductible levels and do not correspond to, or are not equivalent to, medical plans available through public exchanges.*

Major Expense Protection Plan (MEPP) – Symetra

The Major Expense Protection Plan (MEPP) offers you the opportunity to buy additional emergency room and inpatient hospital coverage, which includes inpatient hospitalization for substance abuse, and mental health. The MEPP does not issue restrictions on hospitals, meaning there is no requirement to use participating providers. The following chart is a summary of the plan.

This plan can be purchased as a stand-alone plan or in addition to any one of the three PPO medical plan options (Bronze*, Silver*, Gold*), Bridge Plans, Critical Illness, Accident Insurance and Hospital Indemnity Plan.

Major Expense Protection Plan (MEPP) – Weekly Premiums	
Coverage Level	
Employee	$24.45
Employee & Partner	$50.85
Employee & Child	$50.85
Family	$58.22

Benefit	Coverage
Deductible	None
Copay	None
Lifetime Maximum	500 days lifetime maximum for each benefit per person (except for Mental Illness)
Emergency Room Benefit: Covered events that are the result of an illness or accident are paid at a pre-selected fixed dollar amount per visit up to a calendar year maximum. This benefit will be paid only for procedures received in an emergency room.	$200 per visit/$500 calendar year maximum per person, per calendar year
Inpatient Hospital Benefit: Coverage for inpatient hospital stays is provided and benefits are paid at a pre-selected fixed dollar amount per day of confinement up to a maximum number of days per calendar year. Daily Hospital Substance Abuse Intensive Care Unit Mental Health Facility Nursing Facility	• $1,500 per daily hospital stay/30 days maximum per calendar year • $1,500 per day, per person for stays in a substance abuse facility/30 days maximum per calendar year • $3,000 per day, per person for stays in the Intensive Care Unit/30 days maximum per calendar year • $750 per day, per person for stays in a mental health facility / 30 days maximum per calendar year, 180 days per lifetime • $750 per day, per person for stays in a nursing facility (only if following a covered hospital stay of at least 3 consecutive days and the person is less than age 65)/ maximum 60 consecutive days per stay
Maternity Care	Covered as any other condition

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

The MEPP is not a replacement for a major medical policy or other comprehensive policy. It is designed to cover benefits used on a routine basis at a pre-selected, fixed dollar amount. Coverage may be subject to exclusions, limitation, reductions, and termination of benefit provisions. Exclusions, limitations, definitions, and benefits may vary by state. Please see the policy for details. The Major Expense Protection Plan is insured by Symetra Life Insurance Company, 777 108th Avenue NE, Suite 1200, Bellevue, WA, 98004. Symetra℠ is a service mark of Symetra Life Insurance Company

DISCLAIMER: Plan names distinguish only deductible levels and do not correspond to, or are not equivalent to, medical plans available through public exchanges.

Health Savings Account (HSA)

The HSA, available through Wells Fargo, is a tax-favored account that allows you to prepare for, manage, save and pay for qualified medical expenses tax-free. You may enroll in an HSA if you are in the Allegis high deductible health plan (the Allegis Group Bronze*, Silver* and Gold* medical plans).

HSAs also compliment your retirement plan, helping you prepare for the costs of medical coverage at retirement.

You determine how much you want to save by making contributions to your HSA through pre-tax payroll deductions. You may be reimbursed from the money in your account for current or future medical expenses, including medical expenses after you retire. Even if you leave Allegis, you keep your HSA.

Using Your HSA Money

The money in your HSA can be used to pay for qualified medical expenses that are not covered by the Aetna PPO medical plan, such as your deductible, copays, and other out-of-pocket health care expenses. A list of eligible expenses can be found at **www.irs.gov/pub/irs-pdf/p502.pdf**. Unused HSA money will stay in your account year after year.

HSA Contributions

You determine how much you want to contribute to your HSA on an annual basis. You may contribute up to the following IRS maximums:

2015 HSA Annual Contributions	
Coverage Level	**You may contribute (pre-tax)****
Individual	Up to $3,350
Employee & Partner **Employee & Children** **Family**	Up to $6,650

** You may make an additional catch-up contribution of up to $1,000 if you will be age 55 or older in 2015.

Enrolling in an HSA

To enroll in an HSA, you will to elect it on AllegisMarketplace.com, indicating how much you want to contribute for 2015. For information on setting up your Health Savings Account, visit **www.AllegisMarketplace.com** or call 1-866-886-9798

Dental Plan - MetLife

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.

Dental Benefits

This chart provides highlights of some covered services. For a full description of covered services and exclusions, please see the detailed plan description provided on **www.AllegisMarketplace.com**.

