Employee Benefits Enrollment Guide

2022-2023

MarketStar

New for 2022

- Delta Dental is the new Dental carrier
- Unum is the new Life and Disability carrier
- Adding Short-Term Disability
- Changing from Ameritas to BBP for Vision
- Modern Health going to 6 visits

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At MarketStar, we believe employees are the foundation of our success.

MarketStar is pleased to offer you a selection of comprehensive, high quality employee benefits for eligible employees and their dependents. This enrollment guide is designed to help you understand the options available.

Who is eligible?

- Full-time employees who actively work at least 30 hours per week;
- Your legal spouse or domestic partner;
- Your natural born children, current stepchildren, or legally adopted children up to age 26;
- Your children of any age if they depend on you for support due to a physical or mental disability (documentation may be required).

If you're enrolling a domestic partner...

IRS and some state regulations require that you pay your cost for domestic partner coverage with after-tax dollars. The portion of the cost that the company pays is also subject to income and Social Security taxes. This amount is referred to as imputed income. Please consult your tax advisor for details.

When does coverage begin for New Hires?

Coverage begins on the first of the month following hire date. You must be actively at work for your coverage to become effective.

What do I need to consider for Open Enrollment?

When choosing your insurance coverage for 2022-2023, review the benefit options available to you and make the elections that are right for you and your family.

- Which medical plan will work best for you?
- Which medical carrier fits your needs?
- How much do you want to contribute to the health care account that works with your medical plan?
- Do you need dental or vision coverage?
- Do you need to cover eligible family members under your insurance benefits?
- Do you want to purchase supplemental life or disability insurance?
- Do you have upcoming life events to consider when selecting benefits, such as the birth of a new baby, a marriage, or a child going to college?
- Who should be your beneficiary for life insurance and your Health Savings Account (HSA), if applicable?

Important reminder

If you do not make changes during Open Enrollment, most of your current coverage will rollover. If you have a Dependent Care Account or a Flexible Spending Account (FSA), you MUST log into **Workday** and re-elect the plan and contributions for the 2022-2023 plan year. If you do not make changes during Open Enrollment, your next opportunity to make changes will be during next year's Open Enrollment period or with an IRS qualifying life event. For more details on IRS qualifying life events, visit healthcare.gov.

IMPORTANT NOTICE

During your benefits enrollment period, you can add an eligible dependent to your coverage. Once you're enrolled, if you get married, have/adopt a baby, get a divorce, or another **qualified life event occurs, you must notify HR within 30 days** of the date of change. For more information about who's eligible to be on your plans, see the Notices section of this guide.

Useful Contact Information

Medical

UMR

umr.com (844) 600-0919

Health Savings Account (HSA)

Optum Bank

optumbank.com (866) 234-8913

Flexible Spending Account (FSA)

National Benefit Services

nbsbenefits.com (800) 274-0503

Dental

Delta Dental

deltadentalins.com (800) 521-2651

Vision

BBP Administration

support@bbpadmin.com (630) 773-2337

Life and Disability Insurance

Unum

unum.com (866) 679-3054

Dependent Care Assistance Plan (DCAP)

BBP Administration

support@bbpadmin.com (630) 773-2337

Legal Plan

Hyatt Legal / MetLaw

members.legalplans.com (800) 821-6400

401(k)

Empower

participant.empower-retirement.com (855) 756-4738

Benefits Manager

April Nelson

benefits@marketstar.com (801) 786-5088

Diversified Insurance

Employee Advocate

marketstar@digadvocate.com (801) 325-5094

Important Information About Medical Coverage

Understanding your deductible

Your deductible is the amount you must pay for covered services before your insurance plan begins to pay for covered services. For example, if your plan has a $1,000 deductible, you'll pay the first $1,000 for covered services. You can meet the deductible with an all-at-once charge for an expensive service — such as an MRI or surgery — or with charges from several small services — such as doctor visits — where you might pay a small copay. Keep in mind that copays don't usually count toward your deductible.

Coinsurance

Once you've met your deductible, you'll pay coinsurance for covered services. Coinsurance is the percentage of costs you're responsible for paying, which counts towards your out-of-pocket maximum.

Out-of-pocket maximum

The out-of-pocket maximum is the maximum amount that you'll pay out of pocket in a plan year. Once you've paid your deductible and paid coinsurance up to the out-of-pocket maximum — all covered services will be 100% paid for by the insurance carrier for the remainder of the plan year. When considering your medical plan options, consideration for the out-of-pocket maximum is essential.

Premiums

Premiums are the monthly costs you pay to use your benefits — think of this like paying for a gym membership — you pay a fee to use the equipment. For insurance, you're paying a membership fee for discounted services and access to specific providers.

Contributions

MarketStar pays a portion of your monthly premium to limit your monthly cost and provide you with affordable coverage options.

Embedded Deductible

An embedded deductible is where each family member has an individual deductible in addition to the overall family deductible. When a family member meets their individual deductible before the family deductible is reached, the insurance company will begin paying according to the plan's coverage for that member. If only one family member meets an individual deductible, the rest of the family still has to pay their deductibles until the family deductible is met. No one person will pay more than his or her embedded individual deductible amount.

Traditional PPO Medical Plan

UMR is the Plan Administrator for the Traditional PPO Medical Plan.

You are free to choose any doctor, but you save a bundle when you choose a doctor or facility in the UHC Choice Plus provider network.

When you use an in-network medical provider you don't need a referral to see a specialist. Visit umr.com to find an in-network provider.

	UMR - TRADITIONAL PPO PLAN UHC CHOICE PLUS NETWORK	
	In-Network	Out-of-Network *
Annual Deductible April 1 - March 31	You pay up to **$1,000** per individual **$1,000** per member / **$2,000** per family *Embedded*	You pay up to **$2,000** per individual **$2,000** per individual / **$4,000** per family *Embedded*
Coinsurance	You pay **20%** AD	You pay **40%** AD
Out-of-pocket Maximum	No more than **$3,500** per individual **$7,000** per family	No more than **$7,000** per individual **$14,000** per family
Preventive Services	You pay **$0** according to government guidelines	Not Covered
Office Visits Primary Care Specialist	 You pay **$30** copay You pay **$45** copay	 You pay **40%** AD You pay **40%** AD
Mental Health Services Office Visit Inpatient	 You pay **$30** copay You pay **20%** AD	 You pay **40%** AD You pay **40%** AD
Emergency Services Urgent Care Emergency Room Ambulance	 You pay **$75** copay You pay **$250** copay You pay **20%** AD	 You pay **40%** AD Covered as **In-Network** Covered as **In-Network**
Inpatient & Outpatient Inpatient Hospital Outpatient Surgery	 You pay **20%** AD You pay **20%** AD	 You pay **40%** AD You pay **40%** AD
Prescription Medication Retail (31-day supply)	**Generic / Preferred / Non-preferred / Specialty** You pay **$10** / **$35** / **$75** / **$200**	**Generic / Preferred / Non-preferred / Specialty** You pay **$10** / **$35** / **$75** / **$200**
Health Fund Account Details on page 10	Flexible Spending Account (**FSA**)	

EMPLOYEE COST PER PAY PERIOD				
Employee (EE) Only	EE + Spouse	EE + Child	EE + Child(ren)	EE + Family
$50.50	**$155.91**	**$105.26**	**$120.30**	**$250.23**

AD: After Deductible

***** Providers may charge more than the plan allows when you receive services out-of-network. It is recommended that you ask the out-of-network provider about their billed charges before planning care.

