employee benefits enrollment guide

2021

SEARCH GROUP PARTNERS

The Church of Jesus Christ of Latter-day Saints Employees

welcome

Dear Associate,

Welcome to SEARCH Group Partners! Thank you for joining our firm. We recognize that you have many options when evaluating a partnership with a recruiter and we are honored that you have chosen SEARCH Group Partners as your professional representation.

It is our ultimate goal to serve you and provide resources that support your new vocational adventure. Our benefits are designed to provide you with the highest level of support possible during your engagement with us.

In connection with our partnership with The Church of Jesus Christ of Latter-Day Saints, SEARCH Group Partners offers health, dental, and vision insurance benefits, which you are eligible on the first day of the month following your date of hire. Should you desire to sign up for health insurance benefits, please contact us at (801) 535-4628 to initiate the enrollment process.

You are entitled to paid-time off (PTO) and major holidays. Additional information on these benefits are explained in this guide.

Other benefits include direct deposit and the ability to view your paycheck online. We proudly promote these benefits, as we recognize the importance of offering you support and options throughout your employment.

We ask that you reach out to your local office and recruiter frequently. Our team promotes transparent communication throughout your engagement with us.

Last but not least, THANK YOU. It is because of you, your hard work, professionalism and continued dedication that SEARCH Group Partners has the opportunity to work with talented job seekers, such as yourself, and well-respected organizations.

Sincerest Regards,

Ema Ostarcevic
Founder & Chief Executive Officer

open enrollment considerations

The following guide is here to help you understand and choose the 2020 benefits you'll receive through Search Group Partners.

When choosing your insurance coverage for 2020, 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?
- How much do you want to contribute to the health savings account?
- 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?
- Do you need dental or vision coverage?

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).

When Does Coverage Being for New Hires?

Coverage begins on the 1st day of the month following the date you were hired. You must be actively at work for your coverage to become effective.

Paid-Time Off

You are entitled to receive 10 days of paid-time off (PTO), totaling 80 hours that you may take off for vacation or sick time.

These 10 days of PTO are earned accrued over the year based upon the number of hours you work.

You will accrue 0.038462 of PTO per every hour worked.

