PBS Health and Benefits

Information Booklet

Paychex HR PEO

PAYCHEX
HR | Payroll | Benefits | Insurance

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Health and Benefits

This booklet describes basic features of health benefit plans, how they operate, and how you can receive the maximum advantage from them. Some of the plan types included may not have been selected by your company or may not be available due to cost restrictions or participation requirement. Information related to your specific plan options is included in your enrollment packet. This booklet provides a summary of information to help you choose the plans that are best suited to meet the needs of you and your family. However, it is not intended to provide you with a detailed outline of benefits provided, guarantee of costs, eligibility of expenses, or eligibility to participate.

How to contact the benefits department

Phone: 800-741-6277
Fax: 800-668-7296
Email: peo_benefitsteam@paychex.com

- Address: Paychex Business Solutions (PBS)
  Attn: Health and Benefits Department
  970 Lake Carillon Drive, Suite 400
  St Petersburg, FL 33716-1129

Enrollment

There is one annual enrollment period for employees who have met the eligibility requirements stated in the *Summary Plan Description* (SPD). The effective date for annual enrollment is January 1.

Monthly enrollment is for all newly eligible employees who have met the requirements stated in the SPD. The effective date for monthly enrollment is the first of the month following the date eligibility requirements are met.

An employee who is eligible to enroll, but elects not to participate, will not be eligible again until the following January, unless a qualifying change in status occurs.

How to Enroll

Review the specific plan options available to determine which plan(s) you wish to enroll in. The cost of each plan (monthly and per-pay-period amounts) is outlined on the Employee Benefits Statement enclosed in your enrollment packet. Once you have determined which plan(s) to enroll in, review the following Health and Benefits Checklist, which contains detailed enrollment instructions.

Health and Benefits Checklist

All eligible employees must review the booklet and the plan-specific information contained in your enrollment packet to determine if you are going to participate in the benefit plan(s).

To complete elections online:

- Log on to https://paychexflex.com and select Health and Benefits to elect or decline benefits
- For each benefit you choose to participate in, select Enroll from the Elect Benefits screen
- For each benefit you choose not to participate in, select Decline from the Elect Benefits screen

To complete elections on paper:

- Complete and sign the PBS Health and Benefits Acceptance/Refusal of Coverage located in the back of this booklet
- Complete and sign the Enrollment/Change Form located in the back of this booklet, including the following information:
  - Date of birth
  - Social security number
  - Primary care physician (HMO & POS only)
  - Dependent information (if applicable)
    - Include each dependent's gender, relationship, date of birth, social security number, primary care physician, and address
  - Name of the medical, dental and vision plan from Group Benefit Options or Employee Benefits Statement
  - Select coverage level for each plan
  - All other requested information

Note: Ensure all sections are complete and legible. Incomplete forms may delay the start of coverage.

If you choose not to participate:

- You can decline all benefits through Paychex Flex®
- Complete and sign the PBS Health and Benefits Acceptance/Refusal of Coverage located in the back of this booklet. Fax or email all completed forms to the benefits department.

Changing Your Benefits

You will have an opportunity to change your benefits during each annual enrollment period. Your benefit elections cannot be changed during the plan year unless you have a change in status (qualifying event/domestic partner life event). Refer to Qualifying Event/Domestic Partner Life Event and Supporting Documentation in this booklet for a list of eligible qualifying events/domestic partner life events and the required documentation. Benefit changes must be consistent with the qualifying event.

Summary of Benefits and Coverage (SBC)

The SBC provides participants in the PBS Flexible Benefits Plan with an outline of Plan requirements in an easy-to-read question and answer format. If you elect to participate in any of the benefits offered under the PBS Flexible Benefits Plan, you must be provided with a copy of the Plan's SBC. You may also obtain a copy by logging on to https://paychexflex.com.

Health Care and Insurance Plans

Health Maintenance Organization (HMO)

An HMO is a network-based, managed care health plan offered by many insurance companies (also referred to as carriers). Health care providers contract with insurance carriers to create a network and agree to accept predetermined fees for care and treatment provided to their patients. The HMO consists of a network of doctors, hospitals, and laboratories. Based on where you live, you may have multiple HMO plan options. Every plan is not available in all areas. Review your plan descriptions carefully to select the plan that best meets your needs.

The Open Access HMO plan option requires no primary care physician (PCP) selection and referrals to a participating physician or facility are not required. You pay a co-payment for each covered service. Co-payments may vary between plans.

Some HMO plan options require a primary care physician (PCP) selection and referrals to a participating physician or facility. You may pay a higher rate for services by a physician if you do not receive a referral from your assigned PCP. Refer to your Summary of Benefits and Coverage (SBC) for PCP requirements.

HMO Highlights

- HMO plan options typically have lower premium costs when compared with other types of health insurance plans
- HMOs promote routine preventive care. All routine and preventive care visits to the PCP are covered.
- HMO plan options may require a PCP selection. The PCP is responsible for coordinating your care and referrals are required.
- Open Access HMO plan options do not require a PCP selection. You can receive care directly from any participating provider or facility without a referral
- Your expenses are predictable
- You do not have benefits available outside the network unless it is an emergency situation
- There are no claim forms to file

Is an HMO best for me?

- Review your plan description carefully. More than one HMO plan may be available and plans may vary
- HMOs are usually good for families or individuals concerned with preventive and routine care.
- HMOs are good for individuals who do not have ongoing medical problems that make it necessary to use a non-network medical provider.
- Coverage may be limited or unavailable for dependents who do not live within an HMO network. Refer to your summary of benefits and coverage (SBC) for further details.

Notice Regarding Patient Protection Rights- Aetna

Aetna generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Aetna at 1-800-343-6101 or go to www.aetna.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact Aetna at www.aetna.com.

Source: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf

Notice Regarding Patient Protection Rights- Blue Cross Blue Shield of Texas (BCTX)

BCTX generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, BCTX designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact BCTX at 1-866-243-8349 or go to www.bcbstx.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from BCTX or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact BCTX at www.bcbstx.com.

Source: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf

Notice Regarding Patient Protection Rights- Florida Blue (BCFL)

BCFL generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, BCFL designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact BCFL at 1-800-352-2583 or go to www.bcbsfl.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from BCFL or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact BCFL at www.bcbsfl.com.

Source: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf

Notice Regarding Patient Protection Rights- Tufts Health Plan

Tufts generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Tufts designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Tufts at 1-800-462-0224 or go to www.tuftshealthplan.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Tufts or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact Tufts at www.tuftshealthplan.com.

Source: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf

Notice Regarding Patient Protection Rights- Kaiser

Kaiser generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Kaiser designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser at the specified number below or go to www.kp.org.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Kaiser or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact Kaiser at www.kp.org.

Source: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf

Kaiser CA: 800-464-4000

Kaiser CO:800-632-9700
Kaiser GA: 888-865-5813
Kaiser HI: 800-966-5955

Point of Service (POS)

A Point of Service (POS) is a health care plan that has the benefits of both an HMO and an Indemnity plan (see page XX for more information on an Indemnity plan). At each "point of service", you choose either an in-network or out-of-network provider. While using providers or facilities from the network, the plan typically operates much like an HMO. If you choose to go to an out-of-network provider or facility, the plan operates like an Indemnity plan and deductible and coinsurance will apply. Review your plan descriptions carefully to select the plan that best meets your needs.

PCP selections are not required, nor are referrals to a participating physician or facility. However, in some states, if a PCP is not designated with the carrier, you may be required to pay a specialist co-payment. You are required to pay the deductible amount(s) toward medical expenses before the insurance company pays benefits for both in-network and out-of-network benefits.

In-Network POS Highlights

If you choose to control or minimize medical expenses, you may elect to use the HMO/in-network component of the POS plan.

- The Open Access POS plan option does not require a PCP selection. You can receive care directly from an in-network provider without a referral.
- All routine and preventive care visits to the PCP are covered.
- No balance billing in network

Out-of-Network POS Highlights

If you choose to see any health care provider, at any time, or anywhere, you may elect to use the out-of-network component of the POS plan and agree to the following:

- Pay the deductible amount(s) you are required to pay toward medical expenses before the insurance company pays benefits
- Pay the coinsurance amount for your portion of the cost of health care after the entire deductible has been paid
- Pay for charges in excess of "reasonable and customary" charges as determined by the carrier
- Submit any necessary paperwork (health care provider's bill, claim forms, etc.) to the insurance company for payment or reimbursement.

Is a POS best for me?

- This plan type is good for individuals looking for a managed care plan offering more flexibility than an HMO.
- This plan type is good for individuals who use mostly in-network providers but want the flexibility of an out of network option
- This plan type offers a lower cost option than traditional plans and has more flexibility than an HMO

Notice Regarding Patient Protection Rights- Aetna

Aetna generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Aetna at 1-800-343-6101 or go to www.aetna.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact Aetna at www.aetna.com.

Source: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf

EPO (Exclusive Provider Organization)

An EPO is a network of individual medical care providers, or groups of medical care providers, who have entered into written agreements with an insurer to provide health insurance. In an EPO, medical care providers enter a mutually beneficial relationship with the insured. The insurer reimburses a member only if the medical expenses are derived from the designated network of providers. The providers in turn provide members significantly lower rates than what would have been under normal circumstances.

Only emergency services are available outside of the EPO network.

EPO Highlights

- A PCP may not be required
- EPOs will only cover your medical expenses if the provider you see is part of the network
- Has high standards for contracted doctors and facilities

Is an EPO best for me?

- EPO health plans are often cheaper than PPOs, with a good selection of specialists and adequate emergency care options. This can be a way to save money.
- EPOs can be quite restrictive

ACO (Accountable Care Organization)

An ACO is a group of doctors, hospitals, and other health care providers that work together with a goal of giving you better care at a lower cost. The organization's payment is tied to achieving healthcare quality goals and outcomes that result in cost savings.

An ACO can be an HMO like plan with in-network benefits only or an MCP like plan with out-of-network benefits. They are typically available in select service areas and tied to a specific facility or group of doctors.

ACO Highlights

- A PCP may not be required
- Doctors and facilities are held accountable for meeting healthcare goals
- Predictable costs for services
- Personalized digital tools and analytics

Is an ACO best for me?

- ACOs provide coordinated care for chronic disease management with the goal of improving the quality of patient care
- ACOs can be restrictive if they do not provide out of network benefits
- ACOs are available in select markets. Members traveling outside their service area may be limited to reduced benefits or emergency only coverage.

Preferred Provider Organization (PPO)/ Managed Choice Plan (MCP)

A Preferred Provider Organization (PPO) or a Managed Choice Plan (MCP) is a group of hospitals and physicians that contract on a fee-for-service basis with employers, insurance plans, or other third parties to provide comprehensive medical services. A PPO/MCP plan has an in-network option and an out-of-network option. However, a PPO/MCP does not require the selection of a PCP. Members refer themselves directly to specialists within the network. Due to the increased accessibility to specialized care a PPO/MCP offers, it is typically more expensive than any other type of managed care plan.

MCPs and PPOs are very similar. MCPs can be slightly lower in cost with a more restrictive network of doctors.