This information is designed to help you choose a benefit plan for 2022-23 only. Please refer to the Plan Documents provided by the carrier for information regarding coverage, limitations and exclusions. If there is a difference between this guide and the Plan Documents, the Plan Documents prevail.

High Deductible Health Plan

UMR is the Plan Administrator for the High Deductible Health Plan (HDHP).

You are free to choose any doctor, but you save a bundle when you choose a doctor or facility in the UHC Choice Plus provider network.

When you use an in-network medical provider you don't need a referral to see a specialist. Visit umr.com to find an in-network provider.

	UMR - HIGH DEDUCTIBLE HEALTH PLAN UHC CHOICE PLUS NETWORK	
	In-Network	Out-of-Network *
Annual Deductible April 1 - March 31	You pay up to **$2,800** per individual **$2,800** per member / **$5,000** per family *Embedded*	You pay up to **$5,000** per individual **$5,000** per member / **$10,000** per family *Embedded*
Coinsurance	You pay **20%** AD	You pay **50%** AD
Out-of-pocket Maximum	No more than **$4,000** per individual **$4,000** per member / **$8,000** per family	No more than **$8,000** per individual **$8,000** per member / **$16,000** per family
Preventive Services	You pay **$0** according to government guidelines	Not Covered
Office Visits Primary Care Specialist	 You pay **20%** AD You pay **20%** AD	 You pay **50%** AD You pay **50%** AD
Mental Health Services Office Visit Inpatient	 You pay **20%** AD You pay **20%** AD	 You pay **50%** AD You pay **50%** AD
Emergency Services Urgent Care Emergency Room Ambulance	 You pay **20%** AD You pay **20%** AD You pay **20%** AD	 You pay **50%** AD Covered as **In-Network** Covered as **In-Network**
Inpatient & Outpatient Inpatient Hospital Outpatient Surgery	 You pay **20%** AD You pay **20%** AD	 You pay **50%** AD You pay **50%** AD
Prescription Medication Retail (31-day supply)	**Generic / Preferred / Non-preferred / Specialty** You pay **$10** AD / **$35** AD / **$75** AD / **$200** AD	**Generic / Preferred / Non-preferred / Specialty** You pay **$10** AD / **$35** AD / **$75** AD / **$200** AD
Health Fund Account Details on page 10	Health Savings Account (**HSA**)	

EMPLOYEE COST PER PAY PERIOD				
Employee (EE) Only	EE + Spouse	EE + Child	EE + Child(ren)	EE + Family
$32.00	**$131.74**	**$70.94**	**$81.08**	**$176.13**

AD: After Deductible

***** Providers may charge more than the plan allows when you receive services out-of-network. It is recommended that you ask the out-of-network provider about their billed charges before planning care.

GenYou & Care Prepare Consults

Say "hello" to health care designed with you in mind.

We've reimagined how every generation navigates health care with Generation**You**™. It's a personalized health benefits experience for the entire family, focused on simplicity and comfort. Communication is tailored to each individual's needs and preferences — how and where you choose.

Connect now. Easy access at your fingertips

Don't leave home without your (or your family's) Gen**You** membership ID card(s). Download the app to store a digital version on your phone for easy access at the doctor's office or pharmacy.

Earn rewards.

Don't miss an opportunity to earn a little extra benefit this plan year. Navigate to the Rewards section of your Gen**You** digital experience or call your Gen**You** Guide to learn more about your (and your dependents') eligibility and expiration dates.

Contact GenYou powered by UMR

(844) 600-0919 | umr.com

GenerationYou makes benefits easy:

- **Complete the "Story of You" questionnaire**. You tell us a little bit about your health story and your preferences, and we'll get you up-to-speed on your plan benefits. It's an easy win-win.
- **Get rewarded for receiving high-quality, low-cost care**! Your Guide will show you how through our Care Prepare consultations. Ask about them to learn more.
- **Make connections**. Your family deserves the very best care, and your Gen**You** Guide will show you the way. Available by chat or phone, they will help you locate a top notch provider or facility in your area.

Be prepared before your next visit with Care Prepare.

GenerationYou Care Prepare Consults empower you to feel confident in your health care choices. Before your next health care visit, schedule a **Care Prepare Pre-Service Consult**. Your guide will help you:

1. Prepare for your appointment
2. Understand what to expect and what questions to ask
3. Select a high-quality, affordable provider or location for care

Log in to Generation**You** or call your Guide to learn how to save!

Get On-the-Go Access with the UMR Mobile Website

Your family's health, in your hands.

Just use your mobile browser to log in using the same username and password that you use on our full site. What's even better — we've made it quick and easy! There's no app to down load, nothing to install, no waiting.

What's new! Find out about new tools and information to help you live a healthier life.

Instant Access. Log in to get instant access to all our mobile inquiry tools.

Check your benefits. View medical benefits, as well as persons covered.

Contact UMR

umr.com | (844) 600-0919

Member chat

Get answers to your claims or benefits questions 24 hours a day, Monday through Friday (excluding major holidays) on umr.com. Now it's even easier to get the answers you need — fast. Once you've logged in, just click the Live Chat icon in the menu on the home page. It's that easy.

Simplified navigation

Home: Return to the main screen

Menu: Display menu

Gear: Log out or learn more about UMR and our mobile site

Find a Provider

Need to find a doctor fast? Access an alphabetical list of network providers.

View, scan, or fax your ID card

View your ID card, allow your provider to scan the on-screen bar code for instant access to your benefit information and/or fax a copy to a provider.

Look up claims

Look up a claim for yourself or an authorized dependent.

Need help?

Click the question mark any time you are confused about a term or benefit and get an explanation.

Teladoc

Teladoc® gives you 24/7 doctor visits via phone or mobile app.

