2020 COBRA BENEFITS GUIDE

GENESYS™

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COBRA Continuation Coverage

As a COBRA participant, you have the choice to elect to keep your current benefit offerings. You may also choose to remove coverage that you have previously elected. You may not elect new or different coverage from your previous elections.

The following benefits may be continued through COBRA.

- **Medical with Pharmacy Plans**
- **Dental Plans**
- **Vision Plans**
- **Health Care Flexible Spending Account**
- **Limited Purpose Flexible Spending Account**

Electing COBRA

You will have 60 days from the date your COBRA package is mailed by Alight to elect to participate in COBRA coverage. Once elected and paid for, your coverage will be reinstated back to your separation date so there will be no lapse in coverage.

If you would like to continue coverage, you are required to enroll in COBRA. If you do not elect COBRA coverage within the 60-day election period, you and your dependent(s) will not be covered. To make your COBRA election, complete and mail your COBRA Election Form directly to Alight before the election deadline. The election deadline will be clearly marked on your Election Notice.

You can also elect COBRA online, as well as make COBRA payments online. Online access to benefits and your COBRA package is available on the Alight website once your COBRA package has been generated. If you want to elect COBRA online, you can complete your enrollment on the Alight website at genesys.benefitsnow.com. You will need to provide your name, date of birth, valid personal email address, and Social Security number or your designated Alight account number to register for an Alight user name. The information you provide in connection with your online enrollment is kept confidential in accordance with Alight's privacy policy, which you can find at genesys.benefitsnow.com.

Eligibility

To be eligible for the benefits in this guide, you must be COBRA-eligible and, depending on the qualifying event, there is a maximum coverage period for you and your dependents (see table below). You should also be aware that you will lose your COBRA eligibility if you enroll in benefits offered by your spouse/domestic partner's employer.

Eligible dependents include your:

- **Spouse or domestic partner; and**
- **Children up to age 26, including those of your domestic partner.**

The cost of medical, dental and vision coverage is based on the following levels:

- **You Only**
- **You + Spouse or Domestic Partner**
- **You + Child(ren)**
- **You + Family**

Qualifying Events

The benefits you select will be effective through the end of 2020 and can only be changed if you experience a qualifying change in employment or family status.

Examples of a qualified change in employment or family status include:

- **Marriage, legal separation, divorce or termination of a domestic partnership;**
- **Birth, legal adoption of a child or placement of a child with you for legal adoption;**
- **Death of your spouse, domestic partner or dependent child;**
- **Change in residence (only if your current coverage isn't available in the new location or if you are offered a plan that you were not previously offered);**
- **Change in employee work schedule resulting in gain of employee benefit coverage;**

If you experience a qualifying event and wish to make changes to your benefits, you have 31 days to make any updates. IMPORTANT: If you have a baby, please note that your newborn is not automatically enrolled in your benefits, so please be sure to update your coverage.

Qualifying Event	Qualified Beneficiaries	Maximum Period Of Continuation Coverage
Termination or reduction in hours of employment	Employee Spouse Dependent Child	18 months
Employee enrollment in Medicare	Spouse Dependent Child	36 months
Divorce or legal separation	Spouse Dependent Child	36 months
Death of employee	Spouse Dependent Child	36 months
Loss of "dependent child" status under the plan	Dependent Child	36 months

Medical Plans

PLAN NAME	HDHP 1		HDHP 2		HDHP 3	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible Individual Family	$2,000 $2,800	$2,000 $4,000	$2,800 $4,000	$2,800 $4,000	$1,500 $2,800	$3,000 $6,000
Family Deductible Type	Aggregate		Embedded		Aggregate	
Coinsurance (Applies after your annual deductible is met)	You pay 20%	You pay 40%	You pay 0%	You pay 30%	You pay 10%	You pay 30%
Annual Out-of-Pocket Maximum Individual Family	$4,000 $6,550	$4,000 $8,000	$2,800 $4,000	$4,000 $8,000	$3,000 $6,000	$6,000 $12,000
Preventive Care	You pay 0% Deductible waived	Not covered	You pay 0% Deductible waived	Not covered	You pay 0% Deductible waived	Not covered
Office Visit Physician Specialist	You pay 20% after deductible	You pay 40% after deductible	You pay 0% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible
ER (true emergency)	You pay 20% after deductible		You pay 0% after deductible		You pay 10% after deductible	
Pharmacy (OptumRx) **Tier 1** (Generic) **Tier 2** (Brand-Preferred) **Tier 3** (Brand Non-Preferred)	You pay 20% after deductible	You pay 20% after deductible plus any network cost difference	You pay 0% after deductible	You pay 0% after deductible plus any network cost difference	You pay 10% after deductible	You pay 10% after deductible plus any network cost difference

