Genesys 2021 Benefits Guide

GENESYS™

Table of Contents

What's Changing in 2021

Genesys strives to provide employees with a comprehensive and competitive benefits program. For the 2021 plan year, we are excited to announce that we've kept most benefits offerings the same, and are continuing to enhance our benefits program. Please review this guide to learn more.

If you elect one of the HDHPs or the PPO plan, you will have access to the UnitedHealthcare Choice Plus® Network, administered by UMR. UMR is a third party administrator who will process claims and pay your providers. You will also continue to have access to the new resources and tools introduced last year for HDHP and PPO participants.

The Kaiser HMO plan is not changing. Employees who enroll in coverage with Kaiser will continue to utilize the same available resources offered today.

Changes for 2021:

- **HDHP3 plan no longer offered in 2021**
- **Removal of salary banded rates for medical premiums**
- **NEW! Accident Insurance available through Aflac**
- **Updated Aflac Critical Illness and Hospital Indemnity Plans**

IMPORTANT:

All employees who enroll in the either a HDHP or the PPO plan will receive a new Medical ID card, even if you do not update your elections. Please be on the lookout to receive this card in the mail by the end of this year.

Eligibility

You're eligible for the benefits described in this guide if you are an active U.S. employee working a minimum of 20 hours per week.

You can also cover your dependents under your medical, dental and vision coverage. Eligible dependents include your:

- **Spouse or domestic partner**
- **Child(ren) up to age 26, including those of your domestic partner.**
- **Mentally or physically disabled children over age 26 (if they depend on you for support). You may be required to provide appropriate documentation of their disability.**

Your cost of coverage for medical, dental and vision insurance is based on the coverage level you select. Details on the employee premium amounts are on page 10.

Qualifying Life Events

The benefits you select will be effective through the end of 2021 and can only be changed if you experience a qualifying life event in employment or family status (this does not apply to the contributions you elect toward your 401(k) or Health Savings Account).

Examples of a qualifying life event 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);**
- **Return from unpaid Leave of Absence (LOA) resulting in gain of eligibility;**
- **Return from paid Family and Medical Leave Act (FMLA) leave;**
- **Change in employee work schedule resulting in gain of employee benefit coverage;**
- **Termination of employment resulting in eligibility for COBRA coverage; or**
- **Loss of other coverage (e.g., through spouse or domestic partner due to termination of employment, change in status, death of spouse or domestic partner).**

If you experience a qualifying life event and wish to make changes to your benefits, you have 31 days to make any updates using the **BenefitsNow** website, and to provide supporting documentation to the Benefits team (benefits.team@genesys.com). 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.

How to Enroll

Before you get started, make sure you have the names, birth dates and Social Security numbers of any eligible family members you want to enroll, and any individuals you want to list as beneficiaries. It's important that you verify that all of your personal information on file is correct.

You will need to complete your enrollment in the **BenefitsNow** system. The benefits you choose will be effective through the end of 2021. You cannot make changes to your coverage during 2021 unless you have a qualifying life event change of employment or family status.

To make your elections, you can use the **"Take Me Through Each Benefit"** button, or you can select individual benefits by using the View/Change button. When you're done selecting your benefits, click **"Complete Enrollment."**

Once you've completed your enrollment, you will land on the Confirmation page where you can print a paper copy or save a PDF of the screen for your records.

Medical Plans

Genesys offers the following medical coverage options to eligible U.S. employees:

- **High Deductible Health Plan (HDHP) 1**
- **High Deductible Health Plan (HDHP) 2**
- **Preferred Provider Organization (PPO) Plan**
- **Kaiser HMO Plan**

In addition to these three medical plans, employees in California will continue to have the Kaiser HMO as a fourth option.

All medical options include prescription drug benefits. You do not need to make a separate prescription drug benefit election. A brief summary of each is provided below:

What is an HDHP?

Two of your medical plan options are High Deductible Health Plans, or HDHPs. An HDHP provides you with more control over how you spend your health care dollars, as well as the flexibility to see any provider that you'd like. Please note that you should check to ensure your provider is considered in-network for savings (as compared to out-of-network providers). You also may be eligible to establish and contribute to a Health Savings Account (HSA), which allows you to spend pre-tax dollars on qualified health care expenses. Note: if you are enrolled in any other non-HDHP health plan, including Medicare, you are not eligible to contribute pre-tax dollars to an HSA.

What is an HSA?

A Health Savings Account, or HSA, is a tax-free savings account available to employees enrolled in an HDHP. Genesys contributes to your HSA, and you can also elect to contribute additional money up to IRS limits. Your HSA funds can be used to pay for current or future eligible health care expenses with tax-free dollars. Additionally, your HSA balance is portable if you leave Genesys — it's a great way to save for health care, dental and vision expenses now and into retirement. Think of it as your health care 401(k).

What is a PPO?