Benefit	In-Network	Out-of-Network
Annual (calendar year) Deductible (for Type B and C Expenses Combined)	$50 per person	$50 per person
Annual (calendar year) Plan Limit Maximum Benefit	$1,000 per person	$1,000 per person
Type A Expenses Preventive Oral Exams once every six months Cleaning, polishing once every six months	Plan pays 100%* no deductible	Plan pays 100%** no deductible
Type B Expenses X-rays, fillings, minor oral surgery	Plan pays 80%* after deductible	Plan pays 80%** after deductible
Type C Expenses Crowns, dentures, bridgework, complex oral surgery	Plan pays 50%* after deductible	Plan pays 50%** after deductible
Type D Expenses Orthodontia	Not Covered	

Additional Type A, B & C information can be found in the MetLife Dental Plan Certificate of Insurance. *Plan Benefits subject to the Maximum Allowed Charge for the types of dental services shown in section C of the Plan Certificate of Insurance. The Maximum Allowed Charge is the lower of: a. the amount charged by the Participating Provider for the service or supply; and b. the maximum amount that the Participating Provider agreed with us to charge for that service or supply. This maximum amount is specified or based on the amounts specified in the Preferred Dentist Program Table of Maximum Allowed Charges. ** Plan Benefits subject to Reasonable and Customary (R&C) limits for the types of dental services shown in section C of the Plan Certificate of Insurance. The Reasonable and Customary Charge is the lowest of: a. the usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies; or b. the usual charge of most other Dentists or other providers in the same geographic area for the same or similar services or supplies; or c. the actual charge for the services or supplies.

Dental – Weekly Premiums	
Coverage Level	**Option 1**
Employee Only	$6.54
Employee & Partner	$14.99
Employee & Children	$13.15
Family	$16.94

For more information on the Dental Plan, including how to find a participating dentist, visit **AllegisMarketplace.com** for a direct link to MetLife or go to **www.metlife.com/dental** or **www.metlife.com/mybenefits**. 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 Plan - VSP

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, visit **AllegisMarketplace.com** for a direct link to the VSP website or go to **www.vsp.com**. Select "**Members and Consumers**" and "**Find a VSP Network 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 form to VSP for reimbursement.

Vision Benefits

Benefit	Frequency*	In-Network	Out-of-Network
Eye Exam	Well/Vision: Once every 12 months	$15 copay, then plan pays 100%	Plan pays up to $50
Contact Lens Exam[1] (Fitting & Evaluation)	Once every 24 months	$60 copay (maximum), then plan pays 100%	Plan pays up to $105
Frames	Once every 24 months	Plan pays 100% for selected frames up to $130	Plan pays up to $70
Lenses: Single vision Bifocal (lined) Trifocal (lined) Lenticular	Once every 24 months	Combined $15 copay for lenses and frames, then Plan pays 100%	Plan pays up to: $50 $75 $100 $125
INTERIM BENEFITS for lenses (including contact lenses) and frames every 24 months—If your lens prescription changes before you are eligible for new lenses, lenses & frames will be replaced at a 12 month frequency if your new prescription meets at least one of the following criteria: a) your new prescription differs from the original by at least a .50 diopter sphere or cylinder; b) an axis change of 15 degrees for more; c) a 5 prism diopter change in at least one eye.			
Visually Necessary contact lenses	Once every 24 months	$15 copay, then plan pays 100%	Plan pays up to $210
Elective contact lenses	Once every 24 months	Plan pays up to $130	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.
[1]Member receives 15% off of contact lens exam services.

For more information on the Vision Plan, contact the Benefits Service Center at 1-866-886-9798 to speak with a Benefits Advisor.

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 VSP doctor and provides you information about VSP doctors.
- **"Member Resources"** guides you in using your VSP benefits; provides Frequently Asked Questions and much more.

Vision – Weekly Premiums	
Coverage Level	**Option 1**
Employee Only	$1.69
Employee & Partner	$2.66
Employee & Children	$2.71
Family*	$4.37

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

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.

Disability Plans

Short-Term Disability Coverage (STD) – The Hartford

The company offers a Short-Term Disability (STD) plan through The Hartford 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 The Hartford. Late enrollees are subject to approval by The Hartford and medical questions will be required to be answered.
- Deductions are taken on a post-tax basis, so any benefit paid is tax-free.
- Coverage ends on your last day of employment.
- 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.
- For information about the availability of state leave, please contact the Benefits Department.

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 on **www.AllegisMarketplace.com**, you will be able to automatically calculate your weekly STD premium.

For more information on the STD Plan, contact the Benefits Service Center at 1-866-886-9798 to speak with a Benefits Advisor.

Your Age	STD Weekly Premium Multiplier*
Under 25	$.182
25-29	$.155
30-34	$.155
35-39	$.136
40-44	$.143
45-49	$.162
50-54	$.203
55 and over	$.242

*The costs shown above are 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 $3.92.

