GENESYS™

2023 US Benefits Guide

BENEFITS FOR THE WAY YOU LIVE

This Guide Is Interactive

This guide is designed to give you quick access to your benefits information.

Click these icons to enjoy the full screen experience, print pages, and move back and forth between content.

WELCOME TO YOUR GENESYS BENEFITS!

At Genesys, we're putting our values into action: **Embrace Empathy, Fly in Formation,** and **Go Big**. Our values define how we run our business and how we treat our most important resources — our fellow employees. Our values are the foundation of our company culture and make Genesys a great place to work, connect, and thrive.

We are pleased to provide you with comprehensive benefit choices and personal wealth-building programs that promote your physical, mental, and financial health.

We hope these benefits help you maintain a healthy work-life balance and meet your needs and the needs of your family. Please use this guide to identify the benefits that are right for you, so you can make the most of the options available.

LET'S GET STARTED

Here's what you need to know. We'll keep this simple, so you can move on to the good stuff. Click the sections below to find out more.

Who Gets Benefits?

- You, as long as you're eligible (must be scheduled to work at least 20 hours per week)
- Your legal spouse or domestic partner
- Your kids, but check out the requirements

When Can I Enroll?

- As a new hire–you get 31 days from your date of hire to pick your plans
- If you have a qualifying life event, like getting married or having a baby
- Once a year during Open Enrollment

How Do I Enroll?

Not sure which plan to choose? Ask ALEX at **www.myalex.com/genesys/2023**. Then, log onto **BenefitsNow** to select your benefits.

When Do Benefits Start?

Most of the benefit choices you make when you're hired take effect on your date of hire. If you're making changes during Open Enrollment, your new benefits will be effective on January 1 of the upcoming year.

YOUR BENEFITS, YOUR CALL

Benefits enrollment can be daunting. You have so many options, and there's a lot at stake—but you don't have to be an expert to make great choices. A little bit of planning, preparation, and this handy guide will empower you to pick the best plans for you.

So, How Do I Make Great Benefit Choices?

1. **Plan for the expected.** You already know some of the things you'll need in the coming year. How often do you usually see the doctor? Does your family depend on your income? How much will you spend on the services you need? Start here, and you're on your way.
2. **Prepare for the unexpected.** Decide how you want to protect yourself from unforeseen life events. A car accident, a surprise medical diagnosis, a death in your family. We don't like to think about these things, but they happen, and Genesys offers you several options to ensure you and your loved ones are covered.
3. **Take the time to learn about what's available.** You have so many benefit options. It's important you know what they are and how to use them when that thing you didn't think would happen… happens. Besides, we made this guide just for you, so take a look.

For more information, visit **www.genesyshealthplan.com**.

MEET YOUR MEDICAL PLANS

You Have Choices. Let's Make Them Easier.

A great medical plan is within your reach, but first, you need to know your options. The good news is, we've made it easier for you by giving you several great plans to choose from—two HDHPs, a PPO, a plan just for California employees, and another for Hawaii employees. But which one is best for you?

It depends. On you.

What do you want most in a plan? Answering this question as well as a few others will help you figure out which plan provides the right level of coverage and the greatest financial support.

- How often do you go to the doctor?
- Do you prefer copays or coinsurance? (Not sure about the difference? **Click here**.)
- Do you want to take advantage of tax savings and the Genesys HSA contribution? **Find out how**.

Honestly, each of our plans is a winner, but one may stand out as the best for you, for this year. Here are the highlights for the UMR plans.

UMR HDHP 1	UMR HDHP 2	UMR PPO
This plan costs the least out of each paycheck and comes with a deductible that is lower than the HDHP 2. However, you'll pay 20% of in-network costs for most services after you meet the deductible. You may enroll in an HSA, which means you're investing money that can be saved or used to cover out-of-pocket costs.	Your paycheck costs for this plan are slightly higher than the HDHP 1 but lower than the PPO plan. You'll pay 10% for in-network services once you've met your deductible. You may enroll in an HSA to save money to pay for medical expenses now or in the future.	With a low deductible (just $500 for individuals!) and copays for most services, your out-of-pocket medical costs will be low and predictable, even for prescriptions. However, PPO enrollees pay the most out of each paycheck.

Live in California?

Click here for your medical plan options.

Live in Hawaii?

We've got another medical plan option for you. **Click here**.

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Understanding the High Deductible Health Plans (HDHPs)

The High Deductible Health Plans offer a variety of benefits, but it's important to understand how the plans work to see if they're the right choice for you.

- **Pay for Medical Care**
  In-network preventive care is covered at 100%. For all other services, you will pay 100% of the discounted UMR network costs for medical care until you reach the deductible.You can use your Health Savings Account (HSA) dollars to pay for expenses tax-free. See **page 15** for more information on the HSA.
- **Share the Cost**
  After you meet the deductible, you and the plan will share the cost until you reach the out-of-pocket maximum.
- **Reach the Limit**
  When you reach the out-of-pocket maximum, the plan pays 100% of eligible medical and prescription costs for the rest of the plan year.

WHICH MEDICAL PLAN IS RIGHT FOR YOU?

At Genesys, our goal is to help you reach your highest potential and be the best version of yourself. This starts with taking care of your overall health. Choosing the right plan to meet your needs is the first step to living your healthiest life.

When deciding which medical plan is right for you and your family, it is important to consider the total cost of coverage. This includes what you pay in premiums and what you pay for services out of your pocket. While each medical plan covers in-network preventive screenings in full, the plans vary on annual deductibles, copays, and levels of coinsurance. This means you may pay higher out-of-pocket costs with one plan versus another. The ideal medical plan should cover most of your health needs with out-of-pocket costs that meet your budget.

Benefit	HDHP	PPO	HMO (CA only)	HMSA (HI only)
Primary Care Physician required			✓	✓
Referrals needed for specialists			✓	✓
Annual deductible to satisfy	✓	✓		✓*
Copayment for services		✓	✓	✓
Coinsurance for services	✓	✓		✓*
In-network coverage	✓	✓	✓	✓
Out-of-network coverage	✓	✓		✓
Eligible to enroll in HSA	✓			
Eligible to enroll in FSA	✓**	✓	✓	✓

*Out-of-network only
**Limited Purpose FSA

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TAKE A CLOSER LOOK

Scenarios for Those Who Are Undecided.

The plan that's best for someone else might not be best for you. Let's look at some examples to help you decide for yourself:

UMR HDHPs

Who it's good for	Individuals and families with low or major medical usage
Premiums (what you pay from your paycheck)	Lower than PPO
Copays	None. You pay the full cost of services until the deductible is met. Then you pay 20% (HDHP 1) or 10% (HDHP 2)
Deductible	Higher than the PPO
Out-of-Pocket Maximum	Lower than the PPO
Key Feature	HSA

Note: *Hawaii-based employees are only eligible for the HMSA medical plan.*

UMR PPO

Who it's good for	Individuals or families who anticipate needing copay-related services, like doctor visits and prescriptions
Premiums (what you pay from your paycheck)	Higher than an HDHP
Copays	You pay a set copay for most services
Deductible	$500 for an individual $1,000 for a family
Out-of-Pocket Maximum	Higher than the HDHPs
Key Feature	Predictability partnered with a low deductible

Kaiser HMO (CA Only)

Who it's good for	Individuals or families who live in California with Kaiser medical providers nearby
Premiums (what you pay from your paycheck)	Higher than the HDHPs, lower than the PPO
Copays	You pay a set copay for all services
Deductible	None
Out-of-Pocket Maximum	Lowest of all plans
Key Feature	All services are provided within the Kaiser network, so coordination of care is simplified

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DIG INTO THE DETAILS

Get to Know Your Medical Coverage Options

Finding a plan that fits your expected health care needs and budget sounds complicated, but it doesn't need to be. And if you don't know about HSAs yet, read up. You'll be glad you did.

