WELCOME

Dynamic Energy Solutions, LLC takes pride in offering a comprehensive and competitive benefit package to its employees. Dynamic Energy through all of its benefit partners, offers you a program that allows choice and flexibility. Through this program you can choose the benefits that meets the needs of you and your family.

Take the time to review all of the plan options available to you prior to making your selections. Consider each benefit, the associated cost and choose the plans that will best meet your needs throughout the year.

Benefit elections made during open enrollment remain in place for the full plan year. Elections made when first eligible for benefits remain in place until the end of the plan year in which you are hired.

The Internal Revenue Service *(IRS)* states that eligible employees may only make elections to the plan once a year at open enrollment. Medical, Dental, and Vision benefit choices are binding through July 31st. The following circumstances are the ONLY reasons you may change your benefits during the year:

Marriage	***Death of a Spouse***
Divorce	***Death of a Dependent***
Birth & Adoption	***Loss of Dependent Status***
Loss of Spouse's job where coverage is maintained through a spouse's plan	

These special circumstances, often referred to as life event changes, will allow you to make plan changes at any time during the year in which they occur. For any allowable change, you must inform the Human Resources contact within 30 days of the life event change. All other changes would be deferred until open enrollment.

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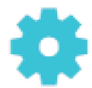
Medical & Prescription Drugs

Dynamic Energy's Medical plan option is designed to provide you and your family with access to high quality healthcare. The medical plan is available through UnitedHealthcare.

The medical option covers a broad range of healthcare services and supplies, including prescription drugs, office visits and hospital services.

Please refer to the summary on Page 2 for specific details on the medical plan option. www.myuhc.com

Eligibility - Medical benefits are effective the 1st of the month following date of hire



Medical & Prescription Drugs

Benefit Description	Base Plan - Gold Choice 1000 AC1R	
	In-Network	**Out-of-Network**
Deductible (per benefit period) Per Member Per Family	 $1,000 $2,000	 $2,000 $4,000
Coinsurance	80% after deductible	60% after deductible
Out of Pocket Maximum Per Member Per Family	 $3,500 $7,000	 $6,000 $12,000
Physician Visit Primary Specialist	 $25 $50	60% after deductible
Preventive Care	100%	60% after deductible
Hospitalization	80% after deductible	60% after deductible
Outpatient Surgery: Free-Standing Hospital Based	 80% after deductible 60% after deductible	60% after deductible
Emergency Room	80% after in-network deductible	
Urgent Care	$100 Copayment	60% after deductible
Outpatient Lab: Free-Standing lab Hospital Based lab	 80% after deductible 60% after deductible	60% after deductible
Outpatient X-Ray: Free-Standing Hospital Based	 80% after deductible 60% after deductible	60% after deductible
Complex Radiology (MRI/MRA/CT/PET): Free-Standing Hospital Based	 80% after deductible 60% after deductible	60% after deductible
Prescription Deductible **Prescription Drugs** Tier 1 Tier 2 Tier 3 Specialty	$100/Individual **Retail** $10 after Rx ded $40 after Rx ded $75 after Rx ded $10/$100/$300 after Rx ded	$100/Individual **Mail Order** $25 after Rx ded $100 after Rx ded $187.50 after Rx ded $10/$100/$300 after Rx ded

Should there be any discrepancies between the above summary and the actual plan contract(s), the Plan contract(s) supersedes this summary.

Dental Plan

Good dental health is important to your overall well being. At the same time, individuals need different levels of dental treatment. The Aetna dental plan provides affordable coverage based on the type of services obtained – **Preventive, Basic or Major** – whether or not you obtain services from an in-network or out-of-network provider.
However, If you use dentists or dental specialists that are part of Aetna's network (In-Network Dental Provider) you will have lower out-of-pocket expenses. Out-of-network reimbursements are based on Aetna maximum allowable charge, therefore you may be balanced billed for services

A complete provider directory can be accessed online at www.aetna.com. For the DMO dental plan select DMO providers and for the PPO plan select PPO providers.

Dental Benefit Description	Voluntary Dental	
Plan Name	Aetna Voluntary Option 6A Ortho FOC PPO High Max	
Network	Aetna DMO Plan	**Aetna PPO Plan
Election of Primary Dentist	Yes	No
Deductible - Calendar Year - (Waived Preventive)	None	$50/$150
Calendar Year Maximum	None	$1,000
Office Visit Copay	$5	None
Diagnostic/Preventive Services Periodic Exams, Prophylaxis, x-rays	100%	100% - In-Network 100% - Out-of-Network
Basic Restorative Services Fillings, Root Canal Therapy (anterior teeth/ bicuspid teeth), Periodontics, Oral Surgery	100%	80% - In-Network 80% - Out-of-Network
Major/Specialty Services Single crowns, inlays, onlays, Canal Therapy (molar teeth)	60%	50% - In-Network 50% - Out-of-Network
Orthodontia Benefit - Children up to age 19	*$2,300 Copay	50% - In-Network 50% - Out-of-Network
Orthodontic Lifetime Maximum	*	$1,000

