

WORKFORCE OPTIMIZATION®



2020 Benefits Book

Freedom Premier



If you or a dependent have Medicare or will become eligible for Medicare in the next 12 months, please read the notice at the back of this booklet and keep it where you can find it. It highlights options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.

Table of contents

Welcome to Insperity	1
Getting started.....	2
Enroll online	3
Eligibility rules for Insperity benefits.....	4
Your benefits at a glance	5
Medical coverage map	10
Medical coverage options	11
Dental benefits at a glance	21
Vision benefits at a glance.....	22
Enrollment basics	23
How ALEX® works	24
Insperity Group Health Plan ID cards	25
If you decide not to enroll	26
Understanding your medical coverage.....	27
Important notices	29

Welcome to Insperity

Insperity is pleased to offer the employee benefits outlined in this book for plan year 2020. Included are brief descriptions of each benefit offered, eligibility details, enrollment instructions and more.

This information is intended to provide only an overview of the major features of Insperity's employee benefits programs. Full details are contained in the Summary Plan Descriptions, Plan documents and insurance contracts that govern each plan or program. Summary Plan Descriptions and Plan documents are available online at portal.insperity.com. They are also available upon request.

Should there be a discrepancy or conflict between the information presented here and the actual Plan documents and insurance contracts, the Plan documents and insurance contracts will govern. Insperity reserves the right to amend or discontinue any Plan or program at any time at its sole discretion. In no event should the benefits provided by Insperity be interpreted as a guarantee of continued employment.



Getting started

Create an account on the Insperity Premier™ platform at portal.insperity.com to:

- Complete your new hire documents
- Use ALEX® to find your coverage fit
- Enroll in Insperity benefits
- Set up direct deposit
- Adjust your tax withholdings
- View your latest paystub or W-2
- Take online training courses
- Browse MarketPlace™ offers and more!

Before you enroll, talk to ALEX

Before you enroll for the Insperity Group Health Plan, use our interactive tool ALEX to help you find your best coverage fit based on your family's anticipated health care needs. ALEX can also explain how HSAs and FSAs work with your medical coverage, and which one can help you save the most money on out-of-pocket health care expenses. To access ALEX, log in to portal.insperity.com and select "Start Now" next to Health Benefits.





Enroll online

Visit “Benefits Enrollment” on portal.insperity.com to view your available enrollment opportunities and deadlines. You can complete online benefits enrollment during any required waiting period.

Initial enrollment period for the Insperity Group Health Plan

To participate in the Insperity Group Health Plan, you must enroll within 30 days of the date you become eligible for coverage. This 30-day period will follow any required waiting period. See the **Enrollment basics** page in this book for more information, including step-by-step instructions for online benefits enrollment.

Initial enrollment period for voluntary benefits

During your initial enrollment period for the Insperity Group Health Plan, you can also apply online for guaranteed issue of voluntary welfare benefits, such as Group Universal Life coverage, without Evidence of Insurability. See the **Voluntary Benefits Book** for more information, as well as coverage amounts and rates.

Initial enrollment period for the Insperity Health Care Flexible Spending Account Plan

There is no waiting period for the Insperity Health Care Flexible Spending Account Plan (Health Care FSA). To participate, you must enroll within 30 days of the date you become eligible for the Health Care FSA.



Enrollment deadlines

Your enrollment for the Insperity Group Health Plan or the Health Care FSA must be complete and submitted no later than 11:59 p.m. Central time on the last day of your initial enrollment period for each benefit.

Enrollments received after the deadline cannot be processed. If you do not have online access, you may request paper enrollment forms by calling the Insperity Contact Center.

Eligibility rules for Insperity benefits

Employee eligibility

Employees must work 30 or more hours per week (20 or more hours in Hawaii) on average, and meet all other eligibility requirements, to be eligible for the Insperity benefits available to full-time employees. Part-time and seasonal employees may be eligible for any Insperity benefit or program with no full-time requirement. See **Your benefits at a glance** for additional information on benefits available to full-time and part-time or seasonal employees.

Part-time and seasonal employees of an Applicable Large Employer (ALE), as defined under the Affordable Care Act (ACA) and reflected in Insperity's records, will be eligible for benefits available to full-time employees if they are found to be working the required number of hours over one of the measurement periods described below:

- Newly hired part-time and seasonal employees—the 12-month period following the employee's hire date
- Ongoing part-time and seasonal employees—the 12-month period beginning each year on Jan. 1

An ALE is an employer who has employed, on average, at least 50 full-time employees (including full-time equivalent employees) during the preceding calendar year. If you have questions about whether your company is an ALE, contact Insperity.

Pretax benefit eligibility

Please note that full-time employees with a post-tax status in Insperity's records are not eligible to participate in the following pretax benefits:

- The Insperity Health Care Flexible Spending Account Plan
- The Commuter Benefits Program

Full-time employees with post-tax status may still participate in other Insperity benefits on a post-tax basis. If you have questions about your tax status, please contact Insperity.

Dependent eligibility

You can enroll eligible dependents in the same Insperity Group Health Plan coverage options that you elect for yourself. If you enroll in medical, dental and vision coverage, you may elect any combination of that medical and/or dental and vision coverage for your dependents. Eligible dependents include:

- Your spouse, common-law spouse or domestic partner
- Any eligible child who meets age limitation rules, including a biological or adopted child, a child placed with the employee for adoption, an employee's stepchild or the child of a domestic partner
- Any child the employee must provide with health coverage by reason of a Qualified Medical Child Support Order (QMCSO)

Complete eligibility information available online

Complete eligibility information for all Insperity-sponsored benefits can be found at portal.insperity.com. Copies of Summary Plan Descriptions (SPDs) and other plan documents can also be requested by calling the Insperity Contact Center.

Your benefits at a glance

The following benefits are available to all Insperity employees, whether full-time, part-time or seasonal:

The Insperity Employee Assistance Program (EAP)

A counseling and consultation service available to all employees (and their dependents) with no hourly eligibility requirement. Most services are available to employees at no cost. The Insperity Employee Assistance Program (EAP) is administered by Optum®, and features:

- 24/7 access to registered nurses and counselors
- Legal consultation and mediation services (no cost for half-hour consultation, 25% discount on continuing services)
- Confidential financial coaching (two sessions included)
- Up to three face-to-face or virtual counseling sessions with EAP-affiliated behavioral health providers at no cost
- Child and elder care referrals
- Critical incident response with onsite employee counseling available
- Substance use disorder support with licensed clinicians
- Behavioral health care support with virtual visit options through liveandworkwell.com

To access Optum EAP resources 24 hours a day, 7 days a week, call 866.402.0003, or visit liveandworkwell.com and use access code "Insperity."

