

2021 Market Based Benefits Guidebook





Welcome

The following guidebook provides a summary of the Market Based benefit plans offered to eligible employees of Mission Support Alliance, LLC. (MSA).

At MSA, we appreciate your commitment and contributions to our company’s success. Each year, we strive to offer benefit plans to our employees that not only reward you for your hard work but offer you and your family comprehensive and affordable health and wellness protection. We are confident that you will find our MSA Benefits Programs to be of excellent value to you and to your dependents.

Please read this guidebook carefully as you prepare to make your elections for the upcoming Plan Year to ensure that you select the coverage that is right for you.

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About This Guidebook

This Benefits Guidebook describes the highlights of the MSA Benefits Programs in non-technical language. Your specific rights to benefits under this program are governed solely, and in every respect, by the official plan documents and not the information contained within this Benefits Guidebook.

If there is any discrepancy between the descriptions of the program elements contained within this Benefits Guidebook and the official plan documents, the language of the official plan documents shall prevail. Please refer to the plan-specific documents published by each of the respective carriers or third party administrators for detailed plan information. Eligibility for any benefit plan is determined by plan documents and policies. You should be aware that any and all elements provided under the MSA Benefits Programs may be modified in the future to meet Internal Revenue Service rules and/or comply with applicable laws and regulations, or otherwise as determined by MSA.



Plan Year

The MSA benefit Plan Year begins on January 1 and ends on December 31. This Benefits Guidebook outlines the MSA Benefits Programs that apply for the plan year.

Employee Eligibility

- ▶ All active regular full-time employees working 40 or more hours per week and regular part-time employees working 20 or more hours are eligible to enroll in the MSA Benefits Programs.
- ▶ Most benefits are effective the 1st day of employment, or when you first become eligible, and terminate the day your employment ends.

Dependent Eligibility

Your eligible dependents may include:

- ▶ Your legal spouse or registered domestic partner (as recognized by Washington State, one partner must be at least 62 years or older and is not a relative). Domestic partner benefits and coverage for his or her children are taxable unless they qualify as your tax dependent(s).
- ▶ Your child(ren) up to age 26 including natural children, legally adopted children, and stepchildren.
- ▶ Your child(ren) over age 26 who are not able to support themselves due to a physical or mental disability. (Must be certified by insurance prior to limiting age.)



How Can I Change My Coverage?

The elections you make during annual enrollment will be in effect January 1, 2021 through December 31, 2021 for medical, dental, and FSA benefits. The elections you make during your enrollment period will remain fixed, unless you experience one of the following qualifying life events:

- ▶ Changes to legal marital and/or domestic partner status – such as marriage, domestic partnerships, divorce, death, legal separation, annulment, or termination of a domestic partnership
- ▶ Change in number of tax dependents – such as birth, adoption, placement of a foster child, death
- ▶ Changes in employment status for either employee, spouse or domestic partner
- ▶ Changes in work schedule of either employee, spouse or domestic partner, including reduction or increase in work hours
- ▶ Dependents becoming ineligible
- ▶ Change in residence or worksite for you, your spouse, domestic partner or dependent that impacts your eligibility for coverage under the MSA Benefits Programs
- ▶ Entitlement to Medicare

These qualifying life events allow you to make changes at any time during the year at the time in which they occur. For most allowable changes, you must inform Human Resources within 31 calendar days of the event and 60 days for the birth of a child or adoption. If you do not notify Human Resources of the event and provide requested documents within the required time frame, you will not be eligible to make changes until the next annual Annual Enrollment period. Benefit changes that are requested due to a “change of mind” cannot be allowed until the next Annual Enrollment period.

*A newborn child will be automatically covered for the first 31 days immediately following birth. If the child is not enrolled within 60 days, coverage will be terminated retroactively to date of birth. To enroll a newborn child you must complete a benefit change in ESS within 60 days of the birth or wait until the next Annual Enrollment period.

Medical Coverage

Coverage choice, cost and convenience are factors each of us considers important when selecting a medical plan. You may choose between two Kaiser Permanente medical plans, whichever one best meets your needs and the needs of your family, or you may choose to waive coverage. The medical plans are designed to provide you and your family with access to quality, affordable health care by covering a broad range of health care services and supplies, including office visits and prescription drugs. Each medical plan is summarized below and within the Medical Plan Summaries on the following pages.

Option 1 – Kaiser Permanente Options Select Plan - HMO

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– Kaiser Permanente Options Plan - PPO

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.

Important Information

Preventive Care: Both plans cover preventive care at 100% in-network, including routine screenings and check-ups. Many of these services are covered as part of routine physical exams. These include regular check-ups, immunizations, routine gynecological visits and well-child exams. You will not have to pay anything for these services if you receive them from a participating in-network provider.