- 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 $.136.
  - When the $.136 is multiplied by $28.80, the employee arrives at his/her weekly premium of $3.92.

Family and Medical Leave (FMLA)

The company provides Family and Medical Leaves of Absence without pay to eligible employees. The Family and Medical Leave Act ("FMLA") provides eligible employees the opportunity to take unpaid, job-protected leave for certain specified reasons. The maximum amount of leave an employee may use is either 12 or 26 weeks within a 12-month period depending on the reasons for the leave. For additional details regarding FMLA (including Military-Related FMLA Leave), please see the full FMLA Policy, which is posted on the Company's intranet, or may be obtained in your local office.

Long-Term Disability Coverage (LTD) - MetLife

The company 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.
- 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.
- Deductions are taken on a post-tax basis so any benefit is tax-free.
- Coverage ends on your last day of employment.
- When you enroll, you can choose a five-year benefit period or a benefit period to age 65.
- LTD benefits are not paid for more than 24 months for mental or nervous disabilities.
- A work incentive benefit lets you return to work during partial disability.
- If you die while on LTD, three months of benefits will be paid to your survivor.
- 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.
- 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.
- For information about the availability of state leave, please contact the Benefits Department.

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 on **www.AllegisMarketplace.com**, you will be able to automatically calculate your weekly LTD premium.

For more information on the LTD Plan, contact the Benefits Service Center at 1-866-886-9798 to speak with a Benefits Advisor.

Your Age	LTD Weekly Premium Multiplier*	
	5 Year Plan	To Age 65 Plan
Under 25	0.031	0.045
25-29	0.036	0.056
30-34	0.050	0.081
35-39	0.067	0.118
40-44	0.090	0.157
45-49	0.144	0.254
50-54	0.237	0.355
55 and over	0.404	0.452

The costs shown above are 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 $3.54.

- 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/$10 = 30).
  - Using the age of the employee (36) and the chart above, the premium multiplier in this example is $0.118.
  - When the $0.118 is multiplied by 30, the employee arrives at his/her weekly premium of $3.54.

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

Life and AD&D Plans

Life Insurance – Reliance Standard Life

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

- **Employee Life Insurance**—You may buy up to $150,000 in term life insurance coverage. Evidence of Insurability is not required if you enroll within your original eligibility period. If you enroll outside of your original eligibility period, you must provide Evidence of Insurability. Coverage is available in increments of $10,000. When you enroll, you must name a beneficiary. The amount of insurance in effect is subject to automatic reduction beginning at age 75.
- **Life Insurance for your Spouse**—You may buy up to $30,000 in term life insurance for your spouse. Evidence of Insurability is not required if you enroll your spouse within your original eligibility period. If you enroll outside of your original eligibility period, you must provide Evidence of Insurability. Coverage is available in increments of $10,000. You are the beneficiary for spouse's coverage. On the date of application, your spouse must be under age 70. Insurance on a spouse 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 6 months is $1,000. Coverage for children age 6 months but less than 26 years is the elected amount. You are the beneficiary.

The cost of employee and spouse'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 multiplier's are shown on the following chart. When completing your new hire enrollment on **www.AllegisMarketplace.com**, you will be able to automatically calculate your weekly Life Insurance premiums.

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 following chart.

When completing your new hire enrollment on **www.AllegisMarketplace.com**, you will be able to automatically calculate your weekly Life Insurance premium.

Your Age	Employee/Spouse Life Insurance Weekly Premium Multiplier*
Under 30	$.141
30-34	$.171
35-39	$.247
40-44	$.351
45-49	$.653
50-54	$1.057
55-59	$1.638
60-64	$2.993
65-69	$4.403
70 and over	$7.145

*The costs shown above are per $10,000 of life insurance coverage.

Example – for an individual age 46 with $50,000 in life insurance, the weekly cost is $3.27 [$.653 (weekly rate for age 46) times 5].

Amount of Insurance	Age	Dependent Child(ren) Life Insurance Weekly Premium Multiplier
$2,500*	6 months but less than 26 years	$.136
$5,000*	6 months but less than 26 years	$.205
$7,500*	6 months but less than 26 years	$.275
$10,000*	6 months but less than 26 years	$.344

* If 14 days but less than 6 months, benefit will be $1,000.

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 **www.AllegisMarketplace.com** for more details, or contact the Benefits Service Center at 1-866-886-9798 to speak with a Benefits Advisor.

Accidental Death and Dismemberment (AD&D) Insurance – Reliance Standard Life

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'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.

Coverage Level	Employee/Family AD&D Weekly Premium Multiplier
Employee Only	$.090
Family	$.210

*The costs shown above are per $10,000 of coverage.

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].

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

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 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, or contact the Benefits Service Center at 1-866-886-9798 to speak with a Benefits Advisor.

Filing Claims

Below are instructions on how to file a claim with each of the benefit carriers. All claim forms (where applicable) can be found on **www.AllegisMarketplace.com**.