PLAN NAME	PPO	
	In-Network	Out-of-Network
Annual Deductible Individual Family	None	None
Copayments /Coinsurance Primary Care office visit Specialist office visit	$20 copay $20 copay	You pay 50% You pay 50%
Preventive Care **(services required by heath care reform)**	You pay 0%	Not covered
Office Visit Physician Specialist	$20 copay $20 copay	You pay 50% You pay 50%
Coinsurance (most services)	You pay 30%	You pay 50%
ER (true emergency)	You pay 30%	
Annual Out-of-Pocket Maximum Individual Family	$5,000 $10,000*	$10,000 $20,000
Pharmacy (OptumRx) **Tier 1** (Generic) **Tier 2** (Brand-Preferred) **Tier 3** (Brand Non-Preferred)	$8 copay $30 copay $50 copay	$8 copay plus any network cost difference $30 copay plus any network cost difference $50 copay plus any network cost difference
Mail Order **Tier 1** **Tier 2** **Tier 3**	$20 copay $75 copay $125 copay	Not Covered

*Embedded at $5,000.

PLAN NAME	Kaiser HMO Plan
	Available in CA only
	In-Network Only
Annual Deductible Individual Family	None
Out-of-Pocket Max* Individual Family	 $1,500 $3,000
Copayments /Coinsurance Primary Care Physician Specialist	 $15 copay $15 copay
Preventive Care	You pay 0%
ER	$100 copay**
Pharmacy Tier 1 (Generic includes diabetic supplies) Tier 2 (Brand Formulary) Tier 3 (Brand Non-Formulary) Specialty	 $15 copay for up to 100 days supply $30 copay for up to 100 days supply N/A $30 copay for up to 30 days supply

* Out-of-pocket maximum includes copays except for prescription drug copays.
** $100 copay waived if admitted.

MONTHLY COBRA PARTICIPANT PREMIUMS FOR MEDICAL PLANS

COBRA Rates	HDHP 1	HDHP 2	HDHP 3	PPO	Kaiser HMO
You Only	$336.92	$627.64	$598.12	$691.21	$660.12
You + Child(ren)	$539.07	$1,004.22	$956.99	$1,105.94	$1,320.25
You + Spouse or Domestic Partner	$875.99	$1,631.85	$1,555.10	$1,797.15	$1,452.28
You + Family	$1,078.15	$2,008.44	$1,913.97	$2,211.88	$1,980.37

Dental Insurance

Your dental coverage is provided by Anthem. While you are free to visit any dentist you'd like, you may save money by visiting a provider that is within the Anthem network.

	Dental Standard		Dental Enhanced	
	In-Network	Out-Of-Network*	In-Network	Out-Of-Network*
Annual Deductible	$50 individual / $100 family		None	
Annual Benefit Maximum	$1,500 per person		$2,250 per person	
Orthodontic Lifetime Benefit Maximum	$1,500 per person		$1,750 per person	
Diagnostic and Preventive Services Periodic Oral Exam Cleanings (Prophylaxis): 2 per 12 months Bitewing X-rays: 1 per calendar year Intraoral X-rays	100% (deductible waived)		100%	
Basic Restorative Services Fillings	Anthem pays 80%		Anthem pays 80%	
Other Basic and Major Services Crowns Prosthodontics (dentures, bridges, etc.) Prosthetic Repairs Endodontics (root canal) Periodontics (scaling, root planing)	Anthem pays 50%		Anthem pays 80%	
Oral Surgery	Anthem pays 80%		Anthem pays 80%	
Orthodontia (Adults and Children)	Anthem pays 50%		Anthem pays 50%	

* Out-of-network coverage is based on the maximum allowed amount determined by Anthem. You may pay more out of pocket for providers that are not in the Anthem network.