One of your medical plan options is a traditional Preferred Provider Organization, or PPO. A PPO grants employees access to the same network as the HDHP plans; however, you'll pay a copay for many services, and for this benefit, you'll pay more out of your paycheck for the PPO plan. The Genesys PPO plan does not have a deductible.

What is an HMO?

If you currently work in California, you're eligible to enroll in the Kaiser Health Maintenence Organization, or HMO plan. Just like with a PPO, you'll also be asked to pay a copay at the time of service for both doctor visits and prescriptions.

Medical Plans

Aggregate vs. Embedded Deductible: What's the difference?

If you're considering enrolling yourself and your covered dependents in one of the HDHP medical plans, it's important that you understand how the family deductible works under each of the options. As shown in the plan highlight chart on page 8, HDHP Plan 1 has an "aggregate" family deductible, while HDHP Plan 2 has an "embedded" plan deductible. Here's what those terms mean:

Aggregate Family Deductible:

The full family deductible must be met before the plan begins to pay a portion of expenses for any covered family members.

Embedded Plan Deductible:

If one covered family member has enough expenses in a calendar year to meet the individual deductible, the plan will begin paying a portion of **that family member's expenses** for the remainder of the year. You do not have to meet the full family deductible before the plan begins to pay.

What is a Deductible?

The amount you need to pay each year before the plan starts paying benefits. For example, if your deductible is $2,000, your plan won't pay anything until you've paid $2,000 for covered healthcare services, unless copays apply.

What is Coinsurance?

Coinsurance is a term used to describe the cost sharing which occurs between you and Genesys. After your deductible (if applicable) has been met, the plan begins to cover a percentage of your claims. For example, an employee on the HDHP 1 will pay 20% of claims costs after meeting his or her deductible of $2,000. This continues until the out-of-pocket maximum is met, at which point the plan covers 100% of all claims costs.

What is a Copay?

This is a fixed amount paid to an in-network provider for a service if you are enrolled in the PPO Plan. The plan pays any amount in excess of the copay.

What is Out-of-Pocket Maximum?

The deductible and your share of coinsurance and copays are collectively referred to as "Out-of-Pocket" expenses. For example, if your Out-of-Pocket Maximum is $4,000, once you have paid this amount, the plan pays 100% of all covered expenses for the remainder of the plan year.

Medical Plan Options

Provider access available through the UnitedHealthcare Choice Plus® Network, administered by UMR.

PLAN NAME	HDHP 1		HDHP 2		PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual HSA Employer Contribution*						
Employee Only	$750*		$750*		N/A	N/A
Family	$1,500*		$1,500*			
Annual Deductible						
Employee Only	$2,000	$2,000	$2,800	$2,800	None	None
Family	$2,800	$4,000	$4,000	$4,000		
Coinsurance (most services) After Deductible	You pay 20%	You pay 40%	You pay 0%	You pay 30%	You pay 30%	You pay 50%
Family Deductible Type	Aggregate		Embedded		N/A	N/A
Annual Out-of-Pocket Maximum**						
Employee Only	$4,000	$4,000	$2,800	$4,000	$5,000	$10,000
Family	$6,550	$8,000	$4,000	$8,000	$10,000	$20,000
Preventive Care	You pay 0% Deductible waived	Not covered	You pay 0% Deductible waived	Not covered	You pay 0%	Not covered
Office Visit						
Primary Care Physician	You pay 20% after deductible	You pay 40% after deductible	You pay 0% after deductible	You pay 30% after deductible	$20 copay	You pay 50%
Specialist					$20 copay	You pay 50%
Urgent Care	You pay 20% after deductible	You pay 40% after deductible	You pay 0% after deductible	You pay 30% after deductible	$50 copay	You pay 50%
ER (true emergency)	You pay 20% after deductible		You pay 0% after deductible		You pay 30%	
Pharmacy						
Tier 1 (Generic)	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	$8 copay	$8 copay plus any network cost difference
Tier 2 (Brand-Preferred)					$30 copay	$30 copay plus any network cost difference
Tier 3 (Brand Non-Preferred)					$50 copay	$50 copay plus any network cost difference
Mail Order						
Tier 1	You pay 20% after deductible	N/A	You pay 0% after deductible	N/A	$20 copay	N/A
Tier 2					$75 copay	
Tier 3					$125 copay	

** One fourth of the annual Genesys contribution is deposited in your HSA account each calendar quarter, on or near the first business day of each quarter. Must be employed and enrolled in a High Deductible Health Plan by the 1st day of each calendar quarter (January 1, April 1, July 1 and October 1) in which the funding occurs in order to receive the employer contribution for that quarter.*

***All plans have an embedded Out-of-Pocket Maximum.*

Medical Plan Options

Provider access available through the Kaiser Permanente Network. Available only to employees in California.

