A Guide to Administering Your Company's Health Insurance

PAYCHEX® INSURANCE Agency INC.

Table of Contents

Welcome to Paychex Insurance Agency

Dear Valued Client:

Thank you for choosing Paychex Insurance Agency as your partner in delivering a comprehensive health care benefits package to your employees.

Who We Are
Paychex Insurance Agency was founded in 1997 with a mission to provide our clients with a cost-effective, service-driven health insurance solution. Working with more than 250 insurance carriers, Paychex Insurance Agency is one of the top 20 insurance agencies in the United States.

Services We Provide
With a dedicated service team, we provide a broad range of services that can be used to help manage your health care plans. Available services include enrollment administration, payroll deduction management, renewal assistance, health advocacy services, COBRA administration, and an insurance premium payment service. We can also assist you in understanding and navigating Health Care Reform.

How This Guidebook Can Help
This guidebook is a reference document that provides information to help administer your company's insurance program, including:

- instructions for managing employee eligibility;
- descriptions of reports and services;
- answers to frequently asked questions; and
- a glossary of common health insurance terms.

Please contact your account manager with any questions or issues you would like to discuss. For more information, please visit our website at www.paychex.com.

Sincerely,

Paychex Insurance Agency

Contact Information

Contacting Paychex Insurance Agency

If you have questions, please contact your account manager or dedicated service team.

You may also contact our Service Center at 800-472-0072 to assist you with questions regarding:

- billing
- eligibility
- enrollment forms
- ID card replacement and correction
- group coverage
- plan brochures

Service Center Business Hours

Monday - Friday, 8:00 a.m. – 8:00 p.m. ET

Contacting Your Insurance Carrier

Since Paychex Insurance Agency is your agent and not your insurer, we are prohibited from obtaining or reporting certain types of employee information. Situations will come up that require direct carrier contact by you or an employee including:

- primary care physician additions and changes
- claims
- certificates of coverage for proof of insurance
- all other employee-specific information

Carrier contact information can be found on the insurance card provided by your carrier. If you are unable to obtain carrier contact information, you may call your account manager or dedicated service team.

Paychex Departments Contact Information

Frequently Contacted Paychex Teams
401K: 800-472-0072
Client: Ext. 7564011 Participant: Ext. 7564002 Email: clientsupport@paychex.com
Balance Care: 877-598-8617
BeneTrac: 877-645-4342
COBRA: 800-472-0072 Ext:
Client: 7530001 Participant: 7235014 Email: APC_COBRA@paychex.com
ERISA Bond: 1-877-266-6850
Handbooks: 877-405-5877
HR Essentials: 1-877-405-5877
Online Support
Benefits.Paychex.com: 888-246-7500 Mypaychex.com: 877-281-6624 Benetrac: 877-645-4342 FLEX: 844-712-3133
Paychex Business Solutions (PBS): 800-741-6277, Option 4 Option 2 **Paychex Benefit Account (PBA):** 800-472-0072, Option 4
Section 125 (FSA): 800-472-0072 Ext: Client: 7542003 Employee: 7542002 Claims Fax Number: 585-389-7003 Claims Address: Paychex Benefit Account Services 1175 John Street West Henrietta, NY 14586
Time & Attendance: 800-472-0072 Option 8
Workers Comp: 1-877-266-6850 Email: PIAPC_customerservice@paychex.com

Managing Your Health Care Plan

Overview of Responsibilities

Successfully delivering the benefits of a health insurance plan for your company is a team effort, and each participant plays an important role. Responsibilities by group are outlined below.

Paychex Insurance Agency **(your insurance agent and benefits administrator)**	• Manage recordkeeping components of your health care benefits including: o Eligibility o Plan benefits o Plan design
Policyholder (you)	• Provide accurate and timely information about enrollments and cancellations • Submit accurate documentation for transaction with your health insurance carrier • Review reports and invoices monthly to ensure enrollments and terminations are accurately reflected
Participant (employee)	• Complete health insurance applications accurately • Meet enrollment deadlines with forms and applications
Provider **(insurance carrier)**	• Provide health insurance coverage based upon your policy choice • Provide certificates of coverage when your employees request them • Provide ID cards

What You Should Expect From Us

As your agent, we will provide you with

- a proactive approach to managing your benefits
- the highest level of professionalism
- unsurpassed customer service
- industry knowledge and expertise
- access to quote alternate options to meet your needs
- access to the full line of Paychex services

Managing Your Health Care Plan

Enrollments

Paychex Insurance Agency will help you manage employee enrollments. Please be sure to submit all enrollment transactions to the agency via email, fax or via the web portal and keep a copy for your records. Please note the carriers may require additional documentation.

We'll record the information in our system, set up deductions as appropriate, and send the enrollment forms to your insurance carrier for processing. Additional forms can be obtained by contacting your account manager or dedicated service team.

When Is an Enrollment Form Required?

An enrollment form is required in the following situations:

New Hire & At Renewal - A newly hired employee who has met the eligibility requirements and wishes to enroll

Qualifying Event – An existing employee who experiences a qualifying event, has met the required waiting period, and wishes to enroll (See the following table for a list of qualifying events and supporting documentation required.)

Qualifying Event	Documentation Required
Change from part-time to full-time status	Payroll documents showing hours/salary
Marriage	Marriage certificate
Birth of a child	Birth certificate
Adoption	Adoption decree
Involuntary loss of coverage	Certificate of prior coverage

When Is a Waiver Form Required?

New Hire & At Renewal - A waiver form is required for a newly eligible employee and any eligible employee at open enrollment who has met the eligibility requirements and declines coverage.

Employee Responsibilities

The employee must complete and sign an enrollment form and submit it to the employer along with documentation (qualifying events only). The enrollment form must contain:

- mailing address
- social security number (SSN)
- plan selection
- date of birth
- date of hire
- primary care physician (PCP)
- dependent information (name, date of birth, SSN, PCP)

Employer Responsibilities

The employer must:

- review each form and verify that the effective date is included and accurate;
- submit completed enrollment forms to Paychex Insurance Agency by the effective date; and
- indicate in the email or on the fax cover sheet the appropriate class in which the employee should be enrolled.

Managing Your Health Care Plan

Cancellations

There are two types of insurance cancellation:

Voluntary – Insurance is cancelled at the request of the employee. Please note the carriers may require additional documentation.

Involuntary –Insurance is cancelled due to circumstances beyond the employee's control such as death, termination of employment, or a change in eligibility status.

Employee Responsibilities (Voluntary Cancellation Only)

To cancel coverage, the employee must:

- complete the enrollment form indicating that coverage is being cancelled and
- sign the enrollment form and submit it to the employer.

Employer Responsibilities

To cancel coverage, the employer must:

- report the voluntary cancellation of coverage to Paychex Insurance Agency,
- report the termination of employment to the Paychex Payroll Department, and
- offer COBRA or State Continuation where applicable.

Refer to carrier-specific guidelines included in the contract provided to you by your carrier for all other cancellation timelines and Section 125 (if applicable).

Note: For cancellations to be effective within a given month, policies issued in **Texas and Arkansas** must report cancellation of an employee terminated during the last week of the month within **3 business days** of the following month; all other terminations must be reported before the end of the month.

Email or fax completed forms to Paychex Insurance Agency:

Email: enrollmentprocessing_nationalhealth@paychex.com
Fax: 585-249-4029

Managing Your Health Care Plan

Carrier Invoice and Payroll Deductions

Carrier invoices are sent to you directly and are expected to be paid as billed. Partial payment or late payment could result in the carrier terminating your group's coverage. Billing credits (if applicable) could take 1-2 billing cycles to be reflected on the invoice.

If your group is set up to have both employer and employee contributions, you will still be responsible for paying the invoice in full, and the employee portion will be collected as a payroll deduction.