Monthly COBRA Participant Rates for Dental Plans

	Dental Standard	Dental Enhanced
EE Only	$52.35	$59.88
EE+CH	$103.47	$117.32
EE+SP / DP	$109.38	$124.00
Family	$176.03	$198.84

Vision Insurance

Your vision coverage is provided by VSP. Be sure and visit an optometrist that is within the VSP network. To locate an in-network provider, visit the VSP website and click “Find a Doctor.”

	VSP Core Plan	VSP Buy-Up Plan	Frequency
Vision Exam	$10 copay	$10 copay	Every calendar year
Prescription Glasses	$25 copay	$10 copay	Every calendar year
Frames Benefit	$150 allowance per person ($170 for featured frames) + 20% discount over allowance or $80 allowance at Costco	$200 allowance per person ($220 for featured frames) + 20% discount over allowance or $110 allowance at Costco	
Lenses Benefit	Included in Prescription Glasses Single vision, lined bifocal, and line trifocal lenses Polycarbonate lenses for dependent children		
Lens Enhancements	$0 - $160 copay, depending on lens type (standard progressive, premium progressive, custom progressive)		
Contact Lenses (in lieu of glasses)	Up to $60 copay (exam and fitting) $130 allowance for contact lenses	Up to $60 copay (exam and fitting) $200 allowance for contact lenses	Every calendar year

Visit www.mygenesysbenefits.com for plan details, including out-of-network benefits.

Monthly COBRA Participant Premiums for Vision Plans

	Core Plan	Buy-Up Plan
EE Only	$9.80	$18.16
EE+CH	$15.93	$29.51
EE+SP /DP	$15.61	$28.89
Family	$25.67	$47.55

Flexible Spending Accounts (For PPO or HMO Participants Only)

If you have a Health Care Flexible Spending Account or Limited Purpose Flexible Spending Account through Genesys, you will be eligible to keep that account open until the end of 2020 by electing to continue under COBRA. Your continued contributions will be made on an after-tax basis.

If you do not choose to continue under COBRA, you are not eligible to be reimbursed for qualified medical expenses incurred after the date you lose coverage.

Tools and Resources

Genesys Care Coordinators (For HDHP and PPO Participants Only)

Offering a personalized, guided health care experience for participants of the HDHP and PPO medical plans.

THE MOST COMMON ISSUES GENESYS CARE COORDINATORS SOLVE FOR YOU:

- **Answering claims, billing and benefits questions**
- **Filing claims appeals**
- **Finding affordable, in-network providers**
- **Assistance with prescriptions**
- **Managing a health condition**
- **Receiving ID cards**
- **Saving money on out-of-pocket costs**
- **Understanding how to get the most out of your benefits**
- **Learning simple steps to improving your health**
- **Helping with medical needs – anything that can make the health care process easier for you**

For care as unique as your health, contact your Genesys **Care Coordinators**
1-877-498-3041 8:30 A.M. - 10:00 P.M., EST
You can access the website at:
genesyshealthplan.com

Tools and Resources

Healthcare Bluebook (For HDHP and PPO Participants Only)

Healthcare Bluebook is an online solution and mobile resource that makes it simple to find high-quality, cost-effective facilities and physicians.

Proper utilization of this solution will drive down your costs and also help you maximize your Health Savings Account (HSA) dollars.

Healthcare Bluebook helps you find the fair price and best quality of care for your procedure by ranking local providers and hospitals. This resource will color code providers as **GREEN** / **YELLOW** / **RED** on cost and facility quality so it is easy for you to evaluate your options. While you can access this solution on your own, you may also reach out to your Genesys Care Coordinators who also have access to help you find the best price and highest facility quality care for all of your needs. Beginning January 1, 2020, contact your Genesys Care Coordinators at 1-877- 498-3041, or visit genesyshealthplan.com for your benefits needs in 2020.

Go Green to Get Green

Genesys would like to reward you when you shop When you schedule a procedure at a "Green-Green" facility (top rated in cost and quality metrics), Healthcare Bluebook will send a check to your address, once the details of your procedure are confirmed.