PPO/MCP Highlights

- A PCP is not required and medical benefits are available in-network and out-of-network. Members can access a network specialist without any kind of referral
- If you use an in-network doctor, coinsurance may apply for office visits and hospital admissions. If you use an out-of-network doctor, you typically will pay a deductible and coinsurance.
- PPOs/MCPs usually have high premiums due to less management of the plan.
- PPOs may only be available if no other plan is available. Refer to your summary of benefits and coverage (SBC) for further details.

Is a PPO best for me?

- PPO/MCP plans are good for individuals looking for a managed care plan that offers the highest level of flexibility.
- PPO/MCP plans are good for individuals who can afford to pay higher premiums and significant out-of-pocket expenses.

Indemnity[1]

This out-of-area health plan allows members to see any physician they choose, but requires the members to pay for the services and file claims for reimbursement themselves. This plan is also known as a "fee-for-service" plan.

Indemnity Highlights

- This type of plan is usually available only in rural, non-network areas.
- There is no network associated with this plan

Is an Indemnity best for me?

- Indemnities are good for individuals who want total freedom of choice for doctor or hospital.
- Indemnities are good for individuals who live in areas that do not have managed care networks.

High Deductible Health Plan (HDHP) and Health Savings Account (HSA)

A qualified HDHP works in conjunction with an HSA. The qualified HDHP puts you in the center of the health care equation by giving you more control over your health care benefits and spending. An HSA gives you a way to manage your health care costs and save for future health care expenses at the same time. The qualified HDHP has high deductibles and coinsurance that may apply to in-network and out-of-network services.

The HSA is an account that you can use to pay for qualified expenses now or save for future medical costs. You contribute to your account through regular payroll deductions at any time, in any amount, up to the maximum limit per year. Using the HSA in conjunction with the qualified HDHP involves you as an active manager of your health care decisions. The HSA is a special tax-advantaged account, which means that money goes in tax-free, earns interest tax-free, and is not taxed when it is withdrawn to pay for qualified expenses. For a general list of qualified expenses, you can contact the IRS at 1-800-829-3676, or go to https://irs.gov and search for Publication 502.

Note: Publication 502 is primarily used in governing personal income taxes and services only as a reference when dealing with a Section 125 plan or HSA. Items may be included that are not reimbursable under a health FSA.

HSA Highlights

- Your account can grow over time
- Your HSA dollars earn interest tax-free.
- Money left in the account at the end of the year rolls over to the next plan year.
- You own the account and keep it even if you change health plans or jobs.
- You are responsible for ensuring that you qualify to contribute to an HSA account.

Note: You may enroll in the qualified HDHP and HSA and also participate in a medical expense reimbursement plan under a Flexible Spending Account (FSA). However, in order to be eligible for both an

[1] Limited availability only.

HSA and FSA, only dental, vision, and preventative care expenses not covered under your HDHP are eligible. For more information, refer to the Section 125 Flexible Spending Account Employee Information booklet.

Mini-Medical Plans with MEC add-on Option

Mini-medical plans cover a limited range of services. These plans offer limited medical coverage and base payment on an allowance system, where they will pay a portion of a covered service. A mini-medical plan that has the Minimum Essential Coverage (MEC) add-on benefit will cover certain Affordable Care Act (ACA) required services including wellness visits and preventative screening. MEC add-on benefits are usually only available to applicable large employers with 50 or more full time employees. These plans do not meet all ACA requirements and are not considered Minimum Value Plan medical coverage. See your Summary of Benefits and Coverage (SBC) for details regarding your specific plan.

Mini-Medical Highlights

- An affordable option for employees who may otherwise not be eligible for coverage
- Limited physician visits
- Discounts on x-rays and diagnostic labs
- Telemedicine visits
- Prescription discounts
- MEC add-on covers preventative services
- MEC add-on is COBRA eligible
- May be subject to pre-existing condition limitations; see your Summary of Benefits and Coverage (SBC) for details

Is a Mini-Medical plan with MEC add-on option right for me?

- Mini-medical plans may be good for individuals or families who may not have other medical options available to them
- Mini-medical plans may be good for individuals who are only concerned with preventive and routine care
- Mini-medical plans may be good for individuals who do not have any ongoing medical problems

Dental

Excellent dental care is important. PBS offers the following types of dental plans.

DMO Plans

Dental Maintenance Organization (DMO) plans are network-based, managed care dental plans that work like HMO medical plans. These plans provide you with high-quality, cost-effective coverage. Participating dentists provide services at negotiated discounted fees. Many of these plans provide very low out-of-pocket expenses for routine and preventive care. Additional services may also be provided at discounted prices.

PPO Option Plan

The Preferred Provider Organization (PPO) plan has an in-network and out-of-network benefit. If you would like to use a non-network dentist, you must choose the PPO option. Using this plan will result in a

deductible. Out-of-pocket expenses and the annual benefit maximum are determined by the plan; you could be subject to balance billing over the allowed reimbursement for covered services.

Vision

Vision benefits offer allowances and discounts towards routine eye exams, contact lens fittings, and … Some medical plans may offer limited vision benefits for medically necessary services. Please refer to your summary of benefits and coverage (SBC) for further details.

Vision Highlights

- Access to a large national network of providers, providing materials and services approximately 40 percent below retail prices
- Allowance towards vision exams
- Allowance and discounted prices on a large variety of frames
- Allowance and discounted Contact lens benefit
- Discount on lasik

Life Insurance

Basic Group Term Life

If you are an active, full-time employee and have completed your waiting period, you may be eligible for employer-sponsored group life insurance coverage, up to a maximum of $1,000,000, based on your eligibility. Refer to the *Employee Deduction Summary* in your enrollment packet, which will indicate any life insurance coverage that may have been elected by your employer.

Accidental Death & Dismemberment

When your company provides basic life insurance options, you automatically receive an equal amount of accidental death and dismemberment (AD&D) coverage. The AD&D policy provides you or your beneficiary a benefit if you suffer a covered injury or die as a result of an accident. This coverage is included in your life insurance policy at no additional cost.

Voluntary (Optional) Group Term Life

If you are an active full-time employee and have completed your waiting period, you are eligible to elect voluntary group term life coverage in increments of $10,000 to the lesser of $1,000,000 or five times your basic annual salary based on your eligibility.

Dependent Life Insurance

Once you are enrolled in basic life insurance or voluntary group term life insurance, dependent life insurance is also available. Dependent life insurance is an optional benefit available through payroll deductions.

Medical EOI

Medical evidence of insurability (EOI) will be required if you decline coverage when first offered and then elect it at a later date, even if you elect coverage during annual enrollment. Additional coverage amounts over the guaranteed issue are subject to EOI and will be issued subsequent to the insurance carrier's approval.

Reduction Rules apply to Basic and Voluntary Life Insurance.

Age Reduction Rule

Your in force Accidental Death and Personal Loss Coverage amount will be reduced after you reach 65 years old. Please refer to your summary of benefits and coverage for further details.. The reduction will take effect on the first of January after you reach the age specified. If you become insured during or after the month in which you reach the above ages, your amount of Accidental Death and Personal Loss Principal Sum will be the applicable percentage of the amount shown for your classification.

Short-term and Long-term Disability

Short-term Disability (STD)

This plan can be offered as either an employer-elected benefit or an employee voluntary benefit. Please refer to the employee benefit plans available to you. It provides temporary short-term income protection in the event you become disabled due to accidental injury or disease paid on a weekly basis. Disability benefits do not work in conjunction with your workers' compensation coverage. If you become injured or ill as the result of an injury or accident on the job, workers' compensation coverage will apply.

Long-term Disability (LTD)

This plan can be offered as either an employer-elected benefit or an employee voluntary benefit. Please refer to the employee benefit plans available to you. It works similarly to the short-term coverage described above, but lasts for a longer period of time with a monthly benefit. The carrier will determine qualification for disability benefits.

Specific information related to the disability coverage elected by your employer will be included in your enrollment packet, if applicable.

Voluntary Employee Benefits

These are employee paid benefits which include Accident, Critical Illness, Hospitalization and Pre-Paid Legal Services. These benefits are solely paid by the employee. You enroll in these benefits just like all other benefits and are enrolled for the entire calendar year. If you are terminated from your employment or the plan, you may have the option to convert these plans to an individual policy. You must contact the carrier directly if you wish to stay enrolled upon termination.

Accident Insurance

This plan pays a specified dollar amount for covered accidents, hospitalizations, medical services, and treatments.

Critical Illness Insurance

This plan pays a specified dollar amount for covered conditions like heart attack, cancer, and stroke.

Hospital Insurance

This plan pays a specified dollar amount for covered services received during a hospitalization.

Legal Insurance

This plan offers access to legal partners who can offer expert legal advice and representation on a large range of matters including wills, real estate contracts, traffic offenses, and adoptions.

Health Advocacy Services

BalanceCare is a program designed to give you expert help and support to ensure that when it comes to your health care needs, you will have someone watching out for your interest. If you enroll in any PBS medical plan, you and your family receive access to the BalanceCare program.

You can contact BalanceCare to receive assistance with, and information relating to, your medical plan. When you call, you will be assigned a Personal Care Guide who will take responsibility for helping you. Your Personal Care Guide can assist you with scheduling appointments, locating a doctor, pharmacy, or hospital, completing claims, and much more.

BalanceCare Highlights

- When you call for assistance, you are assigned a Personal Care Guide
- BalanceCare can help you locate specialists, hospitals, and treatment for medical conditions
- BalanceCare is available 24 hours a day
- Services are available to your parents, in-laws, and children.
- BalanceCare can assist with special services such as:
    - Claims assistance
    - Referrals
    - Care coordination
    - Elder care
    - Medicare
    - Transportation
    - Clinical trials
    - Home health care services
    - Hospital planning
    - Assisted living and finances
    - Rehabilitation services

Employee Assistance Program (EAP)

The employee assistance program is available to all active employees and is designed to help manage work-life balance, help with day-to-day issues, and enhance your well-being.

EAP Highlights

- Confidential counseling referrals
- Legal consultations on issues like budgeting, buying a home, bankruptcy, will preparation, etc
- Virtual concierge services available 24/7
- Dedicated personal assistants to provide research, referrals, or information on many topics
- Wellness program
- Pharmacy discount card

Pretax Benefits

Pretax contributions for medical, dental, and vision premiums, as well as contributions to FSAs and HSAs are governed by Section 125 of the Internal Revenue Code. Section 125 allows health-related premium contributions to be taken out of your paycheck before taxes are applied. The following example illustrates what this means for an employee earning $30,000 each year.

	No Pretax Savings	With Pretax Savings
Annual Salary	$30,000	$30,000
Less: Health Premiums (assumed at $250/mo)		$3,000 Deductions taken pretax
Taxable Income	$30,000	$27,000
Taxes (assumed at 25%)	$7,500	$6,750
Less: Health Premiums (assumed at $250/mo)	$3,000 Deductions taken post-tax	
Spendable Income	$19,500	$20,250
$750 saved annually with pretax deductions		
Note: This example is for illustrative purposes only. The actual amount of your savings will depend on several factors including salary, premium expense, filing status, tax bracket, etc.		

Note: Insurance premium contributions of the Domestic Partner's (or the Domestic Partner's Child(ren) if applicable) do not fall under Section 125. Refer to the Domestic Partner Setup Form (PHB112) included in the back of this document for information related to imputed income value.