For Medical PPO Plan (Bronze*, Silver*, Gold*) Claims:

- In-Network—provider should submit claims to Aetna
- Out-of-Network—The employee will pay the claim out-of-pocket and submit the claim to the address located on the Aetna Medical Claim Form:

Aetna • PO Box 981106 • El Paso, TX 79998-1106

All claims must be submitted within 90 days from the date of service. Claims are not covered if they are filed more than two years after the 90-day deadline.

*To obtain a medical claim form, go to **AllegisMarketplace.com** or visit www.aetna.com or call the member services number at 1-866-894-2770.*

For Prescription Reimbursement Claims:

Submit the claim form, along with your register receipt and the appropriate drug receipt with name of pharmacy, name of the drug etc. to the address located on the Aetna Medical Claim Form:

Aetna • PO Box 981106 • El Paso, TX 79998-1106

All claims must be submitted within 90 days from the date of service. Claims are not covered if they are filed more than two years after the 90-day deadline.

*To obtain a medical claim form, go to **AllegisMarketplace.com** or visit www.aetna.com or call the member services number at 1-866-894-2770.*

**DISCLAIMER: Plan names distinguish only deductible levels and do not correspond to, or are not equivalent to, medical plans available through public exchanges.*

For Bridge Plans (Basic, Enhanced, Premium) and Prescription Reimbursement Claims:

- In-Network—provider should submit claims to Aetna
- Out-of-Network—The employee will pay the claim out-of-pocket and submit the claim to the address located on the Aetna Medical Claim Form:

Aetna • PO Box 981106 • El Paso, TX 79998-1106

All claims must be submitted within 90 days from the date of service. Claims are not covered if they are filed more than two years after the 90-day deadline.

*To obtain a medical claim form, go to **AllegisMarketplace.com** or visit www.aetna.com or call the member services number at 1-866-894-2770.*

For Critical Illness, Accident Insurance, Hospital Indemnity Plan or Major Expense Protection Plan (MEPP) Claims:
Simply mail a copy of your itemized receipt for services (given to you by your provider) to the address below:

CLAIMS: Symetra Select Benefit Administrators of America • P.O. Box 440 • Ashland, WI 54806
Make sure the following information is shown on your service receipt:

- Insured's ID (Social Security Number)
- Patient Name
- Provider name, address and ID
- Diagnosis or ICD-9 code(s) [description of your medical condition]
- Procedure or CPT or revenue codes [that indicate services rendered]
- Associated charges
- Dates of service.

If any of this information is missing, simply write it in.

For Dental Claims:
In Network-the dentist should submit the claim to MetLife

Out-of Network-the employee should submit the Dental Claim form to:

MetLife (National) • P.O. Box 981282 • El Paso, TX 79998

*To obtain a dental claim form, go to **AllegisMarketplace.com** or visit MetLife.com.*

For Vision Claims:
In-Network—the employee pays appropriate copay, and the physician submits the claim to Vision Service Plan

Out-of-Network—the employee should pay the provider the full amount of the bill and request an itemized copy of the bill that shows the amount of the eye examination, lens type, and frame (if applicable). The employee should send a copy of the itemized bill to:

Vision Service Plan Attn: Non-Member Doctor Claims P.O. Box 997105 • Sacramento, CA 95899-7100

The following information must be included:

- Member's name and mailing address
- Member's Social Security Number
- Member's employer (Allegis Group)
- Patient's name, relationship to member, and date of birth
- Submit the above information on any generic insurance claim form that may be available upon request from your Non- Participating provider. (Vision claim forms are not available at the Allegis Corporate offices.)

All claims must be submitted within 6 months from the date of service.

For Life Insurance and Accidental Death & Dismemberment (AD&D) Claims:

The appropriate Reliance Standard Life Insurance Company Claim Form should be completed in full. The form, along the required documentation (listed on the form) should be mailed to:

Allegis Group • Corporate Benefits Department • 7312 Parkway Drive • Hanover, MD 21076

*To obtain a life insurance and/or AD&D claim form, go to **AllegisMarketplace.com**.*

For Short Term Disability (STD) Claims:

You may file a claim by calling The Hartford's toll-free number 1-866-945-7781 8:00 a.m.–8:00 p.m. EST, or you may file a claim online at **www.TheHartfordAtWork.com**. You will be asked to provide:

1. Your name and social security number
2. Department and last day of active full-time work
3. Manager's name and phone number
4. Nature of claim and whether it's work-related
5. Treating physician's name, address and phone number

Family and Medical Leave (FMLA)

Complete the following forms:

- Family and Medical Leave of Absence Form
- Certification of Health Provider Form

You must contact your local office to make a request for leave. The Leave Administrator will reply directly to you via U.S. mail.