Here's How it Works:

1. SEARCH

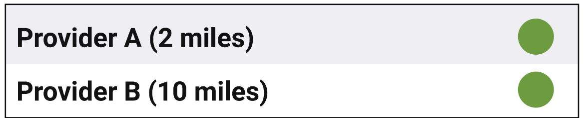
Procedures eligible for a reward will be identified by the Go Green to Get Green Message below.

Go Green to Get Green

You can earn a reward for selecting a Fair Price Provider for your procedure

2. CHOOSE

Choose a Fair Price Provider from the list. They're marked with a green circle, indicating that you'll pay the Fair Price, or less!



3. REWARD

Healthcare Bluebook will automatically send your reward in the mail once it's confirmed that you've visited a Fair Price Provider! No forms to fill out, no receipts to turn in. It's simple!

Eligible Procedures

Shoulder Arthroscopy
Colonoscopy
Knee Arthroscopy
Upper Gastrointestinal Endoscopy

Removal of Adenoids
Sleep Study
Tonsillectomy
Cataract Surgery
Cholecystectomy (Laparoscopic)
Ear Tube Placement
Heart Perfusion Imaging
Lithotripsy

Most CTs
Most MRIs
Transthoracic Echocardiogram (TTE)
Transthoracic Echocardiogram (TTE) (with Doppler)

Please Note: The HCBB Rewards are considered a taxable income.

Tools and Resources

Telehealth (For HDHP and PPO Participants Only)

Genesys partners with OC24health to make visiting a physician as easy as possible. By providing 24/7/365 access to care anytime, anywhere, OC24health allows you to access quality medical services at your convenience. While premiums, health care costs and out-of-pocket expenses are rising at twice the rate of inflation, for a $45 consult fee, OC24health offers care at a fraction of the cost of urgent care and ER visits. Note: if you are on the PPO plan, a standard physician's copay will apply.

Set up your account via the OC24 mobile app. Simply download the OC24health app and follow the four steps below.

1. **Verify Access –** Provide a few pieces of information to verify your access and set up your account.
2. **Create Account –** Enter a username and password and read the terms and conditions to register.
3. **Security Questions –** Select your account security questions to be asked upon password reset.
4. **Patient Details –** To request a visit, you will need to enter required medical information.

Talk to a doctor anytime for $45 per visit.

OC24health.com
1-855-617-2116

Carrier and Vendor Contact Information

For any of your benefit questions, contact your Genesys Care Coordinators first!

1-877-498-3041
8:30 A.M. - 10:00 P.M., EST
You can access the website at: genesyshealthplan.com

Carrier / Vendor	Website	Contact Information
Medical (UHC Choice Plus® Network) Quantum Health	genesyshealthplan.com	1-877-498-3041
Prescription Drug OptumRx	genesyshealthplan.com	1-877-498-3041
Medical (Kaiser Network) Kaiser Permanente	kp.org	1-800-464-4000
Dental Anthem	www.anthem.com/ca	1-877-567-1804
Vision VSP	www.vsp.com	1-800-877-7195
Health Savings Accounts (HSA) Flexible Spending Accounts (FSA) WageWorks	www.wageworks.com	1-877-924-3967
Telehealth OC24health	www.OC24health.com	1-855-617-2116
Healthcare Bluebook	genesyshealthplan.com	1-877-498-3041

Legal Notices

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under the Genesys group health plan. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.
The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- **Your hours of employment are reduced; or**
- **Your employment ends for any reason other than your gross misconduct.**

If you are the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- **Your spouse dies;**
- **Your spouse's hours of employment are reduced;**
- **Your spouse's employment ends for any reason other than his or her gross misconduct;**
- **Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or**
- **You become divorced or legally separated from your spouse.**

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- **The parent-employee dies;**
- **The parent-employee's hours of employment are reduced;**
- **The parent-employee's employment ends for any reason other than his or her gross misconduct;**
- **The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);**
- **The parents become divorced or legally separated; or**
- **The child stops being eligible for coverage under the plan as a "dependent child".**

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- **The end of employment or reduction of hours of employment;**
- **Death of the employee;**
- **Commencement of a proceeding in bankruptcy with respect to the employer; or**
- **The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).**

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify

the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum for 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must provide this notice to: benefits.team@genesys.com.