The Insperity Commuter Benefits Program

Pay for job-related mass transit and/or parking expenses with pretax dollars (if eligible). There is a monthly \$2 administrative fee to participate, except where prohibited by local ordinance. You may enroll or discontinue participation at any time. If you do not enroll, the benefit is considered waived.

Learning and Development

Self-paced online, live virtual and classroom training programs to learn new skills, maintain safety and compliance, improve performance and develop careers.

- 3,500+ self-paced courses on business, safety, liability management, desktop, and IT topics
- 25,000+ books in online, audio, and summary formats
- Business and desktop videos
- Instructor-led virtual training
- Continuing education units on many courses

MarketPlace™

Offers online discounts on a variety of goods and services, including cell phone services, identity theft protection, pet health insurance, travel, electronics, gifts, household needs and more.

Insperity Pay Options

Payroll direct deposit and debit pay card options are available.

Your benefits at a glance

The following benefits are available to full-time (or full-time equivalent) Insperity employees who work 30 or more hours per week (20 or more hours in Hawaii) on average, and meet all other eligibility requirements:

The Insperity Adoption Assistance Program

Reimburses up to \$1,500 of qualifying expenses per qualified adoption. Requires 180 days of continuous service after obtaining eligible status. The continuous service requirement must be satisfied prior to the date of the final adoption decree. Qualifying expenses must be incurred through private adoption or a licensed agency.

The Insperity Educational Assistance Program

Reimburses up to \$1,500 per calendar year for approved undergraduate/graduate courses taken as part of a degree program, or up to \$500 per calendar year for approved continuing education expenses. Maximum \$1,500 reimbursement per calendar year. This program does not apply to courses, seminars, or training provided by Insperity or the client company.

The Insperity Health Care Flexible Spending Account (FSA) Plan

Make pretax contributions (if eligible) up to the annual maximum through payroll deduction for qualifying health care expenses incurred during the plan year.

For plan year 2020, you may elect from \$20 to \$225 in monthly contributions, up to a maximum annual contribution of \$2,700.

Once enrolled, you will receive a Health Care Spending Card (a debit MasterCard® issued by UnitedHealthcare) funded with your elected amount. Use the card for eligible expenses at the time of service, or file a claim for reimbursement. You can file claims for any eligible expenses incurred during the plan year through March 31 of the following year; however, unused funds do not roll over to the next plan year and will be lost.

Please note that to continue FSA participation each year, you must submit a new election during the annual open enrollment period for the Insperity Health Care FSA (Nov. 1 to Dec. 31).



HSA or FSA?

IRS rules prohibit individuals with general purpose health care FSA coverage (including an eligible spouse and dependents) from contributing to an HSA. If you are currently contributing to an HSA (or intend to open and contribute to an HSA), you should not enroll in the Insperity Health Care FSA Plan, as participation in the Health Care FSA will make you ineligible to contribute to an HSA in the same calendar year.

Your benefits at a glance

The Insperity Health Savings Account (HSA) Program

An HSA is a type of consumer-owned and managed savings account for individuals covered by a qualified high deductible health plan (HDHP). If you are an Insperity employee enrolled in an Insperity HDHP coverage option, you can establish an HSA through the Insperity HSA Program.

There are no federal taxes on pretax contributions made to your HSA, and the money you spend out of your HSA is tax-free when you use it for qualified health care expenses. Plus, you keep what you save – any unused funds remain in your account from year to year, earning tax-free interest and dividends when invested.

In 2020, HSA contribution limits are \$3,550 for employee-only coverage, and \$7,100 for family coverage. Your elected HSA contribution amount can be changed as needed throughout the year. If you will turn 55 or older within the tax year, you may contribute an additional \$1,000 of catch-up contributions.

Opening an Optum Bank® account through the Insperity HSA Program

Please note that all transactions for HSA account holders are conducted electronically; internet access and a valid email address are required.

You will receive an email with instructions for setting up your account from Insperity's HSA Program Administrator within 24-48 hours of enrolling in an Insperity HDHP coverage option. If you enroll more than 30 days before your HDHP coverage effective date, however, you will not receive this email until approximately 30 days before the coverage effective date.

Once your HSA has been established, you can make pre- or post-tax contributions (according to your eligibility in Insperity's records) through Insperity payroll deduction. If you already have an HSA elsewhere, you can transfer the assets to your Optum Bank HSA, or link an existing Optum Bank HSA to the Insperity HSA Program to make contributions by payroll deduction.

Insperity will pay the monthly account management fee while you remain an eligible employee of Insperity enrolled in an Insperity HDHP coverage option.

Important tax information for owners, officers, and HCEs

Pretax HSA contributions are made through the Insperity HSA Cafeteria Plan, which is subject to annual nondiscrimination testing. If you are an officer, highly compensated employee (HCE), or owner of a C-Corporation (or lineal relative of such owner), a nondiscrimination testing failure will result in taxation of your pretax HSA contributions.



Interested in investment options for your HSA?

Treat your HSA like a 401(k) and invest it in mutual funds as part of a long-term savings strategy for your retirement. If your HSA reaches an investment threshold of \$2,100 or more, you can set up an investment account with Optum Bank and elect automatic transfers to grow your savings. Learn more at optumbank.com.

Your benefits at a glance

Basic Term Life and Personal Accident Insurance (employer-paid)

Basic term life and personal accident insurance pays an amount equal to 1 x covered annual earnings, up to \$50,000.

Benefits are reduced at age 65.

Basic Disability Insurance (employer-paid)

Disability insurance provides income protection if you are unable to perform your job due to illness or injury.

- **Short-term disability insurance pays up to 60% of covered weekly earnings, up to \$2,308 per week.** There is a 14-day elimination period for short-term disability benefits. Benefits begin on the 15th day of disability and continue for up to 24 weeks following the elimination period or the end of disability, whichever comes first.
- **Long-term disability insurance pays up to 60% of covered monthly earnings, up to \$10,000 per month.** Benefits begin after six continuous months of disability and continue up to age 65 or the end of disability, whichever comes first. An abbreviated payment schedule applies for disability that begins at age 63 or older.