PLAN NAME	Kaiser HMO Plan
	In-Network Only
Annual Deductible Employee Only Family	None
Out-of-Pocket Max* Employee Only Family	 $1,500 $3,000
Copayments /Coinsurance Primary Care Physician Specialist	 $15 copay $15 copay
Preventive Care	You pay 0%
Urgent Care physician services	$15 copay
ER	$100 copay**
Pharmacy Tier 1 (Generic includes diabetic supplies) Tier 2 (Brand Formulary) Tier 3 (Brand Non-Formulary) Specialty (Formulary)	 $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.*

Key Features of your Medical Plans

- **Preventive care services are covered at 100% with no deductible with in-network providers. An outline of preventive care services is listed in your Summary of Benefits and Coverage (SBC), found online at mygenesysbenefits.com. For each applicable plan, visit the Resources tab and under Medical Plans, select your applicable plan from the drop down selections.**
- **Remember, out-of-network claims have a separate deductible to meet and services are covered at a much lower percentage.**

Employee Premiums (Per Semi-Monthly Pay Period)

Employee premiums are based on the plan and coverage level you select.

HDHP 1	
EE Only	$18.00
EE+CH	$75.00
EE+SP / DP	$93.00
Family	$136.50

HDHP 2	
EE Only	$23.00
EE+CH	$85.00
EE+SP / DP	$108.00
Family	$149.50

PPO	
EE Only	$98.00
EE+CH	$190.50
EE+SP / DP	$226.50
Family	$319.50

HMO	
EE Only	$31.00
EE+CH	$90.00
EE+SP / DP	$100.50
Family	$139.00

Preventive Care

Your medical benefits provide essential preventive care to keep you and your covered family members healthy. These services are provided at no cost to you and bypass the deductible. Preventive Care refers to a medical service category covered completely by your Genesys benefits when you utilize an in-network provider. Preventive care services are designated by the Affordable Care Act, and include screenings such as annual wellness checkups, preventive mammograms, certain immunizations, and more. For women, certain products are also included on this list such, as breastfeeding supplies, contraceptives, and certain supplements for pregnancy.

How to find an in-network provider:

In order for these services to be covered at 100% by your medical insurance, you must visit an in-network provider. If you need assistance with this process, employees enrolled in one of the HDHP Plans or the PPO Plan can always reach out to your Genesys Care Coordinators by visiting genesyshealthplan.com or by calling 1-877-498-3041.

Kaiser HMO plan participants may find a provider by clicking https://healthy.kaiser-permanente.org/doctors-locations. Be sure to select your region (northern or southern California). Once done, you can search using a map or enter your zip code to view Kaiser doctors and locations in your area.

Genesys Care Coordinators

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

Genesys Care Coordination and health care navigation

If there's a better way for you to experience health care, your Genesys Care Coordinators will find it. Consider them as your dedicated team of nurses, benefits experts and claims specialists who advocate for your care.

Among other things, the Genesys Care Coordinators:

- **Issue/replace ID cards**
- **Answer claims, billing and benefits questions**
- **Help manage chronic conditions**
- **Find in-network providers**
- **Get to know you and your unique health needs**
- **Help reduce unnecessary out-of-pocket costs**
- **Ensure you receive high-quality, safe and cost-effective care**

Tobacco / Nicotine Cessation Program

Are you interested in kicking the habit? Genesys offers complimentary tobacco and nicotine coaching from your Genesys Care Coordinators. To get started, call 1-877-498-3041 or visit genesyshealthplan.com.

Your Genesys **Care Coordinators** are just a call, click or tap away.

1-877-498-3041 Monday - Friday 8:30 A.M. - 10:00 P.M. EST

You can access the website at: **genesyshealthplan.com**

Download the app: MyQHealth - Care Coordinators

Prescription Drug Plan

If you select one of the HDHP plans or the PPO, your prescription drug benefit will be provided through **OptumRx** for 2021 and is included with your Medical Plan election. Contact your Genesys Care Coordinators or go to genesyshealthplan.com to review the preventive drug list.

You may fill your prescriptions at a participating retail pharmacy (for non-specialty medications up to a 31-day supply) or through a mail order program (for qualifying maintenance medications up to a 90-day supply).

Please Note: It is important that you utilize an in-network pharmacy for your prescriptions. Out-of-network prescription claims will be processed at a higher price, and you will be responsible for the cost difference. Visit genesyshealthplan.com or download the Optum Rx mobile app to find an in-network pharmacy near you.

If you elect the Kaiser plan, you can contact Kaiser directly at 1-800-464-4000 or online at kp.org to learn more about the available prescription drug benefit.

Healthcare Bluebook

Healthcare Bluebook (For HDHP and PPO Participants Only)

Healthcare Bluebook is the online solution and mobile resource 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. Contact your Genesys Care Coordinators at 1-877- 498-3041, or visit genesyshealthplan.com, for additional assistance using this tool.