Due to the Women's Preventive Health Care provision under the health care reform law, the following services are also covered at 100% in network (no deductible):

- ▶ Well-woman visits
- ▶ HPV Immunizations
- ▶ Sexually Transmitted Infection Counseling
- ▶ HIV screening and counseling
- ▶ Certain contraception and contraception counseling
- ▶ Breast feeding support, supplies and counseling
- ▶ Interpersonal and domestic violence screening and counseling



Medical Plan Summary

Benefit	Kaiser Permanente Health Options - PPO		Kaiser Permanente Options Select - HMO
	In-Network	Out-of-Network	In-Network Only
Annual Deductible • Individual • Family	\$1,000 \$3,000	Shared with In-Network	No Annual Deductible
Coinsurance	Plan pays 90%	Plan pays 70%	No Plan Coinsurance
Out-of-Pocket Maximum • Individual • Family	\$2,000 \$6,000	Shared with In-Network	\$2,000 \$4,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Preventive Care Well care physicals, immunizations, Pap smear exams, mammograms	Covered 100%	Deductible and coinsurance apply	Covered 100%
Office Visits	\$25 copay	Deductible and coinsurance apply	\$20 copay
Emergency Services			
Inpatient Hospital Services	Deductible and coinsurance apply	Deductible and coinsurance apply	\$200 copay per admission
Outpatient Hospital Services	Deductible and coinsurance apply	Deductible and coinsurance apply	\$20 copay
Emergency Services Copay Waived if Admitted	\$100 copay, deductible and coinsurance apply	\$100 copay, deductible and coinsurance apply	\$75 copay at designated facility \$75 copay at non-designated
Outpatient Lab/X-Ray	Coinsurance applies	Deductible and coinsurance apply	Covered 100%
Ambulance Services	Deductible and coinsurance apply	Deductible and coinsurance apply	Plan pays 80%
Vision Care			
Routine Eye Exam One Visit Every 12 months	Covered in full	Covered in full	\$20 copay
Optical Hardware Lenses, Contact Lenses & Frames	Age 19 and over: \$150 allowance every 24 months Age 19 and under: 1 pair of frames/lenses per year or contacts lenses covered at 50% coinsurance	Shared with In-Network	Age 19 and over: \$150 allowance every 24 months Age 19 and under: 1 pair of frames/lenses per year or contacts lenses covered at 50% coinsurance
Prescription Drug			
Retail (30 Day Supply) • Formulary Generic • Formulary Brand • Non-Formulary	\$15 copay \$25 copay \$45 copay	Not Covered	\$10 copay \$20 copay \$40 copay
Mail Order (90 Day Supply) • Formulary Generic • Formulary Brand • Non-Formulary	\$30 copay \$50 copay \$90 copay	Not Covered	\$20 copay \$40 copay \$80 copay

This is only a partial list of the covered benefits. For a complete list of covered services, please refer to your Summary Plan Description.

Dental Coverage

The company offers two levels of dental coverage through Delta Dental of Washington. Your dental coverage costs are shared with the company. The level of coverage you select will depend on the level of treatment you and your family require. The plan provides coverage for Preventive/Diagnostic Services, Basic Services, Major Services and Orthodontia. It gives you the freedom to receive care from a participating Delta PPO Network, Delta Premier Network dentist or from any dentist of your choosing. Services provided by Delta Dental PPO or Premier dentist are based upon a negotiated fee schedule. This means if you incur any out-of-pocket costs, they will be based on the Delta negotiated fees and not the dentist's actual charge. However, if you choose to go to an out-of-network dentist, not only will you pay your share of coinsurance and/or deductible, you may also pay the balance bill—the difference between what Delta says is the reasonable and customary cost and what the dentist actually charges. It is further incentive for you to use participating dentists.

Benefit	Buy-Up Plan – “A”	Basic Plan – “B”
	PPO/Premier Non-Participating	PPO/ Premier Non-Participating
Annual Deductible*		
• Individual	\$50	\$50
• Family	\$150	\$150
Annual Maximum	\$1,500	\$1,000
Class I - Diagnostic & Preventive		
• Exams	100%	80%
• Prophylaxis		
• Fluoride		
• X-rays		
• Sealants		
Class II - Restorative		
• Restorations	80%	80%
• Endodontics		
• Periodontics		
• Oral Surgery		
Class III - Major		
• Crowns	50%	50%
• Dentures		
• Partials		
• Bridges		
• Implants		
Orthodontia	50% coinsurance to \$1,000 lifetime max; Adults & Children	Not Covered
TMJ Plan B (Surgical & Non-Surgical)		
• Coinsurance Level	50%	50%
• Annual Maximum	\$1,000	\$1,000
• Lifetime Maximum	\$5,000	\$5,000

*Annual Deductible is waived for Class I services and PPO dentists.