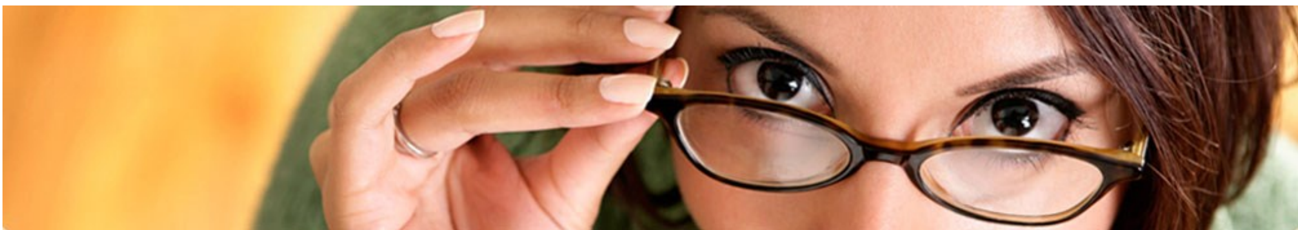
****The PPO MAX plan has a Coverage Waiting Period. You must be an enrolled member of the PPO MAX plan for 12 months before becoming eligible for coverage of any Major and Orthodontic Services. The waiting period does not apply to the DMO.**

Vision Plan

All eligible employees who are enrolled in the medical plan would be eligible for EyeMed vision coverage at no cost to you. Vision coverage will allow participants to get an examination annually and lenses or contact lenses every 12 months. This coverage allows participants to receive frames every 12 months.

Participants have the option of receiving care from an in-network or out-of-network provider; however, if you use a non-network provider you will incur higher out-of-pocket expenses. To find EyeMed participating vision providers go to www.eyemedvisioncare.com.

Description	In-Network	Out-of-Network
Exam	$10 copay	Reimbursed up to $40
Frames	$0 copay; then $150 allowance, 20% off balance over $150	Reimbursed up to $105
Standard Lenses (*in lieu of contact lenses*)		
Single Vision Lenses	$20 copay	Reimbursed up to $30
Bifocal Vision Lenses	$20 copay	Reimbursed up to $50
Trifocal Vision Lenses	$20 copay	Reimbursed up to $70
Contact Lenses (*in lieu of lenses*)		
Conventional	$150 allowance, 15% off balance over $150	Reimbursed up to $150
Disposable	$150 allowance, 15% off balance over $150	Reimbursed up to $150
Medically Necessary	Covered in Full	Reimbursed up to $210



Basic Life and Accidental Death & Dismemberment

Dynamic Energy provides to all full-time employees a Basic Life and Accidental Death Insurance equal to 1 times your annual earnings up to a maximum of $100,000. Amounts above the Guarantee Issue (GI) limit require underwriting approval. Age Reduction Schedule reduce to 65% at age 65, to 40% at age 70, to 25% at age 75 and to 15% at age 80.

These benefits are paid for by Dynamic Energy and provided by The Standard Insurance Company.

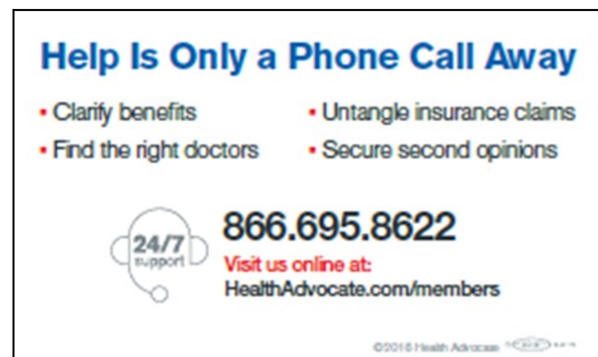
Disability Insurance

Disability benefits provide you with a source of income in the event that you become disabled from a non work-related injury or sickness. Dynamic Energy offers long-term disability benefits to all full-time employees. These benefits are paid for by Dynamic Energy and provided by The Standard Insurance Company.

Long Term Disability: Your long-term disability benefit equals 60% of your monthly base earnings. This LTD plan has an automatic maximum benefit that automatically increases the LTD maximum benefit amount by an annually compounded five percent for the first 5 years. This benefit takes effect after a 90 day waiting period that begins at the start of an absence due to an accident or illness.

Benefit	Long-Term Disability
Benefit Percentage	60% of Monthly Earnings
Benefit Maximum	$5,513 Per Month (Automax benefit)
Elimination Period	90 Days
Pre-Existing Condition Exclusion	3/12
Maximum Duration	The greater of your normal Social Security retirement age as defined in the 1983 amendment to the Social Security Act. If age 62 or older when disability occurs, refer to the employee certificate for duration of benefit schedule.

