NEXA Mortgage

Full Time Employees

# 2022
## Employee Benefit Guide

Effective January 1, 2022

Business Insurance Group—Providing Employee Benefits Solutions

BIG BENEFITS

Inside this Guide:



# CONTACT INFORMATION

## BENEFIT PLANS

### Medical Plan
Direct Care Administrators
(800) 565-3234
Provider Search: https://hcpdirectory.cigna.com/

### Health Savings Account & Flex Spending Accounts
Optum Bank
(866) 234-8913
www.optumbank.com

### Dental, Vision, Life and Disability
Unum
1 (866) 679-3054
www.Unum.com

### Gap Coverage
AmWIN
(800) 400-3042
www.tebcs.com

### COBRA Administrator
Direct Care Administrators
Brittany Booth
(800) 565-3234 ext. 1617
brittany@directcareadministrators.com

## PLAN MANAGEMENT

### HR Contact
NEXA Mortgage, LLC
Marissa Sanchez
(602) 344-9333 Ext. 137
msanchez@nexamortgage.com

Rana Mortensen
(602) 344-9656
rmortensen@nexamortgage.com

### Customer Service Support
BIG Benefits
www.BIG-Benefits.com
707 W 700 S, Suite 204
Woods Cross, UT 84087
(801) 292-0841
(801) 299-8365 fax

For assistance with Enrollments, Changes & Claims:
Nicole Williams x1018
service@big-benefits.com
Sarah Ferguson x1017
sarah@big-benefits.com

Note: This publication is only a partial summary of benefits and is provided for informational purposes only. It does not describe all the policies, procedures and limitations of the summarized plans. For complete information regarding the benefits, plan provisions and/or limitations refer to the insurance carrier's Master Plan Document. In the event of a discrepancy or conflict between the information contained in this publication and the benefit plan provisions, the Master Plan Document and insurance contracts will prevail. No rights shall accrue to you and/or your dependents because of any statement, error or omission in this publication.
Notices & Disclosures: As an employee and participant in the employee benefit program(s), you and your beneficiaries may have various rights and privileges related to these programs. Laws governing health care require us to provide you with these notifications. For individuals who elect to waive coverage, some of these notices will not apply. See plan administrator for further details.

## Welcome to the Benefit Guide. Our commitment to you is to provide the best value, benefits, and services available.

The benefits provided by NEXA Mortgage are an important part of your compensation package. This guide is intended to give an overview of the benefit options available to you and help you make informed choices that best suit your needs.



### ELIGIBILITY

Coverage begins for enrolled eligible employees on the: 1st of the month following

- 60 days of employment for salary and hourly employees
- Date of hire for commission employees

To obtain benefits you must satisfy the following:

- You must be a full-time employee working 30 hours or more per week
- If eligible, you may enroll your spouse and dependent children on the offered benefit plans
- Dependent children are eligible if less than 26 years of age
- Your dependent children of any age, if they depend on you for support due to a physical or mental disability (documentation required)

### OPEN ENROLLMENT

The medical, dental, and vision plan year is from January 1, 2022, through December 31, 2022. The next open enrollment period will be held in December.

During open enrollment, you may enroll in or make changes to your benefit programs. Open enrollment is the only time that you may add or change benefits during the plan year unless you have a qualifying life event. Make sure that you understand the offerings and enroll yourself and your eligible dependents in the programs that you would like for the upcoming plan year.

### ONLINE ENROLLMENT

ALL Eligible Employees must provide plan elections and/or waivers online by completing the following steps:

- ◊ Go to www.employeenavigator.com/benefits/
- ◊ Click on new user registration. Create a username and password. Company identifier is: "NEXABIG"
- ◊ Login with newly created username and password
  - ♦ Click on "Start Benefits"
  - ♦ Verify your personal and family information and make changes if needed. It is VERY important to enter an email address as this is how all future benefits communication will take place
  - ♦ Complete all personal information to ensure eligibility requirements are met
  - ♦ Review the benefits and select your coverage
  - ♦ Review and verify elections made for the coming year
  - ♦ Click "Sign" to confirm benefit elections

### QUALIFYING CHANGES

A qualifying event allows you a 30 day special enrollment period to complete and submit a change request to update your benefits outside of the open enrollment period:

- You get married, divorced or legally separated
- You add a child through birth, adoption or change in custody
- Your spouse or child dies
- You or eligible dependents lose eligibility for coverage under another group plan, Medicaid or state child health plan (CHIP)
- You or eligible dependents becomes eligible for premium assistance with respect to the cost of coverage under our group health plan through either a Medicaid plan under Title XIX (such as Utah's Premium Partnership) or under a state child health plan (CHIP) under Title XXI of the Social Security Act.