Teladoc gives you round-the-clock access to U.S. board-certified doctors, from home or anywhere you happen to be. Call or connect online or use the Teladoc mobile app for quality medical care, when you need it.

Teladoc has a network of doctors that can treat every member of the family and you will receive prompt treatment. Teladoc is less expensive than the ER or urgent care and prescriptions are sent to your pharmacy of choice if medically necessary.

Contact Teladoc

1 (800) Teladoc | teladoc.com

To use Teladoc, you'll need to create an account for yourself and add your dependents under 17 by selecting My Family; dependents over 18 need to create their own accounts. Each person needs to provide their medical history — giving Teladoc doctors the information necessary for an accurate diagnosis.

With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

Create an account:

- **Online**: go to teladoc.com and select **Get started now**;
- **Mobile app**: download the app at teladoc.com/mobile and click **Activate Account**;
- **Via phone**: call Teladoc at 1-800-835-2362 and they will help you register your account.

What does Teladoc cost?

- If you have the **Traditional PPO Plan** you pay a **$10** copay
- If you have the **High Deductible Health Plan** you pay **100%** of the Teladoc service fee which is **$49**. After you hit the deductible, you pay **20%** of the **$49**.

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink eye
- Respiratory infections
- Bronchitis
- Urinary tract infection
- Sinus problems
- Skin problems and more!

Flexible Spending and Health Savings Accounts

NBS is the carrier for the FSA and Optum Bank is the carrier for the HSA. These accounts can be used to help offset your out-of-pocket health care expenses.

The amount MarketStar will contribute to your HSA is based on the family members you cover.

	Flexible Spending Account (FSA)	Health Savings Account (HSA)
Which plans is this account available for?	Traditional PPO	High Deductible Health Plan
Do I need to be enrolled in a medical plan?	No	Yes
What would I use this account for?	Eligible health care expenses, including dental, vision and prescription medication.	To save for future health care expenses, but also to pay for eligible health care expenses, including dental, vision and prescription medication, now.
What is the maximum amount that MarketStar and I combined can put in this account?	**$2,850** is the IRS pretax contribution limit	**$3,650** Employee-only coverage **$7,300** Family coverage If you'll be at least 55 years old in 2022, you can make an additional $1,000 catch-up contribution.
What does MarketStar contribute monthly?	MarketStar does not contribute to this account.	Employee (EE) $83.33 (monthly) EE + One $135.00 (monthly) EE + Family $166.67 (monthly)
Are there investment options?	No	Yes, if you have more than **$2,000** in your HSA, you can invest it, and any growth is generally tax free.
When are the funds available?	Your entire contribution amount is available at the beginning of the year.	Your contribution amount is available as it comes out of your paycheck each pay period — so your entire contribution amount is not available at the beginning of the year or when coverage starts.
What happens if I don't use the money during the year?	Up to $500 in unused funds will roll over automatically to pay for eligible expenses in the following year. Any unused funds upon termination will be forfeited unless the employee enrolls in COBRA.	All unused funds will roll over to the next year. You can take HSA funds with you when you leave the company or retire.

Contact Optum Bank®
optumbank.com | (866) 234-8913

Contact NBS
nbsbenefits.com | (800) 274-0503

Get On-the-Go Access with the Optum Bank® Mobile App

Accessing your benefits just got easier.

Make deposits
Make a deposit to eligible accounts through mobile deposit or bank transfer.

Track payments
Send payment right to your doctor or reimburse yourself.

Capture receipts
Scan and save receipts, and add them to specific expenses.

Download the app by visiting the Apple Store or Google Play.

Contact Optum Bank®
optumbank.com | (866) 234-8913

All the tools you need when you're on the go

Manage your HSA anywhere. Sign in using fingerprint recognition or your password to capture receipts, pay bills, search for qualified medical expenses and more. Discover how to maximize your HSA by tracking your progress along five key stages.

App benefits:

- Track your balance, recent transactions and contribution limits.
- Capture and submit receipts and add receipts to specific expenses.
- Pay bills, track payments and reimburse yourself.
- Search for qualified medical expenses.
- Make an HSA contribution through a mobile check deposit or a bank transfer.
- Get a quick account snapshot any time and log in using fingerprint recognition.

Manage your Health Savings Account easy with the Optum Bank® Mobile App.

Delta Dental Low Plan Options

Delta Dental is our dental carrier.

Stay in network to save. Visit a dentist in the PPO network to maximize your savings. These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill. Find a PPO dentist at deltadentalins.com. If you can't find a PPO dentist, consider a Delta Dental Premier dentist. These dentists have agreed to set fees and offer another opportunity to save.

Out-of-network coverage

A dentist who is "out-of-network" means the provider hasn't agreed to negotiated rates. The plan pays benefits based on a Fee Schedule charge for a particular service. If the out-of-network provider charges more, you'll be responsible for paying the amount that exceeds the Fee Schedule limit plus the applicable coinsurance and deductible.

	DELTA DENTAL LOW PLAN - DELTA DENTAL PPO NETWORK	
	In-Network	Out-of-Network *
Annual Deductible April 1 - March 31	**$75** per individual **$150** per family	
Annual Maximum April 1 - March 31	**$1,500** per individual	**$1,000** per individual
Waiting Period	**None** for Preventive Services, Basic, & Major	
Preventive Services Exams & cleanings (limited to 2 routine visits in any calendar year); sealants (up to age 15); fluoride (up to age 19); space maintainers; and panoramic x-rays (once every 5 years)	Plan pays **100%** of covered services, No deductible	Plan pays **80%** of **UCR** No deductible
Basic & Major Services Basic & Major Restorative, oral surgery, extractions, endodontics, periodontics, implants, prosthodontics-fixed & removable, denture repair-reline, rebase, & adjustments	You pay **50%** AD	You pay **60%** of **UCR**, AD
Orthodontic Services	Not covered	Not covered

AD: After Deductible

UCR: Usual, Customary & Reasonable

***** Providers may charge more than the plan allows when you receive services out-of-network. It is recommended that you ask the out-of-network provider about their billed charges before planning care.

EMPLOYEE COST PER PAY PERIOD				
Employee (EE) Only	EE + Spouse	EE + Child	EE + Child(ren)	EE + Family
$1.95	**$4.78**	**$4.49**	**$4.78**	**$8.10**

This information is designed to help you choose a benefit plan for 2022-23 only. Please refer to the Plan Documents provided by the carrier for information regarding coverage, limitations and exclusions. If there is a difference between this guide and the Plan Documents, the Plan Documents prevail.

Delta Dental High Plan Options

Delta Dental is our dental carrier.