Supporting Documentation Requirements

Qualifying Event Documentation

In order to make a change that affects your tax-sheltered medical, dental or vision premiums, submit the enrollment change and appropriate supporting documentation within 30 days of the qualifying event.

Domestic Partner Life Event and Supporting Documentation

For all domestic partner life events, the employee must already be enrolled in the plan for a life event to apply. If the employee is not already enrolled, they must wait until a qualifying event occurs or the next annual open enrollment.

Notice Regarding Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Paychex Health & Benefits team at 1-800-741-6277 option 4 or peo_benefitsteam@paychex.com.

Source: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf

Qualifying Life Events Chart

Qualifying Event	Documentation Required (copies only)	Eligible Change
Change in Legal Marital Status		
Marriage	Marriage Certificate	Add coverage for spouse and eligible dependents
Establishment of Domestic Partnership	Domestic Partner setup form	Add domestic partner and eligible dependents to existing coverage
Divorce/Annulment	Divorce decree/court ruling verifying annulment	Remove coverage for spouse and/or eligible dependents
Legal Separation (only permitted in states that recognize legal separation)	Court order verifying legal separation	Remove coverage for spouse and/or eligible dependents
Termination of Domestic Partnership	Domestic Partner Coverage change form	Remove domestic partner and eligible children from existing coverage
Death of a Spouse or Domestic Partner	Long form death certificate	Remove coverage for spouse or domestic partner
Change in Number of Dependents		
Birth	No documentation required	Add coverage for self and eligible dependents that is consistent with the qualifying event
Adoption/Placement for Adoption	Court order for adoption/placement for adoption	Add coverage for self and eligible dependents that is consistent with the qualifying event
Death of Child(ren) or Domestic Partner Child(ren)	Long form death certificate	Remove coverage for dependent(s)
Gain or Loss of Other Group Coverage		
Gain or loss of Medical, Dental, and/or Vision Group Coverage	Carrier verification of new group policy commencement or termination	Add or remove coverage for self and/or eligible dependents that is consistent with the qualifying event
Exhaustion of COBRA coverage	COBRA document indicating exhaustion of coverage (termination due to non-payment is not a QE)	Add coverage for self and/or eligible dependents
Change in Employment Status of Employee/Spouse (allowable only if eligibility is affected)		
Termination/Rehire within 30 days (employee only)	Employer verification of rehire	*Reinstatement of benefits with no break in coverage is required; back-bill of premiums will apply
Full-Time to Part-Time or Part-Time to Full-Time Status	Employer documentation indicating PT to FT employment and statement that employee's eligibility has been affected due to change in status	Add or remove coverage that is consistent with the qualifying event
Leave of Absence (non-FMLA)	Employer documentation indicating employee has commenced or returned from leave	Add or remove coverage that is consistent with the qualifying event

Qualifying Event	Documentation Required (copies only)	Eligible Change
Change in Employment Status of Employee/Spouse (allowable only if eligibility is affected)		
Military Leave that qualifies under the Uniformed Services employment & Reemployment Act of 1994 (USERRA)	Copy of the order or other notification indicating call to duty for uniformed services must be provided in advance; if advanced notice is not feasible, arrangements should be made to provide this information as soon as possible	Remove coverage for self and/or dependents
Change in Status Affecting Dependent Eligibility		
Commencement of Student Status (age 19-26 & full-time college student)	Verification of enrollment and student status from accredited school	Remove coverage for eligible dependent(s)
Ineligible: • Loss of full-time student status • Attained age 26 • Financially independent before age 19 • Marriage	Dependent on reason for ineligibility: • Verification of de-enrollment/status change from accredited school • None; birth certificate if actual DOB differs from system information • Most recent check stub • Marriage certificate	Remove coverage for eligible dependent(s)
Entering or Leaving Country	Flight itinerary, boarding pass, stamped passport or visa	Add or remove coverage that is consistent with the qualifying event
Change in Residence Affecting Eligibility		
Address change that causes the network to no longer be available to employee and/or dependents	None; system verification of address change	Remove coverage for self and/or eligible dependent(s) or change plan; if changing plan, no coverage level changes are allowed
Initial Entitlement to Medicare or Medicaid		
Medicare/Medicaid eligibility	Government verification that coverage was gained or lost	Add or remove coverage that is consistent with the qualifying event
Other		
Significant coverage reduction/cost increase (>10% monthly employee cost change)	None; system verification of cost change	Add or remove coverage that is consistent with the qualifying event
Change of custody, judgement, court order or decree requiring medical coverage, including Qualified Medical Child Support Orders (QMCSO): *if employee has court order to cover a dependent child(ren), changes must be consistent with the order and are non-negotiable.*	Court documentation; QMCSO order **A court order is required to terminate coverage for dependents enrolled due to QMCSO**	Add or remove coverage for self and/or dependents consistent with the order

Common Enrollment Questions

Who is eligible to participate?

You must work an average of 30 hours per week to be eligible to enroll in benefits. This average is set by the Plan Administrator.

***Hooray Health mini-medical plans** are available to both full-time and part-time employees.

Do I need to choose a PCP?

PCP requirement is dependent upon the plan you elect. Please refer to your summary of benefits and coverage (SBC) available through the Paychex Flex portal.

Can I cover myself only on the medical plan and cover my entire family on the dental and vision plans?

Yes, you have the flexibility to select different levels of coverage for the medical, dental, and vision plans. To do this, you must cover yourself on any plan you wish to select for your dependents. However, you do not need to have the same coverage level for all plan selections. For example, you must cover yourself under the dental plan in order to cover any other member of your family.

Are there any restrictions to making changes to my benefit elections?

Once you are past your initial eligibility or qualified open enrollment timeframe, you cannot cancel, enroll, switch plans, or add or delete dependents unless a qualifying event/domestic partner life event occurs. You must notify the PEO Health and Benefits department of the qualifying event/domestic partner life event and submit the required documentation **within 30 days** of the event to initiate the change in coverage. If you have experienced a loss of Medicaid coverage, you must submit the required documentation **within 60 days** of the event to initiate a change in coverage.

***Texas State Senate Bill 51** restricts changes to group health plan enrollment after the date that the coverage goes into effect. Please refer to your Summary of Benefits and Coverage (SBC) to see if your plan is written out of the state of Texas.

I am over 65 and have Medicare Part A and B. How does my coverage work if I enroll in a group health plan?

Coordination of care is required whenever you have multiple healthcare plans. Typically, your employer's plan will be primary and your other coverage will be secondary. If your dependent has multiple insurance coverages, there may be several factors to determine which plan is primary. Contact your carrier for the documentation needed to coordinate your coverage.

***Hooray Health Mini-Medical plans** do not coordinate with other plans. Individuals over the age of 65 are not eligible to enroll in these plans.

I am currently being treated for an ongoing condition, or I have surgery scheduled soon after my effective date of coverage. How will I roll over into the new plan without a break in treatment?

A plan is considered new when you change carriers, plan platforms (I.E. moving from an HMO to a PPO) or when you newly enroll in coverage. Notify the PCP/specialist of the change in your insurance and request that they contact your new carrier's member service department immediately.

When enrolling in a new plan, will I need a new prescription for medication I am currently taking?

When changing carriers, your provider may need to obtain new pre-authorization for current prescriptions. If a medication is subject to step therapy, they may need to provide a history of treatment to show why the medication is needed.

When changing providers, will I need a new prescription for medication I am currently taking?

New members may need to obtain a prescription from their new doctor. Simply contact your new PCP and advise them that you are a new patient and need a prescription. Your new PCP will request you schedule a visit so they may become familiar with your medical history. Have your records transferred to the new PCP's office.

I am currently pregnant and noticed that my OB/GYN is not listed as a participating provider. What are my options?

HMO/POS Plans. If you are in your third trimester, you may not be required to select a new OB/GYN. If your provider is willing to accept the negotiated rate on your new plan, coordination of coverage for services can be approved by the carrier. You must contact your provider as well as your carrier for approval. If you are not yet in your third trimester, you may be required to change your doctor.

PPO/MCP Plans. You may continue treatment through a non-network provider or a participating network provider. In order to receive the highest benefit levels and reduce the cost to you, it will be necessary to continue care with a participating network provider. Pregnancy is not subject to a pre-existing condition limitation under federal law.

EPO Plans: You may be able to continue care if the provider agrees to the carrier's terms. The carrier will determine the allowable length of time they will cover services. You must contact your provider as well as your carrier for approval.

ACO Plans: If your ACO is on the HMO platform, you may be able to obtain carrier approval for continuity of care if you are in your third trimester. Please see the HMO/POS plan verbiage above. If your ACO plan is on the MCP platform, you may continue treatment utilizing the out of network benefits as described in your Summary of Benefits and Coverage (SBC).

Hooray Mini-Medical plans: limited coverage is dependent on the type of plan you choose. Refer to your Summary of Benefits and Coverage (SBC) for details.

When will my benefits be terminated by Paychex?

If your benefits have been terminated under the following circumstances, you will be offered COBRA(Consolidated Omnibus Budget Reconciliation Act of 1985):

- The end of the month during which you are terminated as a Paychex employee
- The end of the month when your status changes from full-time to part-time (working less than an average of 30 hours per week).
- The end of the month when you are no longer actively at work. Actively at work is determined by "hours worked".
    - Severance package agreements do not extend active coverage past the month in which you stopped actively working.
- The end of the month in which your FMLA protected timeframe expires
    - Unless specifically stated in the policy, employees on workers' compensation will remain on active benefits for the same period as FMLA before being offered COBRA.

If your benefits have been terminated under the following circumstance, you will not be offered COBRA:

- You are still a Paychex employee, but you choose not to elect benefits or your worksite employer chooses not to offer benefits at Annual Enrollment. Your benefits will terminate on Dec. 31 of the plan year.

What happens if I am placed in an inactive status?

You would be placed in an inactive status the day after you are unable to work. Your benefits will term 12 weeks after you are placed in this status unless you live in a state where there is an eligible extension, then Paychex will work with your employer on the qualification. Upon your benefits being termed at the end of the month, you will then be eligible for COBRA benefits.

When I have a qualifying event/domestic partner life event, can I change from one plan to another?

In most cases, no; however, plan deductibles and maximums under the plan may change. The change must be consistent with the qualifying event/domestic partner life event.

What is the plan (or coverage) year for deductibles?

All plans follow a January 1 through December 31 calendar year deductible. Frequency limitations may also apply.

How does HIPAA protect me and my family?

The Health Insurance Portability and Accountability Act (HIPAA):

- Limits exclusions for pre-existing conditions
- Provides credit for prior health coverage
- Outlines a process for supplying certificates for proof of prior coverage to a new group health plan or issuer
- Provides new rights allowing individuals to enroll for health coverage when they lose health coverage or add a new dependent
- Provides special enrollment rights pertaining to the gain or loss of eligibility under Medicaid and CHIP
- Prohibits discrimination in enrollment and premiums charged to employees and their dependents based on health-related factors
- Guarantees availability of health insurance coverage for small employers and renews ability of health insurance coverage in both small and large group markets

- Preserves the states' roles in regulating health insurance, including the authority to provide greater protection

How does an employee or family member prove prior coverage?