## *Summary of Material Modifications*

The Employee Retirement Income Security Act (ERISA) requires that your employer notify employees each time a material change is made to the health and welfare plan. The changes described in this document affect your benefits and should be kept with your benefit materials for future reference. Please refer to the Summary Plan Descriptions or Certificate of Coverage Booklets for more information regarding the benefits listed herein.

- Medical Plan: new carrier — See page 4 for details
- Dental Plan: new carrier — See page 8 for details
- Vision Plan: new carrier — See page 9 for details

Medical

| Direct Care Administrators Copay Plans | Gold 2000 Copay | Silver 3000 Copay |
|---|---|---|
| Provider Lookup: https://hcpdirectory.cigna.com/ | In-Network Benefits<br>Preferred Provider Organization (PPO) | In-Network Benefits<br>Preferred Provider Organization (PPO) |
| **Preventive Care Services**<br>Office Visits<br>Adult & Pediatric Immunizations<br>Minor Diagnostic Tests | Covered 100% | Covered 100% |
| **Office Visits** | You Pay | You Pay |
| Primary Care Provider | $30 | $35 |
| Telemedicine - Teladoc * | No Cost | No Cost |
| Specialist Physician | $60 | $70 |
| Rehabilitation (20 Visits Per Year) ♦ | $60 | $70 |
| Urgent Care | $85 | $85 |
| Chiropractic (10 visits/year) | $60 | $60 |
| **Prescriptions ♦ *** ** | Tier 1 / Tier 2 / Tier 3 / Spec | Tier 1 / Tier 2 / Tier 3 / Spec |
| Rx Deductible | None | None |
| 30 Day Supply | $10 / $45 / 30% / 30% | $10 / $45 / 30% / 30% |
| Mail Order - 90 Day Supply | $20 / $90 / 30% / N/A | $20 / $90 / 30% / N/A |
| **Deductible**<br>(Individual / Family) | $2,000 / $4,000 | $3,000 / $6,000 |
| **Out of Pocket Maximum**<br>Includes Copays, Coinsurance & Deductible | $4,500 / $9,000 | $7,000 / $14,000 |
| **Diagnostic Lab / X-Ray Services** | | |
| Minor | Covered 100% | 30% After Ded |
| Major ♦ | 20% After Ded | 30% After Ded |
| **Hospital Services ♦** | | |
| Outpatient | 20% After Ded | 30% After Ded |
| Inpatient | 20% After Ded | 30% After Ded |
| Maternity | 20% After Ded | 30% After Ded |
| **Emergency Room** | $350, then 20% (Deductible does not apply) | $350, then 20% (Deductible does not apply) |
| **Mental Health Services ♦** | | |
| Office Visits | $30 | $35 |
| Inpatient / Outpatient | 20% After Ded | 30% After Ded |
| **Durable Medical Equipment ♦** | 20% After Ded | 30% After Ded |
| **Out-of-Network Benefits ** ** | | |
| Deductible | $5,000 / $10,000 | $6,000 / $12,000 |
| Coinsurance | 50% | 50% |
| Out of Pocket Maximum | $20,000 / $40,000 | $20,000 / $40,000 |
| **Services Not Covered *** ** | Organ Transplants, Dialysis, Skilled Nursing, Rx exceeding $2,500 | Organ Transplants, Dialysis, Skilled Nursing, Rx exceeding $2,500 |