Employer Responsibilities

Please review:

1. Your carrier invoices each month to ensure enrollments and terminations are accurately reflected.
2. Your payroll reports to ensure that employees listed on the carrier invoice are having deductions accurately withheld.
3. Your Paychex Employee Enrollment & Deduction Summary Report each month to ensure the information matches what's on the carrier's invoice and the deductions occurring at payroll.

If there are any discrepancies, notify your account manager or dedicated service team for assistance.

Health Insurance Deduction and Carrier Invoice Example

Sally makes $1,000 per month	$1,000
Sally's health and benefits premiums are $100 per month	- $100
$900 per month is taken out of the client's payroll corporate account and paid to Sally	**$900**

The $100 that Sally owes for her health & benefits premium remains in the corporate account and will be paid directly to the carrier

Client is invoiced and pays the carrier directly

Note: Some carriers allow Paychex Insurance Agency to pay the invoice on your behalf. If interested in this service, please contact your account manager or dedicated service team

Eligibility Report

The Eligibility Report lists newly hired employees who have met waiting period requirements and may be eligible to enroll in your health care plan. It is sent 15 days prior to the employee's calculated eligibility date. If no enrollment/waiver is received, an additional report will be sent to you 10 days after the calculated eligibility date. It consists of the following sections, which outline plan details and categorize employees based on available information.

1 - Eligible Employees

These employees have met all eligibility criteria based on the information provided. They should be offered the opportunity to enroll, be presented any required paperwork, and be informed of the deadline(s) for submission.

2 - Employees Who May Not Meet Eligibility Criteria

These employees do not appear eligible to enroll in insurance because they do not meet all the minimum eligibility requirements. You should review this section for accuracy and report any discrepancies to your account manager or dedicated service team immediately.

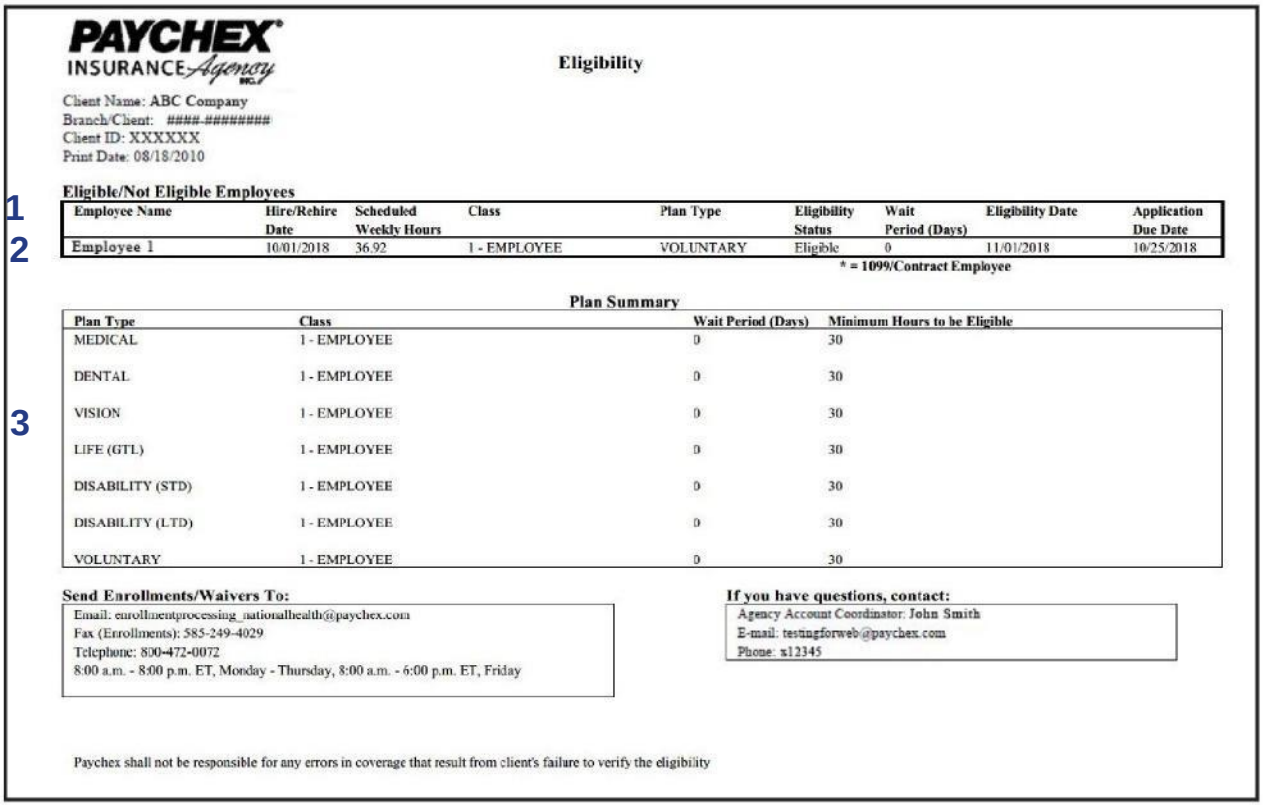
3 - Plan Summary

This section summarizes the plans offered to your employees. Types of plans available, eligibility criteria per plan, wait period, and minimum hours to be eligible are listed.

4 - Employees with Missing Information

Eligibility of these employees cannot be determined because the required information has not been provided. You should provide us with missing information by replying to the missing information email we'll send you.

Sample Eligibility Report



PAYCHEX INSURANCE Agency

Eligibility

Client Name: ABC Company
Branch/Client: ####-########
Client ID: XXXXXX
Print Date: 08/18/2010

1

Eligible/Not Eligible Employees

2

Employee Name	Hire/Rehire Date	Scheduled Weekly Hours	Class	Plan Type	Eligibility Status	Wait Period (Days)	Eligibility Date	Application Due Date
Employee 1	10/01/2018	36.92	1 - EMPLOYEE	VOLUNTARY	Eligible	0	11/01/2018	10/25/2018

* = 1099/Contract Employee

Plan Summary

3

Plan Type	Class	Wait Period (Days)	Minimum Hours to be Eligible
MEDICAL	1 - EMPLOYEE	0	30
DENTAL	1 - EMPLOYEE	0	30
VISION	1 - EMPLOYEE	0	30
LIFE (GTL)	1 - EMPLOYEE	0	30
DISABILITY (STD)	1 - EMPLOYEE	0	30
DISABILITY (LTD)	1 - EMPLOYEE	0	30
VOLUNTARY	1 - EMPLOYEE	0	30

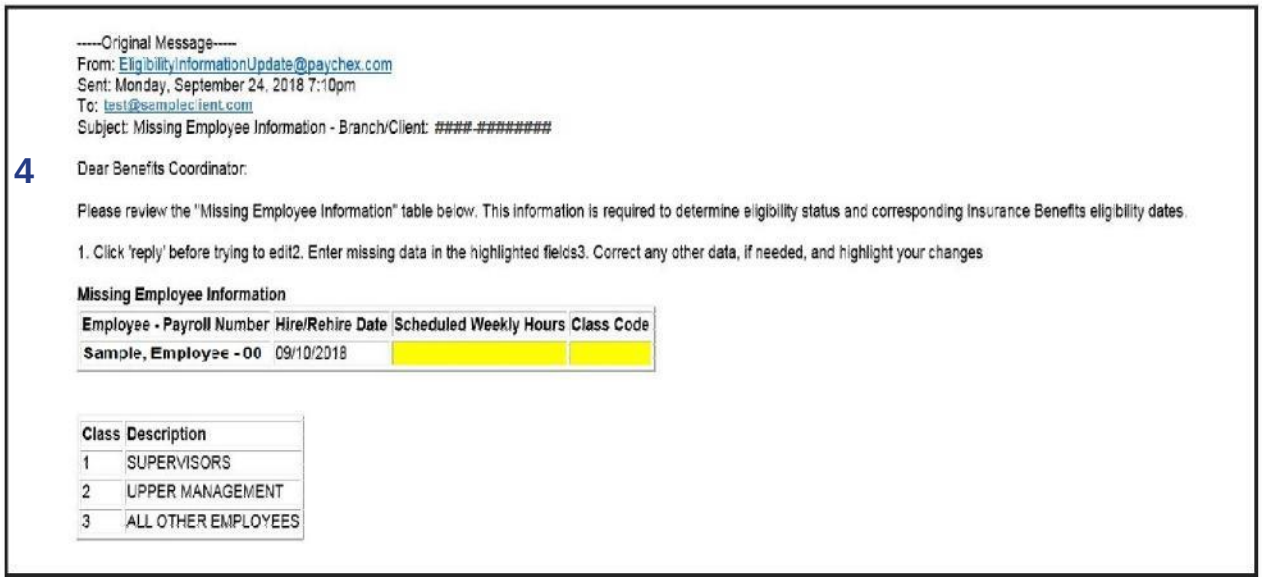
Send Enrollments/Waivers To:

Email: enrollmentprocessing_nationalhealth@paychex.com
Fax (Enrollments): 585-249-4029
Telephone: 800-472-0072
8:00 a.m. - 8:00 p.m. ET, Monday - Thursday, 8:00 a.m. - 6:00 p.m. ET, Friday

If you have questions, contact:

Agency Account Coordinator: John Smith
E-mail: testingforweb@paychex.com
Phone: x12345

Paychex shall not be responsible for any errors in coverage that result from client's failure to verify the eligibility



-----Original Message-----
From: EligibilityInformationUpdate@paychex.com
Sent: Monday, September 24, 2018 7:10pm
To: test@semplecient.com
Subject: Missing Employee Information - Branch/Client: ####-########

4

Dear Benefits Coordinator:

Please review the "Missing Employee Information" table below. This information is required to determine eligibility status and corresponding Insurance Benefits eligibility dates.

1. Click 'reply' before trying to edit2. Enter missing data in the highlighted fields3. Correct any other data, if needed, and highlight your changes

Missing Employee Information

Employee - Payroll Number	Hire/Rehire Date	Scheduled Weekly Hours	Class Code
Sample, Employee - 00	09/10/2018		

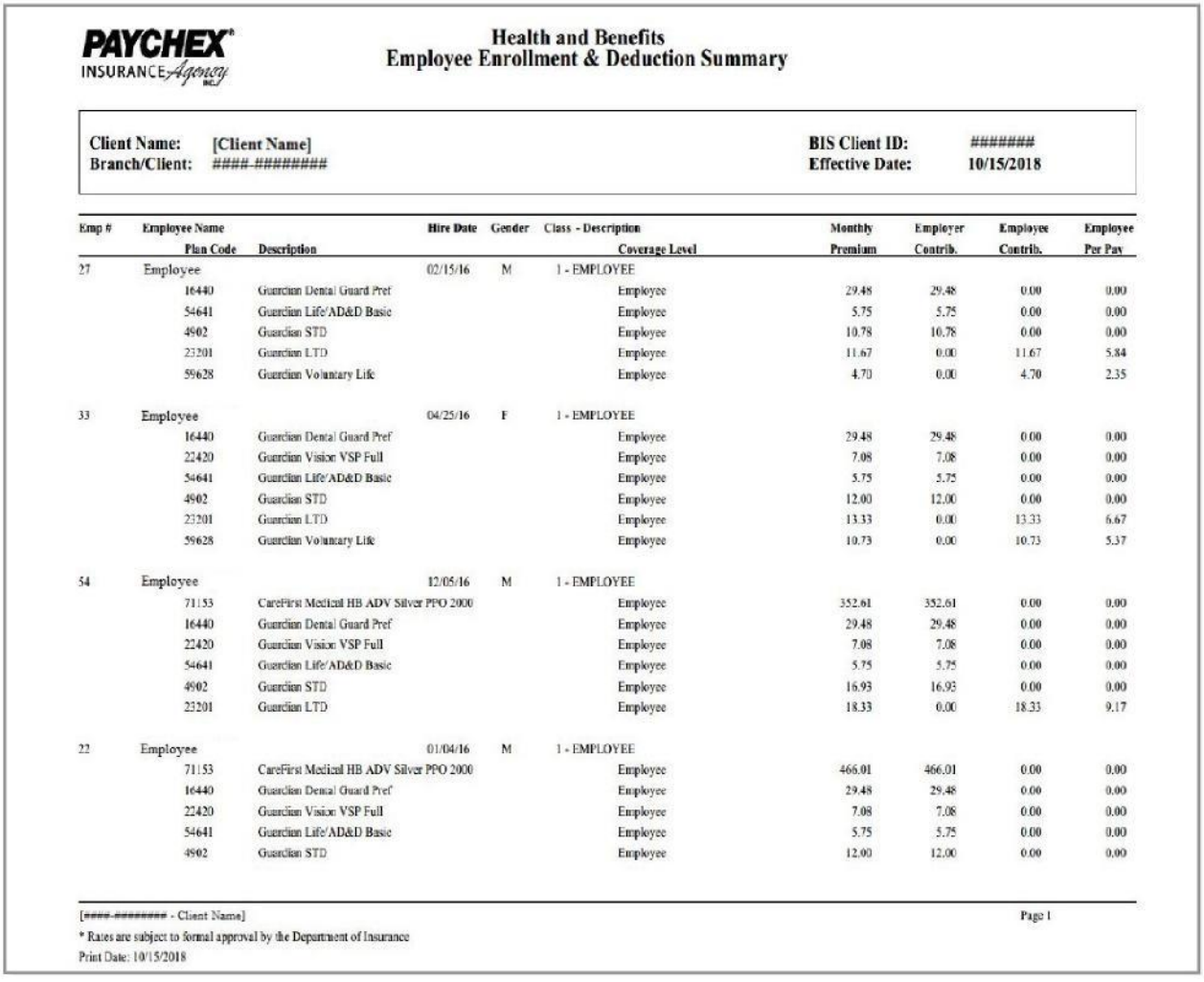
Class	Description
1	SUPERVISORS
2	UPPER MANAGEMENT
3	ALL OTHER EMPLOYEES

Employee Enrollment & Deduction Summary

Employee deductions are processed with your payroll and monitored during the term of your policy. We can manage your deductions, if desired. The Health and Benefits Employee Enrollment & Deduction Summary shows currently enrolled employees as of a specific effective date by last name. Also listed are details of their enrollment, including:

- Employee name
- Plan description
- Hire date
- Coverage level
- Employee premium (monthly)
- Employer contribution (monthly)
- Employee contribution (monthly)
- Employee deduction (per pay period)

This report is generated on the 15th of every month and sent via your preferred method of communication. It is also available on demand by contacting your account manager or dedicated service team.