Both forms must be completed in full and sent together to:

Allegis Group Corporate Benefits Department • 7312 Parkway Drive • Hanover, MD 21076

*To obtain FMLA forms, go to **AllegisMarketplace.com**.*

For Long Term Disability (LTD) Claims:

- The physician must complete the Long Term Disability Claim Form-Attending Physician, in full
- The employee must complete the Long Term Disability Claim Form-Employee Statement, in full
- The employer must complete the Long Term Disability Claim Form-Employer Statement, in full

All three fully completed forms must be sent together to:

MetLife • P.O. Box 14590 • Lexington, KY 40511-4590

*To obtain LTD forms, go to **AllegisMarketplace.com**.*

Allegis Group 401(k) Plan

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

- You can contribute up to 100% of your eligible compensation up to the maximum permitted by the IRS. The dollar limit is $ 18,000* for 2015.
- 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 are eligible to participate in the 401(k) plan on the 1st of the month following 30 days of employment.
- Deductions usually begin during the first full week of payroll.
- Employees age 50 or over may contribute an additional "catch-up contribution." The maximum catch-up contribution is $6,000 for 2015. This full amount can be contributed even if you are "highly compensated," as defined by the IRS.
- 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 5 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.

*Highly compensated employees may not be able to defer the statutory maximum.

For more information or to enroll, visit **AllegisMarketplace.com** for a direct link to the Wells Fargo website or go to **www.wellsfargo.com/allegisgroup**.

529 College Savings Plan – Alliance Capital

Paying for college can be hard; but saving for college is easy with a 529 College Savings Plan. That is why Allegis Group offers access to the Alliance Capital CollegeBoundFund. This plan is not part of Open Enrollment; you can sign up at any time.

- There are no income limits; you can contribute no matter how much you earn.
- You can save as little as $50 per month, and can contribute until your account reaches the current maximum of $350,000.
- You have a variety of investment options through Alliance Capital.
- Earnings on your account grow tax-free.
- You can open an account for yourself, for a family member, or as a gift to a friend.
- Withdrawals from your account can be used at accredited colleges, universities, graduate schools, and most community colleges and vocational-technical schools in the U.S.

You may enroll any time throughout the year.

For more information or to enroll, visit **www.corporate.collegeboundfund.com**. On your first visit, select "**Company**" as your ID type and use "**Allegis**" as your username and "**Allegis529**" as your password. Follow the instructions on the website to enroll. If you do not have access to a computer or the Internet, call Alliance Capital at 1-800-227-2900.

Employee Discount Programs – Allegis Group/Abenity

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.

Auto and Home Insurance – MetLife

MetLife Auto and Home is a voluntary group benefit program that offers special group rates and policy discounts for personal insurance coverage needs. Policies include auto, landlord's rental dwelling, condo, mobile home, renters, recreational vehicle, boat, and personal excess liability ("umbrella") polices. For more information or to get a quote, visit **AllegisMarketplace.com** for a direct link to MetLife. Or go to **www.metlife.com** or call MetLife at 1-800-438-6388.

Health Advocacy, EAP + Work Life Benefit services provided by Health Proponent, powered by Health Advocate

Health Advocacy, EAP + Work Life Benefit Services are an excellent addition to your benefits package. They can help you, your spouse, dependent children, parents and parents-in-law resolve healthcare and insurance-related issues, improve your health, and balance your work and life. Below are key features of the plan.

Health Advocacy

You have unlimited access to a Personal Health Advocate, typically a registered nurse supported by medical directors and benefits and claims specialists who can help you save you time, money and worry.

Your Personal Health Advocate can help you and your family:

- Find the right doctors, hospital and other providers
- Explain benefits coverage, health conditions and research the latest treatments
- Schedule tests, appointments, and secure second opinions
- Resolve billing and claims issues
- And much more!

EAP + Work Life Benefits

This benefit gives you confidential access to a licensed professional counselor who will provide short-term assistance with personal, family and work issues that are having an impact on your life and ability to focus on work.

Get help with personal, family and work issues such as:

- Drug and alcohol abuse, depression, eating disorders, mental illness
- Divorce, new baby, aging parents, grief and loss
- Financial and legal issues, retirement, identity theft
- Job stress, burnout, coping with difficult situations

Health Advocacy, EAP + Work Benefits–Weekly Premium
$1.38

Transportation Benefits – ConnectYourCare

Transportation Benefits 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 ConnectYourCare link located on the left side of your **AllegisMarketplace.com** home page. Once you arrive at the ConnectYourCare home page, you will then:

- Select New Members and Existing User Log in Here » in the upper right-hand corner.
- If it is your first time visiting the site, choose New User Registration to select your user name and password.
- From My Account, select Transportation Benefits to be taken to the Transit and Parking Home Page.
- Once you have selected your metropolitan area, you can select your transit and/or parking provider and the type of pass you require.