Stay in network to save. Visit a dentist in the Premier network to maximize your savings. These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill. Find a Premier dentist at deltadentalins.com.

Orthodontic coverage

Choose a Delta Dental orthodontist by searching for a dentist on the website and enter "orthodontist" in the keyword field. Coverage varies depending your plan but most Delta Dental plans include:

- Pre orthodontic treatment visit
- Exam and start-up records
- X-rays
- Orthodontist-recommended tooth extractions
- Comprehensive orthodontic treatment
- Post-treatment records

	DELTA DENTAL HIGH PLAN - DELTA DENTAL PREMIER NETWORK	
	In-Network	Out-of-Network *
Annual Deductible April 1 - March 31	**$75** per individual **$150** per family	
Annual Maximum April 1 - March 31	**$2,000** per individual	**$1,500** per individual
Waiting Period	**None** for Preventive, Basic, Major, & Orthodontic Services	
Preventive Services Exams & cleanings (limited to 2 routine visits in any calendar year); sealants (up to age 15); fluoride (up to age 19); space maintainers; and panoramic x-rays (once every 5 years)	Plan pays **100%** of covered services, No deductible	Plan pays **100%** of **UCR** No deductible
Basic Services Basic Restorative, endodontics, periodontics, denture repair, reline, rebase, & adjustments	You pay **20%** AD	You pay **20%** of **UCR**, AD
Major Services Major Restorative, oral surgery, simple extractions, prosthodontics-fixed & removable, implants	You pay **50%** AD	You pay **50%** of **UCR**, AD
Orthodontic Services Adults and Children	Covers up to **50%** AD	Plan pays up to **50%** of **UCR**, AD
Orthodontic Lifetime Maximum	**$1,500** per individual	

AD: After Deductible

UCR: Usual, Customary & Reasonable

***** Providers may charge more than the plan allows when you receive services out-of-network. It is recommended that you ask the out-of-network provider about their billed charges before planning care.

EMPLOYEE COST PER PAY PERIOD				
Employee (EE) Only	EE + Spouse	EE + Child	EE + Child(ren)	EE + Family
$6.26	**$14.78**	**$14.24**	**$14.78**	**$23.30**

This information is designed to help you choose a benefit plan for 2022-23 only. Please refer to the Plan Documents provided by the carrier for information regarding coverage, limitations and exclusions. If there is a difference between this guide and the Plan Documents, the Plan Documents prevail.

Delta Dental Mobile App

Stay Connected with the Delta Dental mobile app. On our website, all the information you need is at your fingertips. You can check your plan details, find an in-network dentist and more.

Create an account

1. Go to deltadentalins.com.
2. Click **Log In** at the top of the home page.
3. Click **Create an account.**

With an online account, you can:

- View plan information
- Download documents
- View claims

Find a dentist

1. Go to deltadentalins.com.
2. Click **Find a Dentist** at the top of the home page, enter your ZIP code and select your network from the drop-down menu.
3. Click **Find a Dentist**.

Browse Yelp reviews, check office hours and see the address on a map.

Download the app

1. Open the **App Store** or **Google Play**.
2. Search for "**Delta Dental**."
3. Download the free app titled **Delta Dental** by Delta Dental Plans Association.

Review your plan details, pull up your ID card and try out the musical toothbrush timer.

Get answers

Got a question? We've got answers.

Improve your dental health:

Go to deltadentalins.com, click **For Individuals** and select **Wellness library** from the drop-down menu. You will find valuable resources, including the latest recipes, articles and videos.

Contact Customer Service:

Go to deltadentalins.com and click **Contact Us** at the top of the home page to submit a question online.

Contact Delta Dental

deltadentalins.com | (800) 521-2651

Vision Reimbursement Plan

BBP is our vision reimbursement carrier. The flat maximum provides you with a $300 per plan-year benefit to spend at any vision provider.

	VISION REIMBURSEMENT PLAN No Network
Plan Year Maximum April 1 - March 31	**$300** maximum per subscriber
Routine Vision Exams	Subject to plan year maximum
Eyeglasses **Frames** **Lenses** **Lens Options**	Limited to **one** pair of glasses per plan year. Lenses, lens options and frames are subject to the plan year maximum
Contact Lenses	Subject to plan year maximum
LASIK	Subject to plan year maximum

EMPLOYEE COST PER PAY PERIOD				
Employee (EE) Only	EE + Spouse	EE + Child	EE + Children	EE + Family
$1.73	**$2.00**	**$2.50**	**$2.73**	**$3.50**

You have freedom to choose how you spend your $300 plan year maximum. Pay for your eye glasses, lenses, lens options, frames, or use it towards the cost of a LASIK procedure. You will receive a BBP preloaded debit card equal to your $300 benefit amount. Use the card as payment at the time of services. You do have the option to submit a claim form and an itemized receipt to BBP.

Contact BBP Administration
bbpadmin.com | (630) 773-2337

How to submit a claim: Go to bbpadmin.com, click on "FORMS", choose "PARTICIPANT FORMS" and scroll down to "Forms - Claim Forms" and choose the "Dental & Vision Reimbursement Form". Enter your claim information and submit the form and receipts to claims@bbpadmin.com.

Life Insurance

MarketStar provides Term Life and AD&D coverage and you may apply for additional Voluntary Life coverage for you and your dependents.

Term Life and Accidental Death & Dismemberment (AD&D) Insurance

As part of your core benefits, MarketStar provides base Life and AD&D for each full-time employee in the amount of two times your annual earnings to a maximum of $750,000. This coverage through Unum, is completely free to employees — MarketStar pays the premiums. Coverage amounts reduce to 50% of the original amount at age 70.

Voluntary Life Insurance

MarketStar offers Voluntary Life insurance for you and your dependents. This option gives you the advantage of purchasing life insurance at affordable group rates. It is not a pre-tax benefit option. Premiums are paid with after-tax dollars through an automatic payroll deduction from your paycheck. This coverage is completely voluntary. You can purchase additional Life coverage from $10,000 to $1,000,000 in $10,000 increments, up to 10 times your earnings. You can get up to $500,000 with no health questions. This is your guaranteed issue amount. The total amount of coverage between the base and additional amounts may not exceed $1,750,000.

Voluntary Dependent Life Insurance

You can purchase additional Life coverage for your spouse from $5,000 to $250,000 in increments of $5,000. You must purchase coverage for yourself in order to purchase coverage for your spouse. Spouse coverage must not exceed 100% of the coverage amount you purchase for yourself. Your spouse can get up to $50,000 with no health questions, if eligible *(see delayed effective date). This is their guaranteed issue amount.