As of January 1, 2015, group health plans and insurers are no longer required to issue a certificate of creditable coverage (HIPAA Certificate) to individuals who lost group health plan coverage. The employee or family members can request a letter from the prior insurance company or plan sponsor with the benefit termination showing members enrolled, the effective and termination date of coverage, and the group health plans they were covered under.

How many days without coverage do I have before I must worry about a pre-existing condition?

Under the Affordable Care Act (ACA), insurance companies cannot refuse to cover treatment for your pre-existing condition or charge you more. All ACA compliant medical plans require coverage to begin from the effective date of coverage. Please see your (SBC verbiage) to verify if your plan is ACA compliant.

*__Hooray Health Mini-Medical plans__ are not subject to all ACA requirements and may impose pre-existing limitations before covering certain services.

I have not received my insurance ID cards. What should I do?

The insurance carriers usually take 10 to 15 business days to mail ID cards. If you have not received your insurance ID card and it is beyond the effective date of your coverage, do not panic. **Often you can print your insurance card from the carrier's website.** If you do not have Internet access, call the insurance company directly to inquire about the status of your enrollment. Most carriers can locate members in their system using the social security number of the primary member (the covered employee). The PEO Health and Benefits department can provide you with the appropriate phone numbers to call. If you have an appointment, phone verifications are simple and work as well as presenting your ID card.

What do I need to add my spouse or child to my plan?

If you wish to add dependent(s) outside of the annual enrollment period, you must have a change in status (qualifying event). Insurance carriers and section 125 regulations require that you submit a change form and evidentiary documentation **within 30 days** of the qualifying event. You can access the PBS Health and Benefits Online website to make the change at **https://paychexflex.com.** If you do not have Internet access, contact your office administrator or the PEO Health and Benefits department for an enrollment form.

What do I need to do to add my domestic partner and/or domestic partner's child(ren) to my plan?

If you wish to add your domestic partner and/or your domestic partner's child(ren) outside of the annual enrollment period, please submit the Domestic Partner Setup form. You can access the PBS Health and Benefits Online Website to make the change at **https://paychexflex.com.** If you do not have Internet access, contact your office administrator or the PEO Health and Benefits department for the required documentation.

When can I make changes to the coverage/selections I have made?

You can make changes to your plan(s) during the annual enrollment period or when you experience a qualifying event by accessing PBS Health and Benefits online at **https://PaychexFlex.com.** The PEO Health and Benefits department must approve all mid-year changes.

Note: Annual Enrollment is held during the months of November and December with a January 1 effective date.

Class Code Change: If your employer changes your class code, you are effective in the new class code the first of the following month. Any premium changes will take place at that time.

Where can I fill my prescriptions?

Most major store chains fill prescriptions for health carriers. If you are unsure if a pharmacy will fill your prescription, it is recommended that you call the pharmacy directly to make sure they participate with the health plan you selected.

How can I obtain a new provider directory and how can I change my doctor or dentist?

You can access the member portal on the carrier's website to obtain a provider directory or view a provider listing. If you do not have Internet access, you should contact your insurance carrier to request a provider and to make any provider changes.

My child has become eligible for a state-sponsored children's health plan (for example, Healthy Kids, Kid Care, etc.). Can I remove my child from my benefits?

Changes may be allowed based on a Section 125 qualifying event. Please refer to the qualifying event documentation section for further details.

My address has changed. Is there anything I need to do?

Notify your employer of the new address and have the employer fill out an Employee Change/Termination Form. The benefits team will contact you if this change affects your plan eligibility.

What should I do if I need medical attention after hours, on the weekend, or when traveling?

In the case of life-threatening injuries or emergencies (for example, uncontrollable bleeding, unconsciousness, chest pains, broken limbs, etc.), go directly to the nearest medical facility or call 911 immediately. Urgent care facilities can also be utilized for non-life-threatening injuries and certain urgent medical needs. Notify your PCP as soon as possible.

Who should I call when I have specific questions about the services covered by the insurance carriers?

Call the insurance carrier(s) directly using the number on your ID card. This is the fastest and most accurate way to receive an answer.

Who should I call regarding the status of a claim or to inquire about the amount paid for a claim?

Carriers have made it simple to access the status of a claim on their websites. If you do not have internet access, call the insurance carrier directly using the number on your ID card. Under confidentiality laws, PBS is not able to discuss any details of your claim situation with the insurance carriers.

What should I do when I receive the pre-existing condition letter from my new carrier?

Send a copy of your HIPAA certificate from your prior carrier to your new carrier. The address is on the back of your insurance card.

I have changed my plan. Do I need to do anything?

Verify that your current PCP is on the new plan. If so, present your new ID card at your next visit. This will facilitate the processing of your claims. If not, select a new PCP. Also, inform your pharmacy of the change in plan and present your new ID card. Be sure to destroy your old card.

Who is an eligible dependent?

To be eligible to enroll as a dependent and remain eligible, a person must be:

- The current spouse/domestic partner of the employee, or
- Child(ren) of the employee or the children of a domestic partner, when the domestic partner is participating under the same insurance plan
- Grandchildren may be eligible under certain circumstances. Please contact the PEO Health and Benefits team for further information

Insurance Terminology

Annual Out-of-Pocket Maximum

A dollar amount set by the plan to limit the amount of money paid by the insured in a given year. Once the in-network out-of-pocket maximum has been met, the health plan will cover 100 percent of reasonable and customary charges for covered services for the remainder of the plan year. If services provided are out of network, balance billing may apply for charges over the allowed amount. Refer to your summary of benefits and coverage (SBC) for details.

Balance Billing

When a provider bills you for the difference between the provider's charge and the insurance company's allowed amount. A preferred provider (also known as an in-network provider) may not balance bill you for covered services.

Carrier

A company issuing an insurance policy.

Coinsurance

Coinsurance represents a percentage split of payment responsibility between the insured and the carrier. For example, a common coinsurance arrangement is 80/20, which means the carrier pays 80 percent of reasonable and customary charges for covered services and the insured is responsible for the balance. Deductible amounts may need to be met before coinsurance takes effect.

Co-payment (co-pay)

This is a payment made by the insured. It is a specified dollar amount that must be paid each time certain or specific services are rendered, such as a physician office visit.

Deductible

A flat dollar amount for covered services that is paid by the insured before coinsurance takes effect.

Flexible Spending Account (FSA)

FSAs are pretax benefits allowable under the Internal Revenue Code Section 125. The plan allows eligible employees to set aside a specific pretax dollar amount for unreimbursed medical, dental, and dependent care expenses. Anyone who has predictable out-of-pocket medical, dental, or dependent care expenses should consider opening an FSA.

Limited Purpose FSA (LPFSA) plans are similar, but only cover dental, vision, and preventative expenses.

Note: Expenses for domestic partners and domestic partner children are not eligible for reimbursement under FSA or Dependent Care Accounts.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 is also known as the Kennedy-Kassebaum Act. It protects employees and their families by limiting exclusion for pre-existing conditions. It also limits the type of personal information that can be provided.

Health Savings Arrangement (HSA)

HSAs are tax-favored accounts that eligible individuals covered by a qualified High Deductible Health Plan can establish to pay for eligible medical expenses for account holders, their spouses, and/or tax dependents. Anyone who has a qualified High Deductible Health Plan should consider opening an HSA.

In-Network Providers

Providers who have a contract with your carrier to accept the negotiated rate for covered services.

Insured

The individual(s) covered by an insurance policy.

Negotiated Rate/ Reasonable and Customary

Sometimes called an allowed amount or adjusted rate, is the amount an insurer contracts to pay for all the procedures and services a doctor, medical facility, lab, or pharmacy covers.

- Reasonable and Customary- The negotiated rate for a particular service within a geographic location. Some providers may charge more than what the carrier considers to be reasonable and customary.

Out of Network Providers

Providers who do not have a contract with your carrier to accept the negotiated rate for covered services. These providers may balance bill you for services in excess of what the carrier has paid.

Pre-existing Condition

A health condition you had before the date that new health coverage starts. These can be conditions like asthma, diabetes, or cancer. Most ACA compliant plans cannot refuse to cover treatment for these conditions after the effective date of the plan. See your Summary of Benefits and Coverage (SBC) for ACA compliance

Primary Care Physician (PCP)

A physician who has contracted with a carrier(s) to provide frontline medical services to their members. Typically, a PCP is a general practice physician, internist, or pediatrician who:

- Provides routine and preventive care
- Coordinates the total health services of the insured
  And
- Arranges referrals to specialists and hospitals

Waiting Period

The time period an employee must wait before becoming eligible for benefits. The benefits are effective on the first of the month following completion of the waiting period. The waiting period is set up by the employer and can only be changed at annual enrollment.

Important COBRA Continuation Coverage Notice

COBRA Continuation Coverage offers you and the members of your family covered under the medical, dental, and vision plans offered by Paychex Business Solutions PBS ("Plan") the opportunity to temporarily extend group health coverage under the Plan in certain instances where coverage under the Plan would otherwise end. This notice is a summary of your rights and obligations with respect to COBRA Continuation Coverage under the Plan. You, and if you are married, your spouse, should take the time to read this notice.

Note: Domestic Partner and Domestic Partner's Children are not individually eligible for, or entitled to COBRA coverage. Refer to COBRA language in Domestic Partner Setup form included in this booklet for additional information.

The Right to Elect COBRA Continuation Coverage

The occurrence of a qualifying event makes you and your covered dependents qualified beneficiaries who have the right to elect COBRA Continuation Coverage. In order to be a qualified beneficiary, you must generally be covered under a group health plan on the day before the event that causes a loss of coverage (HIPAA changes this requirement so that a child born to the covered employee, or who is placed for adoption with the covered employee, during the period of COBRA Continuation Coverage is also a qualified beneficiary). Qualifying events are:

For an employee: the loss of group health coverage under the Plan due to termination of employment (for a reason other than gross misconduct), or a reduction in hours of employment.

For a spouse[2]: the loss of group health coverage under the Plan for any of the following reasons:

- Your spouse's death
- Termination of your spouse's employment (unless the termination occurred because of gross misconduct) or a reduction in your spouse's hours of employment
- Divorce or legal separation from your spouse; or
- Eligibility of your spouse for Medicare benefits

For a child: the loss of group health coverage under the Plan for any of the following reasons:

- The death of a parent
- Termination of a parent's employment (unless the termination occurred because of gross misconduct) or a reduction in a parent's hours of employment
- The parent's divorce or legal separation
- Eligibility of a parent for Medicare benefits; or
- The child ceases to be a "dependent child" for purposes of eligibility for group health coverage under the Plan.

For a Domestic Partner (DP) and DP Child(ren): while Domestic Partners and their children do not have an independent COBRA election right, if an employee loses active coverage and elects family COBRA, the domestic partner and their child(ren) can be covered as dependents of that family, for as long as the employee maintains family COBRA coverage under the plan.

[2] As defined under federal law.

You, or a family member, have the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child's loss of dependent status under the Plan within 60 days of the event or the date on which coverage would end under the Plan because of the event, whichever is later. Once the Plan Administrator is notified that one of the qualifying events has occurred, PBS, in turn, will ~~notified~~ notify the qualified beneficiaries of their right to elect COBRA Continuation Coverage.