Go Green to Get Green

Genesys would like to reward you when you shop for medical services with Healthcare Bluebook. 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.

$50 Reward

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!

Provider A (2 miles)	●
Provider B (10 miles)	●

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

$100 Reward

Shoulder Arthroscopy
Colonoscopy
Knee Arthroscopy
Upper Gastrointestinal Endoscopy

$50 Reward

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

$25 Reward

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

Health Savings Account (HSA)

An HSA is a tax-free savings account available to eligible employees enrolled in one of the HDHP medical plans. HealthEquity (formerly WageWorks) administers the Health Savings Accounts (HSA) for Genesys.

Key Features of a Health Savings Account:	
Eligible Participants	Employees enrolled in one of the HDHP Medical Plans, who are not enrolled in other non-HDHP coverage (including Medicare or Tricare), and whose expenses cannot be reimbursed under a spouse's FSA
Employer annual HSA contribution, broken down into quarterly increments, deposited on the first business day of each calendar quarter	Employee only: $750* Employee + Child(ren): $1,500* Employee + Spouse: $1,500* Family: $1,500*
2021 Contributions Maximum (per IRS limits)* (This includes contributions made by Genesys plus Employee contributions)	Employee only: $3,600 Employee + Dependent(s): $7,200 Age 55 and Older: Additional $1,000 "catch up" contribution allowed Please remember to factor in contributions made by Genesys into annual limits
Interest	Account earns interest tax-free
Investment Options	Account balances over $1,000 can be invested in mutual funds provided by the bank
Eligible Expenses	Qualified health care expenses (visit www.irs.gov for a complete list).
Withdrawals	HSA funds withdrawn for non-eligible expenses are subject to ordinary income tax plus a 20% penalty. A list of qualified medical, dental and vision expenses can be found in IRS Publication 502 NOTE: At age 65, enrollees can withdraw funds for any reason without penalty, but may be subject to ordinary taxes on the withdrawal
Funding Availability	Only funds contributed to date (your contributions and those from Genesys) are available for reimbursement
Portability	Your account stays with you, regardless of coverage or employer
Unused Funds	Rolls over every year; there's no "use-it-or-lose-it" feature

**One fourth of the annual Genesys contribution is deposited in your HSA account each calendar quarter, on or near the first business day of each quarter. Must be employed and enrolled in a High Deductible Health Plan by the 1st day of each calendar quarter (January 1, April 1, July 1 and October 1) in which the funding occurs in order to receive the employer contribution for that quarter.*

IMPORTANT INFORMATION ABOUT YOUR HSA

- **You are required to elect new HSA contribution amounts each year.**
- **You are only able to use your HSA funds for eligible health care expenses (medical, dental and vision); otherwise, you may incur taxes and penalties.**
- **Consider your health care expenses when electing how much to contribute to your HSA. Your HSA contributions are deducted from your paycheck.**
- **You are able to increase or decrease your HSA paycheck deduction amount at any point during the year. This is accomplished by accessing the BenefitsNow website.**
- **HSA funds can be used to pay for medical expenses of your spouse, tax dependents, and minor children regardless of tax dependent status. Any non-tax dependent, such as adult children covered by your medical plan, should open their own HSA.**

Flexible Spending Accounts (FSAs) Commuter Benefits

The Genesys Flexible Spending Accounts (FSAs) are administered by HealthEquity (formerly WageWorks). FSAs are a great way to save by paying certain eligible expenses on a pretax basis. You do not pay taxes on the money you put into these accounts. FSAs are use-it-or-lose-it! You should plan to spend any remaining funds in your Flexible Spending Accounts before the end of the year.

	Health Care FSA	Limited Purpose FSA	Dependent Care FSA
Eligibility	• Kaiser and PPO Medical Plan Participants, and employees without Genesys medical coverage • Due to IRS regulations, the Health Care FSA is not available to employees contributing to a Health Savings Account (HSA).	For HDHP Medical Plan Participants	For All Genesys Employees
Eligible Expenses	Out-of-pocket medical, prescription drug, dental, and vision care expenses for yourself and your eligible family members— even if you do not cover your family members under a Genesys medical plan.	Dental and Vision care expenses only.	Child and elder care expenses that is required to allow you and your spouse to be gainfully employed.
Use it or Lose it	You will be able to roll over $550 into the next year.	You will be able to roll over $550 into the next year.	Dollars in this account should be exhausted by 12/31/20. There will be no roll over into 2021.
Claims	You will receive a debit card from HealthEquity for these services.		
Election Required	You may contribute up to $2,750 pre-tax per calendar year.	You may contribute up to $2,750 pre-tax per calendar year.	You may set aside up to $5,000 pre-tax to pay for eligible dependent care expenses ($2,500 if you are married filing taxes separately).
Important Features	• Due to IRS regulations the Health Care FSA is not available to employees contributing to a Health Savings Account (HSA). • If you're currently enrolled in a Health Care FSA plan and enroll in an HDHP medical plan, your funds will automatically convert into a Limited Purpose. You will be able to roll over $550 into the next year.	A LPFSA is a great choice for employees who will have high dental or visions expenses, as it enables you to leave your HSA contributions untouched.	The child or elder care provider must declare the income on his/her tax return for dependent care services provided. Nursing home care and residential summer camps are excluded.