Get $10,000 of coverage for your children if eligible *(see delayed effective date). One policy covers all of your children until their 26th birthday. The maximum benefit for children from live birth to 14 days is $500. The maximum benefit for children 14 days to 6 months is $10,000.

Get Additional Coverage Now - Guaranteed!

MarketStar is giving you the opportunity to get guaranteed life insurance coverage. During this year's special open enrollment, elect coverage for yourself and your dependents without having to answer medical questions. Employees with existing voluntary life coverage will have their benefits rolled over to the new Unum life plan. This year's open enrollment is available to those currently enrolled in life coverage wishing to increase coverage and those who are not currently enrolled but wish to have coverage.

* Delayed effective date: If your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan.

Disability Insurance

Disability insurance can help to replace a portion of your income when you are unable to work.

For many people, unplanned time away from work can make it difficult to manage household costs. If you are unable to work due to a covered injury, illness, or even childbirth, Disability Insurance can provide an ongoing benefit to help keep your finances stable. These benefit are offered to full-time employees.

Short-term Disability (STD) Insurance

Benefits Begin: You must be employed for 6 months before this benefit begins.

Weekly Benefit: You are eligible for 60% of weekly earnings.

Elimination Period: This the number of days that pass between your first day of a covered disability and the day you can begin to receive your disability benefits. Your benefits begin after you become disabled (illness or injury) for 2 weeks.

Benefit Duration: The maximum number of weeks you can receive benefits while you're disabled. You have a 13 week benefit duration.

This benefit is provided through Unum and MarketStar is paying 100% of the premium.

Parental Leave

Eligible employees receive up to 100% paid parental pay for up to 12 weeks. Employees must have been employed 12 months or longer to be eligible.

Long-term Disability (LTD) Insurance

Monthly Benefit: Eligible employees are covered for 60% of your monthly income, up to a maximum payment of $15,000. The monthly benefit may be reduced or offset by other sources of income.

Elimination Period: Your elimination period is 90 days. This is the number of days that must pass after a covered accident or illness before you can begin to receive benefits. Benefits begin on the 91st day of disability

Benefit Duration: This is the maximum length of time you can receive benefits while you're disabled. You can receive benefits up to the Social Security Normal Retirement Age.

This benefit is provided through Unum and MarketStar is paying 100% of the premium.

Contact Unum

unum.com | (866) 679-3054

This information is designed to help you choose a benefit plan for 2022-23 only. Please refer to the Plan Documents provided by the carrier for information regarding coverage, limitations and exclusions. If there is a difference between this guide and the Plan Documents, the Plan Documents prevail.

Dependent Care Assistance Plan

MarketStar is happy to announce that for the 2022-2023 benefit period, we will match your child care expenses dollar for dollar up to $5,000 a plan year.

If you have qualified expenses, you will be able to submit your receipts/invoices to our plan administrator, Better Business Planning Administration (BBP), who will then reimburse you back 50% of those expenses. We are excited for the support this will provide to our team members who have children and need child care to be able to work.

Contact BBP Administration

bbpadmin.com | (630) 773-2337

	Dependent Care Assistance Plan (DCAP)
Who can use It? A DCAP is available to working adults with:	• Dependents younger than 13 years old • Adult dependents who need assistance or elderly care during working hours
How can I use my DCAP? You can use it for expenses that include:	• Day care, preschool, and pre-kindergarten tuition • Before- and after-school care (may be called 'extended day' by your child's institution) • Summer day camps • Child care costs during work and/or college hours • Sick-child care • Adult and elderly care programs
What is NOT eligible?	A DCAP is designed to help pay for the costs of keeping your dependents cared for while you're working or at school. However, this is limited to tuition and similar type expenses.
You CAN NOT use your DCAP to pay for:	• Babysitting not necessitated by working or attending college • Field trips • Lunches or other food items • Overnight camps (where the child does not come home at the end of the day) • Care provided by your spouse, your child under age 19, a parent of the qualifying child who is not your spouse, or another person who counts as your tax dependent • School supplies, uniforms or clothing • Tuition for grades kindergarten and above Reimbursement is for care received during the plan year - April 1, 2022 through March 31, 2023
How do I file for Reimbursement? There are a few pieces of information you'll have to submit to get reimbursed from your DCAP:	• Dependent's name and date of birth • Itemization of charges (receipt) • Start and end dates of service • Caregiver's name, address, tax ID number (or Social Security Number) • Go to bbpadmin.com to access a claim form and submit it electronically

Mental Wellness Support

Modern Health is your new resource that makes mental health care simple. Your path to mental well-being starts here.

Find support in one easy-to-use app

Access care in the way that works best for you, whether that's 1:1 video sessions, group support, or digital courses & meditations.

Get your personalized match in no time

Share your needs and preferences, and we'll guide you to a certified coach or therapist who can best support you.

Receive evidence-based care from quality specialists

Modern Health strives to maintain a diverse network of professionals who use proven techniques to provide you culturally responsive care.

Questions? Email:
help@modernhealth.com

Modern health can help you with:

Emotions

- Anxiety, fear, anger, withdrawn, lack of enjoyment, feeling empty or hopeless, shock

Behaviors

- Fighting with or being overprotective of family, substance abuse, keeping excessively busy, isolating self, avoiding places, activities, or people that bring back memories

Physical

- Tiredness, headache, tension, pain, increased heart rate, changes in breathing

Thoughts

- Difficulty concentrating or following instructions, memory problems, very strong memories of the events, self-blame, other-blame

You will have access to:

- **6 Coaching sessions for you & up to 3 dependents age 18+**
- **6 Therapy sessions for clinical need for you and up to 3 dependents age 13+**
- **100+ Courses & Meditations and unlimited texting**
- **Unlimited Live provider-led group sessions through Circles**

Find what you need, all in one platform. View & schedule video sessions, complete a meditation, message your provider, or take a well-being assessment, right within the app. It takes just 2 minutes to get started. Download the Modern Health mobile app, and we'll guide you through the rest. Or you can go to my.modernhealth.com.

Retirement Plan

A 401(k) is a savings and investing plan that gives you a tax break on money you set aside for retirement.

Below is a brief overview of the plan. For more information please see the plan document or contact a Human Resource representative.

What is a 401(k) plan?

401(k) refers to a section of the IRS Code that allows you to save part of your compensation on a **Traditional PRE-TAX Basis**. This lowers your current taxable income and helps your long-term saving grow faster. You may also choose to save part of your compensation on an **AFTER-TAX Roth Basis**. Roth contributions are taxed before they are contributed to the Plan. This allows tax-free growth and distribution contributions and the earnings on those contributions (assuming the contributions have been invested for at least 5 years and you have reached age 59 1/2).