Second Qualifying Event Extension Of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

If You Have Questions

Questions concerning your medical plan, or your COBRA continuation coverage rights should be addressed through the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act (PPACA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at: www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

benefits.team@genesys.com
605-466-1282
2001 Junipero Serra Blvd,
Daly City, CA 94014

ERISA RIGHTS STATEMENT

As a participant in the Consumer-Driven Health Plan (CDHP) you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan employees shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Securities Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan employees ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan employees and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $114 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA Notice of 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 towards your or your dependents' other coverage). However, you must request enrollment within 31 days or any longer period that applies under the plan after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 31 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact benefits.team@genesys.com.

IMPORTANT NOTICE FROM GENESYS ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Genesys and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Genesys has determined that the prescription drug coverage offered by Genesys is, on average for all plan employees, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Genesys coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Genesys coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Genesys and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact benefits.team@genesys.com NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Genesys changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- **Visit www.medicare.gov.**
- **Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.**
- **Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.**

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Availability of HIPAA Notice of Privacy Practices

In accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the purpose of this communication is to notify you of our privacy practices that limit who in the organization may use, discuss, review, and transmit the Protected Health Information ("PHI") of our employees and their families.

The Notice of Privacy Practices explains how PHI may be used, and what rights you have regarding this information. Please take time to read the notice. It provides details about how we may use and disclose your information. The Notice of Privacy Practices can be found by contacting:

benefits.team@genesys.com
605-466-1282
2001 Junipero Serra Blvd,
Daly City, CA 94014

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, 2019. Contact your State for more information on eligibility:

ALABAMA - Medicaid
Website: www.myalhipp.com
Phone: 855-692-5447

ALASKA - Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS - Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
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

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 678-564-1162 ext. 2131

INDIANA – Medicaid
Website: http://www.in.gov/fssa/hip/
Phone: 877-438-4479
All other Medicaid: http://www.indianamedicaid.com
Phone: 800-403-0864

IOWA – Medicaid
Website: http://dhs.iowa.gov/hawki
Phone: 800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 785-296-3512

KENTUCKY – Medicaid
Website: https://chfs.ky.gov
Phone: 800-635-2570
LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 800-442-6003. TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 800-862-4840

MINNESOTA - Medicaid
http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/employees/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800-694-3084

NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218 or 800-852-3345 ext. 52187

NEW JERSEY – Medicaid CHIP
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

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 800-541-2831

NORTH CAROLINA - Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 844-854-4825

OKLAHOMA - Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx AND
http://www.oregonhealthcare.gov/index-es.html
Phone: 800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurance premiumpaymenthippprogram/index.htm
Phone: 800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

SOUTH CAROLINA - Medicaid
Website: http://www.scdhhs.gov
Phone: 888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 888-828-0059

TEXAS – Medicaid
Website: https://gethipptexas.com/
Phone: 800-440-0493

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

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800-250-8427

VIRGINIA - Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: https://hca.wa.gov/
Phone: 800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, you can contact either:

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

Department of Health andHuman Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
887-267-2323,
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.

Women's Health and Cancer Rights Act Enrollment Notice
Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Contact your plan administrator for more information. If you would like more information on WHCRA benefits, contact your Plan Administrator at benefits.team@genesys.com.

Newborns' and Mothers' Health Protection

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the motheror newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PPACA: Patient Protections

When applicable, it is important that individuals enrolled in health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to employees of these rights when applicable. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.

Guide Disclaimer

This guide describes the benefit plans offered by Genesys. This guide is not intended to be a Summary Plan Description. If there are any inconsistencies between this guide and the terms of the benefit plan documents, the actual plan documents will govern in all cases. Genesys reserves the right to change, amend or end any benefit plans at any time for any reason, subject to certain restrictions set forth in the plan documents.

As a plan participant, you're entitled to a description of your rights and obligations under the Genesys group health plan. We have copies of the Summary Plan Descriptions (SPD), Summary Annual Reports (SAR), Summary of Benefits Coverage (SBC) and Summary of Material Modifications (SMM) on our new website genesyshealthplan.com. If you are enrolled in the Kaiser plan, more information can be found online at mygenesysbenefits.com. In order to ensure that you fully understand the benefits available to you, and your obligations as a plan participant, it is important that you familiarize yourself with the information contained within the plan documents. If any differences exist between this guide and the plan document, the plan document will govern.