Voluntary Group Universal Life Insurance (employee-paid)

You may elect voluntary group universal life for yourself and your eligible dependents in the following amounts:

- **Employee coverage from 1 to 6 x covered annual earnings, up to \$2,500,000**
- Spouse/domestic partner coverage at \$10,000; \$20,000; \$30,000; \$40,000; \$50,000; \$100,000; \$150,000; \$200,000
- Child coverage at \$5,000 or \$10,000 per child

The guaranteed issue amount for employee coverage during the initial eligibility period is up to 3 x covered annual earnings or \$500,000, whichever is less. The guaranteed issue amount for spouse/domestic partner coverage during the initial eligibility period is \$20,000. For coverage over guaranteed issue amounts, or for any amount of coverage (if elected after the initial eligibility period), Evidence of Insurability (EOI) will be required.

Voluntary Personal Accident Insurance (employee-paid)

Voluntary personal accident insurance pays a benefit for an accidental death occurring within 365 days of a covered accident, or for accidental loss of limb or functionality (e.g., eyesight, hearing, paralysis). Evidence of Insurability is not required, and you can apply at any time. Benefits are reduced beginning at age 70.

- **Employee coverage from 1 to 6 x covered annual earnings, up to \$2,500,000**
- Spouse or domestic partner coverage is available at 60% of the coverage amount you elect for yourself
- Coverage for a spouse or domestic partner plus child(ren) is available at 50% of the coverage amount you elect for yourself plus 10% for each dependent child
- Coverage for dependent children only is available at 15% of the coverage amount you elect for yourself

See the Cigna Voluntary Benefits Book for coverage amounts and rates. More information on additional features available through Cigna, including Cigna Secure Travel® and Cignassurance®, is available at portal.insperity.com.

Your benefits at a glance

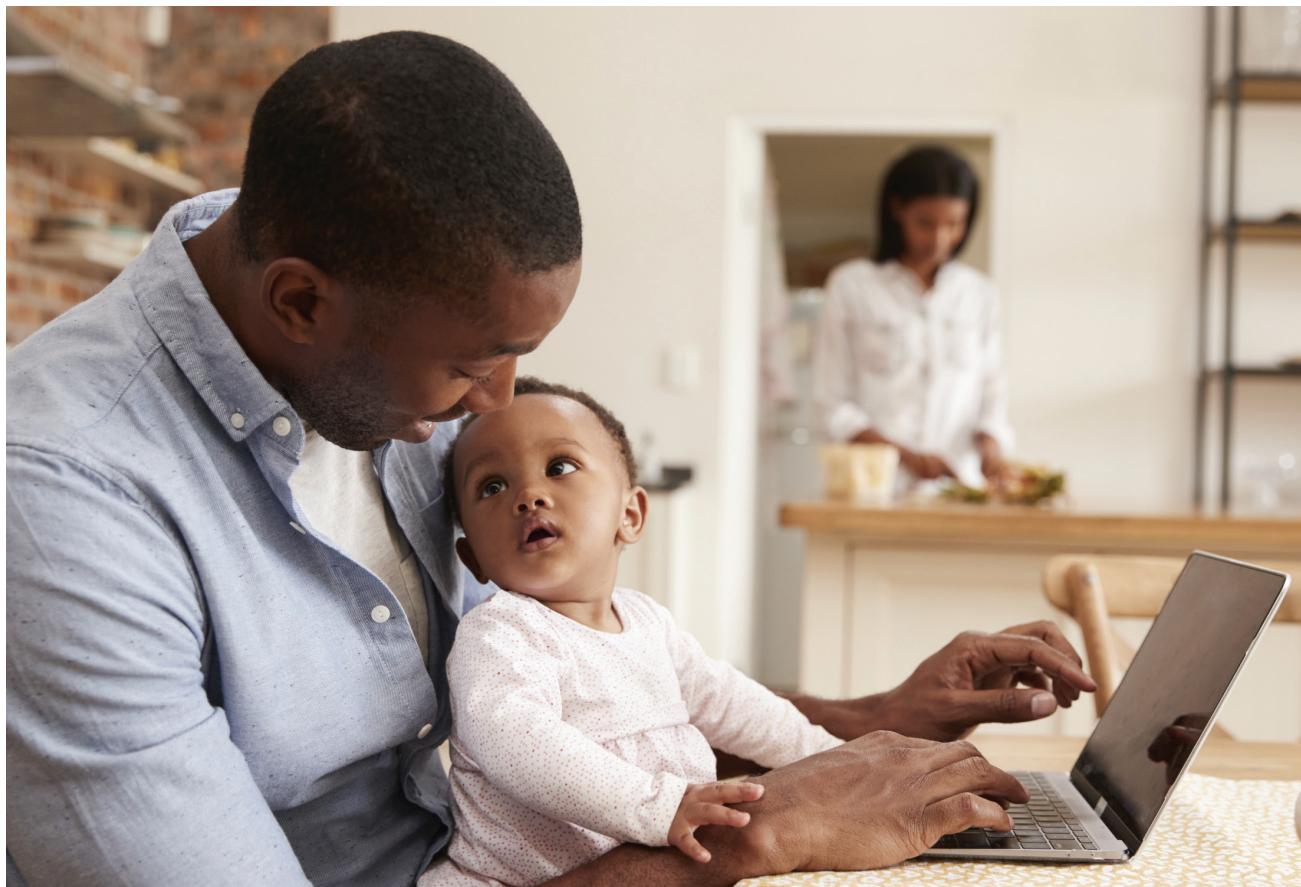
The Insperity Group Health Plan

Medical coverage options include prescription coverage and vary by insurance carrier, region and coverage type. Medical coverage options will also generally include carrier-sponsored wellness programs and telemedicine options (where permitted by state law). Availability is determined by benefits package and ZIP code service area.

Dental and vision coverage is available through UnitedHealthcare Dental and Vision Service Plan nationwide, and must be elected together, but may be elected independently of medical coverage.

The Insperity Group Health Plan is a calendar-year plan based on a 12-month coverage period which begins Jan. 1 and ends Dec. 31. Your deductibles and out-of-pocket maximums will reset each Jan. 1, and generally, any Plan design changes outlined in the Summary of Material Modifications (SMM) for that Plan year will also take effect – even if your client company's open enrollment and 12-month coverage periods do not follow the calendar year.

The following section offers specific details on the coverage options available to you, as well as terms, limits, exclusions, legal notices and requirements that apply to your Insperity Group Health Plan participation. Please review this information carefully before making your elections. If you have any questions, please call the Insperity Contact Center.