Eligibility

You are eligible to enroll in the plan on the first of the month after date of hire and 18 years of age or older. Additionally, you may not be:

- covered by a collective bargaining agreement;
- a non-resident alien who does not receive any US source earned income from your employer;

Once you satisfy these requirements, you will be eligible to become a participant on the first day of the following month.

Enroll with Empower today

participant.empower-retirement.com | (855) 756-4738

Employee contributions

Through automatic payroll deduction, you may contribute between 1% and 100% of your eligible pay up to the annual IRS dollar 2022 limit of a maximum of $20,500 in the 2022 calendar year (adjusted annually). The minimum employee pre-tax contribution is 1% of your salary.

Company contributions

MarketStar makes a discretionary matching contribution to your account. Currently, that amount is 100% for the first 3% and 50% for the next 2%. This match can be changed at any time. You must be making contributions to your account to be eligible for the match.

Catch-up contributions

If you are 50 by the end of the 2022 calendar year, you may make additional pre-tax contributions (known as catch-up contributions) up to $6,500.

Rollover contributions

You may be permitted to roll over eligible contributions into this plan from a previous employer's retirement plan.

Vesting

Vesting refers to the portion of your account balance that you are entitled to under the plan's rules. You are always 100% vested in your employer and employee deferral account(s), rollover account, and any earnings thereon.

Enroll or make changes

You can enroll or make changes to your contributions at any time during the year by either calling Empower directly at (855) 756-4738 or log in to participant.empower-retirement.com and click the “Register” box and follow the instructions to set up your account.

Withdrawal

You may withdraw money from your 401(k) for any reason after you have reached age 59 1/2. Withdrawals are allowed at any time for hardship reasons (noted explicitly in the plan summary). You may be subject to a fee if you withdraw before age 59 1/2. Your benefits will be taxed upon withdrawal.

WellCents

WellCents is a comprehensive, holistic financial wellness solution designed to help you create confidence in your financial life.

Our goal is to help you develop a real-life action plan to move you toward being financially well, and in turn, help you secure a financially sound retirement.

Budget & Spending – Saving for retirement is very important but many people feel that they can't spare the money to participate in a retirement plan or even create a basic savings account. Retirement plan consultants suggest that the first step is to create a budget. Once you figure out where your money is going, you can look for ways to save more.

One on One Meeting – How often do you get to speak with an advisor about all of your financial needs and goals? Now is the time to take advantage of this amazing opportunity.

It all begins with a brief 5 minute online *Personal Financial Wellness Assessment*. Once you take the assessment you will receive a customized analysis of your current financial situation and recommended steps to help improve your position. It will also provide links to resources, articles, checklists and calculators designed to improve your financial literacy.

Take Your Financial Wellness Assessment

mywellcents.com/marketstar

Business Code: MARKETSTAR (Code only needed with the app)

Download the app by visiting the Apple Store or Google Play.

Get Started Today! Check Online for Dates of Upcoming Individual WellCents Appointments

Hyatt Legal / MetLaw Services

Affordable access to a lawyer when you need one.

The program features:

- Access to a nationwide network of attorneys for a variety of personal legal needs including estate planning, financial matters, real estate matters, defense of civil lawsuits, family law, traffic offenses, juvenile matters and consumer protection.
- Attorney access by phone or in person for consultations and certain court appearances.
- A low cost of **$21.00** per month, which covers you, your spouse and your dependents and is paid by convenient payroll deductions.
- The Plan provides access to both In-Network and Out-of-Network attorneys. Covered services provided by an In-Network attorney are generally paid in full by the Plan, while services provided by an Out-of-Network attorney are paid based on a fee reimbursement schedule up to the stated Plan maximum for that service. Whether you use an In-Network or Out-of-Network attorney, there are no waiting periods or limits on how frequently services can be used.

For details, please contact **Hyatt Legal at 1 (800) 821-6400 or** members.legalplans.com

Once you're enrolled, click on "MEMBER LOGIN" at the top of the web page to access services.

Hyatt Legal / MetLaw Services (examples)

Vehicle and Driving Matters

- Defense of traffic tickets (with exception of DUI)
- Driving privileges restoration
- Repossession of vehicle

Home and Real Estate Matters

- Sale or purchase of primary residence and vacation home (not investment properties)
- Refinancing and home equity loan
- Foreclosure
- Tenant negotiations (but not as a landlord)
- Eviction defense

Money Matters

- Negotiations with creditors
- Personal bankruptcy
- Identity theft defense
- Tax audit representation (municipal, state or federal)

Elder Care Legal Services

- Medicare or Medicaid questions
- Review of nursing home agreements

Civil Lawsuits

- Civil litigation defense and mediation
- Disputes over consumer goods and services
- Small claims assistance
- Pet liabilities

Estate Planning

- Simple and complex wills
- Revocable and irrevocable trusts
- Powers of attorney (health care, financial, childcare)
- Living wills
- Health care proxies

Family and Personal Matters

- Adoption
- Prenuptial agreement
- Juvenile court defense
- Protection from domestic violence
- Review of immigration documents

Family and Personal Matters

- Downloadable legal documents available
- Reduced fees for representation for certain excluded services, such as personal injury, probate, and estate administration matters

There are some types of legal services that are not covered under this Plan. Excluded from coverage are certain domestic matters such as divorce, DUI-related offenses, nuisance claims, any business-related matters (including rental property), employment related legal actions or activities and any matter where a spouse's or dependent's interest might conflict with your interest.

Additional Company Benefits

MarketStar provides additional benefits to help you reach goals and navigate life's challenges.

Education Reimbursement Program

Full-time, active employees may request reimbursement for costs they spend toward their development and professional growth. The following expenses, but not limited to, are eligible for this program:

- Tuition
- Books or study materials
- Certification / registration fees
- Non-resident fees

Community Leave Bank (CLB)

Eligible employees may receive CLB based on the following:

Purpose

- Care for employee or immediate family member affected by life altering event (e.g. medical emergency, major disaster resulting in hardship)

Benefit

- CLB runs concurrently with FMLA
- Up to 6 weeks of full pay
- Paid Time Off and STD must be exhausted

Eligibility

- 6 months of employment AND
- In good standing with company AND
- Contributed a minimum of 8 hours of paid time off to the bank

Employee Hardship Loan Program

Full-time, active employees may request a 0% interest loan that they can repay through payroll deductions. Eligible amounts (up to $2,000) determined by tenure, starting at 6 consecutive months of employment (up to $500). Examples of a personal temporary financial hardship include circumstance such as:

- Medical emergency
- Unanticipated family emergency
- Transportation repairs
- Impending eviction
- Existing payday loan

Additional Company Benefits - Paid Time Off (PTO)

MarketStar Time Off Policy

MarketStar recognizes that there are a number of reasons that an employee may need to be away from work. Please refer to the full MarketStar Time Off Policy for full details on the various forms of time away from work that are offered to employees, including:

- Family & Medical Leave (FMLA)
- Bereavement Leave
- Holidays
- Paid Time Off
- Jury Duty
- Military Leave
- Paid Family & Medical Leave
- Community Leave Bank

Paid Time Off (PTO)

MarketStar has implemented a flexible approach to time off, where vacation, personal, and sick days are provided as Paid Time Off. Paid Time Off is not counted towards overtime.