On the next pages, you'll see plan charts that help you compare your options. Need a little insight into how to read the charts? Here are some important things to know:

- **How the deductible works.** Your annual deductible is what you are responsible for paying BEFORE insurance kicks in. After you meet your deductible, you and the insurance company (also called the carrier) split the cost (coinsurance).
- **How coinsurance works.** Some services have copays, but others do it a little differently. So, if you see "20% after deductible," it means after you've met your deductible for the year, the plan starts paying a portion of any additional costs, in this case, 80%. Of course, if you receive the service before you've met your whole deductible, you'll pay the amount agreed upon by the provider and the carrier. Oh! One last thing, the money you pay will go toward your out-of-pocket maximum.
- **Which network to use.** The UMR Plans use the UnitedHealthcare Choice Plus Network. When you stay in-network for care, you pay less money.

Looking for out-of-network coverage details?

We get it. Sometimes you have to go out-of-network. You shouldn't need to, but it's nice to know you can. You'll pay a lot more out-of-pocket, but each UMR medical plan includes an out-of-network coverage option. Before you get treatment, be sure you understand how it works so you can avoid any surprise bills. For detailed plan information and out-of-network coverage benefits, go to: **UMR HDHP 1, UMR HDHP 2, or UMR PPO**.

Live in California?

Click here for your medical plan options.

Live in Hawaii?

We've got another medical plan option for you. **Click here**.

About Your Prescription Drug Coverage

Each medical plan includes prescription drug coverage. Before you flip the page, know that there are a couple of important ways to save money.

- **Stay generic.** Ever wonder what the difference is between those low-cost generic drugs and the higher tier versions with fancy names and big price tags? Not a thing. Generic drugs contain the same active ingredients as their designer counterparts. Ask your doctor to prescribe generic when possible.
- **Have it delivered.** If you take a maintenance prescription drug, (like birth control or meds you take for chronic conditions), you may be able to get a 3-month supply for less money with the mail-order option. And it shows up at your front door, so you can skip the trip to the pharmacy.
- **Connect to the carriers.**
  - **UMR plans: genesyshealthplan.com**
  - **Kaiser plan: kp.org**
  - **HMSA plan: hmsa.com/drug-list**

CHOOSE THE RIGHT PLACE TO GO FOR CARE

Need medical attention, but it's not a true emergency? Save time and money by using telemedicine or telehealth services or visiting urgent care.

Emergency room costs are expensive, and visits can take hours! Urgent care centers provide quality care just like the ER, but you could save hundreds of dollars and hours of time in the waiting room for non-life-threatening issues.

How to Decide Where to Go

Telemedicine (UMR Plans Only)

(Non-Life-Threatening)

Benefit:

- Lower cost
- Speak to a doctor from anywhere
- Reduced waiting room time

Reasons to go:

- Headaches
- Fever & flu symptoms
- Cough & sore throat
- Skin irritations & rashes
- Counseling services
- Psychiatry services

Primary Care Provider (PCP) (In-Person or Telehealth)

(Non-Life-Threatening)

Benefit:

- In-person examination
- Reasonable price in-network
- Familiarity with regular PCP

Reasons to go:

- Earaches and infections
- Preventive care
- Headaches
- Regular treatment for chronic conditions
- Abdominal pain
- Skin irritations & rashes

Urgent Care Center

(Non-Life-Threatening)

Benefit:

- Lower cost than an ER visit
- Same-day visits often available

Reasons to go:

- Earaches & infections
- Minor cuts, bumps, sprains & burns
- Fever & flu symptoms
- Allergic reactions
- Animal bites
- Mild asthma
- Headaches
- Urinary tract infections
- Back & joint pain

Emergency Room

(Life-Threatening)

Benefit:

- Necessary for life-threatening conditions

Reasons to go:

- Sudden numbness or weakness
- Disorientation or difficulty speaking
- Seizure or loss of consciousness
- Severe cuts or burns
- Overdoses
- Uncontrolled bleeding
- Coughing or vomiting blood
- Heart attack or chest pain

UMR MEDICAL PLANS

All Employees

Plan Features	HDHP 1		HDHP 2		PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible Individual/Family	$2,000 / $3,000	$3,000 / $6,000	$3,000 / $6,000	$4,000 / $8,000	$500 / $1,000	$500 / $1,000
Type of Family Deductible	Aggregate		Embedded		Embedded	
Annual Out-of-Pocket Maximum Individual/Family	$4,000 / $6,550	$8,000 / $13,000	$3,500 / $7,000	$8,000 / $16,000	$5,000 / $10,000	$10,000 / $20,000
Type of Family Out-of-Pocket Maximum	Embedded		Embedded		Embedded	
Genesys Annual HSA Contribution* Individual/Family	$750 / $1,500		$750 / $1,500		N/A	
	You pay:		**You pay:**		**You pay:**	
Preventive Care Visit	Covered in full	Not covered	Covered in full	Not covered	Covered in full	Not covered
Primary Care/Specialist Visit	20% after deductible	40% after deductible	10% after deductible	30% after deductible	$20 copay	50%
Urgent Care	20% after deductible	40% after deductible	10% after deductible	30% after deductible	$50 copay	50%
Emergency Room (copay waived if admitted)	20% after deductible		10% after deductible		30%	
Prescription Drug Retail (up to a 30-day supply)						
Tier 1 (Generic)	20% after deductible	20% after deductible**	10% after deductible	10% after deductible**	$8 copay	$8 copay**
Tier 2 (Preferred Brand)					$30 copay	$30 copay**
Tier 3 (Non-Preferred Brand)					$50 copay	$50 copay**
Prescription Drug Mail Order (up to a 90-day supply)						
Tier 1 (Generic)	20% after deductible	N/A	10% after deductible	N/A	$20 copay	N/A
Tier 2 (Preferred Brand)					$75 copay	
Tier 3 (Non-Preferred Brand)					$125 copay	

One fourth of the annual Genesys contribution is deposited in your HSA 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 in order to be eligible to receive that quarter's company HSA contribution.

***Plus any network cost difference.*

GET THE MOST OUT OF YOUR UMR PLAN

Telehealth Via OC24health

OC24health provides 24/7/365 access to U.S. board-certified doctors through secure video visits. UMR members can access OC24health via web or mobile app for many non-emergency illnesses including flu, allergies, sinus infections, and more. Once you register for OC24health, you will have access to their network of local and national certified medical providers. OC24health medical providers can diagnose, treat, and prescribe medication for your non-emergency conditions. Whenever you need care, medical providers are available within minutes.

Genesys Care Coordinators

Let's face it, insurance coverage and processes can feel complicated and overwhelming. If you're a UMR HDHP and UMR PPO medical plan enrollee, you have access to Genesys Care Coordinators who will help you navigate the health care system, make informed decisions, and save money.

Your coordinator can help you:

- Order replacement ID cards
- Find in-network providers
- Manage chronic conditions
- Find answers, claims and billing questions
- Understand medical conditions and treatments
- Keep your health care costs as low as possible

Best of all, they get to know you and your unique health needs. Nurse Coordinators work alongside your medical providers to provide personalized chronic care management. If you need help managing your health care, call your Genesys Care Coordinator at **1-877-498-3041**, download the MyQHealth Care Coordinators app, or go online to **www.genesyshealthplan.com**.