| Direct Care Administrators HDHP - HSA Qualified Plan | Bronze 5000 HDHP |
|---|---|
| Provider Lookup: https://hcpdirectory.cigna.com/ | In-Network Benefits<br>Preferred Provider Organization (PPO) |
| **Preventive Care Services**<br>Office Visits<br>Adult & Pediatric Immunizations<br>Minor Diagnostic Tests | Covered 100% |
| **Deductible**<br>(Individual / Family) | $5,000 / $10,000 |
| **Out of Pocket Maximum**<br>Includes Copays, Coinsurance & Deductible | $7,000 / $14,000 |
| **Office Visits** | You Pay |
| Primary Care Provider | 20% After Ded |
| Telemedicine - Teladoc * | No Cost |
| Specialist Physician | 20% After Ded |
| Rehabilitation (20 Visits Per Year) ♦ | 20% After Ded |
| Urgent Care | 20% After Ded |
| Chiropractic (10 visits/year) | 20% After Ded |
| **Prescriptions ♦ *** ** | Tier 1 / Tier 2 / Tier 3 / Spec |
| Rx Deductible | Combined with Medical |
| 30 Day Supply | 20% After Ded |
| Mail Order - 90 Day Supply | 20% After Ded |
| **Diagnostic Lab / X-Ray Services** | |
| Minor | 20% After Ded |
| Major ♦ | 20% After Ded |
| **Hospital Services ♦** | |
| Outpatient | 20% After Ded |
| Inpatient | 20% After Ded |
| Maternity | 20% After Ded |
| **Emergency Room** | 20% After Ded |
| **Mental Health Services ♦** | |
| Office Visits | 20% After Ded |
| Inpatient / Outpatient | 20% After Ded |
| **Durable Medical Equipment ♦** | 20% After Ded |
| **Out-of-Network Benefits ** ** | |
| Deductible | $10,000 / $20,000 |
| Coinsurance | 50% |
| Out of Pocket Maximum | $15,000 / $30,000 |
| **Services Not Covered *** ** | Organ Transplants, Dialysis, Skilled Nursing, Rx exceeding $2,500 |

AD = After Deductible

HDHP = High Deductible Health Plan

♦ Pre-service authorization may be required

* Teladoc allows you to use your smartphone, tablet, or computer to get basic healthcare. Just log in and speak face-to-face with a caregiver through on-demand video.

** Member pays balance of billed charges above In-Network Rate. Out-of-Network Deductible is accumulated separate from In-Network.

*** Members with prescription drug expenses in excess of $1,000 per month will be enrolled in Rx Help programs and may qualify for reduced and/or subsidized medication costs

| Employee Cost Per Pay Period (26/yr) | Gold 2000 Copay | Silver 3000 Copay |
|---|---|---|
| Employee Only | $145.63 | $116.97 |
| Employee + Spouse | $480.53 | $386.80 |
| Employee + Children | $422.18 | $339.21 |
| Family | $756.17 | $608.67 |

| Employee Cost Per Pay Period (26/yr) | Bronze 5000 HDHP |
|---|---|
| Employee Only | $71.54 |
| Employee + Spouse | $306.02 |
| Employee + Children | $268.86 |
| Family | $487.17 |

# AmWINS — Gap Coverage



- Gap policies reimburse costs for covered In-Patient hospitalization & most Out-Patient procedures
- Gap policies are true guaranteed issue policies with no waiting periods or pre-existing conditions, including maternity & scheduled surgical procedures
- Out-patient claims such as MRIs, CT scans, dialysis, X-Rays in a Dr.'s office, kidney stones in ER, diagnostic Testing in ER, etc. that would otherwise be paid by the plan participant as part of their deductible are covered by the GAP policy as detailed below:

## AmWINS Gap Insurance - TransConnect®

A) **Deductible** — None — N/A

B) **In-Patient** — $3,000 In-Patient — Without Gap

Covers in-patient hospital stays, in-patient procedures, in-patient physician charges, and even routine nursery care for dependent newborns.

| | | |
|---|---|---|
| Claim example - You owe | 4,500.00 | 4,500.00 |
| Gap plan pays/reimburses | 3,000.00 | 0.00 |
| Your net cost of the claim | 1,500.00 | 4,500.00 |

*NOT COVERED: Anything related to Mental Health Hospitalization or Drug and Alcohol treatments*

C) **Out-Patient** — $3,000 Out-Patient — Without Gap

Covers MRI's, PET/CT scans, ultrasounds, echo-cardiograms, surgical procedures in a Dr's office, X—Rays in a Dr.'s office, kidney stones in ER, Diagnostic Testing in ER, surgery & radiological diagnostic testing in a facility & radiation/ chemotherapy. Also covers the ER or Urgent Care for accident or injuries only.

| | | |
|---|---|---|
| Claim example - You owe | 2,300.00 | 2,300.00 |
| Gap plan pays/reimburses | 2,300.00 | 0.00 |
| Your net cost of the claim | 0.00 | 2,300.00 |

*NOT COVERED: Lab, ER for illness, sleep apnea or studies, physical therapy, observation or medical equipment*

D) **Ambulance Benefit - Accident Only** — Plan will pay up to $2,000 per calendar year for ambulance expenses due to an accident or for an illness resulting in hospitalization.