Holiday Time Off

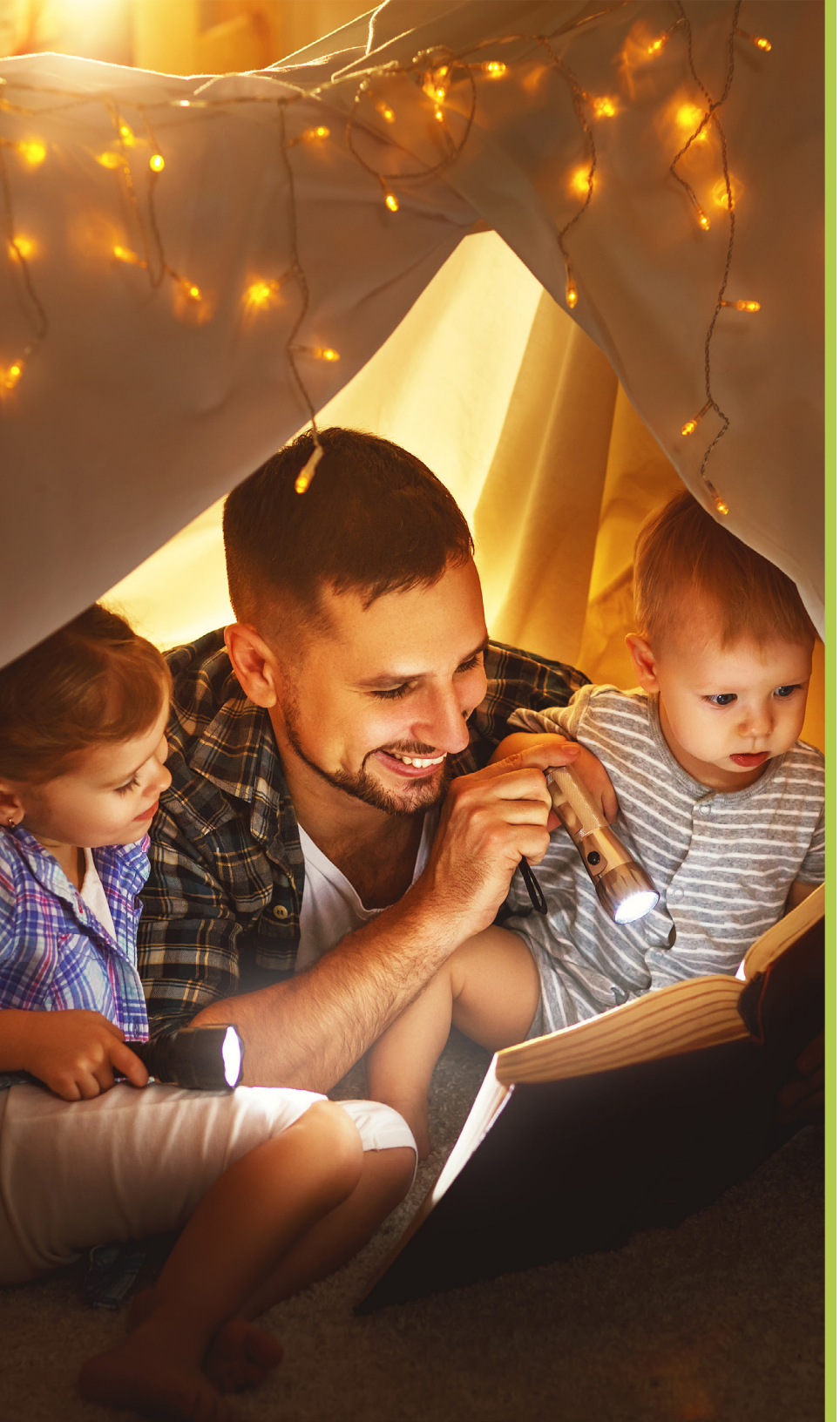
Fulltime employees have the following holidays off: New Year's Day, Martin Luther King Day, Presidents Day, Memorial Day, Independence Day, Pioneer Day, Labor Day, Thanksgiving Day, the day after Thanksgiving Day, Christmas Eve, and Christmas Day.

table of contents

Do you need help or have questions?

You can reach out to your insurance company or benefit provider using the contact numbers provided on page 3.

If your issues are still not resolved, please contact your Diversified Insurance Group Employee Advocate.



At Search Group Partners, we believe employees are the foundation of our success.

Search Group Partners 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 exempt 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).

When Does Coverage Begin for New Hires?

Coverage begins on the first day of the month following 60 days from date of hire. You must be actively at work for your coverage to become effective.

useful contact information

Medical

SelectHealth Group # G1021338

selecthealth.org (800) 538-5038

Health Savings Account

HealthEquity

healthequity.com (866) 346-5800

Dental

DentalSelect Group # 14024319

dentalselect.com (800) 999-9789

Vision

DentalSelect EyeMed Group # 14024319

dentalselect.com (800) 999-9789

Diversified Insurance Group

Employee Advocate (801) 325-5074

SearchGroupPartners@digadvocate.com

Do you have benefit questions?

Please contact the insurance company or benefit provider using the contact information on this page.

If the provider cannot resolve your issues, please contact our Diversified Insurance Group Employee Advocate.

important medical insurance terms

What comes out of my pay?

Annual premium

The annual cost to purchase medical coverage is spread across the year, so you pay a portion of it in each pay period on a pretax basis. Medical premiums are based on the plan you choose and the number of people you cover.

What will I pay after I meet my deductible?

Coinsurance

After you meet the annual deductible, generally, you'll continue to pay the stated coinsurance percentage for in-network covered medical services until you meet the out-of-pocket maximum. The plan pays the rest.

What will I pay when my medical coverage starts?

Annual deductible

You won't pay for in-network preventive care defined by the U.S. Preventive Services Task Force, such as your annual checkup. Generally, for all other covered care, you'll pay the amount of your annual deductible before the plan starts to pay.

How much will I pay out of my own pocket?

Out-of-pocket maximum

This is the most you would pay for covered medical services in a calendar year. Once you meet it, the plan pays the full cost of additional covered care.

Will my doctor be in-network?