KAISER MEDICAL PLAN

California Employees

If you live in California, you may select one of the UMR plans or the Kaiser plan. The Kaiser plan offers in-network coverage only. That means if you enroll in the Kaiser plan, you have access to Kaiser doctors and facilities only. Just something to keep in mind when you're choosing a plan.

Plan Features	HMO In-Network Only
Annual Deductible Individual/Family	None
Annual Out-of-Pocket Maximum Individual/Family	$1,500 / $3,000
Genesys Annual HSA Contribution Individual/Family	N/A
	You pay:
Preventive Care Visit	Covered in full
Primary Care/Specialist Visit	$20 copay
Urgent Care	$20 copay
Emergency Room (copay waived if admitted)	$100 copay
Prescription Drug Retail	
Tier 1 (Generic)	$15 copay (up to a 100-day supply)
Tier 2 (Preferred Brand)	$30 copay (up to a 100-day supply)
Tier 3 (Non-Preferred Brand)	Not covered
Tier 4 (Specialty)	$30 copay (up to a 30-day supply)

Do you have a child who lives out of state?

Families with children who live outside of California, such as those attending college, may wish to enroll in one of the UMR plans, which offers a nationwide network of providers. Kaiser members may only seek care out-of-network in an emergency.

HAWAII EMPLOYEE BENEFITS

HMSA Medical Plan

Hawaii Employees Only

Plan Features	PPO	
	In-Network	Out-of-Network
Annual Deductible Individual/Family	None	$100 / $300
Annual Out-of-Pocket Maximum Individual/Family	$2,500 / $7,500	
Prescription Annual Out-of-Pocket Maximum Individual/Family	$3,600 / $4,200	
	You pay:	
Preventive Care Visit	Covered in full	30%
Primary Care/Specialist Visit	$12 copay	30%
Urgent Care	$12 copay	30%
Emergency Room	20%	20%
Prescription Drug Retail (1-30 day supply)		
Tier 1 (Generic)	$7 copay	$7 copay + 20%*
Tier 2 (Preferred Brand)	$30 copay	$30 copay + 20%*
Tier 3 (Non-Preferred Brand)	$30 + $45 copay	$30 copay + 20%*
Tier 4 (Preferred Specialty)	$100 copay	Not covered
Tier 5 (Non-Preferred Specialty)	$200 copay	
Prescription Drug Mail Order (84-90 day supply)		
Tier 1 (Generic)	$11 copay	Not covered
Tier 2 (Preferred Brand)	$65 copay	
Tier 3 (Non-Preferred Brand)	$65 + $135 copay	

**Deductible does not apply*

HMSA Dental Coverage

Hawaii Employees Only

Did you know good dental care improves your overall health? Your dental coverage is provided by HMSA. Genesys offers dental coverage to Hawaii employees as part of your HMSA medical coverage. No separate benefit election or additional premium is required. All costs are for participating providers only. To find an in-network provider near you, visit **www.hmsadental.com/find-a-dentist**.

Plan Features	HMSA Dental PPO Plan
	In-Network
	You pay:
Annual Benefit Maximum	$1,500
Rollover Amount	Up to $500 (max accumulation $1,250)
Diagnostic & Preventive Services (e.g., x-rays, cleanings,* exams)	Covered in full
Basic & Restorative Services (e.g., fillings, sealants, root canals)	30%
Major Services after 12-month waiting period (e.g., dentures, crowns, bridges, implants)	50%
Orthodontia	Not covered

***Enhanced Dental Benefits:** *Certain medical conditions are eligible for additional dental services and support. Find out more about covered conditions at* **www.hmsa.com/oralhealth**.

HMSA Vision Coverage

Hawaii Employees Only

Keep your vision clear and your eyes in good health with regular eye exams. Genesys offers vision coverage to Hawaii employees as part of your HMSA medical coverage. No separate benefit election or additional premium is required for vision coverage. The vision plan offers an extensive network of optometrists and vision care specialists. All costs are for participating providers only. To find an in-network provider near you, visit **hmsa.com/search/providers**.

Plan Features	HMSA Vision Plan	
	Adult	Child
Exam (once per calendar year)	$10 copay	$10 copay
Eyeglasses **Lenses** (once per calendar year) **Frames** (once per 24 months)	 $10 copay $15 copay	 $10 copay $15 copay
Contact Lenses (in lieu of lenses and frames) (once per calendar year) **Contact Lens Fitting** (once per calendar year)	$25 copay (up to $130 allowance) Charges over $45 plan payment	50% of eligible charge

HMSA Life and AD&D Insurance

Hawaii Employees Only

Our Hawaii employees have Life and Accidental Death & Dismemberment (AD&D) benefits through HMSA.

Benefit	Coverage Amount
Life Insurance	$30,000 benefit per eligible subscriber
Accidental Death & Dismemberment	$30,000 benefit per eligible subscriber
Accelerated Death Benefit	$15,000 benefit per eligible subscriber

WHY CHOOSE AN HDHP?

Think the Health Savings Account (HSA) is confusing? You're not the only one. But it's really not as scary as it seems. Think of an HSA like a 401(k) account for health care.

The HSA Made Easy

If you enroll in an HDHP, you may be eligible to open an HSA to help pay for most **health care expenses**. An HSA makes it easy to pay for current health care costs and save for future health care needs now or in retirement.

What are the benefits of an HSA?

- Genesys starts your savings off with free $$ (shown in table below).*
- Set aside tax-free** money to pay for out-of-pocket health care expenses.
- The HSA is your bank account, so if you leave the company or retire, the account, including the Genesys contributions, goes with you.
- All unused funds roll over year to year, so there's totally no pressure to spend it all in one place.
- HSAs are a good retirement savings account. Think how much peace of mind there is in knowing you are building your nest egg now.
- Simply pay for eligible expenses using the HSA debit card. Or submit your receipts and get reimbursed. It's really easy.

The numbers add up.

Each year, you can give yourself money up to the annual IRS maximums (with pre-tax dollars). We've outlined those for you below.

Coverage Type	2023 Maximum Contribution Limit	2023 Genesys HSA Contribution	2023 Maximum Employee Contribution
Individual Coverage	$3,850	$750	$3,100
Family Coverage	$7,750	$1,500	$6,250
Age 55+ Catch-up Contribution	Additional $1,000		

**One fourth of the annual Genesys contribution is deposited in your HSA each calendar year, on or near the first business day of each quarter. You 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.*

***State taxes may still apply in CA and NJ. For detailed tax implications of an HSA, please contact your professional tax advisor.*

Imagine the Possibilities

Suppose you enroll in the HDHP 2 Plan. Factoring in the Genesys contribution, you elect a contribution amount that equals the annual deductible. Then you use your HSA to pay for **eligible expenses**.

In this scenario, there are two possible outcomes:

1. **You meet your deductible.**
   Congrats! The plan now pays 90% of eligible services, reducing your risk of unplanned financial burden.

2. **You don't meet your deductible.**
   Congrats! You now have a growing HSA account. Those funds never expire.

It's win-win.