ABOVE IS A BRIEF DESCRIPTION OF THE COVERAGE.
For benefits, limitations, exclusions and provisions, please refer to the policy or certificate.

### Procedure for using the Gap Coverage:

**Method 1:** Present your AmWINS card at the time of service in a facility/hospital and the provider will bill AmWINS directly.

**Method 2:** Wait to receive the explanation of benefits from your Major Medical Carrier AND the bill from the Provider and submit both to:

AmWINS Claims Website: www.webtpa.com

**To File a Claim Online:** Visit www.webtpa.com , click Login and then member login. Click Continue on the lower right hand side of the screen and click Create an account. From there follow the prompts to create your account to file claims, view your claims status and more.

Should you need assistance with obtaining Gap payment, contact AmWINS at 1-800-476-4491

| Employee Cost - Per Pay Period (26/yr) | |
|---|---|
| | $3000 IP / $3000 OP |
| EE Only | $22.08 |
| EE+Spouse | $46.67 |
| EE+Child(ren) | $38.48 |
| Family | $66.16 |

## Teladoc—Telemedicine Service

Teladoc provides access to care through your health benefits from anywhere you are. Talk to a U.S. board-certified doctor or get expert medical advise by phone, video, web or app. We're here for you when you need us. Set up or log in to your account to see what services are available.

Telemedicine

- Includes common illnesses such as flu, cold, strep throat, ear infections, allergies, urinary tract infections, etc.
- Ability to call in prescriptions without physically visiting Doctor
- Available 24 hours a day, 7 days a week, 365 days a year

- +7,000 U.S.—License, board-certified doctors
- 24/7 access to doctors by phone, video, web or app from app
- Our experts cover over 450 medical specialties

You can contact Teladoc on the app, by phone or on their website:

1 (800) 835-2362

www.teladoc.com

## RX Help Center (RXHC)

Your plan has partnered with "RX Help Centers" (RXHC) This service is designed to help participants reduce and even eliminate the costs of prescription drugs for expensive brand name and/or specialty medications.

- First, go to the website http://rxc8290250.rxhelpcenters.com to register for the program. If RXHC can assist you in lowering your prescription costs, there is a fee of $50/month to participate that will be paid for by your plan.
- You are not required to use this service; but a cost savings can likely be found if you are spending more than $75 for any one prescription or $100 or more per month for all of your prescriptions.
- This is not a guarantee or an overnight solution. The process can take two weeks to 30 days. Because of this timing, it is highly recommended you fill a 30-day supply filled of your current medication(s) before engaging with RXHC.
- This benefit only applies to medications that exceed $1,000 per prescription.
- Should you have any questions please contact Direct Care Administrators at 800-565-3234

# Optum Bank — Health Savings Account

## What is a Health Savings Account (HSA)?

A qualified high deductible health plan with a Health Savings Account is an alternative to traditional health insurance plans. The HSA is a savings product that offers a different way for consumers to pay for their health care costs. HSAs enable you to pay for current qualified expenses and save for future medical and retiree health expenses on a tax-free basis.

You must be covered by a Qualified High Deductible Health Plan (QHDHP) to be able to contribute to an HSA. You own and control the money in your HSA. As your account balances grow, you may also decide what types of investments to make with your HSA money.

You and/or your employer may contribute to your HSA, up to the legal maximum. In 2022, the maximum annual contribution for single enrollee set by the IRS is $3,650, and the maximum family contribution is $7,300. A catch-up contribution, up to an additional $1,000, is allowed for individuals who are 55 years or older.