Electing COBRA Continuation Coverage

A qualified beneficiary has 60 days to elect COBRA Continuation Coverage from the later of the date of the loss of coverage or the date of the notice of right to continuation due to one of the events described earlier. To elect COBRA Continuation Coverage, the qualified beneficiary must notify PBS of his election. Please note:

- A qualified beneficiary has the responsibility to notify the Plan Administrator of the qualifying event in the case of a divorce, legal separation, or cessation of dependent status.
- You do not have to show that you are insurable to elect COBRA Continuation Coverage.

If you elect COBRA Continuation Coverage, the coverage provided will be coverage that is identical to the coverage provided under the Plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will also be modified. **If you do not elect COBRA Continuation Coverage, your group health coverage will end.**

Cost of COBRA Continuation Coverage

Individuals who elect COBRA Continuation Coverage must pay the full cost of coverage plus 2 percent of administrative expenses. When COBRA Continuation Coverage is extended beyond 18 months because of a social security disability determination, the individual may be charged up to 150 percent of the cost of that coverage for the additional 11 months of coverage. The first premium is due within 45 days of the date COBRA Continuation Coverage is elected. Afterwards, the premium is due on the first of the month. There is a 30-day grace period in which to pay monthly premiums. If the first premium payment or any subsequent monthly **payment is not received on time, the individual will lose COBRA Continuation Coverage.**

How Long COBRA Continuation Coverage Lasts

The maximum period of COBRA Continuation Coverage available to an individual is determined by the qualifying event, as illustrated in the following chart:

Qualifying Events	Maximum Period of COBRA Continuation Coverage
Loss of coverage due to the termination of employment (for a reason other than gross misconduct) or a reduction in hours of employment.	Up to 18 months of COBRA Continuation Coverage. *Social Security Disability Extension* – Coverage may be extended for an additional period up to 11 months for a maximum of 29 months of coverage *if* the Social Security Administration determines that the qualified beneficiary is disabled on the date of the qualifying event, or at any time during the first 60 days of Continuation Coverage. It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to the Plan Administrator within 60 days after the date of determination and before the original 18 months expire. It is also the qualified beneficiary's responsibility to notify the Plan Administrator within 30 days if a final determination has been made that they are no longer disabled. *Secondary Events* – If a second event occurs (divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a dependent), then the original 18 or 29 months of Continuation Coverage can be extended to 36 months from the date of the original qualifying event date for *eligible dependent qualified beneficiaries.* If a second event occurs, it is the qualified beneficiary's responsibility to notify the Plan Administrator in writing within 60 days of the secondary event and within the original 18- or 29-month COBRA timeline. In no event will Continuation Coverage last beyond three years from the date of the event that originally made a qualifying beneficiary eligible to elect coverage.
Death, divorce, Medicare entitlement, child's loss of dependent status	Up to 36 months of COBRA Continuation Coverage for the employee's spouse and dependents.

If, while covered under COBRA, a qualified beneficiary gives birth to or adopts a child, that child may be enrolled for COBRA Continuation Coverage in the same manner that a newly acquired dependent may be enrolled in the Plan by an active employee. Once enrolled, the child will be covered as a qualified beneficiary and his COBRA coverage rights will be independent of the COBRA coverage rights of his parents.

Note: If the Domestic Partner/Domestic Partner's children had insurance prior to the employee's qualifying event, if the employee elects COBRA, the Domestic Partner/Domestic Partner's children may be included in coverage.

Early Termination of COBRA Continuation Coverage

The law provides that COBRA Continuation Coverage **will end prior** to the maximum continuation period for any of the following:

- If the employer no longer provides group health coverage to any of its employees
- The premium for your COBRA Continuation Coverage is not paid on time
- You become covered under another group health plan that does not contain any exclusion or limitations for any of your pre-existing conditions
- You become entitled to Medicare; or
- If coverage was extended to 29 months due to social security disability, a determination that you are no longer disabled.
- If you are on a COBRA eligible plan not administered by Paychex, please consult with your previous employer on specific COBRA rules that may apply to your coverage.

Other Information

Once COBRA Continuation Coverage ends for any person, it cannot be reinstated. However, that person may obtain an individual health care policy without evidence of insurability if provided for under the terms of the Plan.

You will be provided with a certificate of creditable coverage that reflects the period of time for which you have been covered under the Plan. When your COBRA ends, you may request an updated certificate of creditable coverage. The period during which you had coverage, including COBRA coverage, may reduce the period that a pre-existing condition exclusion period, if any, applies to you under your new coverage.

Notice of Address Change

To ensure all covered individuals receive information properly and efficiently, it is important that you notify the Plan Administrator of any address change as soon as possible. Failure on your part to do so will result in delayed COBRA notifications or a loss of Continuation Coverage options.

Questions

This notice is simply a summary of your potential future options under COBRA. Should an actual qualifying event occur, and it is determined that you are eligible for COBRA, you will be notified of all your actual COBRA rights at that time. **Questions about COBRA Continuation Coverage should be directed to PBS at 1-877-244-1771 between 8:00 a.m. and 5:00 p.m. ET, Monday through Friday, or by writing to Paychex Business Solutions – COBRA Department, 225 Kenneth Drive, Rochester, New York, 14623.**

1. **EMPLOYEE INFORMATION** (Print using black or blue ink ONLY) ☐Additional Page(s) Please mark if more than 4 dependents

EMPLOYEE NAME (Last, First, MI)	GENDER	DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER
HOME ADDRESS	CITY	STATE	ZIP CODE
EMAIL ADDRESS		CLIENT NAME/NUMBER	

2. **DEPENDENT(S) COVERED** **For more than 4 dependents, attach additional** *Enrollment/Change Forms.* **All information in this section is REQUIRED for processing.**

Enrollment Action	Plan Selection		Full Names of ALL Covered Dependents (LAST NAME, FIRST NAME, MI)	Gender	Relationship		Date of Birth MM/DD/YYYY	Social Security Number (Required)	Medical Primary Care Physician (PCP Number)	Dental Primary Care Dentist (PCD Number)
☐Add ☐Change ☐Remove	☐Med ☐Den ☐Vis	☐Acc ☐Crt ☐Hos		☐ M ☐ F	☐Child ☐DP Child	☐Spouse ☐DP				
☐Add ☐Change ☐Remove	☐Med ☐Den ☐Vis	☐Acc ☐Crt ☐Hos		☐ M ☐ F	☐Child ☐DP Child	☐Spouse ☐DP				
☐Add ☐Change ☐Remove	☐Med ☐Den ☐Vis	☐Acc ☐Crt ☐Hos		☐ M ☐ F	☐Child ☐DP Child	☐Spouse ☐DP				
☐Add ☐Change ☐Remove	☐Med ☐Den ☐Vis	☐Acc ☐Crt ☐Hos		☐ M ☐ F	☐Child ☐DP Child	☐Spouse ☐DP				
2a.	If any dependent above lives at a different address than the Employee, provide the dependent's address and explain circumstances. Failure to provide this information could result in non-coverage of dependent(s). Domestic Partners and Domestic Partner's Children must reside with the Employee.									

3. **BENEFICIARY INFORMATION** You are automatically the beneficiary for your spouse and/or child(ren). When specifying multiple beneficiaries, you **must** indicate the percentage to be paid to each beneficiary. **For more than two beneficiaries, attach an additional Enrollment/Change Form and check Beneficiary Information in Section 4.**

Beneficiary Name (Print Last, First, MI)	Address	Social Security Number	Date of Birth	Percentage	Primary/Secondary	
					☐ **Primary**	☐ **Secondary**
					☐ **Primary**	☐ **Secondary**

4. **TYPE OF ENROLLMENT OR CHANGE: Date of Event ____/____/____** (Check ALL that apply, attach applicable documentation*, and **return within 30 days of the event)**

☐ **New Hire/Onboarding** ☐ **Annual Enrollment** ☐ **Qualifying Event*** ☐ **Domestic Partner (DP) Life Event*** ☐ **Beneficiary Information**

MEDICAL BENEFITS Or Hooray Health	Plan #	Plan Name/Description			EE PCP#
	☐ Employee	☐ Employee + Child(ren)	☐ Employee + Spouse/DP	☐ Family	☐ I waive medical coverage
DENTAL BENEFITS	Plan #	Plan Name/Description			EE PCD#
	☐ Employee	☐ Employee + Child(ren)	☐ Employee + Spouse/DP	☐ Family	☐ I waive dental coverage
VISION BENEFITS	Plan #	Plan Name/Description			EE PCP#
	☐ Employee	☐ Employee + Child(ren)	☐ Employee + Spouse/DP	☐ Family	☐ I waive vision coverage
VOLUNTARY DISABILITY BENEFITS SHORT-TERM DISABILITY (VSD) LONG-TERM DISABILITY (VLD)	(These plans are ONLY available if your employer does not offer Employer Paid Disability Coverage)				
	☐ VSD001 (26 Weeks - up to $2,000 benefit)		☐ VSD002 (13 Weeks - up to $2,000 benefit)		☐ I waive VSD coverage
	☐ VLD001 (180 Days – up to $5,000 benefit)		☐ VLD002 (90 Days – up to $5,000 benefit)		☐ I waive VLD coverage
	***VSD001 can be elected with VLD001; VSD002 can be elected with VLD002. Conflicting VSD/VLD plans cannot be elected together.**				
VOLUNTARY ACCIDENT BENEFITS	☐ VAI001 (Accident High)		☐ VAI002 (Accident Low)	☐ I waive accident coverage	
	☐ Employee	☐ Employee + Child(ren)	☐ Employee + Spouse/DP	☐ Family	
VOLUNTARY CRITICAL BENEFITS	☐ VCI001 (Critical High)		☐ VCI002 (Critical Low)	☐ I waive critical coverage	
	☐ Employee	☐ Employee + Child(ren)	☐ Employee + Spouse/DP	☐ Family	
VOLUNTARY HOSPITALIZATION BENEFITS	☐ VHI001 (Hospital High)		☐ VHI002 (Hospital Low)	☐ I waive hospital coverage	
	☐ Employee	☐ Employee + Child(ren)	☐ Employee + Spouse/DP	☐ Family	
VOLUNTARY PRE-PAID LEGAL BENEFITS	(This plan is only available at the employee only coverage level)				
	☐ VLG001 (Pre-paid Legal)		☐ I waive pre-paid legal coverage		
VOLUNTARY EMPLOYEE LIFE INSURANCE BENEFITS	Available in $10,000 increments up to 5x annual salary or $1 million, whichever is less. Evidence of Insurability (EOI) may be required. We may not process your full enrollment until your election is approved by the carrier.				
	☐ Amount $________________________		☐ I waive voluntary life coverage		
VOLUNTARY SPOUSE LIFE INSURANCE BENEFITS	Coverage available for the Employee's spouse/DP. Employee must be enrolled in a life product, may only have up to 50% of the employee amount.				
	☐ $5,000	☐ $10,000	☐ $15,000	☐ $20,000	☐ I waive spouse life coverage
VOLUNTARY CHILD LIFE INSURANCE BENEFITS	Coverage available for the Employee's child(ren) or for children of the Employee's Domestic Partner. May only have 40% of the employee amount.				
	☐ $2,000	☐ $4,000	☐ $6,000	☐ $8,000	☐ $10,000 ☐ I waive child life coverage

5. EMPLOYEE SIGNATURE

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on page 3 of this application.