Standard will determine approval of claims. Please see SPD for exclusions and limitation that may apply.



Health Advocate

If you need help obtaining answers involving your medical, hospital, dental, mental health, medication, flexible spending account, or Medicare; Health Advocate is here to help. Health Advocate is a free benefit available to you, your dependents, parents, and parents-in-law 24/7 that can help resolve medical billing problems, claims processing issues, and other insurance-related concerns. All conversations are confidential.

During your first call, you will be assigned a Personal Health Advocate who will begin helping you right away. Personal Health Advocates are typically registered nurses supported by medical directors and benefits and claims specialists. They'll help cut through the red tape and assist with complex conditions, find specialists, address eldercare issues, clarify insurance coverage, work on claim denials, help negotiate fees for non-covered services and get to the heart of your issue.

Email: answers@healthadvocate.com
Web: www.healthadvocate.com/member

HIPAA SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health/dental/vision insurance coverage and if you lose that coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment with 30 days after your other coverage ends. If you are declining coverage for yourself and/or your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, loss of Medicaid or SCHIP coverage, eligibility for Medicaid or SCHIP coverage, or during an open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, or within 60 days of Medicaid and SCHIP.

If you decline coverage for yourself and/or your eligible dependent(s) because of other health/dental/vision coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental/vision coverage.

NON-MEDICAL

If you are voluntarily declining non-medical coverage provided by your employer, you may choose to enroll at a later date depending upon the coverage now being waived. With the late enrollment your cost may be higher, a health questionnaire may be required and the effective date of your coverage may be delayed or denied. If coverage is non-contributory (employer pays entire cost) waivers are not permitted.

Note: Under Section 125, you may make changes to your pre-tax benefit plans only if you experience a qualified event. The change you request must be consistent with the event. The following are the IRS minimum Qualified Events:

1. Marriage, divorce, or legal separation;
2. Birth or adoption of a child;
3. Death of a spouse or child;
4. Change in residence or work location that affects benefits eligibility for you or your covered dependent(s);
5. Your child(ren) meets (or fails to meet) the plan's eligibility rules (for example, student status changes);
6. You or one of your covered dependents gain or lose other benefits coverage due to a change in employment status (for example, beginning or ending a job);
7. Loss or eligibility for Medicaid or CHIP.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers 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 than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours as applicable. In any case, plans and 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.

IMPORTANT NOTICE FROM DYNAMIC ENERGY 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 Dynamic Energy 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. Dynamic Energy has determined that the prescription drug coverage offered under out fully-insured plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Dynamic Energy coverage may be affected. You may keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Dynamic Energy coverage, be aware that you and your dependents may be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Dynamic Energy 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 November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact your plan administrator.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Dynamic Energy 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).

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

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.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	KANSAS – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
ALASKA – Medicaid	**KENTUCKY – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
ARKANSAS – Medicaid	**LOUISIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**MAINE – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
FLORIDA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120
GEORGIA – Medicaid	**MINNESOTA – Medicaid**
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739
INDIANA – Medicaid	**MISSOURI – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IOWA – Medicaid	**MONTANA – Medicaid**
Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

NEBRASKA – Medicaid	SOUTH CAROLINA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEVADA – Medicaid	**SOUTH DAKOTA - Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW HAMPSHIRE – Medicaid	**TEXAS – Medicaid**
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW JERSEY – Medicaid and CHIP	**UTAH – 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	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NEW YORK – Medicaid	**VERMONT– Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	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
NORTH DAKOTA – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
OKLAHOMA – Medicaid and CHIP	**WEST VIRGINIA – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
OREGON – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
PENNSYLVANIA – Medicaid	**WYOMING – Medicaid**
Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
RHODE ISLAND – Medicaid	
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Andrew Smith at 484-323-1168 or asmith@dynamicenergyusa.com.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name			4. Employer Identification Number (EIN)
Dynamic Energy Solutions, LLC			80-0379632
5. Employer address 1550 Liberty Ridge Drive, Suite 310			6. Employer phone number 484-323-1168
7. City Wayne		8. State PA	9. ZIP code 19087
10. Who can we contact about employee health coverage at this job? Andrew Smith			
11. Phone number (if different from above) 484-323-1168	12. Email address asmith@dynamicenergyusa.com		

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

  Employees who work 40 hours or more/week

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

  Spouse & Dependents/Stepchildren to Age 26

  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Notes:

This document describes, in general outline form, the main features of the benefits offered by Dynamic Energy. Limitations and exclusions do apply. Please refer to the Summary Plan Description for coverage details. In case of a conflict between the Benefit Summary and the Group Contract, the Group Contract will govern.

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