USING THE HSA

1. Be eligible for the HSA.
2. Elect the HSA in **BenefitsNow**.
3. Contribute to your account. (Elect up to the full amount to maximize your savings: $3,100 for you or $6,250 for your family.)
4. Register on the **HealthEquity site**.
5. Get the Genesys contribution automatically: up to $750 per year for individual coverage and up to $1,500 for family coverage. The Genesys contribution is divided up and added to your account in equal quarterly payments on the 1st business day of each calendar quarter; must be enrolled in one of the HDHP plans and employed on the first day of the quarter (Jan. 1, April 1, July 1, Oct. 1) in order to be eligible to receive that quarter's employer contribution.
6. Receive your debit card in the mail.
7. Use the available funds in your HSA to pay for **eligible expenses**.
8. Or save the funds for future expenses. Even into retirement.
9. Enjoy the tax savings.

What about the fine print?

- You must be enrolled in a qualified High Deductible Health Plan (HDHP) in order to participate in an HSA.
- You cannot be covered under another non-qualified health plan, including your spouse's Health Care Flexible Spending Account.
- You cannot be enrolled in Medicare or Tricare.
- You cannot be claimed as a dependent on someone else's tax return.
- Your children must be considered qualified dependents for tax purposes for their medical claims to be eligible.

Questions? Refer to **IRS Publication 969** for complete rules.

HealthEquity

Reach out to HealthEquity to replace debit cards, add dependents, or ask questions.

1-877-924-3967
www.healthequity.com/wageworks

DENTAL COVERAGE

For a Healthy Smile

Did you know good dental care improves your overall health? Our dental plans help you maintain a healthy smile through regular preventive dental care and offer coverage to fix problems early. To find an in-network provider near you, visit **www.anthem.com/ca**.

Plan Features	Anthem Dental Standard		Anthem Dental Enhanced	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
	You pay:		You pay:	
Annual Deductible (waived for Preventive Services)	$50 individual / $100 family		None	
Annual Benefit Maximum	$1,750		$2,500	
Diagnostic & Preventive Services (e.g., x-rays, cleanings, exams)	Covered in full		Covered in full	
Basic & Restorative Services (e.g., fillings, extractions, root canals)	20% after deductible		20%	
Major Services (e.g., dentures, crowns, bridges)	50% after deductible		20%	
Orthodontia (adults and children)**	50% after deductible		50%	
Orthodontia Lifetime Maximum	$1,500 per person		$1,750 per person	

**For out-of-network services, members pay applicable coinsurance plus any amount that exceeds the usual, customary, and reasonable charge.*

***With an approved orthodontia treatment plan. Not all adult orthodontia is covered, for example an adult who wants a replacement retainer might not get the retainer covered.*

VISION COVERAGE

Seeing Is Believing

Keep your vision clear and your eyes in good health with regular eye exams. The vision plan offers an extensive network of optometrists and vision care specialists. Don't forget, you'll save money by visiting in-network providers. To find an in-network provider near you, visit **www.vsp.com** and click "Find a Doctor."

Plan Features (Every calendar year)	**VSP Core**	**VSP Buy-Up**
	In-Network	**In-Network**
Exam	$10 copay	$10 copay
Prescription Glasses	$25 copay	$10 copay
Frames	$150 allowance ($170 for featured frames) + 20% discount over allowance or $80 allowance at Costco	$200 allowance ($220 for featured frames) + 20% discount over allowance or $110 allowance at Costco
Lenses	Copay included in Prescription Glasses. Includes single vision, lined bifocal, and lined trifocal lenses, plus polycarbonate lenses for dependent children.	
Lens Enhancements	$0-$160 copay Standard progressive, premium progressive, custom progressive	
Contact Lenses (in lieu of lenses and frames)	Up to $60 copay (exam and fitting) $130 allowance	Up to $60 copay (exam and fitting) $200 allowance

No Vision ID Card Needed

VSP does not issue ID cards. When you seek care from a vision provider, just let them know you are a Genesys employee. They will verify your coverage by your name and Social Security number.

FLEXIBLE SPENDING ACCOUNTS (FSAS)

Make Your Money Work for You

Flexible Spending Accounts (FSAs), administered by HealthEquity, offer a smart way to stretch your dollars by setting aside pre-tax dollars to pay for eligible health care and dependent care expenses. Each year, you must elect the annual amount you want to contribute to each account. Your contributions will be deducted pre-tax from your paycheck, which helps reduce your taxable income.

	Health Care FSA	Limited Purpose FSA	Dependent Care FSA
Eligibility	Eligible employees who are not enrolled in the HDHP	HSA participants only	All eligible employees
Annual Contribution Limit	$3,050	$3,050	$5,000 ($2,500 if married and filing separately)
Eligible Expenses*	Health care plan deductibles, copays, coinsurance, and prescriptions, including dental and vision hardware and expenses	Dental and vision expenses only	Daycare for children age 12 and under, disabled children, and dependent adults
Availability of Funds	The full annual amount you elect is available on your plan effective date	The full annual amount you elect is available on your plan effective date	You can be reimbursed up to the amount available in your account
Payment or Reimbursement Options	Debit card or reimbursement	Debit card or reimbursement	Reimbursement
Rollover Options	Yes, you may rollover up to $610 of unused funds when you re-enroll	Yes, you may rollover up to $610 of unused funds when you re-enroll	Unused funds do not rollover
Deadline for Services	Services must be incurred by 12/31/2023	Services must be incurred by 12/31/2023	Services must be incurred by 12/31/2023
Deadline for Submission for Reimbursement	Reimbursement must be submitted by 3/31/2024	Reimbursement must be submitted by 3/31/2024	Reimbursement must be submitted by 3/31/2024

Refer to IRS Publication **502 and **503** for a complete list of eligible expenses.*

COMMUTER/ PARKING BENEFIT

If You Have to Commute, You Might as Well Save Money.

The HealthEquity commuter benefits program allows employees who commute to and from work to set aside pre-tax funds to pay for their work-related transit and parking expenses. Eligible expenses for the commuter benefit include transit passes, fare cards, ticket books, and vanpool expenses. This may also include parking before boarding mass transit (park and ride) or driving to work and parking daily or monthly near your workplace. There are several benefit options to select, including direct payment to your parking provider, a debit card that is electronically funded with your pre-tax benefit each month, and claims reimbursement for parking you're already paid for (Pay Me Back).

The maximum contribution is:

- Transit: $300/month
- Parking: $300/month

Your benefit elections must be placed by the 10th of the month prior to the month you plan to commute. For example, a benefit to be used in February must be elected online by January 10th.

You may enroll at any time. Register and log in to your account at **www.healthequity.com/wageworks**.

401(k) RETIREMENT PLAN

When's the Best Time to Start? Now.

Being retirement ready is an important part of financial wellness. The key to success is to start saving now. The Genesys Company 401(k) Plan, administered by Fidelity, offers a variety of investment options. The company generously matches employee 401(k) contributions to help grow your retirement savings.

Eligibility

You may enroll in the 401(k) plan, designate beneficiaries, and allocate your asset distribution at any time. You do not need to wait for annual enrollment to make changes. New hires can enroll after receiving their first paycheck.

401(k) Contributions

Genesys will match employee contributions $.50 on the $1.00 up to $4,000 annually. Personal contributions, eligible for the employer match, may be pre-tax (Traditional) or post-tax (Roth) or a combination of both. You also have the option to make after-tax contributions up to 35% of your post-tax earnings; these contributions are not eligible for the employer match. Your contributions are added to your account through convenient payroll deductions. Your funds are immediately vested. Company contributions are vested after one year of service.