Signature ____ Date ____/____/____

PAYCHEXONE

Kaiser Foundation Health Plan Arbitration Agreement

Employees enrolling in California Kaiser Permanente must complete, sign and return this form.

EMPLOYEE INFORMATION (print)

Employee Name _____Social Security Number _____DOB (MM/DD/YYYY) _____

DEPENDENT(S) COVERED **For more than 4 dependents, attach additional Enrollment/Change Forms. All information is this section is REQUIRED for processing.**

Enrollment Action	Plan Selection	Full Names of ALL Covered Dependents (LAST NAME, FIRST NAME, MI)	Gender	Relationship	Date of Birth MM/DD/YYYY	Social Security Number (Required)	Medical Primary Care Physician (PCP Number)	Dental Primary Care Dentist (PCD Number)
☐Add ☐Change ☐Remove	☐Medical		☐ M ☐ F	☐Child ☐Spouse ☐DP Child ☐DP				
☐Add ☐Change ☐Remove	☐Medical		☐ M ☐ F	☐Child ☐Spouse ☐DP Child ☐DP				
☐Add ☐Change ☐Remove	☐Medical		☐ M ☐ F	☐Child ☐Spouse ☐DP Child ☐DP				
☐Add ☐Change ☐Remove	☐Medical		☐ M ☐ F	☐Child ☐Spouse ☐DP Child ☐DP				
	If any dependent above lives at a different address than the Employee, provide the dependent's address and explain circumstances. Failure to provide this information could result in non-coverage of dependent(s). Domestic Partners and Domestic Partner's Children must reside with the Employee.							

TYPE OF ENROLLMENT OR CHANGE: **Date of Event ____/____/____** (Check ALL that apply, attach applicable documentation*, and **return within 30 days of the event)**

☐ **New Hire/Onboarding** ☐ **Annual Enrollment** ☐ **Qualifying Event*** ☐ **Domestic Partner (DP) Life Event*** ☐ **Beneficiary Information**

MEDICAL BENEFITS	Plan #	Plan Name/Description			EE PCP#
	☐ Employee	☐ Employee + Child(ren)	☐ Employee + Spouse/DP	☐ Family	☐ I waive medical coverage

Kaiser Foundation Health Plan Arbitration Agreement- California (CA)

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Signature _____ Date ____/____/____

EMPLOYEE SIGNATURE

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on page 3 of this application.

Signature _____ Date ____/____/____

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Kaiser Foundation Health Plan, Inc., Hawaii Arbitration Agreement*

Binding Arbitration
Except as provided in the Dispute Resolution section of Kaiser Permanente's Guide to Your Health Plan (Guide) or by applicable law, any and all claims, disputes, or causes of action arising out of or related to your Guide or Evidence of Coverage (EOC), its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims, disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration.

This includes but is not limited to any claim asserted:

By or against a Member, a patient, the heirs or the personal representative of the estate of the Member or patient, or any other person entitled to bring an action for damages, arising from or related to harm to the member or patient as permitted by applicable federal or Hawaii state law existing at the time the claim is filed ("Member Parties"). For purposes of this Agreement, all family members of the member or patient who have derivative claims arising from such harm, shall also be deemed "Member Parties" and bound to these arbitration terms; On account of death, bodily injury, physical ailment, mental disturbance, or economic loss arising out of the rendering or failure to render medical services or the provision or failure to provide benefits under this Agreement, except when binding arbitration is explicitly not permitted by applicable law, premises liability, or arising out of any other claim of any nature, irrespective of the legal theory upon which the claim is asserted; and

By or against one or more of the following entities or their employees, officers or directors ("Kaiser Permanente Parties"):
- Kaiser Foundation Health Plan, Inc.,
- Kaiser Foundation Hospitals,
- Hawaii Permanente Medical Group, Inc.,
- The Permanente Federation, LLC,
- Any individual or organization that contracts with an organization named above to provide medical services to Health Plan Members, when such contract includes a provision requiring arbitration of the claim made.

Notwithstanding any provisions to the contrary in this Agreement, the following claims shall not be subject to mandatory arbitration:
- claims for monetary damages within the jurisdictional limit of the Small Claims Division of the District Courts of the State of Hawaii;
- actions for appointment of a legal guardian of a person or property subject to probate laws;
- purely injunctive orders reasonably necessary to protect Kaiser Permanente's ability to safely render medical services (such as temporary restraining orders, and emergency court orders).
- claims that may not be subject to binding arbitration under applicable federal or state law;
- for Medicare members, claims subject to the Medicare appeals process.

Initiating Arbitration
A demand for arbitration shall be initiated by sending a registered or certified letter to each named party against whom the claim is made, with a notice of the existence and nature of the claim, the amount claimed and a demand for arbitration. Any Kaiser Permanente Parties shall be served by registered or certified letter, postage prepaid, addressed to the Kaiser Permanente Parties in care of the Health Plan at Kaiser Foundation Health Plan, Inc., Member Services, 711 Kapiolani Boulevard, Honolulu, HI 96813. The arbitrators shall have jurisdiction only over persons and entities actually served.

Arbitration Proceedings
Within 30 days after the service of the demand for arbitration, the parties shall agree on a panel of arbitrators from which to select arbitrators or shall agree on particular arbitrators who shall serve for the case. If the parties cannot agree on any panel of arbitrators or particular arbitrators within the 30 days, then the panel of arbitrators shall be that of Dispute

Prevention and Resolution, Inc. ("DPR"). Unless the parties agree to any other arbitration service and rules, DPR shall administer the arbitration and its arbitration rules shall govern the arbitration (including rules for selection of arbitrators from a panel of arbitrators, if the parties have not already agreed upon particular arbitrators to serve). Kaiser Permanente shall notify DPR (or such other arbitration service as may be chosen by the parties) of the arbitration within 15 days following the expiration of the 30-day period noted above.
Within 30 calendar days after notice to DPR, the parties shall select a panel of three arbitrators from a list submitted to them by the arbitration service. In all claims seeking a total monetary recovery less than $25,000.00, and in any other case where the parties mutually agree, a panel of one arbitrator selected by both parties from a list submitted to them by the arbitration service will be allowed. The arbitrator(s) will arrange to hold a hearing in Honolulu (or such other location as agreed by the parties) within a reasonable time thereafter.

Limited civil discovery shall be permitted only for production of documents that are relevant and material, taking of brief depositions of treating physicians, expert witnesses and parties (a corporate party shall designate the person to be deposed on behalf of the corporation) and a maximum of three other critical witnesses for each side (i.e., respondents or claimants), and independent medical evaluations.

The arbitrator(s) will resolve any discovery disputes submitted by any party, including entry of protective orders or other discovery orders as appropriate to protect the parties' rights under this paragraph.

Any payment for the fees and expenses of the arbitration service and the arbitrator(s) shall be borne one-third by the Member Parties and two-thirds by the Kaiser Permanente Parties. Each party shall bear their own attorney's fees, witness fees, and discovery costs.

The arbitrator(s) may decide a request for summary disposition of a claim or particular issue, upon request of one party to the proceeding with notice to all other parties and a reasonable opportunity for the other parties to respond. The standards applicable to such request shall be those applicable to analogous motions for summary judgment or dismissal under the Federal Rules of Civil Procedure.

In claims involving benefits and coverage due under this Agreement or disputes involving operation of the Plan, Health Plan's determinations and interpretations, and its decisions on these matters are subject to de novo review. The arbitration award shall be final and binding. The Member Parties and Kaiser Permanente Parties waive their rights to jury or court trial. With respect to any matter not expressly provided for herein, the arbitration will be governed by the Federal Arbitration Act, 9 U.S.C. Chapter 1.

General Provisions
All claims based upon the same incident, transaction or related circumstances regarding the same Member or same patient shall be arbitrated in one proceeding (for example, all Member Parties asserting claims arising from an injury to the same Health Plan Member, shall be arbitrated in one proceeding).

A claim for arbitration shall be waived and forever barred if on the date notice thereof is received, the claim, if it were then asserted in a civil action, would be barred by the applicable Hawaii statute of limitations. All notices or other papers required to be served or convenient in the conduct of arbitration proceedings following the initial service shall be mailed, postage prepaid, to such address as each party gives for this purpose. If the Federal Arbitration Act or other law applicable to these arbitration terms is deemed to prohibit any term in this Agreement in any particular case, then such term(s) shall be severable in that case and the remainder of this Agreement shall not be affected thereby. Class actions and consolidation of parties asserting claims regarding multiple members or patients are prohibited. The arbitration provisions in this Agreement shall supersede those in any prior Agreement.

Arbitration Confidentiality
Neither party nor the arbitrator(s) may disclose the substance of the arbitration proceedings or award, except as required by law or as necessary to file a motion regarding the award pursuant to the Federal Arbitration Act, in any federal or state court of appropriate jurisdiction within Hawaii, and in that event, the parties shall take all appropriate action to request that the records of the arbitration be submitted to the court under seal.

Special Claims
Medical Malpractice Claims Prior to initiating any arbitration proceedings alleging medical malpractice, Member Parties shall first submit the claim to a Medical Inquiry and Conciliation Panel pursuant to Chapter 671, Hawaii Revised

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Statutes, Sections 11-19. Following the rendering of an advisory decision by the Medical Inquiry and Conciliation Panel, if the claim has not been withdrawn or settled, Member Parties shall serve a demand for arbitration on Kaiser Permanente Parties as specified in the "Initiating arbitration" section.

Benefit Claims If the Member Party has a claim for benefits that is denied or ignored (in whole or in part), the Member Party may pursue legal action in federal or state court, as appropriate, after the Member Party has exhausted the claims and appeals process and, if applicable, external review process. The court will decide who should pay court costs and legal fees. If the Member Party is successful, the court may order the person or entity the Member Party has sued to pay these costs and fees. If the Member Party loses, the court may order the Member Party to pay these costs and fees, for example, if it finds the Member Party's claim is frivolous. If the Member Party has any questions about the Member Party's plan, the Member Party should contact Health Plan at 1-800-966-5955.

Although benefit-related claims may not be required to be resolved by binding arbitration pursuant to this section, Member Parties may still make a voluntary election to use binding arbitration to resolve these claims, instead of court trial, by filing a demand for arbitration upon Kaiser Permanente Parties pursuant to the provisions of the "Initiating Arbitration" section. If a voluntary election to use binding arbitration is made by a Member Party, the arbitration shall be conducted pursuant to the "Dispute Resolution" section of your Guide or EOC.

External Appeal of Internal Review Decisions If you disagree with Kaiser Permanente's final internal benefit determination, you may request voluntary binding arbitration pursuant to the procedures in this Agreement. In addition to the arbitration procedures set forth in this Agreement which may be elected by the Member (but are not mandatory), Hawaii Revised Statutes Chapter 432E also creates certain external review rights for Members to submit a request for external review to the State Insurance Commissioner within 130 days from the date of Kaiser's final internal determination. These rights are subject to the limitations noted in the next paragraph, and are subject to the requirements and limitations in Hawaii Revised Statutes Chapter 432E (including exhausting all of Kaiser Permanente's internal complaint and appeals procedures before requesting external review, except as specified in Chapter 432E for situations when simultaneous external review is permitted to occur or Kaiser Permanente has failed to comply with federal requirements regarding its claims and appeals process). A complete description of Kaiser Permanente's claims and appeals process is described in the "Appeals" section of your Guide or EOC.