Provider network

You can confirm whether your doctor is in-network by going to the SelectHealth website, listed on page 3 of this benefit guide.

What is Search Group Partners contributing?

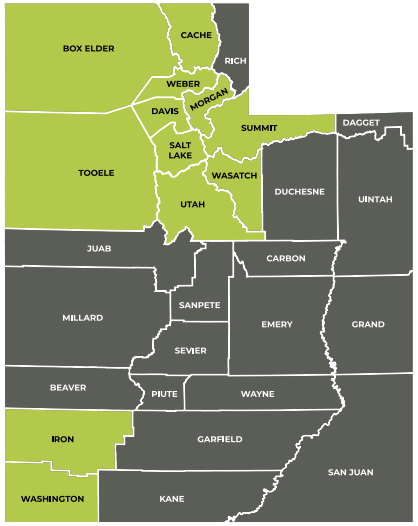
Search Group Partners contribution

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

Choosing the right network is important.

SelectHealth offers provider and facility networks that range in size and coverage area. You can search for participating providers at selecthealth.org/provider, where you can find patient satisfaction ratings for many providers and clinics.

SelectHealth Value Network

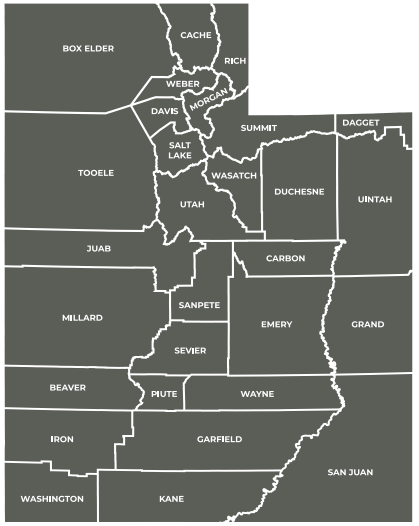


The SelectHealth Value is a highly integrated regional network that services members along the Wasatch Front. Although it is smaller, it is considered the best value available in Utah.

Remember: in the event of an emergency, even if you are out of the covered area, your services will be covered as if in-network.

You must live in the highlighted area to enroll in this network.

SelectHealth Med Network



The SelectHealth Med network is affordable and comprehensive. It is a statewide HMO that covers all of Utah.

Remember: if you have a family member who lives out of the network area, please contact HR to explore your best options.

important info about medical coverage

During your benefits enrollment period, you can add an eligible dependent to your coverage.

Important reminder

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 the change.

An embedded or non-embedded deductible?
With an embedded deductible, the insurance carrier will begin paying for services for any covered member who meets the individual deductible. With a non-embedded deductible, the entire family deductible must be met before the carrier will begin paying.

Here's how deductibles and maximums for employees with family coverage compare across plans.

Traditional Plan	High Deductible Health Plan
Annual deductible/coinsurance Coinsurance begins: • For any family member who meets their individual annual deductible. • For everyone on the plan once two people have costs that combine to meet the family deductible. **Out-of-pocket maximum** 100% of eligible costs are covered: • For any family member who meets their individual out-of-pocket maximum. • For everyone on the plan once two or more people combine to reach the out-of-pocket maximum.	**Annual deductible/coinsurance** Coinsurance begins: • If anyone covered on the plan meets the family annual deductible, or two or more family members combine to reach it, coinsurance begins for everyone on the plan. **Out-of-pocket maximum** • The in-network out-of-pocket maximum is $14,000 per family. • If one person covered under the plan meets the individual out-of-pocket maximum of $7,000, 100% of the costs for covered services for that person are covered under the plan. • If another family member adds $7,000 (for a total of $14,000) in covered expenses, 100% of the costs for covered services for everyone on the plan are covered.