Commuter Benefits (For All U.S. Genesys Employees)

If you pay for monthly parking or commute to work via public transit, you can utilize a commuter FSA to contribute pre-tax funds towards these expenses. Currently, the IRS allows employees to contribute up to **$270** each month for each expense type (parking or transit).

You can enroll in the Health Care, Limited Purpose, and/or Dependent Care FSAs above during the Open Enrollment period, as a new hire, or if you experience a Qualified Life Event (described on page 4). You may enroll in the plan online at https://genesys.benefitsnow.com. Enrollment for transit must occur by the 10th of the month prior to the month you plan to use your pass. For example, passes to be used in the month of February must be purchased online by January 10th. Transit expenses cannot be reimbursed. All reimbursement claims for parking must be prepaid and submitted to HealthEquity within 180 days of the date in which the expense was incurred.

Dental Insurance

Your dental coverage is provided by Anthem. Genesys offers two different plans to ensure you and your family receive the level of coverage that is right for you. 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.*

Dental Premiums (Per Semi-Monthly Pay Period)

	Dental Standard	Dental Enhanced
EE Only	$4.00	$8.00
EE+CH	$11.00	$18.50
EE+SP / DP	$11.50	$19.50
Family	$18.50	$31.00

Vision Insurance

Your vision coverage is provided by VSP. Choose from one of two plans to suit the needs of you and your family. For the optimal level of benefits, be sure to 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.

Vision Premiums (Per Semi-Monthly Pay Period)

	Core Plan	Buy-Up Plan
EE Only	$0.00	$4.30
EE+CH	$0.50	$6.98
EE+SP /DP	$0.50	$6.84
Family	$0.50	$11.25

Life Insurance

Basic Employee Life and AD&D Insurance

Genesys provides eligible employees basic life insurance in the amount of two times your annual base salary up to $1,500,000. To complement your basic life coverage, Genesys also provides accidental death and dismemberment (AD&D) insurance. AD&D insurance protects you and your loved ones by providing a cash benefit in the event of your death by accident, or if are involved in an accident resulting in dismemberment. AD&D coverage is provided in the amount of two times annual base salary up to $1,500,000.

Optional Group Universal Life (GUL) Insurance

The Group Universal Life plan provides the typical term life coverage with additional investment benefits. You have the option to contribute additional funds into a cash accumulation fund (CAF) which earns interest. You can apply for supplemental universal life coverage at any time.

Optional Group Universal Life Rates per $1,000		
Age Band EE, SP, DP	**Smoker**	**Non-Smoker**
<30	$0.060	$0.043
30-34	$0.068	$0.043
35-39	$0.085	$0.068
40-44	$0.136	$0.094
45-49	$0.238	$0.162
50-54	$0.408	$0.272
55-59	$0.578	$0.408
60-64	$0.918	$0.689
65-69	$1.496	$1.139
70-74	$2.457	$2.117
75-79	$3.613	$2.958
80-84	$5.823	$4.616
85-89	$8.925	$7.293
90-94	$12.750	$10.523
95-99	$17.250	$14.238
Child	$0.20 per $1,000	

Employee Life Coverage

Employees may purchase up to five times your annual salary (rounded to the next $1,000) up to a $2 million maximum.

Spouse / Domestic Partner Life Coverage

Eligible spouses or domestic partners may receive coverage up to 50% of the amount of supplemental employee insurance elected. Coverage is provided in $10,000 increments and may not exceed $100,000.

Dependent Child Life Coverage

Employees may elect either $5,000 or $10,000 of coverage for children up to age 19 (24 if full-time student). Rates are based on the amount of insurance purchased.

Please note: When you elect optional life coverage, your coverage amount automatically increases each April to account for merit increases. If you would like to opt out of this feature, you must contact Cigna at 1-800-828-3485.

To apply for supplemental coverage, visit www.genesys.cignatrustedadvisor.com. You will be asked to complete a brief health questionnaire. An evidence of insurability form will be required for non new-hires applying for coverage.

Optional AD&D Insurance

You may elect additional AD&D insurance for yourself and your family. You can elect coverage in $25,000 increments up to a maximum of $500,000.

Employee Only	Employee + Family
$0.013 per $1,000	$0.039 per $1,000

For additional details on Optional AD&D and CAF, employees should visit the Cigna website at https://genesys.cignatrustedadvisor.com/.