You can set your order up as recurring, meaning ConnectYourCare will automatically process it each month until you notify them otherwise. ConnectYourCare can also send you an email each month reminding you that you have an order in the system and prompting you to re-enter the site if you need to make a change.

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 10 are for vouchers to be used in April). The amount of your purchase, plus a $2.00 post-tax administrative fee, will be deducted from your paycheck on or around the 12th of the month.

After you place your order your passes or vouchers will be mailed directly to you, or if you elect, your parking provider will be paid directly.

Additional information regarding Transportation Benefits, including eligible and ineligible expenses, can be found in IRS publication 15B. You may also call ConnectYourCare at 1-866-468-7010.

Changing Your Benefits During the Plan Year

Once you enroll in a plan that you pay for with pre-tax contributions (pre-tax Medical/PPO Plans, Bridge Plans, Critical Illness Insurance, Accident Insurance, Hospital Indemnity Plan, Major Expense Protection Plan, Dental, and Vision), you generally cannot change elections during the plan year unless you have a qualifying status change as defined by the IRS.

Qualifying Status Changes and Effective Dates		
Status Change Event	**What You May Change**	**Effective Date**
Marriage	Add yourself, spouse, child(ren) and/or stepchild(ren)	First of the month following the event
Birth or adoption or placement for adoption of a child(ren)	Add yourself, spouse, child(ren) and/or stepchild(ren)	Date of the Event
Divorce/Legal Separation (only in states that recognize legal separation)	Cancel coverage for your spouse and stepchildren if enrolled in your employer's plan/Add coverage for yourself and your children if enrolled in your spouse's plan	First of the month following the event
You, spouse or child(ren) loses other coverage[1]	Add yourself, spouse or child(ren)	First of the month coinciding with or following the event
You, spouse, or child(ren) gains other group coverage[2]	Cancel coverage for yourself, spouse, and/or child(ren) who gain coverage	End of the week in which coverage is gained
Change in dependent's eligibility for benefits, such as age	Cancel coverage for your dependent	End of the month following the event

[1]Cancelling an individual health plan is not ordinarily considered a qualifying change and does not allow you to add coverage with Allegis Group.
[2]Purchasing an individual health plan is not considered a qualifying change and does not allow you to cancel your coverage with Allegis Group.

This is a brief overview of some potential qualifying events. Eligible qualifying events are dictated by Internal Revenue Code Section 125.

Also note that you may be able to add coverage mid-year for yourself and/or your dependents (including your spouse or same-sex domestic partner) 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. 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 **AllegisMarketplace.com** or submit a change form. In either case, you need to submit hard copy 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 add dependent life insurance and change your medical plan coverage level (i.e. employee plus one or family), but you may not change or cancel your medical plan.

Please note, if you choose pre-tax contributions you may not change or cancel your benefits unless you incur a qualifying status change. If you choose post-tax contributions you may cancel your benefits at any time during the year without restriction. However, you cannot change your benefits (i.e., adding/removing dependents) unless you incur a qualifying status change.

Additionally, you may be able to drop your medical coverage during the year if your position changes and you are no longer expected to work at least 30 hours a week. 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.

When Coverage Ends

Your coverage under the following plans will end at midnight on the Saturday following your last day of employment: Medical/PPO Plans, Bridge Plans, Critical Illness Insurance, Accident Insurance, Hospital Indemnity Plan, Major Expense Protection Plan, Dental, and Vision.

Example: If you work your final day on Friday, June 12 2015, then your coverage under any of the plans listed above will end at midnight on Saturday, June 13, 2015. Disability, Life and AD&D 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 the definition of an eligible dependent.

COBRA information will be mailed to you when your COBRA eligible coverage ends. This information will come in the mail to you from Kelly & Associates Insurance Group in Hunt Valley, Maryland. You may want to verify that your address is correct in the Benefits System to prevent any delays in receiving your information.

COBRA eligible plans include: Medical PPO plans (Bronze*, Silver* Gold*), Dental, Vision, Major Expense Protection Plan (MEPP), Health Advocacy, EAP + Work Life Benefits).

Please note, Bridge Plans, Critical Illness Insurance, Accident Insurance and the Hospital Indemnity Plan are not COBRA eligible plans. They are portable, meaning you can elect to continue these plans after your coverage ends with Allegis Group. Please contact Symetra directly for instructions.

Life Insurance, AD&D Insurance and Disability Insurance are also not COBRA eligible plans. However, you may elect to continue Life Insurance & 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. You will be reinstated with the same coverage and contributions you had prior to your employment ending. Please keep in mind, you will be responsible for any missed weekly premiums—payment will automatically be made up with double deductions.