medical plan options

	SELECTHEALTH - TRADITIONAL GOLD 2000 MED NETWORK		SELECTHEALTH - TRADITIONAL GOLD 2000 VALUE NETWORK
	In-Network	Out-of-Network *	In-Network
Annual Deductible Embedded	You pay up to **$2,000** per individual **$4,000** per family	You pay up to **$5,000** per individual **$10,000** per family	You pay up to **$2,000** per individual **$4,000** per family
Accumulator Period	**January - December**		**January - December**
Coinsurance	You pay **15%** AD	You pay **50%** AD	You pay **15%** AD
Out-of-pocket Maximum Embedded	No more than **$7,350** per individual **$7,350** per member **$14,700** per family	No more than **$20,000** per individual **$20,000** per member **$40,000** per family	No more than **$7,350** per individual **$7,350** per member **$14,700** per family
Preventive Services	You pay **$0** according to government guidelines	Not Covered	You pay **$0** according to government guidelines
Office Visits Primary Care Specialist	 You pay **$15** co-pay You pay **$30** co-pay	 You pay **50%** AD You pay **50%** AD	 You pay **$15** co-pay You pay **$30** co-pay
Mental Health Services Office Visit Inpatient	 You pay **$15** co-pay You pay **15%** AD	 You pay **50%** AD You pay **50%** AD	 You pay **$15** co-pay You pay **15%** AD
Emergency Services Urgent Care Emergency Room Ambulance	 You pay **$30** co-pay You pay **$350** AD You pay **15%** AD	 You pay **50%** AD Covered as **In-Network** Covered as **In-Network**	 You pay **$30** co-pay You pay **$350** AD You pay **15%** AD
Inpatient & Outpatient Inpatient Hospital Outpatient Surgery	 You pay **15%** AD You pay **15%** AD	 You pay **50%** AD You pay **50%** AD	 You pay **15%** AD You pay **15%** AD
Prescription Medication	**Generic / Generic Non-preferred / Brand-name / Mostly Brand-name / Injectable and Specialty**		**Generic / Generic Non-preferred / Brand-name / Mostly Brand-name / Injectable and Specialty**
Retail (30-day supply)	You pay **$20** / **$30** / **25%** / **50%** / **25%**		You pay **$20** / **$30** / **25%** / **50%** / **25%**

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.

EMPLOYEE COST PER MONTH			
Employee (EE) Only	EE + Spouse	EE + Child(ren)	EE + Family
$100.00	$125.00	$150.00	$200.00

EMPLOYEE COST PER MONTH			
Employee (EE) Only	EE + Spouse	EE + Child(ren)	EE + Family
$90.00	$112.50	$135.00	$180.00

This information is designed to help you choose a benefit plan for 2021 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.

medical plan options

	SELECTHEALTH - SILVER HDHP 1750 MED NETWORK		SELECTHEALTH - SILVER HDHP 1750 VALUE NETWORK
	In-Network	Out-of-Network *	In-Network
Annual Deductible Non-embedded	You pay up to **$1,750** individual **$3,500** family	You pay up to **$5,000** per individual **$10,000** per family	You pay up to **$1,750** individual **$3,500** family
Accumulator Period	**January - December**		**January - December**
Coinsurance	You pay **40%** AD	You pay **50%** AD	You pay **40%** AD
Out-of-pocket Maximum Embedded	No more than **$7,000** per individual **$7,000** per member **$14,000** per family	No more than **$20,000** per individual **$20,000** per member **$40,000** per family	No more than **$7,000** per individual **$7,000** per member **$14,000** per family
Preventive Services	You pay **$0** according to government guidelines	Not Covered	You pay **$0** according to government guidelines
Office Visits Primary Care Specialist	 You pay **$30** AD You pay **$50** AD	 You pay **50%** AD You pay **50%** AD	 You pay **$30** AD You pay **$50** AD
Mental Health Services Office Visit Inpatient	 You pay **$30** AD You pay **40%** AD	 You pay **50%** AD You pay **50%** AD	 You pay **$30** AD You pay **40%** AD
Emergency Services Urgent Care Emergency Room Ambulance	 You pay **$50** AD You pay **$350** AD You pay **40%** AD	 You pay **50%** AD Covered as **In-Network** Covered as **In-Network**	 You pay **$50** AD You pay **$350** AD You pay **40%** AD
Inpatient & Outpatient Inpatient Hospital Outpatient Surgery	 You pay **40%** AD You pay **40%** AD	 You pay **50%** AD You pay **50%** AD	 You pay **40%** AD You pay **40%** AD
Prescription Medication Retail (30-day supply)	**Generic / Generic Non-preferred / Brand-name / Mostly Brand-name / Injectable and Specialty** You pay **$20 AD / $30 AD / 25% AD / 50% AD / 50% AD**		**Generic / Generic Non-preferred / Brand-name / Mostly Brand-name / Injectable and Specialty** You pay **$20 AD / $30 AD / 25% AD / 50% AD / 50% AD**
Health Care Account	Health Savings Account (**HSA**)		Health Savings Account (**HSA**)

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.