Disability Insurance

Short-Term Disability (STD)

If you become sick or injured away from work, and can't work because of the illness or injury, the company is looking out for you. If you're eligible for short-term salary continuance benefits, your first five days off are covered as sick time. After you've been out of work for seven calendar days and have been deemed unable to work by a qualified physician, the salary continuance plan begins to cover 100% of your annual base salary, stepping down to 70% after eight weeks. These benefits last for up to 26 weeks, including the seven calendar day waiting period. Genesys pays the full cost of this benefit.

Short-Term Disability (STD)	
Benefits Begin	On the 8th day of injury or illness
Benefit Amount	100% of weekly base pay (8 Weeks) 70% of weekly base pay (Weeks 9-26)

Note: If you need to file a claim, it is important to do so as soon as possible to avoid delays. Contact the Genesys Benefits Team at benefits.team@genesys.com. Short-term disability benefits will be offset by state mandated benefits, where applicable.

Long-Term Disability (LTD)

LTD coverage is designed to provide income for you and your family in the event of an extended disability. If you are disabled beyond 26 weeks, LTD will replace 66.67% of your monthly salary up to a maximum of $15,000 per month. Genesys also provides this coverage at no cost to you.

Long-Term Disability (LTD)	
Benefits Begin	On the 181st day of injury or illness
Benefit Amount	66.67% of monthly base pay

Employeee Assistance Program

The Optum EAP offers confidential information, support and referral services to help you be productive and handle day-to-day challenges. EAP services are available to you and your family at no additional cost. There are eight (8) face-to-face counseling visits per issue per year available to employees and household members. To learn more about some of the issues the EAP can help you address, contact the Optum EAP by calling 1-866-248-4094 or by visiting www.liveandworkwell.com (access code: genesystele).

Available through our EAP program, Genesys employees have access to Talkspace, an online therapy service that connects users to a dedicated, licensed therapist in their state of residence via private messaging or live video. Users can regularly message their dedicated therapist via text, voice or video as life happens - anywhere, anytime. For enrollment instructions, visit mygenesysbenefits.com, and access Talkspace online at www.liveandworkwell.com.

Voluntary Benefits

Accident Insurance - NEW FOR 2021

Are you prepared for high medical costs in addition to everyday household expenditures and lost wages? If you have a covered accident, medical insurance will help with many medical expenses, but you could be left with out-of-pocket expenses. Aflac group accident insurance plans are designed to provide you with cash benefits throughout the different stages of care, such as:

- **Emergency treatment**
- **Hospital confinement**
- **Burns**
- **Fractures/dislocations**
- **Appliances**
- **Accidental Dismemberment and more**

Critical Illness Insurance

Critical illness insurance through Aflac provides coverage for the added costs of battling a critical illness. The plan pays a lump sum cash benefit upon initial diagnosis of a covered critical illness:

- **Heart Attack, Stroke and Coronary Artery Disease**
- **End-Stage Renal (Kidney) Failure**
- **Limited Major Organ Transplant**
- **Invasive and Non-Invasive Cancer (Carcinoma In Situ)**
- **Skin Cancer**

You may elect between $5,000 - $30,000 for yourself and up to $30,000 for your spouse or domestic partner in $5,000 increments. When you elect coverage for yourself, your dependent children under 26 are included at no additional cost.

Hospital Indemnity Insurance

Hospital indemnity insurance provides cash benefits in the event that you or a loved one are admitted into the hospital. These payments are designed to help cover out-of-pocket expenses such as transportation, meals or childcare. Hospital indemnity benefits are not considered income and are not taxable. The plan pays you a cash benefit of:

Hospitalization Benefits	
Hospital Admission (per confinement) Once per covered sickness or accident per calendar year	$1,000
Hospital Confinement (per day) Maximum confinement period: 31 days per covered sickness or covered accident	$150
Hospital Intensive Care (per day) Maximum confinement period: 10 days per covered sickness or covered accident	$150
Intermediate Intensive Care Step-Down Unit (per day) Maximum confinement period: 10 days per covered sickness or covered accident	$75
Mammography Benefit	
Mammography Benefit Payable once per calendar year per insured	$100
Health Screening Benefit	
Health Screening Benefit Payable once per calendar year per insured	$50

Employees pay the full cost of these voluntary benefits via payroll deduction.

Some benefit amounts may be taxable.

Legal Services

Genesys has partnered with LifePlan to offer an integrated legal, financial, tax, and insurance service platform to assist with all of life's complexities. By providing easy access to a suite of financial and legal resources, LifePlan helps you take care of tomorrow, so you can live your best life today.