Helpful Tips on Saving for Retirement

- Start saving as soon as possible to grow your retirement account.
- Begin with small contributions, if necessary, and increase contributions over time.
- Make setting aside money for retirement a habit.
- Understand investment returns may fluctuate.
- Let it sit. Avoid penalties by leaving funds in your 401(k) until retirement.
- If you change jobs, you can roll over your retirement account.

Your 401(k) Resource

Fidelity

1-800-835-5097
www.401k.com

401(k) Fast Facts

- The company will match employee contributions $.50 for every $1.00 you contribute up to $4,000 annually.
- You may contribute up to 60% of pre-tax earnings to the IRS maximum of $22,500 is the current estimate.
- The after-tax contribution limit is 35% of post-tax earnings (up to an additional $39,500).
- If you are age 50 or over, you can make "catch-up" contributions up to $7,500.

MENTAL HEALTH CARE

A Helping Hand for the Whole Family

Lyra Health – Comprehensive Care

Lyra Health provides care for your emotional and mental health how, when, and where you need it, at no additional cost to you. Whether you're feeling stressed, anxious, or depressed, support from Lyra Health's top therapists and coaches can get you back on your feet. Learn how to get unstuck, communicate better, improve relationships, and feel better overall.

- Access personalized matches and recommendations for top coaches and therapist just for you
- Meet with a coach via live video or live messaging or meet with a therapist via live video, phone, or in-person
- Up to 12 sessions per calendar year for you, your partner, and your dependents

Lyra Renew

Lyra Renew provides confidential access to Lyra's alcohol and mental health recovery program. You'll receive cost-effective, high-quality care from the privacy of your own home. A coordinated and dedicated provider team supports you to stay on track and avoid relapse. If you need additional care, Lyra can help you search and vet treatment facilities.

Schedule appointments online at **genesys.lyrahealth.com** or via phone at **1-877-335-0372**.

LIFE AND AD&D INSURANCE

Prepare for the Unexpected

It can be hard to think about it, but if the worst were to happen, are your loved ones financially protected?

Life and Accidental Death and Dismemberment (AD&D) insurance, through New York Life - Group Benefit Solutions (formerly Cigna), provides financial security to you and your family if you pass away or become seriously injured.

Basic Life and AD&D Insurance

As an eligible employee, you receive Basic Life and AD&D insurance equal to two times your annual earnings to a maximum of $1,500,000 at no cost to you. The cost of coverage exceeding $50,000 is considered imputed income. This means that the premium cost for the coverage over $50,000 must be included as income and will be subject to Social Security and Medicare taxes, which may be reflected in your paycheck.

Who's Your Beneficiary?

You may choose anyone to be the beneficiary of your Life and AD&D policy in the event of your death or serious injury. Review your beneficiary designation periodically. You may change your beneficiary as often as needed at:

- Basic Life and AD&D: **Benefits Now**
- Optional Life and AD&D: **genesys.cignatrustedadvisor.com**

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LIFE AND AD&D INSURANCE (CONT.)

Optional Group Universal Life Insurance

In addition to Basic Life and AD&D, you may buy Optional Group Universal Life coverage at discounted rates. You may contribute additional funds into a cash accumulation fund (CAF) which earns interest. The chart below describes the amounts of coverage you can buy for yourself, your spouse, and your child(ren). To apply for optional coverage, visit **genesys.cignatrustedadvisor.com**. Evidence of Insurability will be required for those applying for coverage after the new hire eligibility period.

Benefit Features	Optional Life*			Optional AD&D
	Employee	**Spouse**	**Dependent Child(ren)** (up to age 19, 24 if full-time student)	**Employee + Family**
Coverage Options	5x annual salary or $2,000,000 whichever is less	$100,000 in increments of $10,000 (cannot exceed 50% of employee coverage)	$5,000 or $10,000	$500,000 in increments of $25,000
Guaranteed Issue Amount	2x annual compensation, rounded to the next higher $1,000, or $500,000, whichever is less	$20,000		Based on election amount
Guaranteed Issue Period	Within 30 days of benefits eligibility or a qualifying life event			

**Evidence of Insurability (EOI) may be required.*

How much Optional Life and AD&D Insurance should I buy?

When deciding how much voluntary Life and AD&D coverage to buy, consider the following:

1. How much will your dependents need to pay debts, such as a mortgage, car loan, or credit card balances?
2. How much do your dependents need to maintain their current standard of living?
3. What kind of future would you like to provide for your dependents or others who depend on you for financial support?

What Is EOI?

Evidence of Insurability (EOI) is the process of providing health information to qualify for certain types of insurance coverage. If you elect Optional Life and AD&D coverage above the guaranteed issue limit or after the guaranteed issue period, you will be required to submit a health questionnaire (in some cases, a physical exam may be required). Your questionnaire will be reviewed by the carrier, and you will be notified of their decision directly.

DISABILITY COVERAGE

Income Replacement When You Need It Most

If you couldn't work for a period of time, do you have enough money saved up to pay your bills? Disability insurance, through New York Life - Group Benefit Solutions (formerly Cigna), ensures you and your family continue to receive a percentage of your salary if you become sick or injured and are unable to work. Think of it as a parachute wrapped in a safety net.

Short-Term Disability (STD)

Short-Term Disability coverage, through Cigna, provides you with a portion of income replacement if you are unable to work due to a non-occupational illness or injury. You are automatically enrolled in STD at no cost to you.

Short-Term Disability (STD)	
Percent of Earnings	100% (up to 8 weeks) / 70% (9-26 weeks)
Waiting Period	5 business days

STD benefits will be offset by benefits you receive from the state-mandated disability plans in California, Connecticut, Colorado, District of Columbia, Hawaii, Massachusetts, New Jersey, New York, Oregon, Rhode Island, Washington, or the Commonwealth of Puerto Rico.

Long-Term Disability (LTD)

Long-Term Disability pays you a portion of your earnings if you cannot work for an extended period of time due to a disabling illness or injury. You are automatically enrolled in LTD at no cost to you.

Long-Term Disability (LTD)	
Percent of Earnings	66.67%
Monthly Maximum	$15,000
Waiting Period	26 weeks
Maximum Duration	To age 65 based on benefit schedule*

**Refer to plan document for additional information.*

You will continue to receive benefits if you meet the definition of disability or reach age 65 based on benefit schedule. Benefits are reduced by other sources of disability income you may qualify for such as Social Security and Workers' Compensation.

Did You Know?

More than half (51%) of Americans have less than three months' worth of emergency savings. Disability insurance can help you be better prepared.

VOLUNTARY BENEFITS

Protection for You and Your Family

Aflac Benefits

Even with great insurance, out-of-pocket costs can add up quickly. Are things like crutches covered? Will you have to travel to receive treatment? Do you need to hire someone to do yardwork while you are down and out?

Accident, Critical Illness, and Hospital Insurance pay a lump sum if a covered person experiences an eligible condition. These funds can be used however you see fit.

No health questions are required, but the plans do have some exclusions and limitations.

- **Accident Insurance:** Pays a lump sum if a covered person experiences an eligible accident. The amount paid is based on the condition/accident.
- **Critical Illness Insurance:** Pays a lump sum if a covered person is diagnosed with an eligible critical illness.
- **Hospital Indemnity Insurance:** Pays a lump sum if a covered person is hospitalized for an eligible condition.

MetLife Legal Plan

When you enroll in the MetLife Legal Plan, you have unlimited access to a network of attorneys who can offer assistance and advice on a variety of legal issues for just $13.50 per month. There are no attorney fees, copays, deductibles, or claim forms for covered legal matters.