## What you can do with your HSA

- Pay qualified health care expenses: You can use a debit card, request check by phone or online, or transfer funds online, depending on the capabilities available through your account administrator.
- Save money for future medical expenses: You may not have significant health care expenses every year, but saving the maximum amount every year helps you build a sizeable savings for when you are faced with larger medical expenses
- Save for post-retirement expenses: Once you reach age 65, you can use your HSA funds to pay for anything you wish. Qualified medical expenses are still not taxed; any other expenses are subject to tax but not penalties

Your HSA is your money. Whatever you do not spend in a given year *rolls over* to the next. If you change jobs or retire, your HSA balance goes with you.

## Qualified and Non-Qualified Medical Expenses

Use your health savings account to pay for or get reimbursed for a variety of medical goods and services. See the complete list of qualified and unqualified medical expenses in *IRS Publication 502 at* https://www.irs.gov/publications/p502/index.html

## Whose Expenses Can Be Covered

The money in an HSA can be used to pay for qualified medical expenses of any family member who qualifies as a dependent on your tax return, even if the family member is not covered on your health plan. Conversely, you can't use the HSA for someone who doesn't qualify as a tax deduction, even if they are covered on your health plan – for example, you can't use the HSA for a child who wouldn't qualify as a tax deduction, or for a domestic partner who doesn't meet the requirements of IRS Code Sec. 152.

The penalty for using HSA funds for non-qualified medical expenses is 20%. Keep all itemized receipts and copies of prescriptions for over-the-counter medications in case of an IRS audit.

| HSA / HDHP ANNUAL LIMITS | | |
|---|---|---|
| | Single Coverage | Family Coverage |
| 2022 Maximum Contribution | $3,650 | $7,300 |
| Catch-up contribution (age 55 years and over) | $1,000 | $1,000 |

# Optum Bank — Flexible Spending Account

You have the option to participate in an employee benefit that may increase your spendable income and lower your taxes. A Cafeteria Plan allows you to pay for un-reimbursed health care expenses and dependent or child care services with pre-tax dollars. With a Cafeteria Plan, contributions are deducted from your paycheck before state and federal taxes. By making these contributions with pre-tax dollars, you will reduce your taxable income and take home a larger portion of your paycheck.

Over-the-counter medications and other items will not be eligible without a prescription. See IRS list for eligible expenses at http://www.irs.gov/publications/p502/ar02.html

## Three Components of the Cafeteria Plan:

1. Group Benefit Premiums: A Cafeteria Plan allows your portion of group medical, dental, vision and most supplemental plan premiums to be deducted from your paycheck on a pre-tax basis.
2. Flexible Spending Account (FSA) - Health Care Reimbursement (Including Dental and Vision): Each year, you may set aside up to $2,850 pre-tax dollars to pay for qualifying out-of-pocket medical, dental, vision, and some over the counter expenses.
3. Flexible Spending Account (FSA) - Dependent Care Reimbursement: Each year, you may set aside up to $5,000 pre-tax dollars (or $2,500 if you are married and filing individually) to pay for eligible dependent care expenses. This may include child care, elder care or other eligible dependent care. Funds are available for reimbursement only as they are deducted from your paycheck.

# Dental

| Unum | Passive Mac Low | | Passive Mac High | |
|---|---|---|---|---|
| Provider Lookup: www.UnumDentalCare.com | In-Network | Out-of-Network * | In-Network | Out-of-Network * |
| Deductible | You Pay | | You Pay | |
| Individual / Family | $100 / $300 | | $50 / $150 | |
| Maximum Annual Benefit | Plan Pays | | Plan Pays | |
| Includes Preventive, Basic & Major Services | $500 | | $750 | |
| Carryover Benefit | Up to $1000 | | Up to $1,250 | |
| Per Member Per Year | | | | |
| Preventive Services | 2 cleanings & exams / year | | 2 cleanings & exams / year | |
| Routine Exams, Cleaning, Fluoride & Bitewing X-Rays | Covered 100% | | Covered 100% | |
| Basic Services | 30% AD | 30% AD | 80% AD | 80% AD |
| Fillings, Simple Extractions, Emergency Pain, etc. | | | | |
| Major Services | 30% AD | 30% AD | 50% AD | 50% AD |
| Crowns, Bridges, Dentures, etc. ** | | | | |
| Endodontics & Periodontics | Covered as Major | | Covered as Major | |
| Orthodontics | None | None | 50% up to $1,000 Lifetime Maximum | None |
| Children Age 19 and Under | | | | |

* The out-of-network percentage of benefits is based on the Fee Schedule(FS). You pay the difference between FS and billed charges, if any.