Chapter 432E external reviews are limited to situations where (a) the complaint is not for allegations of medical malpractice, professional negligence or other professional fault by health care providers, and (b) the complaint relates to an adverse action as defined in Hawaii Revised Statutes Chapter 432E. Health Plan may object to external reviews under Chapter 432E which do not meet the standards for external review under applicable federal and state law and Health Plan reserves its full rights and remedies in this regard. The recitation of state law provisions shall not be deemed to constitute any waiver of such objections.

Senior Advantage Member Claims
Complaints and appeals procedures for Senior Advantage Members are described in the Kaiser Permanente Senior Advantage Evidence of Coverage (KPSA EOC). The arbitration provisions of this KPSA EOC apply only to Senior Advantage Member claims asserted on account of medical malpractice or a violation of a legal duty arising out of this KPSA EOC, irrespective of the legal theory upon which the claim is asserted.

_____ _____

Signature Required for all Kaiser Permanente Plans **Date**

*Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans

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Instructions

Employee – Complete Sections 1-9. You will need your *Employee Benefits Statement* to complete this form.

Section 1 – Employee Information

Complete **all** information for your enrollment/change request to be processed without delays.

Section 2 – Dependents Covered

Complete **all** information for your enrollment/change request to be processed.

- Add/Change/Remove – to indicate whether you are adding, changing or removing coverage for an individual.
- Print all the covered dependents including your spouse/Domestic Partner (DP), child(ren) or children of the DP, if applicable. All information in this section must be completed for each individual listed.
- From the appropriate provider directory, locate the office ID number for the primary care physician and/or dentist (if applicable). Indicate office ID number selection(s) on the form. (Medical=PCP ID#; Dental=Facility or PDP ID#)
- If a dependent is a full-time college student, you must attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits).
- If you have a disabled child(ren), attach the appropriate Carrier-required forms. Failure to provide the required documents could result in non-coverage of the dependent(s).

Section 3 – Beneficiary Information

- Designate your beneficiaries for any life insurance provided and/or elected.

Section 4 – Type of Enrollment or Change

- *Indicates supporting documentation is required. For a list of required supporting documentation, refer to the PEO Qualifying Event Checklist or the Domestic Partner Life Event Checklist – PEO as applicable.
- Refer to your *Employee Benefits Statement* to determine which benefits are offered by your employer.
- Write the plan election in the spaces provided and select the level of coverage.
- If waiving coverage, you must complete a waiver form for medical, dental, and vision plans only.
- Basic Life and AD&D Insurance is paid by your employer. If offered, you automatically receive this benefit and the information will appear on your *Employee Benefits Statement.*
- **Voluntary Life Insurance:** If your employer does not offer Basic Life and AD&D, you can elect voluntary life insurance for yourself, your Spouse/Domestic Partner and/or Child(ren) or Child(ren) of your Domestic Partner. Refer to your *Carrier Benefit Summary* for cost.
- If you are electing life insurance coverage after your initial eligibility or in addition to your existing life coverage, you will have to provide Evidence of Insurability.

Section 5 – Employee Signature

- Complete this section for all new enrollments or coverage changes.
- You must sign and date this *Enrollment/Change Form* for it to be processed.

Conditions of Enrollment

Applicant Acknowledgements and Agreements

On behalf of myself and those individuals eligible and listed on the reverse side, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, and signing the front of this enrollment form, coverage will be provided by the following entities (collectively referred to as "the insurance carrier(s)").
    - Medical
    - Dental
    - Vision
    - Life
    - Voluntary Benefits

Coverage will not be effective unless and until the required supporting documentation is received timely by PBS.

2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. Accident Insurance
    - Benefit Election Disclosure
    - *Your Accident certificate provides limited benefits – read your certificate carefully. By enrolling in Accident Insurance, I declare that all persons to be insured have medical coverage in force that provides benefits for medical treatment, including hospital, surgical and medical expenses; I acknowledge that I have received and read a copy of the outline of coverage or other disclosure document for the group Accident plan. In addition, I have read the enrollment documentation and declare that all information I have given is true and complete to the best of my knowledge and belief; I have read the applicable Fraud Warning(s) provided.*
4. Critical Illness Insurance
    - Benefit Election Disclosure
    - *Your Critical Illness certificate provides limited benefits – read your certificate carefully. By enrolling in Critical Illness Insurance, I declare that no person proposed for Critical Illness coverage is covered under any Title XIX program (Medicaid or any similarly named program); that all persons to be insured have medical coverage in force that provides benefits for medical treatment, including hospital, surgical and medical expenses; I acknowledge that I have received a Shopper's Guide to Cancer Insurance; and I have received and read a copy of the outline of coverage or other disclosure document for the group Critical Illness plan. In addition, I have read the enrollment documentation and declare that all information I have given is true and complete to the best of my knowledge and belief; I have read the applicable Fraud Warning(s) provided.*
5. Hospitalization Indemnity Insurance
    - Benefit Election Disclosure
    - *Your Hospital Indemnity certificate provides limited benefits – read your certificate carefully. By enrolling for Hospital Indemnity Insurance, I declare that all persons to be insured have medical coverage in force that provides benefits for medical treatment, including hospital, surgical and medical expenses; I acknowledge that I have received and read a copy of the outline of coverage or other disclosure document for the group Hospital Indemnity plan. In addition, I have read the enrollment documentation and declare that all information I have given is true and complete to the best of my knowledge and belief; I have read the applicable Fraud Warning(s) provided.*
6. The plan documents (Schedule of Benefits, Group Agreement, Certificate of Coverage, Group Policy, Group Insurance Certificate, etc.) will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary, or other description of the plan, including the Summary Plan Description.

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EMPLOYEE INFORMATION (print) All eligible employees must complete, sign and return this form.

Employee Name _____Social Security Number _____DOB (MM/DD/YYYY) _____

Acceptance of Coverage I am electing coverage in the following benefits: (check all that apply)					**Refusal/Waiver of Coverage*** (see below for required refusal/waiver information) I am waiving coverage or requesting termination for the following benefits*: (check all that apply)				
☐ Medical	☐ Dental	☐ Vision	☐ Vol Short Term DBL	☐ Life	☐ Medical	☐ Dental	☐ Vision	☐ Vol Short Term DBL	☐ Life
☐ Accident	☐ Hospital	☐ Critical Illness	☐ Vol Long Term DBL	☐ Pre-Paid Legal	☐ Accident	☐ Hospital	☐ Critical Illness	☐ Vol Long Term DBL	☐ Pre-Paid Legal

The reason I am waiving coverage or requesting termination for my PBS medical plan enrollment is: (check one)

☐ I am covered under an individual health plan. *
☐ I am covered under another group health plan offered to my spouse/domestic partner. *
☐ I am covered under another group health plan offered by my Employer. *
☐ I am covered under another group health plan offered by the Military. *
☐ I am covered under Medicare. *
☐ I am covered under Medicaid. *
☐ I do not have any dependents that need or require coverage.
☐ The plan(s) is (are) too expensive.
☐ I am declining coverage for other reasons:
Specify _____

*Medical Carrier _____ *Policy Number_____

PAYCHEX ACKNOWLEDGEMENT INFORMATION

I acknowledge receipt of the PAYCHEX BUSINESS SOLUTIONS, INC (PBS) FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION AND PEO EMPLOYEE BENEFITS SUMMARY PLAN DESCRIPTION. I understand that if I do not elect benefits at the time of my initial eligibility, I will not be permitted to enroll at a later date, or make any changes unless a qualifying or domestic partner life event occurs, or until Annual Enrollment. I understand if I experience a qualifying event or domestic partner life event and would like to enroll or make any changes to my benefit elections, I must notify PBS and submit evidentiary documentation within thirty (30) days of my qualifying event or domestic partner life event. If these procedures are not followed, I will not be permitted to enroll or to make changes until the following Annual Enrollment period. I understand that the authorized changes must be consistent with the reason that such change was permitted.
I understand the Internal Revenue Service defines "Qualifying Events" as follows:

- Marriage (as defined by federal law), divorce, or legal separation
- Birth or adoption of dependent
- Dependent reaches ineligible age or status
- Death of a spouse or dependent
- Eligibility (or ineligibility) for Medicare/Medicaid
- Termination or commencement of employee or spouse's employment
- Employee or spouse takes unpaid leave of absence
- Significant change in employee or spouse's health coverage
- Employee or spouse's employment status changes from full-time to part-time (or vice-versa)

For a definition of domestic partner life events, I can refer to the Domestic Partner Life Event Checklist (phb364). I also understand that the list above may be subject to change and limited in scope based on eligibility. PBS reserves the right to interpret the rules for administering pretax benefit plans, outlined in Section 125 of the Internal Revenue Code, as they deem appropriate. These rules will be applied consistently to all participants in any PBS-sponsored group benefit plan.
In addition, I understand that should I separate from my employment for any reason, my current elections will continue through the end of the month during which PBS receives notification of my separation. My share of the premiums for this period may be satisfied by payroll deductions from my final paycheck.

LATE ENROLLEES

1. Other Employer health Benefit Plan Coverage. You and your dependents (collectively "you") shall not be considered late enrollees if you meet each of the following requirements:
    a. You are covered under another employer health benefit plan ("Plan"), although you are also eligible to enroll in a PBS Benefit Plan;
    b. You certify in writing on this *Acceptance or Refusal of Coverage* form, that you are declining PBS Benefit coverage because you are already covered under another group plan;
    c. You learn at a later date that you have lost or will lose coverage under the other plan because of:
        i. The termination of your employment or the employment of the person through whom you are covered as a dependent;
        ii. A change in your employment status or the employment status of the person through whom you are covered as a dependent;
        iii. The termination of coverage under the other plan;
        iv. The death of the person through whom you are covered as a dependent; or
        v. The divorce from the person through whom you are covered as a dependent; and
    d. You request enrollment within 30 days after the termination of your coverage under the other plan due to the reasons stated above in subsection (c).
2. **Multiple Plans.** If your employer offers multiple health plan options under the PBS Benefit Plan, and you enrolled in one of such plans during a previous enrollment period, you will not be classified as a late enrollee if you decide to change plans and enroll in another plan, during open enrollment, for the following plan year.
3. **Court Order**. If a court has ordered that you obtain health care coverage for your minor child, you must submit an application for enrollment within 30 days after issuance of the court order for yourself and minor child.
   I understand that in the event I and/or my eligible dependents choose to enroll in a PBS Benefit Plan at a later date, we may be considered "late enrollees" and may have to wait for coverage for a period of up to 12 months to enroll. I understand that if ONE of the THREE circumstances set forth above apply to us, we will not be considered late enrollees, and thus, will not have to wait for a period of up to 12 months to enroll in a PBS Plan.