EMPLOYEE COST PER MONTH			
Employee (EE) Only	EE + Spouse	EE + Child(ren)	EE + Family
$84.00	$105.00	$126.00	$168.00

EMPLOYEE COST PER MONTH			
Employee (EE) Only	EE + Spouse	EE + Child(ren)	EE + Family
$76.00	$95.00	$114.00	$152.00

health care account options

Health care accounts can be used to help offset your out-of-pocket health care expenses, including co-pays, prescriptions, glasses, and lab work.

	Health Savings Account (HSA)
Which plans is this account available for?	Silver HDHP 1750
Do I need to be enrolled in a medical plan?	Yes
What would I use this account for?	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 I can put in this account?	**$3,600** Employee-only coverage **$7,200** Family coverage If you'll be at least 55 years old in 2021, you can make an additional $1,000 catch-up contribution.
Are there investment options?	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 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?	All unused funds will roll over to the next year. You can take HSA funds with you when you leave company or retire.

wellness program

Earn up to $240 per person or $580 per family, per year!

The Wellness Rewards are an incentive to maintain healthy habits that contribute to your overall wellness.

Eligibility

- Be age 18 or older
- Agree to the Fitness Program Terms and Conditions

Gym Membership Reward

- Join any gym you like or get low rates through clubs in the Virgin Pulse network (that's more than 12,000 clubs nationally)
- Try a one-week trial membership at a club in the Virgin Pulse Network
- Upload your receipts to Membership Rewards and choose from several rewards card options.

Physical Activity Reward

- Track your activity and complete 20 days or more of 7,000 steps or the equivalent in non-stepping exercise in a calendar month and the 7K Steps for 20 Days Badge will appear in your Virgin Pulse Trophy Case.
- Claim your reward(s), select Membership Re-wards from your Member Checklist and link to Redeem Rewards to choose from several rewards card options.
- Activity tracking must be completed by the end of that calendar month to receive the reward.

To get started and learn more, visit selecthealth.org/getfit **or call at 800-538-5038.**

employee assistance program

An employee assistance program to help you navigate life's challenges.

Intermountain Employee Assistance Program is a staff of licensed mental health professionals to help employees and their family members resolve problems.

Free, confidential help when you need it

- Telephone consultation available 24/7 with licensed mental health professionals
- Online chat information and services
- Referrals to supportive resources

Contact Intermountain EAP

intermountainhealthcare.org/eap

(800) 832-7733

What happens at an appointment?

You or your family member will meet with a licensed, experienced counselor. Your situation will be assessed and together you will develop a plan for improvement. Counseling will continue until the problem is improved or resolved.

Is there a visit limit?

No, Intermountain EAP does not have a visit limit. If the assessment indicates a specialist is needed, the EAP counselor will refer you outside the EAP and help coordinate with your insurance requirements.

Current health and well-being information

- Managing stress
- Handling relationship issues
- Balancing work and life
- Quitting tobacco, alcohol or drug use
- Caring for children or aging parents
- Dealing with conflict or violence
- Working through grief and loss issues
- Controlling depression and anxiety
- Wellness strategies

Help is just a click or a phone call away. For more information or free counseling call Intermountain EAP. Call anytime, 24 hours a day, seven days a week, to set up an appointment.

selecthealth mobile app

The SelectHealth mobile app puts tools right at the tips of your fingers.

Get access to all of the information you need about your health plan.

- **ID cards:** View, email, and fax images of your ID card
- **Provider search:** Search for providers
- **Claims:** Access your explanations of benefits and amounts owed
- **Benefits & coverage:** Find out who and what is covered on your plan

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

Contact SelectHealth

selecthealth.org | (800) 538-5038

Connect care

Convenient, high-quality care - whenever and wherever you need it. A skilled clinician is just a swipe or a click away with Intermountain Connect Care.