Experienced attorneys are available to help with:

- Estate planning
- Home buying or selling
- Tax audits
- Traffic matters
- Identity theft
- Document creation

To enroll (only during open enrollment or after a qualified life event) go to **BenefitNow**. Once you enroll, simply find an attorney in the MetLife network and call to make an appointment. For more information, call **1-800-821-6400**.

Pet Insurance

Your pets can now receive coverage to stay healthy, too. Voluntary pet insurance helps you be financially prepared, as veterinary bills can add up quickly. With Nationwide pet insurance, you can save on unexpected veterinary expenses plus optional coverage to help pay for routine veterinary care, such as vaccines, wellness exams, and teeth cleaning. Visit **benefits.petinsurance.com/genesys** to get an instant quote and enroll at any time. Plan premiums are paid directly by you to Nationwide and are not funded via payroll deductions. Premiums vary based on type of pet and state of residence. Call Nationwide at **1-877-738-7874** to speak with a pet insurance expert if you have any questions.

Auto & Home Insurance

Save money on important coverage that protects your assets. Our benefits partner, MetLife, will help you find the lowest rates on auto, home, and other insurance coverage. Reach out to MetLife at **1-800-438-6388** or **metlife.com/mybenefits** for a quote.

ADDITIONAL BENEFITS

Support for You and Your Family

Paid Parental Leave

Paid Parental Leave provides income when you need to take time away from work to manage your or a family member's serious health condition, to welcome a new child, or for certain military situations. If approved, benefits will replace 100% of your regular earnings for up to 12 weeks (eligible FMLA qualified parents) or up to 6 weeks (eligible non-FMLA qualified parents).

Paid Parental Leave coordinates and runs concurrently with other leave benefits, such as short-term disability and any applicable state/local leave benefits. As such, the total amount paid to you will not exceed your regular weekly pay. Contact the Genesys Benefits Team at **benefits.team@genesys.com** with questions about this policy.

BrightPlan Financial Planning

Genesys has partnered with BrightPlan to offer an incredibly valuable, personalized financial planning resource for employees. Once enrolled, you'll have unlimited access to certified fiduciary advisors to help you make the right financial decisions.

Visit **www.BrightPlan.com/enroll** today and start planning for your financial future.

Varsity Tutors

Genesys employees receive 20% off expert online tutoring and instructions with Varsity Tutors. Between managing your career and juggling the educational needs of your family, you need one less thing to worry about this year. Whether you want to sign your youngest up for some homework help or dive into a new professional certification program, **Varsity Tutors** has you covered. Genesys employees receive a complimentary academic needs consultation and 20% off services.

- **Private Tutoring** connects a student with a highly vetted expert tutor on our purpose-built Live Learning Platform.
- **Free Live Classes** are taught by subject-matter experts and offer students of all ages an engaging way to learn almost anything.
- Students will enjoy engaging in exclusive classes taught by **celebrity instructors and top experts**.
- **Small Group Classes** provide more instructor interaction, more online collaboration with fellow students, and are tailored to the group.
- Tutoring for students with **learning differences meets individuals' unique needs.**
- **Tutoring is available for all ages including college, graduate school, and medical school.**

Visit **Varsity Tutors** to learn more.

ADDITIONAL BENEFITS

Support for You and Your Family

Rally Program

We support your efforts at adopting healthy lifestyle choices through Rally, a free, interactive program. This digital health tool, available to employees enrolled in a Genesys medical plan, helps you improve your wellness by making simple changes to your daily routine. The program is easy to use.

- Learn how to make more informed health care decisions, create a personalized action plan, and complete specific health actions.
- You and your covered spouse or domestic partner are eligible to earn up to $200 each in wellness incentives by completing activities.
- Wellness incentives can be used to purchase gift cards at some of your favorite retailers.

The more you check in to Rally and track your progress, the more incentives you can earn. Learn more about **Rally**.

Elements Financial Federal Credit Union

Elements Financial is a credit union that offers lower rates, fewer fees, financial health checkups, workshops, and much more. You have free access to financial educational webinars on a variety of topics. With Elements Financial, you will enjoy:

- One-on-one financial counseling on credit, budgeting and account reviews
- Higher deposit rates and lower borrowing rates
- Access to shared branching network
- Wealth management services to help you reach your savings and retirement goals

Learn more about **Elements Financial**.

YOUR COST FOR COVERAGE

Ready to Crunch the Numbers?

Your semi-monthly (24) payroll deductions for medical, dental, and vision are shown in the table.

Benefit Plan	Employee Only	Employee + Spouse / Domestic Partner	Employee + Child(ren)	Employee + Family
Medical				
UMR HDHP 1	$21.00	$109.50	$88.00	$160.00
UMR HDHP 2	$26.50	$124.00	$97.50	$171.50
UMR PPO	$112.50	$260.00	$218.50	$366.50
Kaiser HMO	$41.00	$132.50	$119.00	$183.50
HMSA PPO	$24.50	$114.00	$90.00	$158.00
Dental				
Anthem Standard	$4.00	$12.00	$11.50	$19.50
Anthem Enhanced	$8.50	$20.50	$19.50	$32.50
Vision				
VSP Core	$0.00	$0.50	$0.50	$0.50
VSP Buy-Up	$4.50	$7.00	$7.50	$12.00

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YOUR COST FOR COVERAGE (CONT.)

Optional Life and AD&D Insurance Premiums

Optional Life Premiums		
Employee/Spouse/Domestic Partner		
Age	**Smoker** Per $1,000 of coverage	**Non-Smoker** Per $1,000 of coverage
<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	$0.587	$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	

Optional AD&D Premiums	
Employee	**Employee + Family**
$0.013 per $1,000 of coverage	$0.013 per $1,000 of coverage

AM I ELIGIBLE FOR BENEFITS?

Most Employees Are.

If you're a regular employee working at least 20 hours per week, you're eligible! In fact, you're eligible for benefits on your first day of employment. Just make your plan selections by the end of your first week and we'll back-date your benefits to your start date. Note: Interns are not eligible for voluntary benefits or the company HSA contribution.

What about my dependents?

You can sign them up too. Eligible dependents include:

- Your legal spouse or domestic partner
- Your child(ren) or those of your spouse or domestic partner, up to age 26
- Also, your children up to any age if they are incapable of self-support due to a mental or physical disability. In order for this rule to apply, they must already be on Genesys's plan and be disabled when they turn 26

WHEN CAN I ENROLL?

Great Question.

If you miss your enrollment window, you'll have to wait until next Open Enrollment to enroll in or make changes to your benefits (unless you have a Qualifying Life Event—more about that below). This is Uncle Sam's call… not ours!

As a New Hire

Congrats on the new gig! You have 31 days from your hire date to enroll in benefits. The choices you make when you're hired are effective on your date of hire.

During Open Enrollment

You can update your benefit elections and covered dependents once a year during Open Enrollment. Annual Open Enrollment is usually held for two weeks in mid-to-late November. Your Open Enrollment choices are in effect for the following plan year, January 1st to December 31st.

If You Have Qualifying Life Event

Sometimes, a big change happens in your life and your benefits need to change too. These changes are called Qualifying Life Events and are the only reason you would be able to change benefits outside of your initial enrollment window (when you're first hired) or the Genesys annual Open Enrollment. You have 31 days from the date of your qualifying life event to change your benefits and submit your supporting documentation to the Benefits team.