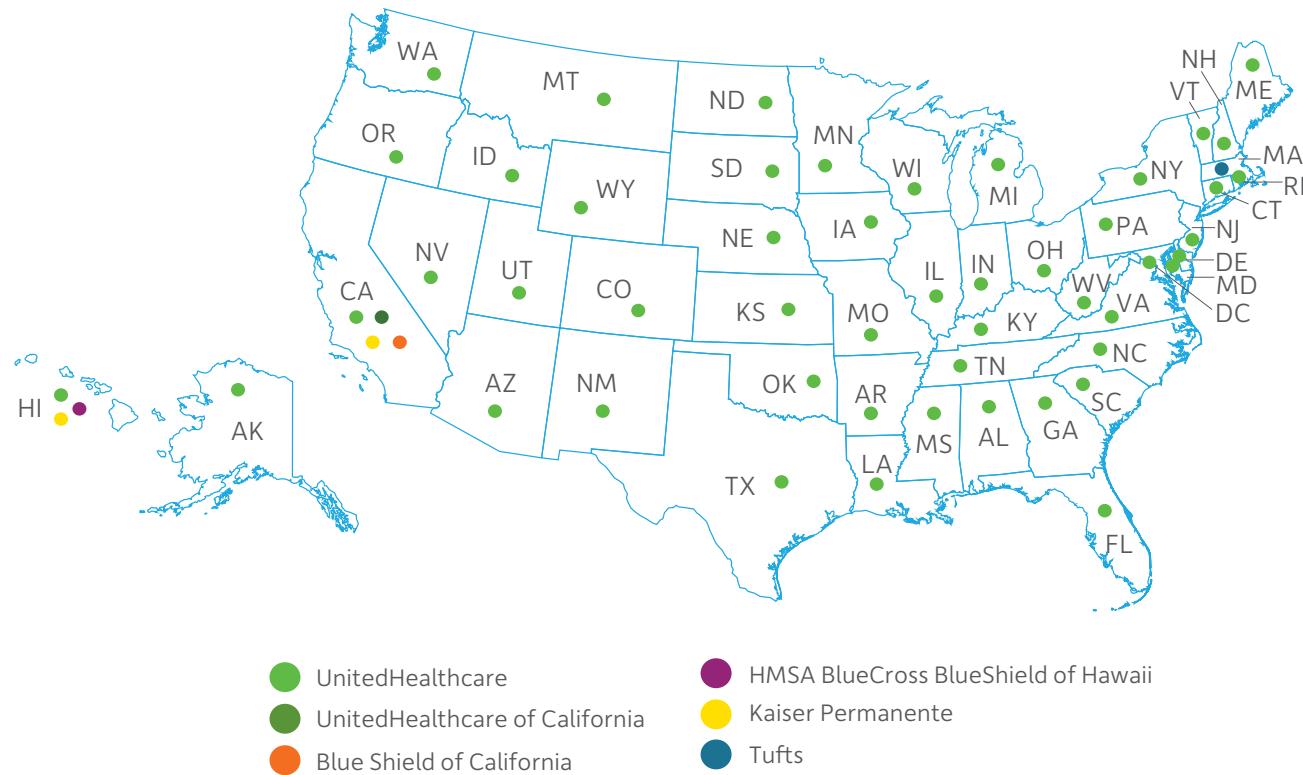


Medical coverage map

Availability of medical coverage options

The Insperity Group Health Plan medical coverage options available to you are determined by:

- Your Insperity benefits package, and
- Your residential ZIP code service area, and
- The insurance carrier(s) and networks available in your area



To participate in a coverage option, you must live in a ZIP code service area included in that insurance carrier's network. ZIP codes associated with an insurance carrier's network service area are determined by the insurance carrier (not Insperity) and are specific to the health insurance product offerings defined in the carrier's contract with Insperity.

You can find detailed Insperity Group Health Plan information, including what coverage options are available to you, on the Insperity Premier™ platform at portal.insperity.com. You may also contact Insperity by phone at 866.715.3552, weekdays from 7 a.m. to 7 p.m. Central time, or by email at contactcenter@insperity.com.

National medical coverage options

Premier-level packages

Coverage options	UHC Choice Plus 250	UHC Choice Plus 500/90	UHC Choice Plus HDHP 1500 (aggregate)	UHC Choice Plus HDHP 5000
Coinsurance plan pays after deductible	100% 70%	90% 70%	90% 70%	80% 60%
Medical calendar-year deductible	Individual	\$250 \$500	\$500 \$1,000	\$1,500 \$3,000
	Family	\$750 \$1,500	\$1,500 \$3,000	\$3,000 \$6,000
Annual out-of-pocket maximum	Individual	\$3,000 \$6,000	\$4,000 \$8,000	\$4,000 \$8,000
	Family	\$6,000 \$12,000	\$8,000 \$16,000	\$7,350 \$14,700
Office visit	\$30	\$30	10%	20%
Specialist visit	\$50	\$50	10%	20%
Virtual visit	\$20	\$20	10%	20%
Urgent care	\$75	\$75	10%	20%
Emergency room	\$250	\$250	10%	20%
Outpatient surgery	\$100	10%	10%	20%
Inpatient hospital	0%	10%	10%	20%

Out-of-network costs for covered services are indicated in green. Coverage options have embedded deductibles and OOPMs unless otherwise noted. Copays and coinsurance rates listed are for non-preventive care. An explanation of the terms used in this chart can be found in the section "Understanding your medical coverage." Additional limits and exclusions apply. See the Certificates of Coverage for complete coverage details.

Want to save on covered care? Log in to [myuhc.com](#) and select Find Care & Costs to compare providers and costs for urgent care, labs, imaging, procedures, condition management and more.



Wellness

Wellness resources available for UnitedHealthcare members include the Quit for Life® tobacco cessation program, discounts for gym memberships, weight loss programs, and Rally®, an interactive app that provides personalized health and wellness advice. For more information, see "Health Resources" on [myuhc.com](#), or contact UnitedHealthcare Member Services.



Ask a nurse

Care24® nurses and counselors can provide confidential guidance on a variety of health topics and concerns. Information provided is general and not to be used as a substitute for consultation with a health care provider. Access registered nurses and counselors anytime through Care24 at 888.887.4114, or visit [nurselinechat.com/Insperity](#).