** Limitations may apply; See carrier plan document for detailed plan terms, limitations, and exclusions.

Discount Only = No benefit will be paid

AD = After Deductible

| Employee Cost - Per Pay Period (26/yr) | Passive Mac Low | Passive Mac High |
|---|---|---|
| EE Only | $3.37 | $6.42 |
| EE+Spouse | $9.77 | $19.32 |
| EE+Child(ren) | $15.90 | $20.86 |
| Family | $24.61 | $35.15 |

| EyeMed<br>Administered by Unum | Vision Plan | |
|---|---|---|
| Provider Lookup:<br>www.EyeMedVisionCare.com/Unum | Insight Network | |
| | In-Network | Out-of-Network * |
| Frames | Plan Pays | |
| Allowance Based on Retail Pricing | $150 Allowance | Up to $105 |
| Contact Lens Options | | |
| Conventional | $150 Allowance | Up to $105 |
| Frequency: Exams, Lenses, Frames, or Contacts | Once Every 12 Months | |
| Eye Exam | You Pay | |
| Eyeglass Exam | $10 Co-pay | Up to $40 |
| Standard Plastic Lenses | | |
| Single Vision | $10 Co-pay | Up to $30 |
| Bifocal | $10 Co-pay | Up to $50 |
| Trifocal | $10 Co-pay | Up to $70 |
| Lenticular | $10 Co-pay | Up to $70 |
| Premium Progressive Lens | | |
| Premium Progressive Tier 1 | $95 Co-pay | Up to $50 |
| Premium Progressive Tier 2 | $105 Co-pay | Up to $50 |
| Premium Progressive Tier 3 | $120 Co-pay | Up to $50 |
| Premium Progressive Tier 4 | $75 Co-Pay | Up to $50 |

* Out-of-Network benefit may not be combined with promotional items. Online purchases at approved providers only.

Laser vision correction: Discounts are available with particpating surgery providers across the country. (Not an insured benefit)

| Employee Cost - Per Pay Period (26/yr) | |
|---|---|
| EE Only | $1.68 |
| EE+Spouse | $5.03 |
| EE+Child(ren) | $5.50 |
| Family | $9.80 |

## Unum — Life and AD&D Coverage

Basic Life Coverage (No cost to you): Employee: $ 10,000

Basic Accidental Death and Dismemberment (No cost to you): $ 10,000

Employee Voluntary Supplemental Life Coverage:

- You have the option to purchase Supplemental Life insurance coverage in increments of $10,000, from $10,000 to a maximum of the lesser of 5x your annual salary or $500,000.
- *If voluntary supplemental life is elected at an employee's first enrollment after his/her date of hire, he/she is eligible for $300,000 of guaranteed issue coverage regardless of health ($25,000 for spouse). For all other enrollment circumstances, a Personal Health Application and evidence of good health will be required.*

Dependent Supplemental Life Coverage:

- You may also elect coverage on the lives of your Spouse and/or Dependent Children. To qualify, children must be unmarried and under the age of 26. Also, unmarried children who are disabled may be eligible if certain conditions are met.
- All Dependent Supplemental Life coverage amounts elected for the Spouse or eligible children are subject to providing evidence of good health.
- Spouse Benefit Amount: Increments of $5,000 to a maximum of the lesser of 100% of the Employee Life amount or $500,000. Spouse premium is based on Employee's age.
- Child Benefit Amount: You may apply for Supplemental Life coverage on your Dependent Children in increments of $2,000 up to a maximum of $10,000.

Coverage Reductions: Coverage reduces 65% upon the person's attainment of age 65, and an additional 15% of the reduced amount at age 70.

## Unum — Long Term Disability

### Long Term Disability (No cost to you):

Monthly Benefit: 50% of your monthly covered earnings up to $1,000

Coverage begins after a 180-day elimination period and may continue for 24 months or until your Social Security Normal Retirement Age.

♦ This is a brief summary only. For a full explanation of benefits, including a complete list of restrictions, limitations and exclusions, please see your master plan documents.

## WHCRA

The Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call your health insurance issuer for more information.