Here are some of those big changes that are Qualifying Life Events:

- Marriage, divorce, or legal separation
- Birth or adoption of a child (including placement for adoption), foster child placement, or court-appointed guardianship
- Death of a dependent
- Loss or gain of other health coverage for you and/or your dependents
- Change in employment status
- Change in Medicaid/Medicare eligibility for you or a dependent
- Change in residency that leads to a loss of coverage
- Change in daycare rates
- A Qualified Medical Child Support Order
- Military leave

Qualifying Life Events Are Important: Take Action!

Did you recently get married? Have a baby? Or experience another Qualifying Life Event?

If so, and if you need to change your benefits, contact **benefits.team@genesys.com** no later than 31 days following the effective date of the event. You'll be required to show proof of the event and the date it happened.

HOW DO I ENROLL?

Glad You Asked.

We recommend a little pre-work:

1. **Review your benefit options**
   You're here reading this so you're totally already doing it. Nicely done.

2. **Make your decisions**
   There are a few really important decisions you need to make before enrolling, such as:
   - Who will I cover?
   - Which benefits meet my needs?
   - How much can I spend?

3. **Enroll online**
   Log into **BenefitsNow**. Follow the prompts. You know the drill.

4. **Confirm your elections**
   Don't skip this part! You probably nailed it, but if you make a mistake, this is the time to fix it. We suggest you print or save your confirmation statement as a pdf for your records.

5. **Submit your enrollment**
   Make sure you submit your enrollment. You're covered by great benefits.

Choose the Right Plans & Save Money with ALEX

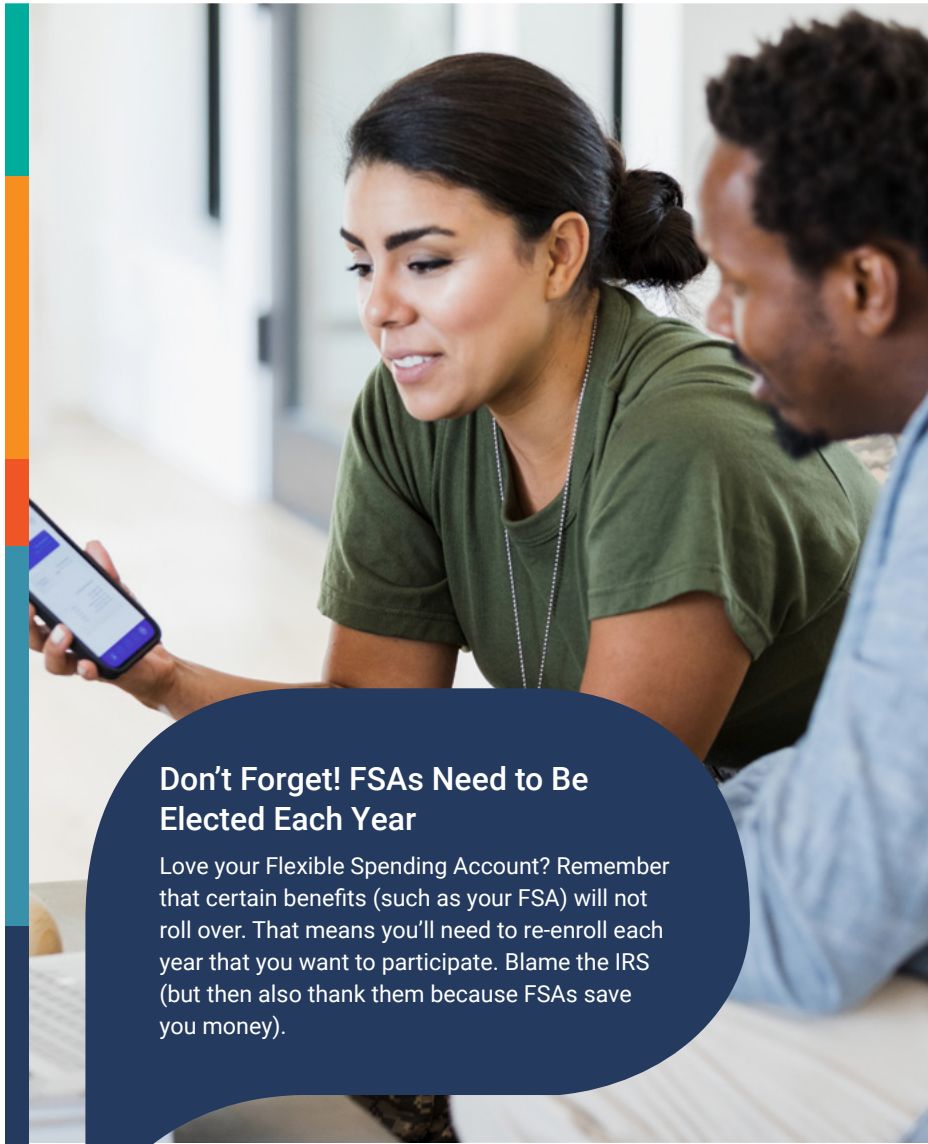
Meet ALEX, your easy-to-use online benefits counselor. ALEX makes it easy to learn more about your benefits and make the best financial decisions for you and your family.

When you use ALEX, you'll be asked a few questions about you and your health care, financial, and retirement needs. Then, ALEX will crunch some numbers and recommend what may be the best plan option for you and your family.

Before you make your enrollment decisions, let ALEX help you find the plans that make the most sense for your situation. The process takes several minutes, and all your information is completely confidential. You will also receive an email outlining the plan recommendations, making enrollment easy.

Find out which plans are right for you and more at **www.myalex.com/genesys/2023**.

THEN, KICK YOUR FEET UP. YOU'RE DONE UNTIL NEXT YEAR!



Don't Forget! FSAs Need to Be Elected Each Year

Love your Flexible Spending Account? Remember that certain benefits (such as your FSA) will not roll over. That means you'll need to re-enroll each year that you want to participate. Blame the IRS (but then also thank them because FSAs save you money).

HELPFUL BENEFIT TERMS AND DEFINITIONS

To better understand your coverage, it's helpful to be familiar with benefits vocabulary. Take a moment to review these terms, which may be referenced throughout this guide.

BALANCE BILL

When a health care provider bills a patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge.

COPAY

A fixed dollar amount you pay the provider at the time of service.

COINSURANCE

The percentage paid for a covered service, shared by you and the plan. You are responsible for coinsurance until you reach your plan's out-of-pocket maximum.

DEDUCTIBLE

The amount you pay each plan year before the plan begins paying benefits. Not all covered services are subject to the deductible.

EMERGENCY ROOM CARE

Care received at a hospital emergency room for life-threatening conditions.

FORMULARY

A list of preferred drugs chosen by a panel of doctors and pharmacists. Both brand and generic medications are included on the formulary.

IN-NETWORK CARE

Care provided by contracted doctors within the plan's network of providers. This enables participants to receive care at a reduced rate compared to care received by out-of-network providers.

OUT-OF-NETWORK CARE

Care provided by a doctor or at a facility outside of the plan's network. Your out-of-pocket costs may increase, and services may be subject to balance billing.

OUT-OF-POCKET MAXIMUM

The maximum amount you pay per year before the plan begins paying for covered expenses at 100%. This limit helps protect you from unexpected catastrophic expenses.

PREMIUM

What you pay from your paycheck to participate in each plan. You may share this cost with your employer or be responsible for the full amount.

PREVENTIVE CARE

Routine health care including annual physicals and screenings to prevent disease, illness, and other health complications. In-network preventive care is covered at 100%.

URGENT CARE

Urgent care centers are helpful when care is needed quickly to avoid developing more serious pain or problems. Visit urgent care for sudden illnesses or injuries that are not life-threatening.