What you get with LifePlan:

- **30 minute one-on-one advisor sessions with legal and financial professionals**
  - **Advice from Independent network attorneys***
  - **Financial planning and coaching**
- **Attorney assisted estate plan for two including**
  - **Last will or trust**
  - **Living will**
  - **Power of attorney**
- **Identity theft protection for two including**
  - **Credit and data monitoring**
  - **Full service identity restoration**
  - **Stolen funds reimbursement**

LifePlan is available via payroll deductions and is $13.10 per month. Visit Lifeplan.legalzoom.com for more information.

**limitations apply*

Pet Insurance

You want the best for your pet. And while it's hard to anticipate accidents and illnesses, Nationwide's veterinary pet insurance makes it a little easier to be prepared for them. From wellness care to significant medical incidents, veterinary pet insurance is the smart way to protect your pet's health — and your pocketbook. Here are a few examples of what the insurance covers:

- **Tests and X-rays**
- **Prescriptions**
- **Surgeries and Hospitalization**

To use your pet insurance, you simply pay for your pet's treatment at the time of service, then fax or mail the easy-to-use claim form along with your receipts. After meeting your policy's deductible, you'll be reimbursed according to your plan's benefit schedule.

To purchase pet insurance through Nationwide on a discounted basis because you are a Genesys employee, you may call 1-877-738-7874, or visit https://benefits.petinsurance.com/genesys. The premiums are **paid directly by you to Nationwide**, and not funded via payroll deductions. Premiums are based on type of pet, and the state you live in.

Home and Auto Insurance

MetLife's Auto & Home group insurance program is available to you as a voluntary benefit. As part of the program, you have access to value-added features and benefits on auto and home insurance, as well as a variety of other insurance policies. The program also offers significant potential savings and special group discounts for paying through payroll deduction. In addition to home and auto insurance, you may also elect other coverages, such as excess personal liability, boat, condo, renter's, motor home, recreational vehicle and motorcycle insurance.

401(k) Retirement Plan

Enrollment

Eligible employees can enroll in the plan, make payroll deferral changes and change investment elections at any time by contacting Fidelity directly at www.401k.com or (800) 835-5097. Note that enrollment and any changes may take up to two (2) payroll periods to be processed.

Traditional 401(k) and Roth 401(k)

Genesys employees may elect to contribute pretax (Traditional) or post-tax (Roth) earnings to the Genesys Retirement Savings Plan. The maximum employee contribution is 60% of eligible earnings on a pretax basis not to exceed $19,500 for 2020, and 35% of annual earnings on an after-tax basis. You can split your annual elective deferrals between designated Roth contributions and traditional pre-tax contributions, but your combined contributions can't exceed the deferral limit. Employees age 50 or older may also contribute an additional "catch-up" amount of $6,500 for 2020.

After-tax Contribution

The After-tax contribution is not eligible for the employer match, so participants should first take advantage of the Traditional and/or Roth options to the annual limit in order to be eligible for the maximum employer match. The after-tax contribution limit is an additional $33,500 in 2020. After-tax contributions are limited to 35% of earnings.

Note: The 2021 limits have not yet been announced by the IRS. Genesys will follow the 2021 IRS limit.

Employer Matching Contribution

The employer 401(k) match is another way that Genesys — much like its effort to offer HDHPs and HSAs — is helping you save for your future. The match is calculated every pay period and provides an employer match of $.50 for every $1.00 you contribute. The maximum matching contribution is $4,000 annually. Matched funds will vest after one year of service.

Investing

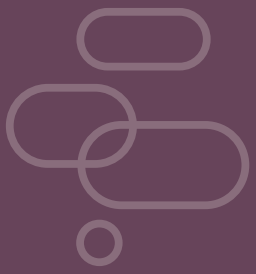
Genesys is continuously monitoring the performance of the investment funds we offer. For a current list of the standard investment lineup, go to www.mygenesysbenefits.com. In addition to the standard investment lineup, 401(k) participants can choose to participate in Fidelity BrokerageLink, which offers you the flexibility to select from numerous other investment options. The option enables you to create a customized retirement portfolio to match your personal situation, including your goals, time horizon and risk tolerance. Note, however, that if you're not up for actively managing your account, it may not be right for you.

Below is a link to the Summary Annual Report ("SAR") for the Genesys Retirement Savings Plan (the "Plan"). The purpose of this SAR is to provide a basic summary of the Plan's financial information, plan expenses, value of plan assets and employer and employee contribution amounts. Please note that you may access a current copy of the SAR online at any time by visiting https://mygenesysbenefits.com/. You also have the right to request a paper copy of the SAR, free of charge, by contacting the Genesys Benefits team at Benefits.team@genesys.com. **401(k) Summary Annual Report**

Carrier and Vendor Contact Information

Employees enrolled in the HDHP or PPO Plans should contact their Genesys Care Coordinators first, for any of their benefits questions.