PAYCHEX INSURANCE Agency

Health and Benefits
Employee Enrollment & Deduction Summary

Client Name: [Client Name]
Branch/Client: ####-########
BIS Client ID: #######
Effective Date: 10/15/2018

Emp #	Employee Name / Plan Code	Description	Hire Date	Gender	Class - Description / Coverage Level	Monthly Premium	Employer Contrib.	Employee Contrib.	Employee Per Pay
27	Employee		02/15/16	M	1 - EMPLOYEE				
	16440	Guardian Dental Guard Pref			Employee	29.48	29.48	0.00	0.00
	54641	Guardian Life/AD&D Basic			Employee	5.75	5.75	0.00	0.00
	4902	Guardian STD			Employee	10.78	10.78	0.00	0.00
	23201	Guardian LTD			Employee	11.67	0.00	11.67	5.84
	59628	Guardian Voluntary Life			Employee	4.70	0.00	4.70	2.35
33	Employee		04/25/16	F	1 - EMPLOYEE				
	16440	Guardian Dental Guard Pref			Employee	29.48	29.48	0.00	0.00
	22420	Guardian Vision VSP Full			Employee	7.08	7.08	0.00	0.00
	54641	Guardian Life/AD&D Basic			Employee	5.75	5.75	0.00	0.00
	4902	Guardian STD			Employee	12.00	12.00	0.00	0.00
	23201	Guardian LTD			Employee	13.33	0.00	13.33	6.67
	59628	Guardian Voluntary Life			Employee	10.73	0.00	10.73	5.37
54	Employee		12/05/16	M	1 - EMPLOYEE				
	71153	CareFirst Medical HB ADV Silver PPO 2000			Employee	352.61	352.61	0.00	0.00
	16440	Guardian Dental Guard Pref			Employee	29.48	29.48	0.00	0.00
	22420	Guardian Vision VSP Full			Employee	7.08	7.08	0.00	0.00
	54641	Guardian Life/AD&D Basic			Employee	5.75	5.75	0.00	0.00
	4902	Guardian STD			Employee	16.93	16.93	0.00	0.00
	23201	Guardian LTD			Employee	18.33	0.00	18.33	9.17
22	Employee		01/04/16	M	1 - EMPLOYEE				
	71153	CareFirst Medical HB ADV Silver PPO 2000			Employee	466.01	466.01	0.00	0.00
	16440	Guardian Dental Guard Pref			Employee	29.48	29.48	0.00	0.00
	22420	Guardian Vision VSP Full			Employee	7.08	7.08	0.00	0.00
	54641	Guardian Life/AD&D Basic			Employee	5.75	5.75	0.00	0.00
	4902	Guardian STD			Employee	12.00	12.00	0.00	0.00

[####-######## - Client Name] Page 1
* Rates are subject to formal approval by the Department of Insurance
Print Date: 10/15/2018

Sample Census Report

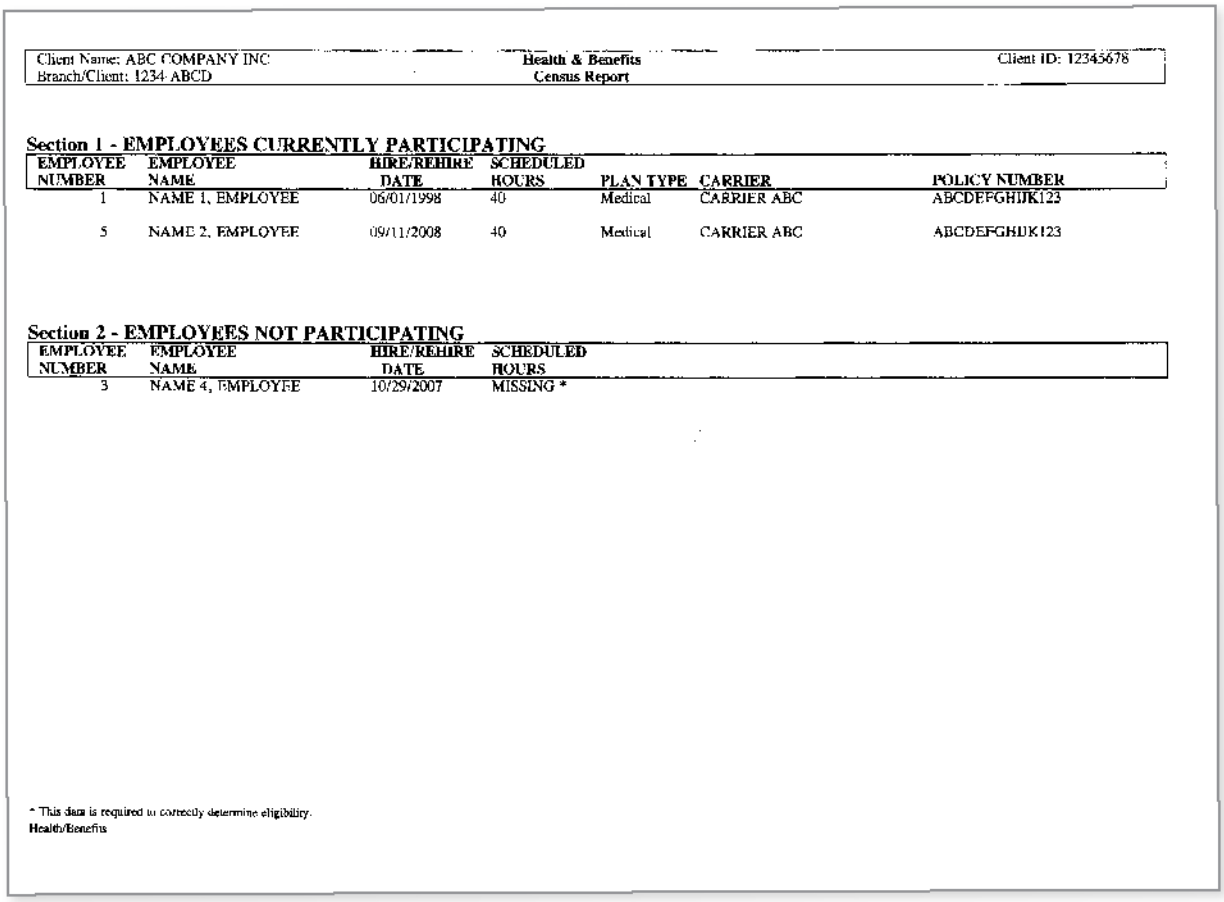
The Health and Benefits Census Report is sent on the 10th of each month through your preferred communication method. It is similar to the Eligibility Report and includes two sections listing all active payroll employees and their current enrollment status:

Section 1 – Employees Currently Participating

Currently enrolled employees and the plans they participate in are listed here.

Section 2 – Employees Not Participating

Any employees who have declined to participate in the insurance options offered or have not satisfied the wait period will be listed in this section.



Client Name: ABC COMPANY INC
Branch/Client: 1234/ABCD

Health & Benefits Census Report

Client ID: 12345678

Section 1 - EMPLOYEES CURRENTLY PARTICIPATING

EMPLOYEE NUMBER	EMPLOYEE NAME	HIRE/REHIRE DATE	SCHEDULED HOURS	PLAN TYPE	CARRIER	POLICY NUMBER
1	NAME 1, EMPLOYEE	06/01/1998	40	Medical	CARRIER ABC	ABCDEFGHIJK123
5	NAME 2, EMPLOYEE	09/11/2008	40	Medical	CARRIER ABC	ABCDEFGHIJK123

Section 2 - EMPLOYEES NOT PARTICIPATING

EMPLOYEE NUMBER	EMPLOYEE NAME	HIRE/REHIRE DATE	SCHEDULED HOURS
3	NAME 4, EMPLOYEE	10/29/2007	MISSING *

* This data is required to correctly determine eligibility.
Health/Benefits

Renewal

Renewing Your Insurance Policy

Most insurance policies renew annually. As your agent, Paychex Insurance Agency will help lead you through this process. Your account manager can evaluate your current insurance needs and help you find new or alternative plan designs.

The open enrollment process occurs approximately 30 days before the renewal of your insurance. Please note that this is the only time during the year that employees can add or decline coverage or make changes to current enrollment without experiencing a qualifying event. (See page 5 for a list of qualifying events.)

Employee Responsibilities at Open Enrollment

Employees must complete and sign an enrollment form or a valid waiver form and submit it to the employer.

The enrollment form must contain:

- date of hire
- mailing address
- social security number (SSN)
- plan selection(s)
- primary care physician (PCP)
- dependent information (name, date of birth, SSN, PCP)

Employer Responsibilities at Open Enrollment

Each year, you must:

- review each form and verify that the effective date for coverage change is included and accurate, and
- email or fax completed enrollment forms to your account manager or dedicated service team prior to the renewal date of the policy.
- collect any medical waivers and retain on file.