- **Mobile App:** With a smartphone or tablet, you can get access through the Connect Care mobile app.
- **Web:** If you'd rather use a larger screen, you can access Connect Care using a video-capable computer at your home or office.
- **Your Visit:** Most visits take less than ten minutes. Your clinician will review your history, answer questions, diagnose, treat, and even prescribe medications.
- **Coverage:** Contact SelectHealth for coverage details.
- **Get Started:** Download the app on Android or IOS, or visit intermountainconnectcare.org to register for free.

Know before you go

Don't guess how much your upcoming surgery or maternity stay will cost. Log into your selecthealth.org and visit the **MyHealth** link. From there you can utilize the **Cost Estimator** which pulls claims data from the SelectHealth networks using that data to provide estimates that represent the cost of care. This tool will help you avoid surprise medical bills.

dental plan options

DentalSelect is the carrier for our dental plan.

Visit dentalselect.com/find-a-provider to find a provider in the network.

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 negotiate fee schedule for a particular service. If the out-of-network provider charges more, you'll be responsible for paying the amount that exceeds the negotiated fees.

* Waiting period is for employees electing as new coverage without continuing from a prior plan.

	PPO MAC CLASSIC	
	In-Network	Out-of-Network *
Annual Deductible January - December	**$50** per individual **$150** per family	**$50** per individual **$150** per family
Annual Maximum	**$2,000** per individual	
Waiting Period	**None** for Preventive and Basic Services **12** months for Major & Orthodontic Services	
Preventive Services Cleanings, routine exams, fluoride, and x-rays	Plan pays **100%** of covered services, No deductible	Plan pays **100%** of **Fee Schedule** No deductible
Basic Services Fillings, sealants, extractions, scaling & root planing, space maintainers, and bridge & crown maintenance	You pay **20%** AD	You pay **20%** of **Fee Schedule**, AD
Major Services Crowns, bridges, implants, dentures, inlays, onlays, veneers, general anesthesia, endodontics, and periodontics	You pay **50%** AD	You pay **50%** of **Fee Schedule**, AD
Orthodontic Services Children and adults	Covers up to **50%** under age 19, **20%** discount for adults	Covers up to **50%** of **Fee Schedule** AD, for children under 19
Orthodontic Lifetime Maximum	**$1,000** per individual	

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.

EMPLOYEE COST PER PAY PERIOD		
Employee (EE) Only	EE + 1 Dependent	EE + Family
$4.62	$6.46	$9.23

vision plan options

DentalSelect is our vision carrier.

Visit dentalselect.com/find-a-provider to find a provider in the network. This vision plan is on the EyeMed Select network.

	DENTALSELECT - VISION 21 EYEMED SELECT	
	In-Network	Out-of-Network
Routine Vision Exams	**$10** copay	Plan reimburses up to **$45**
Frequency		
Exams	**Once** per calendar year	
Contact Lenses	**Once** per calendar year	
Frames	**Once** per calendar year	
Lenses	**Once** per calendar year	
Eyeglasses		
Single Vision Lenses [1]	**$25** copay	Plan reimburses up to **$40**
Lined Bifocal Lenses [1]	**$25** copay	Plan reimburses up to **$60**
Lined Trifocal Lenses [1]	**$25** copay	Plan reimburses up to **$80**
Frame Allowance	Plan provides a **$130** allowance [2]	Plan reimburses up to **$45**
Contact Lenses		
Prescription Elective (in lieu of eyeglasses)	Plan provides a **$150** allowance	Plan reimburses up to **$150**

EMPLOYEE COST PER PAY PERIOD		
Employee (EE) Only	EE + 1 Dependent	EE + Family
$1.15	$1.62	$2.31

[1] Limited to standard, uncoated plastic lenses.

[2] A **20%** discount is applied to frames over the **$130** allowance

This information is designed to help you choose a benefit plan for 2021 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.

dress code for headquarters campus

Headquarters Campus in downtown Salt Lake City, UT

All workers are expected to dress modestly and in a conservative, professional manner consistent with the local customs and standards. Avoid extreme clothing of any style. Wear shoes that are in good repair and shined, avoiding athletic or similar shoes of any color. Wear clothing that is clean, well-cared for, and neatly pressed. The fit and style of clothing for both men and women should be modest. the following guidelines should be followed, unless the Human Resources representative for the relevant Church department obtains a waiver for particular job assignments.