National pharmacy coverage

Premier-level packages

Coverage options		UHC Choice Plus 250	UHC Choice Plus 500/90	UHC Choice Plus HDHP 1500 (aggregate)	UHC Choice Plus HDHP 5000
Prescription deductible	Individual	\$100	\$100	Copays apply once medical deductible is met	Copays apply once medical deductible is met
	Family	\$300	\$300		
Tier 1 copays	Retail	\$10	\$10	\$10	\$10
	Mail order	\$25	\$25	\$25	\$25
Tier 2 copays	Retail	\$35	\$35	\$35	\$35
	Mail order	\$87.50	\$87.50	\$87.50	\$87.50
Tier 3 copays	Retail	\$60	\$60	\$60	\$60
	Mail order	\$150	\$150	\$150	\$150
Tier 4 copays	Retail	\$120	\$120	\$120	\$120
	Mail order	\$300	\$300	\$300	\$300

An explanation of the terms used in this chart can be found in the section "Understanding your medical coverage." Additional limits and exclusions apply. See the Certificates of Coverage for complete coverage details.

Reimbursement of out-of-network services

The following is a general overview of how out-of-network services are paid by these coverage options. See the applicable Certificate of Coverage for more details.

UnitedHealthcare Choice Plus coverage options pay benefits for non-emergency, non-network services after the deductible is met and according to a Medicare cost-based payment methodology defined by UnitedHealthcare as the Maximum Non-Network Reimbursement Program, or MNRP. Under MNRP, reimbursement amounts are a percentage of the published rates allowed by Medicare for the same or similar services. Any difference between the amount billed by the non-network provider and the amount allowed by UnitedHealthcare may be balance billed to the participant by the provider. UnitedHealthcare Choice Plus coverage options available through the Insperity Group Health Plan are subject to Texas insurance law. Any state laws regarding balance billing outside of Texas will not apply to participants enrolled in a UnitedHealthcare Choice Plus option.

If you are balance billed in excess of the applicable deductible, copay or coinsurance for emergency services received in any state, contact UnitedHealthcare Member Services for assistance.



Condition management

Programs, provider referrals, coordination of care and additional resources for the management of serious or chronic conditions are available. UnitedHealthcare may contact eligible participants directly with program information. Call Member Services at the number on your Member ID to learn more.



Virtual care

Talk to a doctor any time using your mobile device or computer for urgent care issues such as sinus infections, UTIs or flu. Providers for UnitedHealthcare include Dr. On Demand, Amwell®, and Teladoc®. Log on to myuhc.com to select a provider and learn more.

California medical coverage options

Premier-level packages (choose from National UnitedHealthcare Choice Plus options or regional HMOs below)

Coverage options		UHC of California HMO	Blue Shield of California HMO	Kaiser Permanente HMO
Coinsurance plan pays after deductible		100% <i>n/a</i>	100% <i>n/a</i>	100% <i>n/a</i>
Medical calendar-year deductible	Individual	n/a	n/a	n/a
	Family	n/a	n/a	n/a
Annual out-of-pocket maximum	Individual	\$3,000 <i>n/a</i>	\$3,000 <i>n/a</i>	\$3,000 <i>n/a</i>
	Family	\$6,000 <i>n/a</i>	\$6,000 <i>n/a</i>	\$6,000 <i>n/a</i>
Office visit		\$25	\$25	\$25
Specialist visit		\$50	\$50	\$50
Virtual visit		\$25	\$5	\$0
Urgent care		\$25	\$25	\$25
Emergency room		\$200	\$200	\$200
Outpatient surgery		\$125	\$150	\$100
Inpatient hospital		\$500	\$500	\$250

Out-of-network costs for covered services are indicated in green. Coverage options have embedded deductibles and OOPMs unless otherwise noted. Copays and coinsurance rates listed are for non-preventive care. An explanation of the terms used in this chart can be found in the section "Understanding your medical coverage." Additional limits and exclusions apply. See the Certificates of Coverage for complete coverage details.



Wellness

Personalized coaching and wellness programs are available for tobacco cessation, weight loss, and nutrition counseling. Kaiser members can schedule sessions at 866.862.4295 or KP.org/wellnesscoach. Blue Shield members can register at wellvolution.com. Wellness program information for UnitedHealthcare of California is available at myuhc.com.



Ask a nurse

Nurses and counselors can give confidential guidance on a variety of health concerns. Information provided is general and not to be used as a substitute for consultation with a health care provider. Call the Member Services number on your ID card to reach a registered nurse at any time.

California pharmacy coverage

Premier-level packages

Coverage options	UHC of California HMO		Blue Shield of California HMO	Kaiser Permanente HMO
Prescription deductible	n/a		n/a	n/a
Tier 1 copays	Retail	\$10	\$10	\$10
	Mail order	\$25	\$20	\$20
Tier 2 copays	Retail	\$30	\$25	\$30
	Mail order	\$75	\$50	\$60
Tier 3 copays	Retail	\$50	\$40	n/a
	Mail order	\$125	\$70	
Tier 4 copays	Retail	Rx 30% max \$200	Rx 30% max \$200	Rx 30% max \$150
	Mail order	Rx 30% max \$200	Rx 30% max \$400	Rx 30% max \$150

An explanation of the terms used in this chart can be found in the section “Understanding your medical coverage.” Additional limits and exclusions apply. See the Certificates of Coverage for complete coverage details.

Reimbursement of out-of-network services

The following is a general overview of how out-of-network services are paid by these coverage options. See the applicable Certificate of Coverage for more details.

California regional HMO coverage options provide benefits for in-network providers only. Covered services are generally payable to non-network providers only for urgent care when a participant has traveled out of the area, or for emergency services received at any emergency room. Claims may need to be filed by the participant for reimbursement. In some cases, non-emergency services from a non-network provider at an in-network facility may be also covered when authorized by an in-network primary care provider. California law prohibits balance billing of HMO participants in these circumstances.

If you are a California resident enrolled in a UnitedHealthcare National Choice Plus coverage option, please note that UnitedHealthcare Choice Plus coverage options available through the Insperity Group Health Plan are subject to Texas insurance law. Any California state law regarding balance billing will not apply to your coverage option.



Condition management

Programs, provider referrals, coordination of care and additional resources for the management of serious or chronic conditions are available. Carriers may contact eligible participants directly with program information. Call the number on your UnitedHealthcare or Kaiser ID card to learn more. Blue Shield members call 877.455.6777.



Virtual care

Talk to a doctor any time using your mobile device or computer for urgent care issues such as sinus infections, UTIs or flu. Use Dr. On Demand, Amwell® or Teladoc® for UnitedHealthcare, Teladoc for Blue Shield, and My Doctor Online for Kaiser. Access virtual care options on your carrier’s Member Services website.