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



Carrier / Vendor	Website	Contact Information
Enrollment Platform Alight	https://genesys.benefitsnow.com	1-844-868-6230
Medical (UMR with the UHC Choice Plus® Network) Quantum Health	genesyshealthplan.com	1-877-498-3041
Prescription Drug OptumRx	optumrx.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)** HealthEquity	Healthequity.com/Wageworks	1-877-924-3967
Employee Assistance Program Optum	www.liveandworkwell.com (access code: **genesystele**)	1-866-248-4094
Life, AD&D Cigna	www.genesys.cignatrustedadvisor.com benefits.team@genesys.com	1-800-828-3485
STD, LTD Cigna	www.genesys.cignatrustedadvisor.com benefits.team@genesys.com	1-800-36-CIGNA
Accident **Critical Illness** **Hospital Indemnity** Aflac	www.aflacatwork.com	1-800-433-3036
Legal Plan LifePlan	Lifeplan.legalzoom.com	1-888-556-0888
Home & Auto Program MetLife	www.metlife.com/mybenefits	1-800-438-6388
Pet Insurance Nationwide	https://benefits.petinsurance.com/genesys	1-877-738-7874
401(k) Fidelity Investments	www.401k.com	1-800-835-5097

Legal notices

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the 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 and other members of your family when group health coverage would otherwise end. For more 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 it would otherwise end because of a life event. This is also called 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're 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 continuation 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;**
- **The employee becoming entitled to Medicare benefits (under Part A, Part B, or both).**

For all 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. You must provide this notice to benefits.team@genesys.com.

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 of 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.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event.

This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); 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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- **The month after your employment ends; or**
- **The month after group health plan coverage based on current employment ends.**

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

[1] *https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods*.

If you have questions

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 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

Your Rights Under USERRA The Uniformed Services Employment and Reemployment Rights Act

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

Re-employment Rights

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

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

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

Right to Be Free from Discrimination and Retaliation

If you:

- **Are a past or present member of the uniformed service;**
- **Have applied for membership in the uniformed service; or**
- **Are obligated to serve in the uniformed service;**

Then an employer may not deny you:

- **Initial employment;**
- **Reemployment;**
- **Retention in employment;**
- **Promotion; or**
- **Any benefit of employment**

Because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

- **If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.**

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

Enforcement

- **The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.**
- **For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its**

website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

- **If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.**
- **You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.**

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

Employee Rights and Responsibilities - Under the Family and Medical Leave Act

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- **For incapacity due to pregnancy, prenatal medical care or child birth;**
- **To care for the employee's child after birth, or placement for adoption or foster care;**
- **To care for the employee's spouse, son, daughter or parent, who has a serious health condition; or**
- **For a serious health condition that makes the employee unable to perform the employee's job.**

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service-member during a single 12-month period.

A covered service-member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

**The FMLA definitions of "serious injury or illness" for current service-members and veterans are distinct from the FMLA definition of "serious health condition."*

Benefits and Protections

During the FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from the FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

**Special hours of service eligibility requirements apply to airline flight crew employees.*

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a healthcare provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a healthcare provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family is unable to perform daily activities, the need for hospitalization or continuing treatment by a healthcare provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts of Employers

FMLA makes it unlawful for any employer to:

- **Interfere with, restrain or deny the exercise of any right provided under FMLA; and**
- **Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.**

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination or supersede any State or local law which provides great family or medical leave rights.

FMLA section 109 (29 U.S.C. 2619) requires FMLA covered employers to post the test of this notice. Regulation 29 C.F.R. 825.300(a) may require additional disclosures.

FOR ADDITIONAL INFORMATION:

1-866-4US-WAGE (1-866-487-9243)
TTY: 1-877-889-5627
https://www.dol.gov/whd

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 participants 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 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 participants 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 participants 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 30 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 30 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 participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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 Magellan Rx at 800-424-0472. 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 in your Plan Document.

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, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
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)

CALIFORNIA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 916-440-5676

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
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

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

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
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: 1-800-977-6740./ TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

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: https://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

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 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/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852- 3345, ext 5218

NEW JERSEY – Medicaid and 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: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

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: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311
(Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

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

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: https://hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
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, 2020, 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)

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, 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 mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the 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 participants 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.

Summary Annual Report

The Summary Annual Report ("SAR") for the Genesys Telecommunications Laboratories, Inc Health & Welfare Plan can be found online at https://mygenesysbenefits.com/. The purpose of this SAR is to provide a basic summary of the contracted vendors, the 5500 and employee contribution amounts. To obtain a copy of the full annual report, or any part thereof, contact the Genesys Benefits team at Benefits.team@genesys.com.

The information provided in this guide is only a summary of key features of your benefit program. You can find more detailed descriptions of the plans in your Summary Plan Descriptions. Regardless of any statement made in this guide, benefits will be provided in accordance with the plan documents and contracts between Genesys. and the various provider organizations and in the event of any conflict between this summary and any plan document, the plan document will govern.