This notice informs you of the Federal regulation that requires all health plans that cover mastectomies to also cover reconstruction of the removed breast. If you have had or are going to have a mastectomy, you may be entitled to certain benefits. 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 lymphedemas.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and Treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at the number listed above.

## NMHPA

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

## USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

## SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days or any longer period that applies under the plan, after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the plan administrator mentioned above.

### Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

### Right to Be Free From Discrimination and Retaliation

If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you: initial employment; reemployment; retention in employment; promotion; or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

### Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

### Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at the website below. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. http://www.dol.gov/elaws/userra.htm

*As an employee and participant in our employee benefit programs, you and your beneficiaries may have various rights and privileges related to these programs. Laws governing health care require us to provide you with these notifications. Listed below are important notices to retain for your records. In the past, many of these notices were sent individually and are now grouped together to more clearly communicate your rights, and to simplify distribution. If you have any questions please contact your employer.*

For individuals who elect to waive coverage, some of these notices will not apply to you. See the plan administrator for further details.

## HIPAA

*The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. If you are declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the plan administrator indicated in this notice.*

## HIPAA Notice of Privacy Practices

*The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.*

*You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information. **As Required by Law**: We will disclose Health Information when required to do so by international, federal, state or local law.*

*You have the right to inspect and copy, a copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.*

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

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

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

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

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

If you live in the following state, you may be eligible for assistance paying your employer health plan premiums. Contact your State for more information on eligibility –

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
Phone: 1-877-543-7669
CHIP Website: http://health.utah.gov/chip

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

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

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

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

## GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

## Discrimination is Against the Law

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
The Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the plan administrator.

If your Company has fifteen (15) or more employees and you believe that The Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, refer to the Plan Administrator for Grievance Procedures or if you need help filing a grievance can be filed in person, by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

## QMCSO (Qualified Medical Child Support Order)

QMCSO is a medical child support order issued under state law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant is an alternate recipient. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer; know the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

## RESCISSIONS

The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be cancelled prospectively but not retroactively.

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and as provided in the member's plan benefit documents. Please be aware that if you rescind a member's coverage, you must provide the proper notice to the member.

## PREVENTIVE CARE

Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, please visit: https://www.healthcare.gov/coverage/preventive-care-benefits/

## WOMEN'S PREVENTIVE HEALTH SERVICES

All of the following women's health services will be considered preventive (some were already covered). These services generally will be covered at no cost share, when provided in-network:

- Well-woman visits (annually)
- Prenatal visits (routine preventive visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Generic formulary contraceptives, certain brand formulary contraceptives, and FDA-approved, over-the-counter female contraceptives with prescription are covered without member cost share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Marketplace Notice

# New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2017)

## PART A: General Information

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

### What is the Health Insurance Marketplace?

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

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

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

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

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

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

### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your employer.

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

## PART B: Information About Health Coverage Offered by Your Employer

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

| | | |
|---|---|---|
| 3. Employer name<br>NEXA Mortgage, LLC | 4. Employer Identification Number (EIN) | |
| 5. Employer address<br>3100 West Ray Road Office #209 Suite 201 | 6. Employer phone number<br>602-344-9333 | |
| 7. City<br>Chandler | 8. State<br>AZ | 9. ZIP code<br>85226 |
| 10. Who can we contact about employee health coverage at this job? Marissa Sanchez | | |
| 11. Phone number (if different from above) | 12. Email address<br>msanchez@nexamortgage.com | |

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

- As your employer, we offer a health plan to:
  - [ ] All employees.
  - [x] Some employees. Eligible employees are: Regular full-time employees who work an average of 30 or more hours per week
- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are: Legal spouse and dependent children of eligible employee. Dependent children include a natural child, step-child, legally adopted child, or a child for whom the employee is the legal guardian.
  - [ ] We do not offer coverage.

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

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

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

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


## About BIG Benefits

With over 100 years of combined industry experience, BIG Benefits is an industry expert and a valuable partner in helping businesses navigate the dynamic landscape of health reform and benefit compliance, analyze and manage claims utilization, and provide unique, targeted benefits strategies and tools that accomplish the goals of employers, benefits managers and employees. A partnership with BIG Benefits is founded upon vision, execution, integrity, and accountability and leads to client satisfaction and loyalty. Our goal is to become your trusted advisor and a partner to the success of your employee benefits.

For more information, visit www.big-benefits.com

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