

BENEFITS AT A GLANCE



WELCOME! We are pleased you decided to join our team, and we look forward to working with you.

One way we can show our appreciation for your contribution to our success is to offer you a comprehensive benefits package that meets your needs and the needs of your family.

Mission Support Alliance, LLC (MSA) offers you the flexibility to choose from a list of plans and options, the specific benefits that work best for your situation.

Depending on the particular plan and/or level of coverage you elect, the company may pay the full cost of the benefit, may share the cost with you or the total cost may be paid by you. It's an approach to benefits that supports Section 125 of the Internal Revenue Code, which allows you to get directly involved in designing your own benefits program.

MSA BENEFITS OVERVIEW

Included in the package are:

- **Health Care Benefits**
MSA pays the major share of the cost of the health plans, including medical, vision and dental coverage for you and your family.
- **Flexible Spending Accounts (FSA)**
Two FSA's, Health Care and Dependent Care, allow you to set aside money on a pre-tax basis for the purpose of paying for IRS-allowable, unreimbursed health care and/or dependent care expenses.
- **Life & Disability Plans**
MSA offers insurance plan options to help replace income for you and your survivors in the event of illness, injury or death.
- **Retirement Plan**
Our 401(k) savings plan provides a vehicle for you to build a solid financial future. In addition to your contribution, the company makes an automatic contribution to your account each pay period.

- **Paid Time Off**

You will accrue hours in your Personal Time Bank that can be used for vacation, holidays, sick or personal time off. Additionally, there is paid time off for jury duty, bereavement and military leave.

- **Additional Benefits**

The company provides an Employee Assistance Program (EAP) and a Voluntary Legal Plan.

PLAN YEAR

The Plan year will begin on January 1 and end on December 31 each year. In the fall, you will have the opportunity to change your medical, dental and FSA elections for the upcoming plan year.

ELIGIBILITY

Regular full-time employees who work a minimum of 40 hours per week and regular part-time employees who are regularly scheduled to work 20-39 hours per week are eligible to participate in the MSA benefit plans.

Eligibility begins on your first day of work or when you first become eligible and ends immediately on termination or when you are no longer eligible.

DEPENDENT COVERAGE

In addition to electing coverage for yourself, you can elect to cover eligible dependents. For medical and dental plans, your eligible dependents include your legal spouse or domestic partner (if certain criteria are met). In addition, eligible children for medical includes married or unmarried children under the age of 26, if coverage not available through another group plan. Eligible dependents for dental are unmarried children to age 26. For Supplemental Life & Personal Accident Insurance, dependents include your legal spouse, domestic partner and children up to age 19 (up to age 25 if full-time student).



MEDICAL BENEFITS

CHANGING YOUR BENEFITS

The Internal Revenue Service (IRS) states that employees enrolled in pre-tax benefit plans may only make benefit elections once a year. As such, your health care benefit choices are binding until the next open enrollment. The following special circumstances are the ONLY reasons you may change your benefits during the plan year:

- Marriage
- Birth, adoption or placement for adoption of an eligible child
- Divorce, legal separation or annulment
- Loss of spouse's job or change in work status where coverage is maintained through the spouse's plan
- A significant change in your or your spouse's health coverage attributable to your spouse's employment
- Death of a spouse or dependent
- Loss of dependent status
- Becoming eligible for Medicare, Medicaid, or a state Children's Health Insurance Program (CHIP) during the year
- Receiving a Qualified Medical Child Support Order (QMCSO)

These special circumstances often referred to as "Qualifying Life Events" or life event changes, will allow you to make changes at any time during the year in which they occur. For any allowable change, you must notify Human Resources of the event and provide the requested documents within 31 days of the event to avoid a lapse in coverage. Changes that are requested due to a "change of mind" or financial hardship without a Qualifying Life Event, are not allowed until the next annual open enrollment period.

Coverage choice, cost and convenience are factors each of us considers important when selecting a medical plan. You may choose between two Group Health medical plans, whichever one best meets your needs and the needs of your family. The plans cover the same types of services, but differ in how they share costs with you and how they provide access to care. Each option is summarized below and within the Medical Plan Summary on the following page.

OPTION 1 – GROUP HEALTH OPTIONS SELECT PLAN

This plan incorporates a specific network of physicians, hospitals and other health care providers into a single service organization. The plan covers preventive care, outpatient care, hospitalization, vision care and prescription drugs. You will be required to select a primary care physician (PCP) who will be responsible for coordinating all of your healthcare needs and providing you with referrals. This plan covers most medically necessary services at 100% or requires you to pay a small co-pay. However, benefits are not available for services obtained outside of the network.

OPTION 2– GROUP HEALTH OPTIONS PLAN

This plan provides you with added flexibility when seeking covered medical services by allowing you to receive care within or outside of the network. You will be required to elect a primary care physician (PCP), and you will maximize your coverage by having care provided or referred by your PCP. You will also have the freedom to self-refer your care without consulting/receiving a referral from your PCP to both in-network and out-of-network providers. However, self-referring your care results in lower benefit levels and higher out-of-pocket costs.