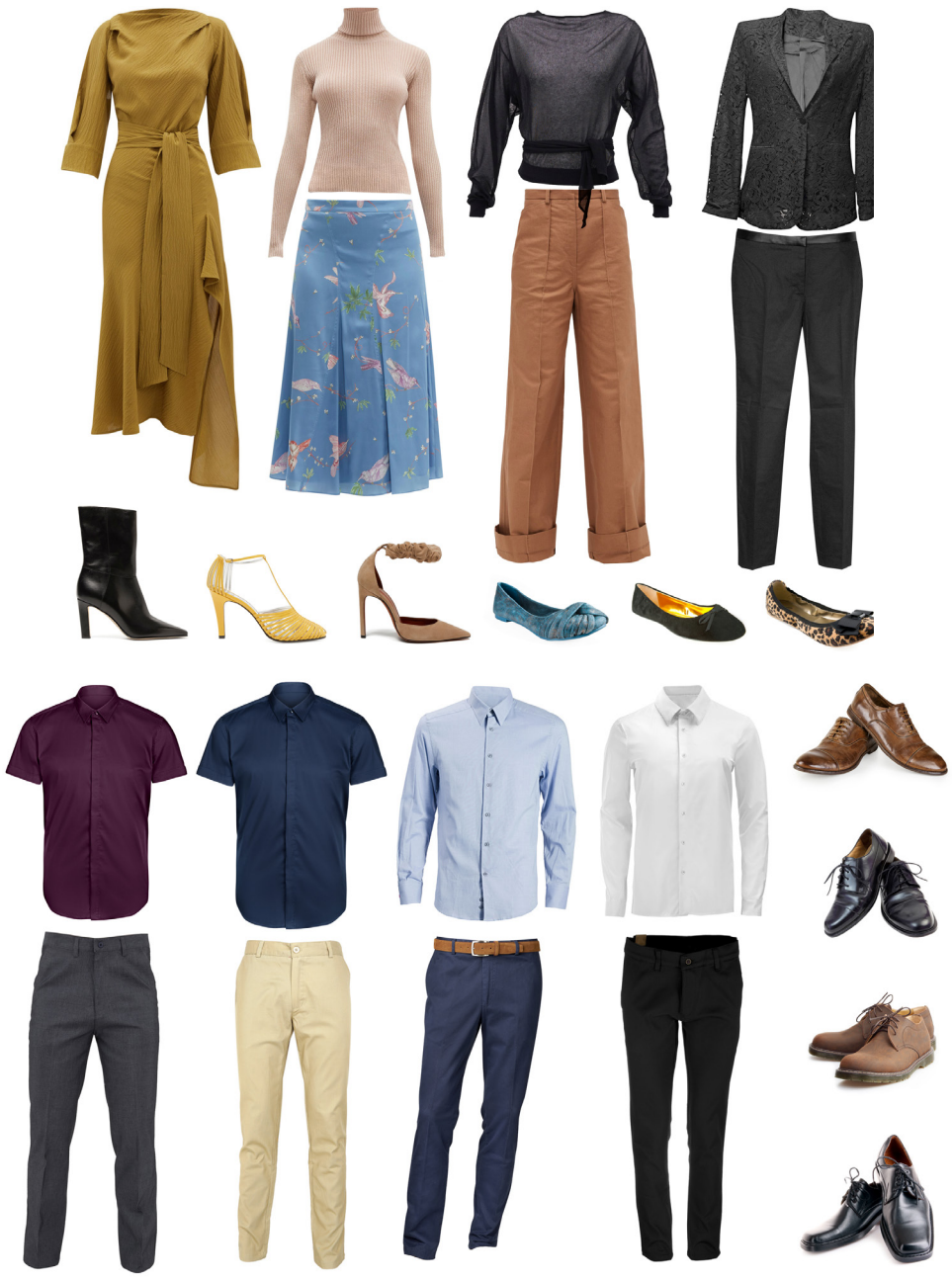
Business Professional

Women	Men
» Professional, business-appropriate skirts or dresses of at least knee length (Skirts with immodest slits are inappropriate.) » Casual sandals or flip-flops are not acceptable » Pants, pantsuits and split skirts are not acceptable	» Ties and suits or sport coats and dress slacks » White or light-colored dress shirts » A suit or sport coat should be worn when leaving the department area. (On a hot day, it is appropriate to remove the coat after leaving the building.)