Each full-time, regular employee has a “bank” of time to use for vacation, sick, and personal reasons. Eligible full-time employees will be on the following Paid Time Off accrual system:

Vacation Bank - Full-time Employees		
Time of Service	Days Per Year	Total Hours Per Year
0 - 4 Years	10	80
5 - 9 Years	15	120
10+ Years	20	160
Sick & Personal Banks - Full-time Employees		
Time of Service	Days Per Year	Total Hours Per Year
Sick (All Tenure)	5	40
Personal (All Tenure)	8	64

Each part-time, regular employee (less than 30 hours per work week) has a “bank” of time to use for sick and medical reasons. Eligible part-time employees will be on the following Sick Leave system:

Sick Leave Bank - Part-time Employees	
Hours Worked Per Week	Total Hours Per Year
1 - 10 Hours / Week	20 Hours / Year
11 - 19 Hours / Week	30 Hours / Year
20 - 29 Hours / Week	40 Hours / Year

Holiday Pay

Eligible full-time employees (part-time employees are not eligible for Holiday Pay) will receive 8-hours of holiday pay for the following base* holidays each year:

- New Year's Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day
- Employee Birthday**

* Employees that are billable to one particular client account may be required to observe different holidays at the discretion of the client and/or management. Please refer to the MarketStar Time Off policy for full details..

** Employee's birthday holiday is eligible after one year of service.

Your Employee Advocate

Diversified Insurance has a dedicated employee advocacy team to help resolve claims problems, enrollment complications, and other service related issues.

Contact your Employee Advocate

(801) 325-5094

marketstar@digadvocate.com

Our Employee Advocates will work with you and your providers to ensure that each party gets their questions answered and problems resolved.

Our Employee Advocates can:

- Work with carriers on billing and claim payment issues for employee medical, dental, vision, and life insurance
- Coordinate between the pharmacy and the health plan for escalated pharmacy issues
- Explain network access and payment process for in and out-of-network providers
- Work with providers to file paperwork if claims have been denied due to lack of required authorization
- Clarify the total and out-of-pocket cost for services provided
- Assist with referrals and prior authorizations
- Help with all levels of appeals
- Ensure services are being coordinated when multiple doctors or coverages are involved
- Help gain access to care and services
- Define preventive care and associated guidelines
- Assist in finding a specialist for a condition or diagnosis
- Explain benefit plan details and coverage provisions

General Participation Guidelines and Notices

MarketStar recognizes the importance of a benefit program that provides high-level protection to employees and their families. Our comprehensive benefits program has been created to fulfill a wide range of needs and to provide an effective security net for both you and your family.

Who is eligible?

- Full-time employees who actively work at least 30 hours per week;
- Your legal spouse or domestic partner;
- Your natural born children, current stepchildren, or legally adopted children up to age 26;
- Your children of any age if they depend on you for support due to a physical or mental disability (documentation may be required).

General definitions

Special enrollment rights (other than open enrollment)
There will be an Open Enrollment period each year. During this Open Enrollment period you will have the opportunity to renew coverage or make changes as appropriate. Changes under most plans can only be made during Open Enrollment. This is a requirement of our benefit providers and IRS regulations. However, certain qualifying status changes are allowed during the plan year (see below). If you have a qualifying change of status, the change must be submitted to your local HR/Payroll Representative within 30 days of the event, with supporting documentation. The coverage effective date will be retroactive to the qualifying change of status event date.

A qualifying change of status occurs for the following:

- You get married, legally separated, or divorced;
- You add a dependent child through birth, adoption, or change in custody;
- Your parent/spouse or child dies which affects your coverage;
- Your work schedule permanently changes i.e., permanent reduction of hours;
- You or a dependent enroll in the Exchange during the Exchange Open Enrollment;
- Your parent/spouse begins or terminates employment which affects benefit coverage;
- Your parent/spouse loses health coverage through his/her employer, which affects your coverage;
- You receive a qualified medical child support order (QMCSO);
- Your parent/spouse's Open Enrollment may be considered a qualifying change of status.

Or

You have a 60-day special election period for the following:

- You and/or your spouse and dependents gain or lose Medicaid and/or state CHIP coverage;
- You and/or your spouse and dependents gain or lose eligibility for the state sponsored Utah Premium Partnership Program (UPP).

When does coverage begin for new hires?
Coverage begins on the first of the month following hire date. You must be actively at work for your coverage to become effective.

You must complete your online enrollment within 14 days from your date of hire. If the online enrollment and appropriate forms are not completed within the stated deadline, coverage does not become effective, and you may not be eligible to enroll until the next Open Enrollment period or until you have a qualifying change of status event. Refer to the terms, conditions, and limitations defined by the carrier plan documents.

When coverage ends
Medical, dental, and vision terminates on the last day of the month that you are employed with MarketStar. Refer to carrier literature, summary plan descriptions, and master plan documents for specific plan provisions, limitations, and exclusions.

Coverage ends at the earliest time when any of the following changes occur:

- Your employment with MarketStar ends;
- The group policy ends;
- You are no longer eligible under the plan;
- Your death;
- You retire.

Dependent eligibility verification notice
MarketStar reserves the right to audit dependency status. The goal is to ensure that benefits are provided only to those who are eligible. This process may include a complete eligibility verification of all enrolled dependents or verifying relationship and status of new dependents registered during Open Enrollment, new hires and a qualifying change of status. You must only cover eligible dependents when you enroll in the plan offerings. For a detailed definition of an eligible dependent, refer to the ***"Who is eligible"*** section.

General Participation Guidelines and Notices

Important notice
The benefit summaries contained in this guide are for ease of comparison. This guide provides only a summary of benefits available to eligible employees and their dependents. The information in this guide supersedes all prior guides. However, since this guide is only a summary, it does not describe every detail of the benefit programs outlined. If there are inconsistencies or discrepancies between this guide and the governing plan documents and benefit contracts, the governing plan documents and benefit contracts will control. The governing plan documents and benefit contracts are available for your review in the Human Resources Department.