Hawaii medical coverage options

Premier-level packages

Coverage options	UHC Options PPO	HMSA BCBS of Hawaii HMO	Kaiser Permanente HMO
Coinsurance plan pays after deductible	90% 70%	90% n/a	100% n/a
Medical calendar-year deductible	Individual \$100 Combined in/out of network	n/a	n/a
	Family \$300 Combined in/out of network	n/a	n/a
Annual out-of-pocket maximum	Individual \$2,500 Combined in/out of network	\$2,500 (medical only) n/a	\$2,000 n/a
	Family \$7,500 Combined in/out of network	\$7,500 (medical only) n/a	\$6,000 n/a
Office visit	10%	\$20	\$20
Specialist visit	10%	\$20	\$20
Virtual visit	\$20	\$0	\$20
Urgent care	10%	\$20	\$20
Emergency room	10%	\$100	\$50
Outpatient surgery	10%	10%	\$20
Inpatient hospital	10%	10%	\$50 per day

Out-of-network costs for covered services are indicated in green. Coverage options have embedded deductibles and OOPMs unless otherwise noted. Copays and coinsurance rates listed are for non-preventive care. An explanation of the terms used in this chart can be found in the section "Understanding your medical coverage." Additional limits and exclusions apply. See the Certificates of Coverage for complete coverage details.



Wellness

Personalized coaching and wellness programs are available for tobacco cessation, weight loss, and nutrition counseling. Kaiser members can schedule sessions at 866.862.4295 or KP.org/wellnesscoach. Wellness program information for UnitedHealthcare is available at myuhc.com. HMSA members can view wellness resources at HMSA.com.



Ask a nurse

Nurses and counselors can provide confidential guidance on a variety of health issues and concerns. Information provided is general and not to be used as a substitute for consultation with a health care provider. Call the Member Services number on your ID card to reach a registered nurse at any time.

Hawaii pharmacy coverage

Premier-level packages

Coverage options	UHC Options PPO	HMSA BCBS of Hawaii HMO		Kaiser Permanente HMO
Prescription deductible	n/a	Prescription-only OOPM		n/a
		\$3,600 Individual	\$4,200 Family	
Tier 1 copays	Retail	\$10	\$7	\$10
	Mail order	\$20	\$11	\$20
Tier 2 copays	Retail	\$15	\$30	\$35
	Mail order	\$30	\$65	\$70
Tier 3 copays	Retail	\$30	\$30 + \$45	\$35
	Mail order	\$60	\$65 + \$135	\$70
Tier 4 copays	Retail	n/a	\$100 \$200	\$200
	Mail order		n/a	n/a

An explanation of the terms used in this chart can be found in the section “Understanding your medical coverage.” Additional limits and exclusions apply. See the Certificates of Coverage for complete coverage details.

Reimbursement of out-of-network services

The following is a general overview of how out-of-network services are paid by these coverage options. See the applicable Certificate of Coverage for more details.

UnitedHealthcare Options PPO pays benefits for non-emergency, non-network services after the out-of-network deductible is met according to a Medicare cost-based payment methodology defined by UnitedHealthcare as the Maximum Non-Network Reimbursement Program, or MNRP. Under MNRP, reimbursement amounts are a percentage of the published rates allowed by Medicare for the same or similar services. Any difference between the amount billed by the non-network provider and the amount allowed by UnitedHealthcare may be balance billed to the participant by the provider. If you are balance billed in excess of the applicable deductible, copay or coinsurance for emergency services received in any state, contact UnitedHealthcare Member Services for assistance.

Hawaii HMO coverage options provide benefits for in-network providers only. Covered services are generally payable to non-network providers only for urgent care when a participant has traveled out of the area, or for emergency services received at any emergency room. Claims may need to be filed by the participant for reimbursement.



Condition management

Programs, provider referrals, coordination of care and additional resources for the management of serious or chronic conditions are available. Carriers may contact eligible participants directly with program information. Call the number on your UnitedHealthcare Member ID card to learn more. HMSA members call 855.211.4527.



Virtual care

Talk to a doctor any time using your mobile device or computer for urgent care issues such as sinus infections, UTIs or flu. Virtual care is available for Kaiser Permanente members at kp.org, for UnitedHealthcare members at myuhc.com, and on the HMSA Online Care® app for HMSA.

Massachusetts medical coverage options

Premier-level packages

Coverage options	Tufts CareLink Advantage PPO 250	Tufts CareLink Advantage PPO 500/90	Tufts CareLink Advantage Saver PPO HDHP 1500 (aggregate)	Tufts Value HMO	Tufts Advantage Saver HMO HDHP 3000 (aggregate)
Coinsurance plan pays after deductible	100% 80%	90% 70%	90% 70%	100% n/a	65% n/a
Medical calendar-year deductible	Individual	\$250 \$500	\$500 \$1,000	\$1,500 Combined in/out of network	\$3,000 n/a
	Family	\$750 \$1,500	\$1,500 \$3,000	\$3,000 Combined in/out of network	\$6,000 n/a
Annual out-of-pocket maximum	Individual	\$3,000 \$6,000	\$4,000 \$8,000	\$4,000 Combined in/out of network	\$4,000 n/a
	Family	\$6,000 \$12,000	\$8,000 \$16,000	\$7,350 Combined in/out of network	\$7,350 n/a
Office visit	\$30	\$30	10%	\$25	35%
Specialist visit	\$30	\$30	10%	\$40	35%
Virtual visit	\$30	\$30	10%	\$25	35%
Urgent care	\$30	\$30	10%	\$25	35%
Emergency room	\$250	\$250	10%	\$250	35%
Outpatient surgery	0%	10%	10%	\$100	35%
Inpatient hospital	0%	10%	10%	\$500	35%

Out-of-network costs for covered services are indicated in green. Coverage options have embedded deductibles and OOPMs unless otherwise noted. Copays and coinsurance rates listed are for non-preventive care. An explanation of the terms used in this chart can be found in the section "Understanding your medical coverage." Additional limits and exclusions apply. See the Certificates of Coverage for complete coverage details.

Want to save on covered care? Use the Tufts Treatment Cost Estimator + Provider Search Tool at mytuftshealthplan.com to compare providers and costs for urgent care, labs, imaging, procedures, condition management and more.



Wellness

Choose from one of six goal-specific programs and receive six months of personalized coaching over the phone or through a virtual interactive program from Tufts Health Plan. Enroll in wellness coaching at mytuftshealthplan.com, or by calling 866.201.7919.



Ask a nurse

Nurses and counselors can provide confidential guidance on a variety of health issues and concerns. You can access registered nurses and counselors anytime through Nurse24™. To reach a nurse, call 866.201.7919.