Additional Services Available

Health Care Reform Resources

With access to legislative and regulatory specialists in Washington, D.C., and in-house resources, Paychex Insurance Agency is your source for help in understanding Health Care Reform. We will help keep you up to date on the latest Health Care Reform news and deadlines, such as:

- Medical Loss Ratio rebate
- Medicare Part D Notice Information
- Form 5500
- PCORI fee
- W-2 health reporting

Employer Shared Responsibility

Under the Affordable Care Act (ACA), also known as Obamacare, employers with an average of 50 or more full-time employees (including full-time equivalents) in the preceding calendar year could potentially face significant penalties if they don't offer adequate, affordable coverage to their full-time employees and their dependents. They're also required to report information about their full-time employees' health coverage to the IRS. Our Employer Shared Responsibility service provides reporting and end-of-year filing assistance to help clients navigate these requirements.

Dedicated Service Team and Health Care Reform Support Team

You have access to a dedicated service team who works with our Health Care Reform team to provide you with information and resources to help adapt to the ever-changing landscape of health insurance requirements.

Compliance Guide

When you pair your payroll service with benefits through the Paychex Insurance Agency, you gain online access to a robust compliance guide to help you stay compliant, including:

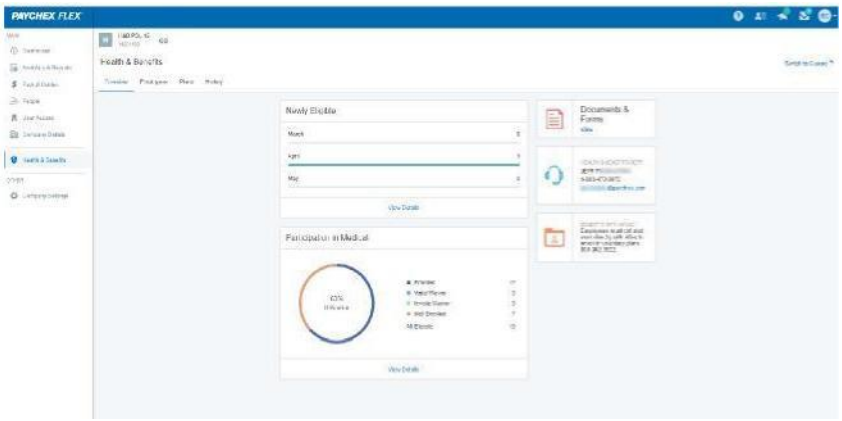
- A comprehensive list of notice requirements
- Checklists for key regulations
- A calendar for deadline-driven requirements
- Access to required forms
- Educational materials and instructions on required federal regulations
- Access to a vast library of online resources to help keep you in compliance

Additional Services Available

Paychex Flex Benefits for Employers Website

Access your health and benefits information on-line with the Paychex Health & Benefits Insurance Services for Employers website. You can use the website to:

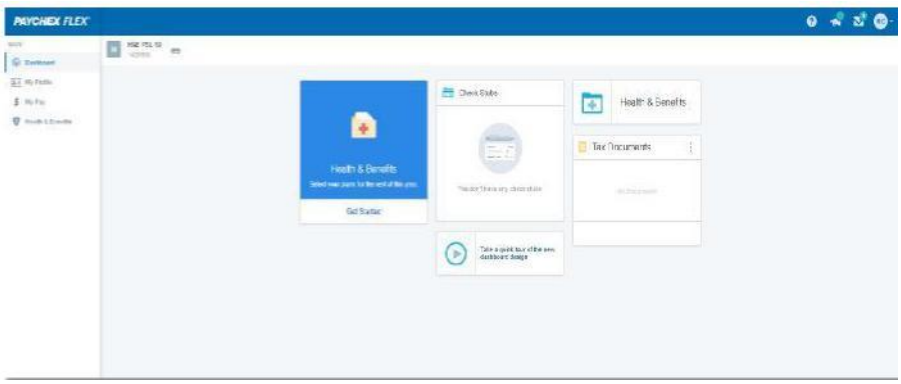
- view account information and status,
- receive helpful alerts and reminders,
- review plan options,
- enroll employees,
- review and update eligibility information for employees,
- allow your employees online access to make updates and enroll, and
- review reports to ensure accuracy and timing of enrollments,



Paychex Flex Benefits for Employee's Website

Employees can access the portal via their Paychex Flex account and our mobile friendly app to:

- view plan descriptions in detail,
- enroll as a new hire, during open enrollment, or for a qualifying event,
- view cost per pay period - if applicable, and
- add dependent information.



Additional Services Available

Balance*Care*℠ Health Advocacy Services

As part of your benefits package, you may be eligible* to take advantage of Balance***Care*** through eni, a confidential and complimentary service designed to help you understand and maximize your health care benefits.

Available 24 hours a day, 7 days a week, Balance***Care*** will connect you to a health care professional ready to assist your employees in managing and resolving a variety of health care issues including:

- Claims Assistance
- Referrals
- Care Coordination
- Specialty Care
- Eldercare
- Medicare
- Transportation
- Clinical Trials
- Home Health Care Services
- Hospital Planning
- Assisted Living and Finances
- Rehabilitation Services

Access to Balance***Care*** is easy, with two convenient options:

Toll-Free Number: 877-598-8617
Email: balancecare@eniweb.com

*Balance***Care** Health Advocacy Services are available for clients who meet certain criteria and have 10 or more participants in their plan.

Additional Services Available

COBRA Administration

Paychex offers both Consolidated Omnibus Budget Reconciliation Act (COBRA) and State Continuation services to help our clients comply with federal and state mandates for the temporary continuation of health care coverage for employees and their dependents that would otherwise end because of certain qualifying events. Paychex COBRA Administration helps employers stay in compliance with regulations and reduce their administrative burden while avoiding potentially costly penalties. You may review COBRA regulations by visiting www.dol.gov/.

COBRA or State Continuation?

COBRA applies to employers with 20 or more employees on 50 percent of the typical business days in the previous calendar year.

State Continuation regulations generally apply to employers not subject to COBRA. This can include not only those employers who don't meet the employee count in the previous calendar year, but also new employers in their first year of business. Refer to the State's guidelines for further information.

Regardless of the size of your business, through COBRA Administration, Paychex can:

- set up and maintain federal COBRA and State Continuation administration programs;
- send timely notices to qualified individuals of their rights under COBRA;
- provide access to COBRA enrollment forms to covered individuals;
- collect participant payments and reimburse the premiums to you bimonthly;
- track terminations from payroll and send you a reminder notification (optional service);
- provide Eligibility Reports that include your obligation to offer or cancel insurance for qualified dependents (by request);
- help you comply with COBRA-mandated programs; and
- answer questions through a toll-free customer service line.

If you are not currently enrolled in the COBRA Administration service but would like to learn more, please call 800-472-0072, Option 5, Option 1 or APC_COBRA@paychex.com.

Additional Services Available

COBRA Administration

How It Works		
EVENT	**EMPLOYEE / EMPLOYER**	**PAYCHEX COBRA ADMINISTRATION**
New employee is enrolled in company-sponsored insurance plan(s) (Medical, Dental, Vision or Prescription).	Sends enrollment form to Paychex to enroll employee in group insurance plan.	Provides initial COBRA notice to new employees informing them of their COBRA rights. **Note:** This does not apply to State Continuation.
Participant experiences qualifying event.	Notifies Payroll of termination within 30 days of qualifying event. Submits COBRA employee data sheet to Paychex if qualifying event is any-thing other than a termination. Email: APC_COBRA@Paychex.com **Fax:** 585-249-4290	Contacts insurance carrier(s) to cancel coverage for participant.
COBRA department receives termination from payroll (or employee data sheet).	N/A	Mails COBRA notification and enrollment packet to eligible participant within 14 days.
Employer receives COBRA confirmation notification.	N/A	N/A
COBRA department receives COBRA enrollment form and initial payment from participant. **Note:** Participants have 45 days (may vary for State Continuation) from postmark date of enrollment to make initial payment of COBRA premium.	N/A	Enters insurance election information into Paychex system.
Employer receives Reinstatement Information (noted on the Month-to-Date Activity report).	N/A	Contacts insurance carrier(s) to re-activate coverage for participant back to effective date.
COBRA department collects monthly COBRA premiums from participants.	N/A	Remits premiums collected to employer on a biweekly basis.
Employer receives COBRA premium refund statement.	Verifies amounts being refunded based on carrier invoice.	N/A
Participant fails to pay premium or is no longer eligible for COBRA.	N/A	Contacts insurance carrier(s) to cancel coverage of participant.
COBRA department receives COBRA termination information.	N/A	Contacts insurance carrier(s) to cancel coverage of participant.