This is only a partial list of the covered benefits. For a complete list of covered services, please refer to your Summary Plan Description.

Flexible Spending Accounts (FSA)

MSA allows you to redirect a portion of your pay through payroll deduction to a Health Care and/or Dependent Care FSA. The FSAs are managed by UnitedHealthcare. The money is deducted from your pay on a pre-tax basis, which means it is deducted from your pay before Federal and Social Security taxes are calculated. Because you do not pay taxes on the money that goes into your FSA(s), you decrease your taxable income and potentially increase your spendable income. Each pay period money accumulates in an FSA based on the elections you have made.

If you have not used all of the money in your FSA by the end of the plan year, federal law requires that you forfeit the balance.

Health Care FSA

A Health Care FSA provides you with the ability to save money on a pre-tax basis for any IRS-allowed health expenses not covered by your medical benefits plan. These expenses include deductibles, copays and coinsurance payments, unreimbursed medical expenses, non-reimbursed dental expenses, qualified over-the-counter product costs, vision care expenses (i.e. eyeglasses or contact lenses), hearing care expenses (i.e. a hearing exam or a hearing aid) and orthodontia. With a Health Care FSA, you can begin to use all or some of the total amount elected as soon as the plan year begins.

The maximum amount you can contribute to a Health Care FSA is \$2,750 for the January 1, 2021 – December 31, 2021 plan year. In addition, you are allowed to rollover a maximum of \$500 in unspent Health Care FSA funds from the prior year.

Dependent Care FSA

A Dependent Care FSA provides you with the ability to set aside money on a pre-tax basis for day care expenses for your child, disabled parent or spouse. With a Dependent Care FSA, you will be reimbursed only for dependent care services that you have already funded in your account. If you submit a claim for an amount that exceeds your account balance, you will be reimbursed on a pay period basis until you have made enough additional contributions to cover the expenses.

Generally, expenses will qualify for reimbursement if they are the result of care for:

- ▶ Your children, under the age of 13, for whom you are entitled to a personal exemption on your federal income tax return; and/or
- ▶ Your spouse or other dependents, including parents, who are physically or mentally incapable of selfcare.

Please Note: This benefit may only be used to pay for dependent care services that enable both you and your spouse to work fulltime, seek employment and/or attend school. This does not include overnight camp or overnight care.

The maximum annual amount you can contribute to a Dependent Care FSA is \$5,000 for the January 1, 2021 – December 31, 2021 plan year.



Life and Disability plans are an important part of your financial security and that of your family's.

Basic Life and AD&D

MSA provides eligible employees with \$50,000 of Basic Life Insurance through Cigna. Basic AD&D Insurance is also provided through Cigna in an amount that equals the Basic Life Insurance benefit.

Voluntary Life Insurance

Eligible employees may enroll in Voluntary Life Insurance through Cigna for themselves and their eligible family members. An employee must be enrolled in order to purchase coverage for eligible dependents. If you elect this coverage, you are responsible for paying 100% of the benefit cost.

You may choose from the following options:

Coverage Type	Benefit Amount	Benefit Maximum	Guaranteed Issue at Initial Eligibility
Employee	1,2,3,4 or 5x base salary	\$500,000	2x base salary or \$300,000
Spouse	\$10,000 increments	\$50,000	\$50,000
Child	\$2,000 increments	\$10,000	\$10,000

Evidence of Insurability (EOI): EOI/health questionnaire is required by Cigna if:

- ▶ Coverage requests that exceed the Guaranteed Issue Amount during your initial eligibility period.
- ▶ Any amount of coverage that is requested outside of your initial eligibility period; and
- ▶ Increases in coverage outside your initial eligibility period.

Personal Accident Insurance

The cost is fully paid by you. You may choose from the following:

- ▶ **Employee Options**
Five options (or no coverage): 1x, 2x, 3x, 4x, 5x annual base salary
- ▶ **Dependent Options**
 - Spouse: 10 options or no coverage: \$10,000 - \$100,000
 - Children: 1 option or no coverage: \$10,000

Business Travel Insurance

MSA will pay for protection from financial hardship in the event of death or an accident that causes dis- memberment (as defined by the insurance company) while traveling on company business. The benefit is 2x annual earnings up to a maximum of \$500,000.

Short-Term Disability

Short-Term Disability benefits replace a portion of your income when you are unable to work due to an off-the-job injury or illness. The company will pay for a weekly benefit of 66 2/3% of annual base pay up to a maximum of \$1,500 per week for a maximum of 26 weeks.