Refer to the carrier's literature for specific details. No rights shall accrue to you and/or your dependents because of any statement, error, or omission in this comparison. Reasonable efforts are made to keep employees apprised of any changes in benefit plans including medical, dental, vision, life and AD&D, voluntary life, long-term disability (LTD), Health Savings Account (HSA), and Flexible Spending Accounts (FSA).

MarketStar may choose to communicate certain plan documents and benefits information electronically to participants. You may obtain copies of these documents, upon written request, from Human Resources.

Summary of benefits coverage
As a result of the Affordable Care Act (the health care reform law) all health insurance issuers are required to provide a Summary of Benefits Coverage (SBC). The SBC has a uniform glossary of terms commonly used in health insurance coverage and also uses a new, standardized plan comparison tool called "coverage examples," similar to the Nutrition Facts label required for packaged foods.

The coverage examples will illustrate sample medical situations and describe how much coverage the plan would provide. The SBC will be posted on the employee website. If you would like a paper copy of this summary, please contact HR.

Waiving coverage
If you and/or your dependents have appropriate benefits from an alternate source, you may choose to waive coverage.

If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other coverage, you may be able to enroll yourself and/or your dependents in this plan in the future, providing that you request enrollment within 30 days after your other coverage ends and can provide supporting documentation.

Medical coverage assistance options

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 healthcare.gov.

If you or dependents are already enrolled in Medicaid or CHIP, 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 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 askebsa.dol.gov or call 1-866-444-EBSA (3272).

Health Insurance Marketplace
healthcare.gov
1 (800) 318-2596

General Participation Guidelines and Notices

ACA notices about eligibility and coverage periods

- MarketStar has adopted a 12 month "initial measurement period" and 12 month stability period for all new part-time, variable hour, and seasonal employees which begins as of the date of employment/start date for each new employee in these categories. The administrative period for such new part-time, variable hour, or seasonal employees who measure full-time in their initial measurement period is approximately 30 days depending on whether you started your job on the 1st of the month or in the middle of the month.
- You are being offered the opportunity to enroll yourself and your dependents (if any) in MarketStar's health plan because you were either hired as a full-time employee or you have measured as full-time during a given, applicable measurement period.
- If you "waive" or "decline" coverage then you may be prevented from qualifying for a premium tax credit or cost share reduction subsidy for coverage you may purchase for yourself or your dependents on the health insurance marketplace/exchange applicable to your state of residence, which may be the federal health insurance marketplace/exchange.
- If you choose to enroll in coverage, the coverage period is 12 months. Federal law and MarketStar's cafeteria plan provide very limited situations in which you will be allowed to dis-enroll in healthcare coverage during your 12-month coverage period. Therefore, if you change your mind after your coverage begins, you will not be allowed to cancel your coverage unless you meet one of the situations allowed by law or in our plan.

Women's health and cancer rights act enrollment 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 coinsurances applicable to other medical and surgical benefits provided under this plan.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) affects the amount of time you and your newborn child are covered for a hospital stay following childbirth. In general, health insurers and Health Maintenance Organizations (HMOs) may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. If you deliver in the hospital, the 48-hour (or 96-hour) period starts at the time of delivery.

If you deliver somewhere other than the hospital and you are later admitted to the hospital in connection with the childbirth, the period begins at the time of admission.

Also, a health insurer or HMO cannot require you or your attending provider to obtain prior authorization for your delivery or show that the 48-hour (or 96-hour) stay is medically necessary. However, a health insurer or HMO may require you to get prior authorization for any portion of stay after the 48 hours (or 96 hours).

Privacy policy

Summary of privacy practices

This Summary of Privacy Practices summarizes how medical information about you may be used and disclosed in the administration of your claims, and of certain rights you have.

Our pledge regarding medical information

The company is committed to protecting your personal health information. As required by law, we:

1. make sure that any medical information that identifies you is kept private;
2. provide you with rights with respect to your medical information;
3. give you a notice of our legal duties and privacy practices; and
4. follow all privacy practices and procedures currently in effect.

How the company may use and disclose medical information about you

Any use and disclosure of your medical information requires your written authorization. Your personal health information may be used and disclosed without your permission to facilitate your medical treatment, for payment of any medical treatments, and for any other health care operation. Your personal health information may be disclosed without your permission as allowed or required by law. You cannot be retaliated against if you refuse to sign an authorization or revoke an authorization you had previously given.

General Participation Guidelines and Notices

Your rights regarding your medical information
You have the right to inspect and copy your medical information, request corrections of your medical information and to obtain an accounting of your medical information. You also have the right to request that additional restrictions or limitations be placed on the use or disclosure of your medical information, or that communication about your medical information be made in different ways or at different locations.

Michelle's Law

A new federal law allows continued coverage for seriously ill college students. A college student will be able to maintain health care eligibility for up to one year after full-time student status is lost due to medically necessary leave of absence from school.

Genetic Information Nondiscrimination Act (GINA)

Under this federal law, group health plans are prohibited from adjusting premiums or contribution amounts for a group based on genetic information. A health plan is also prohibited from requiring an individual or his/her family member to undergo a genetic test, although the plan may require that a voluntary test be taken for research purposes.

Mandatory insurer reporting law

This law took effect 1/1/2009 and is part of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). Under this federal law, providers of group health plans are required to report certain information to the Secretary of Health and Human Services to determine Medicare entitlement. As such, employees are required to provide social security numbers for all dependents enrolled in the medical plan. You will be asked to enter social security numbers for all dependents you cover on your medical plan.

Patient Protection and Affordable Care Act (ACA)

Pursuant to the Patient Protection and Affordable Care Act (ACA) and its applicable regulations, MarketStar offers eligible employees affordable, minimum essential health care coverage that meets minimum value. This guide and the enrollment forms are your offer of coverage. If you decline or waive this coverage, you may be prevented from qualifying for a premium tax credit or cost share reduction subsidy for coverage you may purchase for yourself or your dependents on the health insurance marketplace/exchange applicable to your state of residence, which may be the federal health insurance marketplace/exchange.

Medicare Part D creditable coverage notice

Important notice from MarketStar 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 MarketStar 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:

- 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.
- MarketStar has determined that the prescription drug coverage offered by the MarketStar Benefit 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.

These are only summaries. Full statements are available from Human Resources.

The information in this guide has been provided for you by:

DIVERSIFIED INSURANCE
An IMA Inc. Company

136 E. South Temple, Suite 2300 | Salt Lake City, Utah 84111
(801) 325-5000 | diversifiedinsurance.com