Additional Services Available

COBRA Administration

Frequently Asked Questions

What is COBRA?

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law requiring employers to offer continuation of coverage to employees, their spouses, and their dependent children who would otherwise lose coverage under a group plan for specific reasons, including employee termination, divorce, and age limitations.

Why must I offer health insurance to someone who doesn't work for me anymore?

It's the law. COBRA requires businesses with 20 or more employees on 50 percent of the typical business days in the previous calendar year that offer group health insurance to give former employees as well as their covered spouses and/or dependents the opportunity to continue health insurance coverage for a limited period. Most states have similar requirements for businesses not subject to COBRA.

Am I subject to COBRA if most of my workers are part-time or seasonal?

Businesses subject to COBRA must have had 20 or more employees on 50 percent of typical business days the previous calendar year. Both full-time and part-time employees are counted. If a company's typical workweek is 40 hours, then a part-time employee working 20 hours is counted as half a full-time worker. Employers who are not subject to COBRA regulations may be subject to State Continuation laws.

Does Paychex offer COBRA for FSA/HSAs?

No, we do not offer COBRA administration for FSA plans at this time. HSA plans are not subject to COBRA continuation coverage regulations.

What would happen if I didn't offer COBRA insurance?

Your business could be in violation of federal and possibly state law. You could be fined for each day of a violation as well as be ordered to pay legal fees, court costs, and medical claims.

Must I pay for their health insurance if my employees continue coverage under COBRA?

No. Employees who continue health insurance coverage under COBRA can be required to pay the entire cost. Employees who elect COBRA coverage will be charged 102 percent of the premium cost, with the additional 2 percent retained by Paychex for administrative costs.

How much time do I have to notify Paychex when one of my workers has a qualifying event?

You must notify Paychex within 30 days of a qualifying event. However, earlier is better so that we can begin the COBRA process.

Additional Services Available

Insurance Payment Service

With the Insurance Payment Service, we can remit payments for your insurance premiums on your behalf depending upon your carrier. In addition, we provide you with a monthly billing statement report to help you review and reconcile your health insurance bill. We will also work with the carrier on your behalf to make any changes you identify.

The method of payment, live check draft (LCD) or Automated Clearing House (ACH), is determined by your location and by state regulations. You may still receive a carrier invoice for your records.

Live Check Draft (LCD)

- With the LCD option, Paychex Insurance Agency cannot debit funds from your account each month to pay your carrier(s). We will send your payment by a live check drawn on your bank account.
- LCD drawn on your bank account will be generated between the 26th and 29th of each month, and the check is mailed to your carrier(s) by the 1st of the following month.
- Funds will be drawn from your bank account when the check is cashed by the insurance carrier,
- For Aflac, LCD drawn on your bank account will be generated between 3rd and 9th of each month, and the check is mailed to Aflac by the 3rd week of the current month

Automated Clearing House (ACH)

- The amount due to your carrier(s), according to the monthly statement, will be drawn from your bank account. The payment will be forwarded to the carrier on your behalf.
- For national carriers or if you are located in Upstate NY (Albany, Syracuse, Utica or Watertown), the draft will occur on the last business day of the calendar month.
- If you are located in Upstate NY (Buffalo or Rochester), Paychex Insurance Agency will deduct your monthly payment from your bank account on the second Friday of the month for the current month's coverage. The exact date of the draft will be indicated on the monthly billing statement.
- If you have Aflac, Paychex Insurance Agency will deduct your monthly payment from your bank account on the second Friday of the month for the previous month's coverage; The exact date of the draft will be indicated on the monthly billing statement.

Please refer to the sample statement on the following pages.

Additional Services Available

Insurance Payment Service –Sample Monthly Premium Statement – Cover

Please review the notations on this sample invoice to understand its components and how Paychex Insurance Agency processes payments on your behalf. Monthly premium statements for all national carriers, and select Upstate New York Carriers (Albany, Syracuse, Utica or Watertown), will be emailed or faxed to clients between the 23rd and the 27th of each month. Monthly premium statements for all remaining Upstate New York (Buffalo or Rochester) carriers and Aflac will be sent via hard copy statement between the 2nd and the 7th of each month.

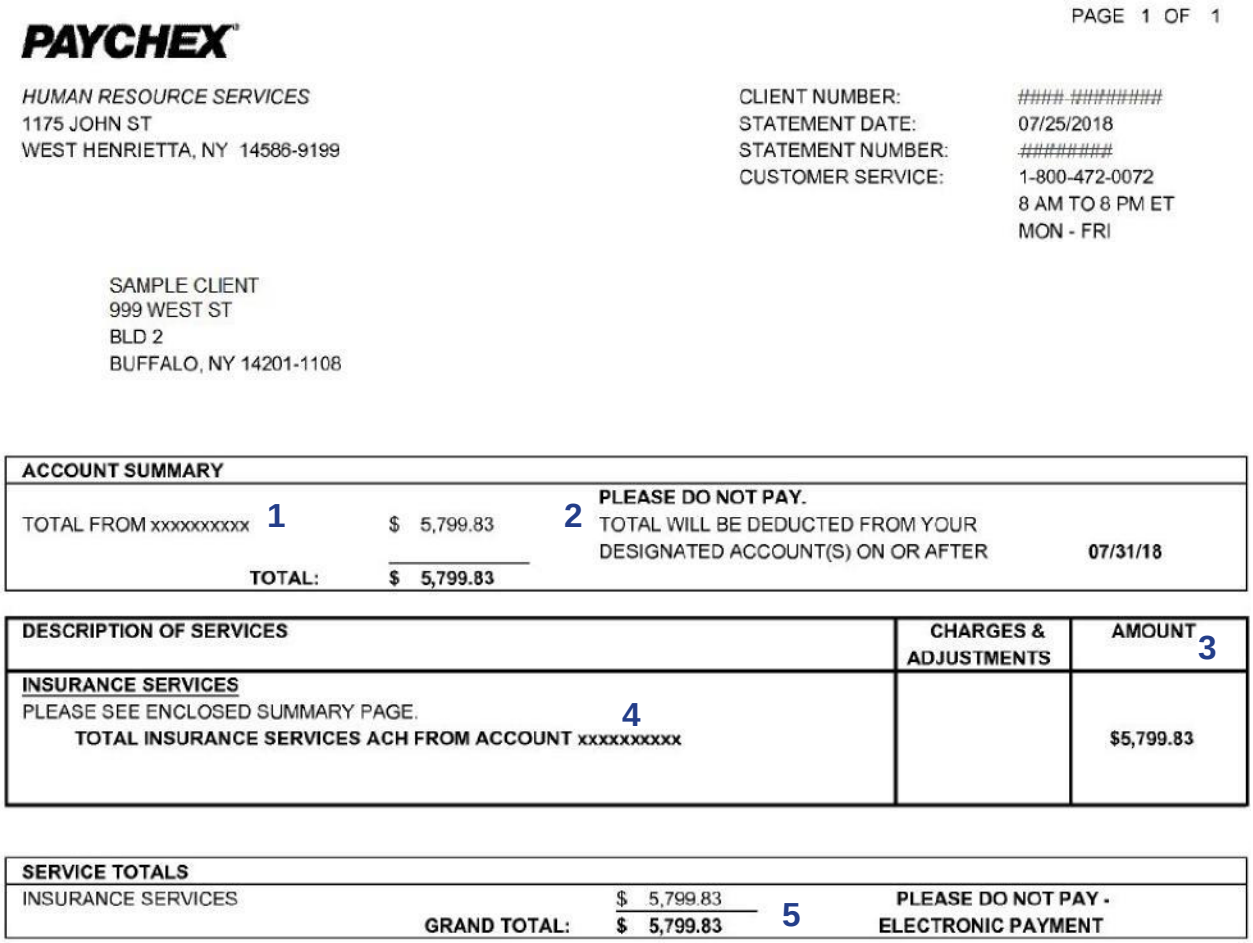
1 - The last four digits of the bank account that Paychex Insurance Agency will use are listed in this section. Note: If the last four digits of the bank account are incorrect, call 800-472-0072 immediately.