Employee Signature _____ **Date** ____/____/____

Paychex Business Solutions, LLC
Domestic Partner Setup Form
Declaration of Domestic Partner Relationship

Domestic Partners who complete and execute this Declaration of Domestic Partnership Relationship will be considered for eligibility in the Paychex Business Solutions, LLC. ("PBS") sponsored benefits including medical, dental, vision and life insurance plans, assuming they meet all other eligibility requirements. This Declaration does not initiate plan enrollment and/or participation. Specific benefit applications must be completed, and are subject to review and approval after the Declaration has been approved by PBS.

Please read this form in its entirety. Your signature and that of your Domestic Partner is required to execute this form. **This Declaration must be submitted to PBS** with your initial benefit enrollment or within thirty (30) days from the day you experience a corresponding life event (the actual date of the event). This form may be submitted by facsimile to 800-668-7296, by e-mail at peo_benefitsteam@paychex.com, or by mail to Paychex HR Solutions, ATTN: Health & Benefits Dept., 970 Lake Carillon Drive, Suite 400, St. Petersburg, FL 33716-1129.

A. Domestic Partner Certification

We, _____

EMPLOYEE NAME (PRINT)

and _____,

DOMESTIC PARTNER NAME (PRINT)

certify that we are Domestic Partners in accordance with the following criteria:

1. We are each eighteen (18) years of age, or older, and we are legally competent to consent to enter into contract regarding our Domestic Partnership;
2. We share a spouse-like relationship and hold ourselves out as mutually exclusive committed partners responsible for each other's common welfare;
3. We are each other's sole Domestic Partner; and we affirm our Domestic Partnership or marriage has been in existence since __/__/____ (the Domestic Partnership effective date must reflect a

   DATE

   period of no less than six (6) consecutive months prior to the date of this Declaration; the six-month period is not required if married);
4. We are not married to anyone else and are not legally separated from anyone nor have either of us had another Domestic Partner or civil union within the prior six months;
5. We are not related by blood in a manner that would bar marriage in the state in which we reside;
6. We share the same regular and permanent residence;
7. We share joint responsibility for our common welfare, living expenses, and financial obligations. Joint responsibility for each other's common welfare and financial obligations is evidenced by the existence of at least two (2) of the following (check types of documentation that **you will provide upon request** (not required for California residents)):

   ☐ A Domestic Partnership agreement or marriage certificate;

   ☐ A joint mortgage or lease;

☐ Designation of Domestic Partner as a beneficiary for life insurance or retirement benefits;

☐ Joint wills or designation of the Domestic Partner as executor and/or primary beneficiary;

☐ Designation of the Domestic Partner as durable power of attorney or health care proxy; and either:

- ☐ Joint bank account, joint credit cards, motor vehicle or other evidence of joint financial responsibility; or
- ☐ Other evidence that establishes economic interdependence, to the satisfaction of the Plan Administrator

We understand that this Declaration shall be terminated upon the death of either Domestic Partner, or by a change in a necessary circumstance attested to in this Declaration.

We agree to provide written notice to PBS if there is any change of circumstances attested to in this Declaration within thirty (30) days of the change, and if we no longer meet the necessary criteria for Domestic Partner Certification, by filing a PBS Declaration of Termination of Domestic Partnership.

The Plan Administrator, in the exercise of its discretion, shall determine the effective date of the termination of the Domestic Partnership whether or not the completed termination form has been received.

A six (6) month waiting period from the termination of the Domestic Partnership or the filing of the termination notice, if later, applies before registering another Domestic Partner, except if registering the same Domestic Partner within thirty (30) days of filing a Declaration of Termination of Domestic Partnership.

B. Dependent Child Certification

We further certify that any Domestic Partner Child(ren) enrolled in a PBS sponsored plan meet the following requirements:

1. A parent-child relationship exists between the child(ren) and the PBS employee.
2. The child(ren) is (are) unmarried and meet(s) the age eligibility requirements for the coverage that we are applying for.
3. We assume full responsibility and control, including any and all debts incurred by the child(ren).
4. The Domestic Partner is the biological parent of the child or, has a court-appointed legal relationship with the child(ren) (i.e., adoption, guardianship, foster child).

Domestic Partnership Special Considerations

Tax Considerations

If a Domestic Partner and his or her dependent children are enrolled, you should be aware of the tax implications of this election. The tax consequences of a Domestic Partnership are the responsibility of the employee, not PBS. Please consult with your tax advisor regarding your specific tax situation.

The Internal Revenue Code considers the fair market value of your Partner's coverage to be imputed income. This is based on the fair market value of the coverage, which is not the same as the amount you contribute towards the cost. PBS will be required to treat the value of the benefits provided to the employee's Domestic Partner (and the Domestic Partner's eligible child(ren), if any) as imputed income to the employee. PBS will treat this dollar amount (your imputed income) as actual income in calculating federal and FICA taxes as well as most state, local, and any other applicable payroll taxes. The imputed income amount will be shown on your pay statements throughout the year and will be reported on your

W-2 Form at the end of each calendar year. Therefore, you can expect to have an increased tax liability without an increase in cash compensation. Imputed income may or may not be included when calculating other benefits, such as your 401(k) eligible earnings. Please refer to your retirement Plan Document(s).

Note: Contributions deducted for the Domestic Partner's (or for the Domestic Partner's Child(ren) if applicable) coverage will be taken on a pretax basis; however, they will be reflected in the imputed income amount.

Health Flexible Spending Accounts/Health Savings Accounts

IMPORTANT: Domestic Partner and Domestic Partner Child(ren) expenses are not eligible for reimbursement under either the Health Flexible Spending Account or the Dependent Care Assistance Spending Account. It is recommended that you seek tax advice from your personal CPA before reimbursing expenses from your HSA related to expenses incurred by or on behalf of a domestic partner and/or domestic partner's children.

COBRA

Please be advised these regulations do not apply to Domestic Partners or Domestic Partner Children. The Federal Government and Medicare do not recognize Domestic Partners. However, to the extent you, the employee, are eligible for COBRA and you elect the same coverage level as you held prior to your COBRA qualifying event (to include your Domestic Partner and Domestic Partner Child(ren)), the Domestic Partner and Domestic Partner Child(ren), if applicable will be covered, provided you remain eligible and retain your COBRA coverage at the same coverage level. Domestic Partners and Domestic Partner Child(ren) are not individually eligible for, or entitled to, COBRA coverage.

I have read the Domestic Partnership Declaration. I understand the Internal Revenue Service considers the fair market value of the Domestic Partner and Domestic Partner Child(ren)'s coverage to be imputed income, and such income will be imputed each pay cycle.

I further declare, under penalty of perjury, the foregoing information is true and correct and understand that providing fraudulent information to secure insurance coverage may subject us to criminal and/or civil penalties and may result in the rescission of coverage resulting in our requirement to reimburse PBS or its insurance carriers for any and all claims paid based on statements provided herein which are untrue or in error, including that the Domestic Partner named above does not, in fact, qualify as a Domestic Partner as defined herein. If a civil action is required to recover any losses, we jointly and severally, agree to reimburse PBS or its insurance carriers for reasonable attorneys' fees.

Employee Signature _____

Domestic Partner Signature _____

Date ____/____/_____

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☐ Some employees. Eligible employees are:

- With respect to dependents:

☐ We do offer coverage. Eligible dependents are:

☐ We do not offer coverage.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____(mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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

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

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

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3. Employer name	4. Employer Identification Number (EIN)	
5. Employer address	6. Employer phone number	
7. City	8. State	9. ZIP code
10. Who can we contact at this job?		
11. Phone number (if different from above)	12. Email address	

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2004
Amended May 3, 2013

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Obtain Access To This Information. Please Review It Carefully.

If you have any questions about this notice, please contact Sarah Williams, at Paychex Business Solutions, Inc., 970 Lake Carillon Drive, Suite 400, St. Petersburg, Florida 33716-1129. Telephone: **1-727-556-2812**.

WHO WILL FOLLOW THIS NOTICE

This notice describes the medical information practices with respect to the Paychex Business Solutions Health Flex Spending Account (FSA) Plan, and the practices of any third party that assists in the administration of claims for the FSA Plan.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create records of the health care claims reimbursed under the FSA Plan for plan administration purposes. This notice applies to all of the medical records we maintain. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information for the FSA Plan. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment

The plan does not provide actual medical services, and will not disclose medical information to other individuals without prior consent.

For Payment

We may use and disclose medical information about you to determine eligibility for plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the FSA Plan, or to coordinate plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary

or to determine whether the FSA Plan will cover the treatment. We may also share medical information with a utilization review or precertification service provider. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Plan Operations

We may use and disclose medical information about you for other plan operations. These uses and disclosures are necessary to run the FSA Plan. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; premium rating and other activities relating to plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general plan administrative activities. Please note the following:

- Any uses and disclosures outside of those outlined in the Notice of Privacy Practices will require the individual's authorization.

- You will be notified in the event that a breach has occurred of his/her unsecured personal health information.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required By Law

We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

To Avert a Serious Threat to Health or Safety

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering the Plan, we may disclose to certain employees of Paychex Business Solutions, Inc. protected health information. However, those employees will only use or disclose that information as necessary to perform plan administrative functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

SPECIAL SITUATIONS

Military and Veterans

If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors

We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy medical information that may be used to make decisions about your plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the contact person set forth on the first page. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the contact person set forth on the first page. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations.

To request this list or accounting of disclosures, you must submit your request in writing to the contact person set forth on the first page. Your request must state a time period, which may not be longer than six years and may not include dates before April 2004. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request.

To request restrictions, you must make your request in writing to the contact person set forth on the first page. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the contact person set forth on the first page. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact the contact person set forth on the first page.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Paychex Business Solutions FSA Plan or the Secretary of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the contact person set forth on the first page. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Newborns' and Mothers' Health Protection Act of 1996

Under Federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn child to less than:

- 48 hours following a vaginal delivery, or
- less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, under Federal law, plans and issuers may not:

- require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours), or
- set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Please contact the PEO Health and Benefits Service Center at 800-741-6277 if you have additional questions.

Woman's Health and Cancer Rights Act Annual Notice

Under this Federal law, group health plans that provide medical and surgical benefits for mastectomies must provide coverage in connection with the mastectomy, in the manner determined by the attending physician and the patient for:

- 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 at all stages of mastectomy, including lymphedema.

Group health plans and health insurers may not deny eligibility to enroll, renew or continue group health plan coverage to avoid providing coverage for breast reconstruction or mastectomy complications. Further, the law prohibits:

- Penalizing or otherwise reducing or limiting the reimbursement of an attending physician for the required care;
- Providing any incentive (monetary or otherwise) to induce the attending physician to provide care that would be inconsistent with the law.

The above-described coverage required by the law may only be subject to the annual deductibles, copayment, and coinsurance provisions that apply to similar benefits.

Please contact the PEO Health and Benefits Service Center at 800-741-6277 if you have additional questions.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA-Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA-Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS-Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY-Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA-Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE-Medicaid

Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711

Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS-Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA-Medicaid

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI-Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA-Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA-Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA-Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE-Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY-Medicaid and CHIP	SOUTH DAKOTA-Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK-Medicaid	**TEXAS-Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA-Medicaid	**VERMONT-Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA-Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON-Medicaid	**WASHINGTON-Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND-Medicaid and CHIP	**WISCONSIN-Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA-Medicaid	**WYOMING-Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)