**DISCLAIMER: Plan names distinguish only deductible levels and do not correspond to, or are not equivalent to, medical plans available through public exchanges.*

Continuation of Health Care Coverage – COBRA

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 your eligible dependents covered at the time your Company 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 the Company (for reasons other than gross misconduct on your part).
- Your hours are reduced so that you are no longer eligible for the Company Plan.

If you—or a dependent—qualify as disabled (for Social Security benefit purposes) when the group coverage ends or within the first 60 days of COBRA coverage, coverage for the disabled person may continue for up to a total of 29 months.

Your spouse 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 coverage for up to 36 months when they no longer qualify as your dependents.

Applying for COBRA coverage

When your coverage under the Company 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, the Company 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 the Company within 60 days of the event. You then will be provided with information on your COBRA rights.

When COBRA coverage ends

The Company has the right to end your COBRA continued coverage if:

- The Company 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 no longer considered disabled

2015 COBRA Premiums

Medical PPO Plans (Bronze*, Silver*, Gold*)
To obtain the Medical PPO Plan monthly COBRA premiums, please contact the Benefits Service Center via email at askbenefits@allegisgroup.com or by calling 1-866-886-9798.

Major Expense Protection Plan	
Coverage Level	**Monthly Premium**
Employee Only	$108.08
Employee & Partner	$224.75
Employee & Child	$224.75
Family	$257.34

Dental and Vision		
Coverage Level	**Dental Monthly Premium**	**Vision Monthly Premium**
Employee Only	$28.93	$7.48
Employee & Partner	$66.24	$11.74
Employee & Children	$58.14	$11.97
Family	$74.86	$19.32

Health Advocacy & EAP/Work Life Benefits
$6.12

Please note, the Aetna Bridge Plans, Critical Illness Insurance and Accident Insurance, and Hospital Indemnity Plan are not COBRA eligible. You may elect to continue these plans after your Allegis Group coverage ends. Please contact Symetra for instructions.

**DISCLAIMER: Plan names distinguish only deductible levels and do not correspond to, or are not equivalent to, medical plans available through public exchanges.*

Key Contacts, Telephone Numbers, & Websites

For Enrollment, Eligibility or Administrative Questions, contact the Benefits Service Center

1-866-886-9798
www.AllegisMarketplace.com
askbenefits@allegisgroup.com

For Medical/Prescription PPO Bronze*, Silver*, or Gold* Coverage or Claim Questions, or Questions About How the Benefits Work, contact Aetna

1-855-873-9409
www.aetna.com

For Bridge Plans (Basic Enhanced, Premium) Coverage or Claim Questions, or Questions About How the Benefits Work, contact Aetna

1-855-873-9409
www.aetna.com

For Critical Illness Coverage or Claim Questions, or Questions About How the Benefits Work contact Select Benefits

1-800-497-3699

For Accident Insurance Coverage or Claim Questions, or Questions About How the Benefits Work contact Select Benefits

1-800-497-3699

For Hospital Indemnity Claim Questions, or Questions About How Hospital Indemnity Benefits Work, contact Select Benefits

1-800-497-3699

For Major Expense Protection Plan (MEPP) Benefits or Claims Questions, contact Select Benefits

1-800-497-3699

For Health Advocate Advocacy Services, Employee Assistance Plan (EAP) and Work Life Benefits

1-866-949-3435
www.healthproponent.com/Allegis

For Health Savings Account (HSA), contact Wells Fargo

1-866-884-7374
www.wellsfargo.com

For Dental Benefits, Claim Questions, or Participating Dentists, contact MetLife

1-800-942-0854
www.metlife.com/dental

For Vision Benefits, Claim Questions, or Participating Eye Care Providers, contact VSP

1-800-877-7195
www.vsp.com

For Short Term Disability, contact The Hartford

1-866-945-7781

For Long Term Disability, contact MetLife

1-800-300-4296

For Life and Accidental Death & Dismemberment (AD&D) Insurance, contact Reliance Standard Life Insurance

1-800-351-7500

For 401(k), contact Wells Fargo

1-800-728-3123
www.wellsfargo.com/allegisgroup

For 529 College Savings Plan, contact Alliance Capital

1-800-227-2900
www.corporate.collegeboundfund.com

For Auto & Home Insurance contact MetLife

1-800-438-6388
www.metlife.com

For Transportation Benefits contact ConnectYourCare

1-866-468-7010
www.connectyourcare.com

**DISCLAIMER: Plan names distinguish only deductible levels and do not correspond to, or are not equivalent to, medical plans available through public exchanges.*

Appendix: Important Annual Medical Plan Notices

The Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires Allegis Group Inc., to notify you, as a participant of the Allegis Group Inc. Health Plan for Contract Employees, of your rights related to benefits provided through the plan in connection with a mastectomy.