2 - This is not a bill. This is a statement that reflects your premium charges.

3 - You can refer to this portion of your invoice to verify whether your premium payment will be made by LCD or ACH debit.

4 - See the second page for specific information for each of your employees enrolled on insurance.

5 - Paychex Insurance Agency will send payment on your behalf to the carrier(s) for the total amount listed in this section.



PAGE 1 OF 1

PAYCHEX

HUMAN RESOURCE SERVICES
1175 JOHN ST
WEST HENRIETTA, NY 14586-9199

CLIENT NUMBER: ##### #########
STATEMENT DATE: 07/25/2018
STATEMENT NUMBER: ########
CUSTOMER SERVICE: 1-800-472-0072
8 AM TO 8 PM ET
MON - FRI

SAMPLE CLIENT
999 WEST ST
BLD 2
BUFFALO, NY 14201-1108

ACCOUNT SUMMARY

TOTAL FROM xxxxxxxxxx 1 $ 5,799.83

TOTAL: $ 5,799.83

2 **PLEASE DO NOT PAY.**
TOTAL WILL BE DEDUCTED FROM YOUR DESIGNATED ACCOUNT(S) ON OR AFTER **07/31/18**

DESCRIPTION OF SERVICES	CHARGES & ADJUSTMENTS	AMOUNT 3
INSURANCE SERVICES		
PLEASE SEE ENCLOSED SUMMARY PAGE. 4		
TOTAL INSURANCE SERVICES ACH FROM ACCOUNT xxxxxxxxxx		**$5,799.83**

SERVICE TOTALS

INSURANCE SERVICES		$ 5,799.83	
	GRAND TOTAL:	**$ 5,799.83**	5 **PLEASE DO NOT PAY - ELECTRONIC PAYMENT**

Additional Services Available

Insurance Payment Service –Sample Monthly Premium Statement – Page 2 Detail

1 - Each employee who is enrolled in the insurance plan will be listed here along with the type of coverage elected and the premium total (non-Upstate NY carriers).

2 - This section indicates the grand total bill for insurance services. Paychex Insurance Agency will send payment on your behalf to the carrier(s) for the total amount listed in this section.

PAYCHEX
HUMAN RESOURCE SERVICES
1175 JOHN ST
WEST HENRIETTA, NY 14586-9199

SAMPLE CLIENT
999 WEST ST
BLD 2
BUFFALO, NY 14201-1108

CLIENT NUMBER: ####-########
STATEMENT DATE: 07/25/2018
STATEMENT NUMBER: ########
CUSTOMER SERVICE: 1-800-472-0072

INSURANCE PAYMENT SERVICE SUMMARY

PARTICIPANT PREMIUM

PARTICIPANT/PLAN	COVERAGE	MONTH	TYPE	AMOUNT	TOTAL
Employee					
METLIFE DENTAL	Family	AUG 2018	PREMIUM	$ 52.76	
METLIFE VIS II	Employee+Child(ren)	AUG 2018	PREMIUM	$ 11.30	
METLIFE LIFE (EE)**	Employee	AUG 2018	PREMIUM	$ 4.90	
METLIFE LTD (EE)	Employee	AUG 2018	PREMIUM	$ 16.10	
METLIFE VOL LIFE	Employee	AUG 2018	PREMIUM	$ 9.70	
				$ 94.76	
Employee					
METLIFE DENTAL	Employee	AUG 2018	PREMIUM	$ 18.59	
METLIFE VIS II	Employee	AUG 2018	PREMIUM	$ 6.66	
METLIFE LIFE (EE)**	Employee	AUG 2018	PREMIUM	$ 4.90	
METLIFE LTD (EE)	Employee	AUG 2018	PREMIUM	$ 3.49	
				$ 33.64	
Employee					
METLIFE DENTAL	Employee	AUG 2018	PREMIUM	$ 18.59	
METLIFE VIS II	Employee	AUG 2018	PREMIUM	$ 6.66	
METLIFE LIFE (EE)**	Employee	AUG 2018	PREMIUM	$ 4.90	
METLIFE LTD (EE)	Employee	AUG 2018	PREMIUM	$ 3.49	

**Our records for this participant differ from your carrier's. If the correct coverage and rate is not reflected on your next billing statement, please contact Paychex Insurance Agency.

Frequently Asked Questions About Your Health Insurance Plan

When should an enrollment form be used?
An enrollment form is used to initially sign up in the plan, to change coverage, or to add or remove a dependent.

What happens if a submitted enrollment form is incomplete?
Incomplete enrollment forms will be returned to you for additional information. This may result in delay or denial of your coverage. Please follow the guidelines provided so that we can process your enrollment forms quickly and accurately.

What is open enrollment?
Open enrollment is the opportunity offered annually for employees to make changes in their current coverage or enroll in coverage without a qualifying event (carrier permitting). Open enrollment each year coincides with your company's effective date of coverage.

If employees do not enroll in the health insurance plan now, can they do so in the future?
If eligible, employees will be able to join at the next open enrollment period (carrier permitting), or if they experience a qualifying event. Check with your insurance carrier for specific guidelines.

What is a qualifying event?
A qualifying event is a change in family status or coverage that may allow for modifications to, enrollment in, or additions to health benefits. Examples include marriage, birth of a child, involuntary loss of coverage from another policy, and death of an insured spouse. Please contact your carrier for specific guidelines.

What is the deadline for submitting an enrollment form after a qualifying event?
An enrollment form must be submitted to the carrier within 30 days of the qualifying event.

Who is eligible for the plan?
Eligible employees are active and work for a minimum number of hours as defined by the employer and carrier. Eligible dependents are defined as the spouse of the employee or the children of the employee, up to a specific age, as defined by the carrier.

When is a new hire eligible for benefits?
A new employee is eligible to join the plan after satisfying the waiting period established by his employer (typically 30, 60, or 90 days). The waiting period can't exceed 90 days. The effective date will be determined by the current carrier contract (typically the date of event, the first day of the following month, or the 15th of the month).

Frequently Asked Questions About Your Health Insurance Plan

How does a new hire enroll?
An enrollment form can be completed and submitted to your account manager or dedicated service team or be processed online where applicable. If any information is missing, the form will be returned for completion.

Can family members or dependents be added to a policy?
Yes. Participants can make additions to the policy at initial enrollment, open enrollment, and at the time of a qualifying event.

What is the process for a participant who has not yet received a health insurance ID card but needs medical care?
Find out the effective date of coverage. If the effective date has passed, Paychex Insurance Agency can call the insurance company directly for verification of coverage. Most carriers can locate a member in their system using a social security number. Typically, ID cards are received within three weeks of a participant's approval date.

How can coverage be cancelled?
A change form must be submitted to the employer to terminate coverage.

Who do employees contact with questions?
Employees should contact the designated Benefits Administrator at your company, carrier member services, or Balance***Care***, if available. If you as the employer need assistance you may contact your account manager or dedicated service team.

Who do I contact with billing questions?
You should contact the insurance carrier directly.

Glossary

These common health insurance industry terms can help you navigate your way through selecting and maintaining a health insurance plan for your company.