Extreme hairstyles are not aceptable. Hair should be clean and neatly combed. Sideburns below the earlobes and beards are not acceptable. Mustaches, where worn, should be neatly trimmed and not extend beyond the corners of the mouth. Men's hair length should be above the collar.

High standards of personal hygiene and cleanliness are expected. Cologne and perfume should be used sparingly, with sensitivity to allergies of co-workers.

dress code for buyer's campus



Buyer's Campus in Riverton, UT

Always strive to present a professional, clean, and well-groomed appearance. You should always wear professional, conservative clothing that is consistent with our sacred work for The Church of Jesus Christ of Latter-day Saints. The dress and grooming standards for the Riverton Office Building is business casual.

Business Casual

Women	Men
» Modest, Conservative, Professional	» Modest, Conservative, Professional
» Not acceptable: All blue denim jeans, sloppy/faded demin pants of any color, cargo pants, short pants (above mid-calf), athletic shoes, or casual flip flops/slip-ons. Shoes must be worn at all times	» Not acceptable: All blue denim jeans, sloppy/faded denim pants of any color, cargo pants, short pants, athletic shoes, flip flops, or open-toed shoes. Socks should be worn with shoes. Shoes must be worn at all times
» No extreme hairstyles	» No extreme hairstyles

Hair should be clean and neatly combed. Sideburns below the earlobes and beards are not acceptable. Mustaches, where worn, should be neatly trimmed and not extend beyond the corners of the mouth. Men's hair length should be above the collar.

High standards of personal hygiene and cleanliness are expected. Cologne and perfume should be used sparingly, with sensitivity to allergies of co-workers.

your employee advocate is here for you

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

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

Contact your Employee Advocate

(801) 325-5074 | (888) 244-1212 ext. 5074

searchgrouppartners@digadvocate.com

online enrollment instructions

You must register before you can enroll in or make changes to your Employee Benefit elections and personal information.

Please follow the steps outlined here to register in Ignite, Search Group Partners's online enrollment system. Once you have registered, you will be able to enroll in benefits or make changes to your existing benefits and personal information in the Ignite system.

ignite
POWERED BY DIVERSIFIED

Step 1

Open your internet browser and navigate to ignitebenefits.com

Step 2

Click on **New Registration** and enter your information.

If you already have a **Username** and **Password** please select **Login** and skip ahead to **Step 4**.

Search Group Partners's identifier is:
SearchGroup

Step 3

Follow the instructions to set up your **Username** and **Password**.

Please use secure password storage practices to safeguard your personal information.

Step 4

Now that you're registered and logged into the system, you can navigate to your **Profile**, **Benefits**, **Required Tasks** (benefits or HR related items that Search Group Partners requires you to complete), and **Resources**.

general participation guidelines and notices

Search Group Partners 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 1st day of the month after 60 days from date of hire. 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 Search Group Partners. 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 Search Group Partners ends;
- The group policy ends;
- You are no longer eligible under the plan;
- Your death;
- You retire;
- You enter the armed forces of any country on a full-time basis.

Dependent eligibility verification notice
Search Group Partners 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, and Health Savings Account (HSA)..

Search Group Partners 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.

Utah Medicaid and CHIP Information
health.utah.gov/chip
1 (877) KIDS-NOW

Children's medical coverage assistance
health.utah.gov/upp
1 (866) 435-7414

Low-income family medical coverage assistance
medicaid.utah.gov
1 (801) 538-6155

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

general participation guidelines and notices

ACA notices about eligibility and coverage periods

- Search Group Partners 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 Search Group Partners'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 Search Group Partners'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, Search Group Partners 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 Search Group Partners 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 Search Group Partners 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.
- Search Group Partners has determined that the prescription drug coverage offered by the Search Group Partners 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:

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