You as a participant or beneficiary have the right for coverage to be provided in a manner determined in consultation with your attending physician for:

a) All stages of reconstruction of the breast on which the mastectomy was performed;

b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

c) Prostheses; and

d) Treatment of physical complications of all stages of then mastectomy, including lymphedemas.

These benefits are subject to the same deductibles and coinsurance applicable to other medical and surgical benefits under the plan as described in the plan's Summary Plan Description (SPD). For further details, refer to your SPD.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers federally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery or less that 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother or newborns attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours as applicable. In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours/96 hours.

Medicare Part D

PLEASE NOTE: This Notice only applies to you if you are eligible for Medicare. If your covered spouse or dependent is covered by Medicare please share this notice with them.

Important Notice from Allegis Group Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Allegis and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Allegis has determined that the prescription drug coverage offered with this plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What are My Choices

If you decide to join a Medicare prescription drug plan, your current prescription drug coverage with Allegis will not be affected.

Before choosing whether to enroll in a Medicare prescription drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. You could choose to:

#1 Keep your medical and prescription drug coverage through Allegis, and not enroll in a Medicare prescription drug plan yet.

This choice is available to you because the prescription drug coverage that is offered to you as part of the overall package of medical benefits provided by Allegis is "creditable"—meaning that, on average, it is at least as good as the standard Medicare prescription drug coverage.

#2 Keep your medical and prescription drug coverage through Allegis, but also enroll in a Medicare prescription drug plan now.

Under this choice, you will be paying premiums for both the Medicare prescription drug plan you select and for medical and prescription drug coverage through Allegis. You will continue to receive medical and prescription drug benefits through Allegis. The benefits (if any) that you receive from the Medicare prescription drug plan you select will depend on the cost and type of prescription drugs that you use, the coverage of the plan that you choose, and the prescription drug coverage provided under Allegis's plan. If you enroll in a Medicare prescription drug plan, you must notify the Allegis Benefits Service Center so that your Allegis benefits can be coordinated with the benefits you receive through the Medicare prescription drug plan.

#3 Enroll in a Medicare prescription drug plan now and drop your medical and prescription drug coverage through Allegis.
Under this choice, you will have prescription drug coverage only through the Medicare prescription drug plan that you have selected. However, you will also be dropping ALL of your medical coverage through Allegis—not just the prescription drug coverage—and you may not be able to re-enroll or otherwise get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Allegis and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Maxim changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date: October 2014
Name of Entity/Sender: Allegis Group, Inc.,
Contact—Position/Office: Benefits Service Center Address: 7312 Parkway Drive, Hanover, MD 21076
Phone Number: 1-866-886-9798

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2014. You should contact your State for further information on eligibility.

ALABAMA – Medicaid
Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447

ALASKA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP
Website: http://www.azahcccs.gov/applicants
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

IDAHO – Medicaid
Medicaid Website:
http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx
Medicaid Phone: 1-800-926-2588

INDIANA – Medicaid
Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

IOWA – Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

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

LOUISIANA – Medicaid
Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/publicassistance/index.html
Phone: 1-800-977-6740
TTY 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3629

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

MONTANA – Medicaid
Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633

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

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

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

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

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

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

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

OREGON – Medicaid
Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: www.ohhs.ri.gov
Phone: 401-462-5300

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

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

TEXAS – Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Website: http://health.utah.gov/upp
Phone: 1-866-435-7414

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: http://health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 10/31/2016)

A Final Word

In this brochure, we describe your employee benefits in a clear, simple, and concise manner. Complete descriptions of the plans are contained in the corresponding contracts or plan documents. If there is any disagreement between this brochure and the wording of the corresponding contract or plan document, the contract or plan document will govern. Allegis Group reserves the right to modify, amend, suspend, or terminate any plan, in whole or in part, at any time. This brochure does not constitute a guarantee of employment.

Health Care Benefits Acknowledgment

Please initial each of the statements below to acknowledge the following:

____ I have received the summary of the benefit plans in which I am eligible to participate and understand that I am eligible to enroll in medical coverage.

____ I have received the notice titled "New Health Insurance Marketplace Coverage Options and Your Health Coverage."

____ I have received a Summary of Benefits and Coverage describing the benefits available to me.

____ I acknowledge this is only a summary of the benefits. This brochure describes my employee benefits in a clear, concise manner. Complete descriptions of the plans are contained in the corresponding plan documents. If there is any disagreement between this brochure and the wording of the corresponding 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 **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 if I choose to participate in the benefit for which I am eligible, I will need to visit **AllegisMarketplace.com** or complete the required paper enrollment forms to enroll.

This brochure does not constitute a guarantee of employment.

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: _____

Designed & Prepared by:

KELLY BENEFIT STRATEGIES | THE BUSINESS OF *Better*®

Group Insurance Brokers & Consultants Specializing in Healthcare

A Division of Kelly & Associates Insurance Group
301 International Circle • Hunt Valley, MD 21030