Benefit Acronyms

AD&D:
Accidental Death & Dismemberment

EAP:
Employee Assistance Program

FSA:
Flexible Spending Account

HDHP:
High Deductible Health Plan

HMO:
Health Maintenance Organization

HSA:
Health Savings Account

LTD:
Long-Term Disability

OOPM:
Out-of-Pocket Maximum

PPO:
Preferred Provider Organization

STD:
Short-Term Disability

YOUR BENEFIT CONTACTS

You Have Questions? We've Got Answers.

Looking for more information on everything covered in this guide? Visit the Genesys **Benefits Resource Center** or feel free to contact any of the carriers below.

Coverage	Carrier/Vendor	Phone	Website/Email
Enrollment	Alight	**1-844-487-5599**	**genesys.benefitsnow.com**
Medical	UMR/Quantum Health	**1-877-498-3041**	**www.genesyshealthplan.com**
	Kaiser	**1-800-464-4000**	**www.kp.org**
	HMSA (includes Medical, Dental, Vision & Life/AD&D)	**1-800-776-4672**	**www.hmsa.com**
Prescription Drug	OptumRx	**1-877-498-3041**	**www.optumrx.com**
Health Savings Account (HSA)	HealthEquity	**1-877-924-3967**	**www.MyHealthEquity.com**
Dental	Anthem	**1-877-567-1804**	**www.anthem.com/ca**
Vision	VSP	**1-800-877-7195**	**www.vsp.com**
Mental Health Care	Lyra Health	**1-877-335-0372**	**genesys.lyrahealth.com**
Flexible Spending Account (FSA)	HealthEquity	**1-877-924-3967**	**www.healthequity.com/wageworks**

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YOUR BENEFIT CONTACTS (CONT.)

Coverage	Carrier/Vendor	Phone	Website/Email
Commuter Benefit	HealthEquity	**1-877-924-3967**	**www.healthequity.com/wageworks**
Life and AD&D	New York Life - Group Benefit Solutions (formerly Cigna)	**1-800-828-3485**	**genesys.cignatrustedadvisor.com benefits.team@genesys.com**
Disability	New York Life - Group Benefit Solutions (formerly Cigna)	**1-800-36-CIGNA**	**genesys.cignatrustedadvisor.com benefits.team@genesys.com**
401(k)	Fidelity Investments	**1-800-835-5097**	**www.401k.com**
Legal Services	MetLife	**1-800-821-6400**	**www.legalplans.com**
Home & Auto Insurance	MetLife	**1-800-438-6388**	**www.metlife.com/mybenefits**
Pet Insurance	Nationwide	**1-877-738-7874**	**benefits.petinsurance.com/genesys**
Voluntary Insurance Products	Aflac	**1-800-433-3036**	**www.aflacgroupinsurance.com**
Financial Planning	BrightPlan	N/A	**www.BrightPlan.com/enroll**
Online Tutoring	Varsity Tutor	**1-800-836-0181**	**www.varsitytutors.com/partners/genesys**
Digital Health Tool	Rally Program	**1-877-722-7693**	**health.werally.com/client/genesys/register**
Federal Credit Union	Elements Financial Federal Credit Union	**1-800-621-2105**	**www.elements.org**

This communication highlights some of your Genesys benefit plans. Your actual rights and benefits are governed by the official plan documents. If any discrepancy exists between this communication and the official plan documents, the plan documents will prevail. Genesys reserves the right to change any benefit plan without notice. Benefits are not a guarantee of employment. To obtain more information, contact **benefits.team@genesys.com**.

LEGAL NOTICES

Important Notice to Employees from Genesys

About Creditable Prescription Drug Coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Genesys medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2023. This is known as "creditable coverage."

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2023 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Genesys and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of Creditable Coverage

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Genesys prescription drug plans, you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2023. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Genesys plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Genesys coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment or other qualifying event, or otherwise become newly eligible to enroll in the Genesys plan mid-year, assuming you remain eligible.

You should know that if you waive or leave coverage with Genesys and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this Genesys coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit **www.medicare.gov** for personalized help.

- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number) or visit the program online at **https://www.shiptacenter.org/**.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact: **benefits.team@genesys.com**

Notice of Special Enrollment Rights for Health Plan Coverage

As you know, if you have declined enrollment in Genesys's health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plans without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Genesys will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Genesys group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at **benefits.team@genesys.com**.

Newborns' and Mothers' Health Protection Act Notice

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). If you would like more information on maternity benefits, contact your plan administrator at **benefits.team@genesys.com**.

CHIP/Medicaid Notice

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

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

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

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

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

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

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: **http://myalhipp.com/** Phone: 1-855-692-5447	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
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: **http://myakhipp.com/** Phone: 1-866-251-4861 Email: **CustomerService@MyAKHIPP.com** Medicaid Eligibility: **https://health.alaska.gov/dpa/Pages/default.aspx**	Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html** Phone: 1-877-357-3268

ARKANSAS – Medicaid

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

CALIFORNIA – Medicaid

Website:
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: **hipp@dhcs.ca.gov**

IOWA – Medicaid and CHIP (Hawki)

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

KANSAS – Medicaid

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

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx**
Phone: 1-877-524-4718
Kentucky Medicaid Website: **https://chfs.ky.gov**

GEORGIA – Medicaid

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

INDIANA – Medicaid

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

MONTANA – Medicaid

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

NEBRASKA – Medicaid

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

NEVADA – Medicaid

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

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

MINNESOTA – Medicaid

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

MISSOURI – Medicaid

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

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

NEW HAMPSHIRE – Medicaid

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

NEW JERSEY – Medicaid and CHIP

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

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

PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: **https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx** Phone: 1-800-692-7462	Website: **https://www.coverva.org/en/famis-select** **https://www.coverva.org/en/hipp** Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924 Email: **HIPPcustomerservice@dmas.virginia.gov**
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: **http://www.eohhs.ri.gov/** Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: **https://www.hca.wa.gov/** Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: **https://www.scdhhs.gov** Phone: 1-888-549-0820	Website: **https://dhhr.wv.gov/bms/** **http://mywvhipp.com/** Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: **http://dss.sd.gov** Phone: 1-888-828-0059	Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm** Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: **http://gethipptexas.com/** Phone: 1-800-440-0493	Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/** Phone: 855-294-2127 or (307) 777-7531

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

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

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

Genesys HIPAA Privacy Notice

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Genesys health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of Genesys's health plans. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Genesys as an employer — that's the way the HIPAA rules work. Different policies may apply to other Genesys programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with Genesys

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Genesys for plan administration purposes. Genesys may need your health information to administer benefits under the Plan. Genesys agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law.

Here's how additional information may be shared between the Plan and Genesys, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Genesys, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.

- The Plan, or its insurer or HMO, may disclose to Genesys information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Genesys cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Genesys from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)

Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless

the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request.

You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2023. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact your benefits administrator at **benefits.team@genesys.com**

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact **benefits.team@genesys.com**

Model COBRA Continuation Coverage General Notice

Model General Notice of COBRA Continuation Coverage Rights

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 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; or
- The employee's 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 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

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 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

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 Cloud Services, 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**.

No Surprises Act notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an innetwork provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact U.S. Department of Health and Human Services. The federal phone number for information and complaints is: 1-800-985-3059. Visit **No Surprises Act I CMS** for more information about your rights under federal law.

Provider-Choice rights notice

The Kaiser HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Kaiser HMO designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at benefits.team@genesys.com.

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

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