Massachusetts pharmacy coverage

Premier-level packages

Coverage options	Tufts CareLink Advantage PPO 250	Tufts CareLink Advantage PPO 500/90	Tufts CareLink Advantage Saver PPO HDHP 1500 (aggregate)	Tufts Value HMO	Tufts Advantage Saver HMO HDHP 3000 (aggregate)
Prescription deductible	n/a	n/a	Copays apply once medical deductible is met	n/a	Copays apply once medical deductible is met
Tier 1 copays	Retail	\$10	\$10	\$10	\$15
	Mail order	\$20	\$20	\$20	\$30
Tier 2 copays	Retail	\$35	\$35	\$30	\$30
	Mail order	\$70	\$70	\$60	\$60
Tier 3 copays	Retail	\$60	\$60	\$60	\$60
	Mail order	\$120	\$120	\$120	\$120
Tier 4 copays	Retail	n/a	n/a	n/a	n/a
	Mail order				

An explanation of the terms used in this chart can be found in the section "Understanding your medical coverage." Additional limits and exclusions apply. See the Certificates of Coverage for complete coverage details.

Reimbursement of out-of-network services

The following is a general overview of how out-of-network services are paid by these coverage options. See the applicable Certificate of Coverage for more details.

Tufts CareLink Advantage PPO coverage options pay benefits for non-emergency, non-network services after the deductible is met and according to a Reasonable Charge payment methodology. Reasonable charges are determined based on Medicare relative values. Any difference between the amount billed by the non-network provider and the amount allowed by Tufts may be balance billed to the participant by the provider. Contact Tufts Member Services for assistance with any non-network claims.

Tufts HMO coverage options provide benefits for in-network providers only. Covered services are generally payable to non-network providers only for urgent care when a participant has traveled out of the area, or for emergency services received at any emergency room. Claims may need to be filed by the participant for reimbursement.



Condition management

Programs, provider referrals, coordination of care and additional resources for the management of serious or chronic conditions are available. Tufts may contact eligible participants directly with program information. Visit mytuftshealthplan.com or call the number on your ID card to learn more.



Virtual care

Talk to a doctor any time using your mobile device or computer for urgent care issues such as sinus infections, UTIs or flu. Virtual visits are available through Teladoc®. Visit mytuftshealthplan.com to learn more or schedule a virtual appointment.

Out-of-area medical coverage options

Premier-level packages

Coverage options	UHC out-of-area 500	UHC out-of-area HDHP 1500 (aggregate)	UHC out-of-area HDHP 5000
Coinsurance plan pays after deductible	80%	80%	80%
Medical calendar-year deductible	Individual \$500 No network limitation	\$1,500 No network limitation	\$5,000 No network limitation
	Family \$1,500 No network limitation	\$3,000 No network limitation	\$10,000 No network limitation
Annual out-of-pocket maximum	Individual \$6,350 No network limitation	\$4,000 No network limitation	\$6,650 No network limitation
	Family \$12,700 No network limitation	\$7,350 No network limitation	\$13,300 No network limitation
Office visit	20%	20%	20%
Specialist visit	20%	20%	20%
Virtual visit	20%	20%	20%
Urgent care	20%	20%	20%
Emergency room	20%	20%	20%
Outpatient surgery	20%	20%	20%
Inpatient hospital	20%	20%	20%

Out-of-network costs for covered services are indicated in green. Coverage options have embedded deductibles and OOPMs unless otherwise noted. Copays and coinsurance rates listed are for non-preventive care. An explanation of the terms used in this chart can be found in the section “Understanding your medical coverage.” Additional limits and exclusions apply. See the Certificates of Coverage for complete coverage details.

Want to save on covered care? Log in to [myuhc.com](#) and select Find Care & Costs to compare providers and costs for urgent care, labs, imaging, procedures, condition management and more.



Wellness

Wellness resources available for UnitedHealthcare members include the Quit for Life® tobacco cessation program, discounts for gym memberships, weight loss programs, and Rally®, an interactive app that provides personalized health and wellness advice. For more information, see “Health Resources” on [myuhc.com](#), or contact UnitedHealthcare Member Services.



Ask a nurse

Care24® nurses and counselors can provide confidential guidance on a variety of health topics and concerns. Information provided is general and not to be used as a substitute for consultation with a health care provider. Access registered nurses and counselors anytime through Care24 at 888.887.4114, or visit [nurselinechat.com/Insperity](#).

Out-of-area pharmacy coverage

Premier-level packages

Coverage options		UHC out-of-area 500	UHC out-of-area HDHP 1500 (aggregate)	UHC out-of-area HDHP 5000
Prescription deductible	Individual	\$100	Copays apply once medical deductible is met	Copays apply once medical deductible is met
	Family	\$300		
Tier 1 copays	Retail	\$10	\$10	\$10
	Mail order	\$25	\$25	\$25
Tier 2 copays	Retail	\$35	\$35	\$35
	Mail order	\$87.50	\$87.50	\$87.50
Tier 3 copays	Retail	\$60	\$60	\$60
	Mail order	\$150	\$150	\$150
Tier 4 copays	Retail	\$120	\$120	\$120
	Mail order	\$300	\$300	\$300

An explanation of the terms used in this chart can be found in the section "Understanding your medical coverage." Additional limits and exclusions apply. See the Certificates of Coverage for complete coverage details.

Indemnity (out-of-area) options

The following is a general overview of how out-of-network services are paid by these coverage options. See the applicable Certificate of Coverage for more details.

Out-of-area (indemnity) medical coverage options are only available to eligible employees who live in a ZIP code service area not served by a carrier contracted with the Insperity Group Health Plan. No network limitations apply to covered services; however, your share of the costs will be less if you use an in-network provider or a non-network provider that participates in UnitedHealthcare's Shared Savings Program.

You may be responsible for any difference between the amount billed by a non-network provider and the amount allowed by UnitedHealthcare for non-emergency covered services. If you are balance billed beyond the applicable deductible, copay or coinsurance for emergency services received in any state, contact UnitedHealthcare Member Services for assistance.



Condition management

Programs, provider referrals, coordination of care and additional resources for the management of serious or chronic conditions are available. UnitedHealthcare may contact eligible participants directly with program information. Call Member Services at the number on your Member ID to learn more.



Virtual care

Talk to a doctor any time using your mobile device or computer for urgent care issues such as sinus infections, UTIs or flu. Providers for UnitedHealthcare include Dr. On Demand, Amwell®, and Teladoc®. Log on to myuhc.com to select a provider and learn more.

Dental benefits at a glance

Insperity dental and vision benefits must be elected together, but may be elected independently of medical coverage. Benefits are available to eligible employees nationwide.