Long-Term Disability

The cost of this coverage is fully paid by you. If you remain disabled for 180 consecutive calendar days due to any one disability, injury or illness, you will be eligible to apply for Long-Term Disability benefits. You may choose from two options:

- ▶ **Option 1:** 50% of your base monthly salary to a maximum monthly benefit of \$8,333 or
- ▶ **Option 2:** 60% of your base monthly salary to a maximum monthly benefit of \$10,000

NOTE: If you do not elect Voluntary Life, Dependent Life and/or Long-Term Disability at hire, you must complete and pass Evidence of Insurability before you can elect these plans in the future.



Investment Retirement / Savings Plan

The Defined Contribution 401(k) Plan is a valuable benefit that rewards your long-term MSA employment and helps you prepare for a solid financial future.

- ▶ **Non-elective Company Contribution:** MSA will contribute 3% of your base pay to the 401(k) plan regardless of how much you elect to contribute to the plan.
- ▶ **Eligibility:** You are immediately eligible to participate in the plan as of your date of hire.
- ▶ **Employee Contributions:** Pre-tax contributions (deferrals) are allowed as well as pre-tax catch up deferrals for participants age 50 and older. The maximum contributions are determined by the IRS on a yearly basis. In addition, after tax-contributions are allowed.
- ▶ **Vesting:** You are immediately 100% vested in contributions.
- ▶ **Investment Options:** You decide how the company contributions and your contributions will be invested. A diversified line up of investment funds are available through The Vanguard Group.
- ▶ **Loans:** Permitted
- ▶ **Hardship and In-service Withdrawals:** Permitted
- ▶ **Rollovers:** Permitted

Employee Assistance Program (EAP)

The EAP is available to all employees and their dependents. The program is provided at no cost to you, and offers confidential counseling and other tools and resources to help manage the stress and strain of balancing personal needs with work responsibilities. The EAP can provide assistance with relationship problems, substance abuse, stress, grief, emotional difficulties and much more. The services and resources are available through United Behavioral Health.

Voluntary Legal Plan

Coverage is provided by Countrywide Pre-Paid Legal Services, Inc. The cost of this coverage is fully paid by you. This plan provides affordable access to legal assistance. Some of the matters that you might seek legal assistance for include wills and trusts, legal documents review, advice on government programs, legal letters and phone calls, consumer protection and warranty problems and identity theft protection and assistance.

PTB Accrual *(Unless a Wage Determination Prevails)*

The accrual rates listed in the table below include time for leisure time off (vacation), personal time off, facility closure days (holidays), time lost from work due to illness or injury, family emergencies, or medical/dental appointments.

Exempt Accruals/Bi-weekly	
0 to < 4 years	7.69
4 to < 19 years	9.23
19 or more years	10.77
Non-Exempt Accruals/Bi-weekly	
0 to < 5 years	8.31
5 to < 10 years	9.85
10 to < 20 years	11.38
20 or more years	12.92

An employee may accumulate up to a maximum of 400 PTB hours.

Facility Closure Days

10 days (80 hours)

- ▶ New Year's Day
- ▶ President's Day
- ▶ Memorial Day
- ▶ July 4
- ▶ Labor Day
- ▶ Thanksgiving Day
- ▶ Day after Thanksgiving
- ▶ December 24
- ▶ Christmas Day
- ▶ Plus 1 floating holiday determined annually

Medicare Part D - Creditable Coverage

Important Notice from Mission Support Alliance 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 MSA 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. MSA has determined that the prescription drug coverage offered by the Aetna plans 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 MSA coverage will not be affected. If you elect Part D coverage, the plan will coordinate with Part D.

If you do decide to join a Medicare drug plan and drop your current MSA coverage, be aware that you and your dependents may not 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 MSA and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For more information about this notice or your current prescription drug coverage:

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through MSA 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).

Name of Entity/Sender:	MSA
Contact—Position/Office:	Melissa Slahtasky - Human Resource Specialist
Address:	P.O. Box 650 H2-23, Richland, WA 99352
Phone Number:	509-376-8833

Medical Benefits

Kaiser Permanente | www.kp.org/wa

1.888.901.4636

Mail Order Pharmacy

1.800.245.7979

Dental Benefits

Delta Dental of Washington | www.deltadentalwa.com

1.800.554.1907

Life and Disability Benefits

CIGNA | www.cigna.com

1.800.362.4462

Flexible Spending Account (FSA)

United HealthCare | www.myuhc.com

1.866.755.7648

Plan number: 717205

Employee Assistance Program

United Behavioral Health | www.liveandworkwell.com

1.800.273.8255 Access Code: MBP

401(k) Plan Administrator

The Vanguard Group | www.vanguard.com

Plan Number: 093232

1.800.523.1188

Market Based Benefits

MBP@rl.gov

Melissa Slahatsky | 509.376.8833

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