Agent
An individual or organization that is licensed to sell, negotiate, or affect insurance contracts on behalf of an insurer.

Annual out-of-pocket maximum
A dollar amount set by the insurer to limit the annual amount the insured must pay himself. The health plan pays 100 percent of reasonable and customary costs for covered services after the out-of-pocket maximum has been met.

Benefit
An amount payable by the insurance company for a covered service.

Carrier
An entity that may underwrite, administer, or sell a range of health benefit programs. This term may refer to an insurer or to a managed health plan.

Case management
A system used by employers and insurance companies to ensure that covered individuals receive appropriate health care services.

Claim
A request by an insured or a health care provider to an insurance company for the payment for services delivered by a health care professional.

Claim form
The form used to file for health plan benefits.

Co-insurance
A split of payment responsibility between the insured and the insurer. For example, the insurer pays 80 percent of the medical expenses and the insured, usually the employee, pays 20 percent.

COBRA
The Consolidated Omnibus Budget Reconciliation Act (COBRA) adopted by the U.S. Congress in 1986 to provide workers and their families who lose their health insurance under certain circumstances the right to continue coverage for limited periods. COBRA generally applies to employers who offer a group health plan and who employed 20 or more employees (full-time and part-time) on 50 percent of typical business days during the previous calendar year. Continuation requirements may differ for employers subject to State Continuation regulations.

Glossary

Community rated
A method of setting a health insurance plan's premium cost based on the total experience of the subscribers or members within a given geographic area or community regardless of the claims experience of any one individual or group.

Composite rating
An insurance premium based on the average risk profile of a group. It implies that all members of a particular group pay the same insurance premium for insurance against a specific peril.

Co-payment
A payment made by the insured for a specified dollar amount paid each time services are performed.

Covered employees
Those employees eligible for insurance coverage based on criteria set by an insurance carrier or the employer. For example, a plan or employer may provide insurance only for full-time employees.

Deductible
The amount of money that must be paid each year to cover medical care expenses before the insurance policy starts paying. For example, a plan may require an individual to pay the first $200 in medical expenses annually, or a family to pay the first $400, before the insurance company begins making payments.

Dependent
A person who relies on another for economic support, usually a covered individual's spouse or children.

Effective date
The date on which insurance coverage goes into effect.

Eligibility date
The date an individual or dependents qualify for benefits – e.g., after 90 days of employment.

Eligible dependent
A dependent of a covered person (spouse, child, or other dependent) who meets all requirements specified in the insurance contract to qualify for coverage. A student or fully disabled child may be eligible for coverage beyond the maximum age for a dependent child. "Child" and "children" as used by medical and dental plans' eligibility provisions can include:

- biological children,
- adopted children,
- stepchildren, and
- any other child supported by and living with the insured and for whom the insured is legally responsible as determined by the plan administrator or the insurance company based on all the facts and circumstances.

Glossary

Emergency care
Treatment provided in a hospital's emergency room to evaluate and manage medical conditions of a recent onset and severity. These conditions include, but are not limited to, severe pain that would lead a prudent layperson with an average knowledge of medicine and health to believe that this condition, sickness, or injury is such that failure to get immediate medical care could result in:

- serious jeopardy to the person's health,
- serious impairment to bodily function,
- serious dysfunction of a body part or organ, or
- serious jeopardy to the health of the fetus of a pregnant woman.

Enrollment
The procedure by which an individual or dependents subscribe to a health insurance plan.

EPO
An Exclusive Provider Organization plan. As a member of an EPO, you can use the doctors and hospitals within the EPO network, but cannot go outside of the network for care.

Formulary
A list of specific, covered brand-name and generic medications chosen to provide the best therapeutic care at a lower cost.

HMO
A Health Maintenance Organization is a group of medical insurance providers that limit coverage to medical aid provided from doctors that are under contract of a HMO. You typically are required to designate a Primary Care Physician.

In-network
Health services obtained by participants from a contracted, preferred provider. Benefits are paid at a preferred level when in-network care is received.

Indemnity plan
A medical insurance plan in which the insured selects any preferred doctor or hospital. The insured must meet the annual deductible and pay co-insurance for each medical visit. Routine care and preventive care are usually not covered; pre-existing medical conditions may be excluded from coverage for a period of time; and an annual maximum out-of-pocket cost limit usually applies. Amounts charged in excess of reasonable and customary charges are the responsibility of the insured.

Insurer
A company issuing an insurance policy.

Insured
An individual covered by an insurance policy.

Invoice
An itemized list of goods shipped or services rendered, stating quantities, prices, fees, shipping charges; a bill.

Glossary

Length of stay
The time an individual stays in a hospital or inpatient facility.

Managed care
A medical delivery system that manages the quality and cost of medical services. Most managed care systems offer health maintenance organizations (HMO) and preferred provider organizations (PPO) that individuals are encouraged to use for their health-care services.

Medically necessary
Health services or medical supplies that are appropriate and needed for the diagnosis or treatment of a medical condition; are provided for the diagnosis, direct care, and treatment of a medical condition; meet the standards of good medical practice in the medical community; and are not principally for the convenience of the plan participant or provider. The claim administrator determines if the care is appropriate to the diagnosis.

Member level rating
Premiums are assigned based on each member's individual risk level, based on factors such as age, zip code and tobacco status.

Network
Group of doctors, hospitals, and pharmacies organized by a health plan to provide health care to the plan’s members. Using the plan’s network generally provides the most benefits for the lowest cost.

Out-of-area benefits
The scope of emergency benefits and related services available to managed care members while temporarily outside their service areas.

Out-of-network
Eligible health services obtained by participants from a provider who does not participate in the plan administrator’s designated network. Benefits are paid at a non-preferred level for care received out-of-network.

Out-of-plan
Physicians, hospitals, or other health-care providers who do not participate in an insurance plan. Expenses for services performed by out-of-plan health professionals may be covered in part or not at all by the carrier.

Out-of-pocket maximum
A predetermined, limited amount of money that an individual must pay before an insurance company or self-insured employer will pay 100 percent for that individual’s health care expenses.

Outpatient
An individual who is not required to be hospitalized overnight to receive medical treatment. Many insurance companies will not pay for certain services unless they are performed on an outpatient basis.

Glossary

Patient's bill of rights
Requirements for group health plans and issuers of health insurance to provide members and insured individuals with rights to obtain certain health care services.

POS
A point of service plan is a type of managed care health insurance. It combines characteristics of HMO and PPO plans with benefit levels varying on whether you receive your care in or out of the health insurance company's network of providers.

PPO
Preferred Provider Organization that provides more flexibility when picking a doctor or hospital. They also feature a network of providers, but there are fewer restrictions on seeing non-network providers.

Pre-existing condition
A physical or mental condition of an insured that first manifested itself before the effective date of a health insurance policy.

Preventive care
A program of health-care designed to prevent or reduce illness by providing such services as regular physical examinations that allow for early detection and early treatment. Preventive care is a primary goal of managed care systems.

Primary care physician
Usually a general practitioner, internist, or pediatrician who coordinates the health services of the insured in a managed care plan and arranges referrals to specialists and hospitals.

Provider
Health professionals who supply health care services.

Qualifying event
An action that causes an employee or dependent to lose or require additional health coverage, including a change in family or job status.

Reasonable and customary
An amount an insurance company determines to be appropriate to pay for a medical service that is most consistent with the fee charged by physicians, hospitals, or other health care providers within a specific community. Insurance carriers usually pay only the reasonable and customary amount even if the charge is more.

Specialist
Doctors and other providers who focus on a particular branch of medicine or surgery and are certified by the medical profession. In most traditional health maintenance organizations, a primary care physician must refer a patient to a specialist before the insurance carrier pays for the specialist's services.

Waiting period
The time during which some plans or employers require new employees to be employed before becoming eligible for health insurance coverage.

158494 Rev. 05/19