Benefit levels shown below are in-network. The provider network is UnitedHealthcare Dental National Options PPO 30. Services received from non-network providers will be paid at reasonable and customary rates, and the participant will be responsible for any remaining balance.

UnitedHealthcare Dental | myuhc.com | 877.816.3596

Calendar-year deductible per person	Calendar-year maximum per person	Orthodontia lifetime maximum	Preventive and diagnostic services	Basic services	Major services	Orthodontic services
\$50 \$150 max per family	\$1,500 per year	\$1,500 to age 19 only	Plan pays 100% no deductible	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 50% no deductible

- **Preventive and diagnostic services** include routine exams, cleaning, topical application of fluoride, diagnostic cast, bite-wing x-rays, sealants, and space maintainers.
- **Basic (restorative) services** include extractions, fillings, oral surgery, palliative emergency treatment, apicoectomy, occlusal guards, periodontic services, root canal therapy, and therapeutic pulpotomy.
- **Major services** include inlays, crowns, bridges, dentures, denture rebase or reline, repair of removable dentures, re-cementing of crowns and bridges, and repairs to fixed bridges.
- **Orthodontic services** include braces, retainers, and other appliances that correct misalignments for dependent children to age 19 only.
- There is no coverage for placement/replacement of dental implants, implant-supported crowns, implant-supporting structures, abutments, or prostheses.
- ID cards are issued when enrollment is processed.

Additional limits and exclusions apply; see the Certificate of Coverage for complete coverage details.



Clear aligner therapy available through SmileDirectClub™

SmileDirectClub, which provides at-home clear aligner therapy for moderate orthodontic concerns, is part of the UnitedHealthcare Dental network. Covered services are available through the orthodontia benefit for enrolled dependents up to age 19. Visit smiledirectclub.com/uhc for more information.

Vision benefits at a glance

Insperity dental and vision benefits must be elected together, but may be elected independently of medical coverage. Benefits are available to eligible employees nationwide.

Benefit levels shown below are in-network. The provider network is VSP Choice. The plan generally pays 100% of eligible expenses after the copay when network providers are used. Services from non-network providers must be paid at full cost by the participant at the time of service. A claim may then be filed for reimbursement of eligible expenses up to the out-of-network benefit allowance.

Vision Service Plan | vsp.com | 800.877.7195

WellVision® exam every 12 months	Glasses frames every 24 months	Single vision lenses every 12 months	Lined bifocal lenses every 12 months	Lined trifocal lenses every 12 months	Lenticular lenses every 12 months	Contact lens every 12 months
\$15 copay	Plan pays up to \$130 frame allowance	\$25 copay	\$25 copay	\$25 copay	\$25 copay	Plan pays up to \$125 lens/exam allowance

- You may receive a benefit for either glasses (lenses only) or contact lenses per 12-month period, but not both.
- Benefits for frames are once every 24 months.
- Diabetic Eyecare Program Plus provides medical exams for diabetic eye disease, glaucoma, and age-related macular degeneration (AMD), as well as retinal screening for eligible members with diabetes, at a \$20 copay. Limitations and coordination with medical coverage may apply.
- Retinal screening for non-diabetic members is covered on an as-needed basis after a \$39 copay.
- Visually necessary contact lenses are covered 100% after a \$25 copay upon review and authorization by VSP.
- Progressive, polycarbonate, tinted and photochromic lenses, as well as anti-reflective or scratch-resistant coatings and other lens enhancements, will generally receive a 20-25% discount off provider price after base lens copay.
- **No ID card is required. Simply tell your network provider you are a VSP member.**

Additional limits and exclusions apply; see the Certificate of Coverage for complete coverage details.



VSP savings for your eyes and ears

Additional discounts and special offers for contact lens exams, LASIK, eyeglass frames, sunglass frames, diabetes care, and TruHearing™ digital hearing aids are available to VSP members. Visit vsp.com/offers for more information.

Enrollment basics

Participation is not automatic. You must enroll if you wish to be covered under the Insperity Group Health Plan. Your 30-day initial enrollment period (*or any longer period required by a state insurance law that may apply to your coverage*) begins the day after any applicable waiting period ends. The first day of your initial enrollment period is also your coverage effective date.

When your benefits enrollment request is processed, your group health coverage is retroactively effective as of your eligibility date, which is the first day you are entitled to coverage under the Insperity Group Health Plan. Any contribution amounts you may owe for retroactive coverage will be deducted from future Insperity paycheck(s).

Step-by-step instructions for online benefits enrollment

1. Log in to portal.insperity.com. Under “Benefits Enrollment,” select “Start Now” next to Health Benefits. Your enrollment deadline will be displayed at this screen.
2. Launch ALEX® to find your best coverage fit. At the next screen, select “Yes, Help Me Find the Best Fit!” to launch ALEX, a benefits enrollment tool that will estimate your anticipated health care costs, compare your available coverage options and suggest the option that will best fit your needs.
3. If you know which coverage option you want, select “I Already Know What I Want” or simply close ALEX once you’re done with the tool.
4. Proceed with online benefits enrollment, entering any dependents you wish to cover, then make your desired coverage elections.
5. Review your Enrollment Summary for covered individuals, as well as the contribution rates for your elected coverage. If you need to make changes, select “Edit.” Once the summary displays your desired enrollment, select “Next.”
6. Submit your Group Health Plan Enrollment Request by indicating you have reviewed both your submission information and Terms of Participation, then click “Submit.” Print the Group Health Plan Enrollment Confirmation for your records, then proceed with Beneficiary Designation or any other enrollments if desired.

Insperity must receive your completed enrollment request by 11:59 p.m. Central time on the last day of your initial enrollment period. If you do not have online access, you may request paper enrollment forms by calling the Insperity Contact Center.



Making changes to your Insperity Group Health Plan coverage

After your initial enrollment period, your next opportunity to enroll in (or make changes to) Insperity Group Health Plan coverage will be your annual open enrollment period – unless you experience a qualifying mid-year event (such as marriage, divorce, birth or adoption of a child, or a gain or loss of other group coverage). For more information, visit “Mid-Year Change” under “Benefits” on portal.insperity.com.

How ALEX® works

ALEX is an interactive decision support tool in online benefits enrollment that will help you select the best coverage for you and your family. When you talk to ALEX, he'll ask you a few questions about your health care needs, crunch some numbers and point out what makes the most sense for you.

How long will this take?

Most users spend about 10 minutes with ALEX, but it depends on how much guidance you need. You can try multiple scenarios and visit as often as you like during your enrollment period.

How should I prepare?

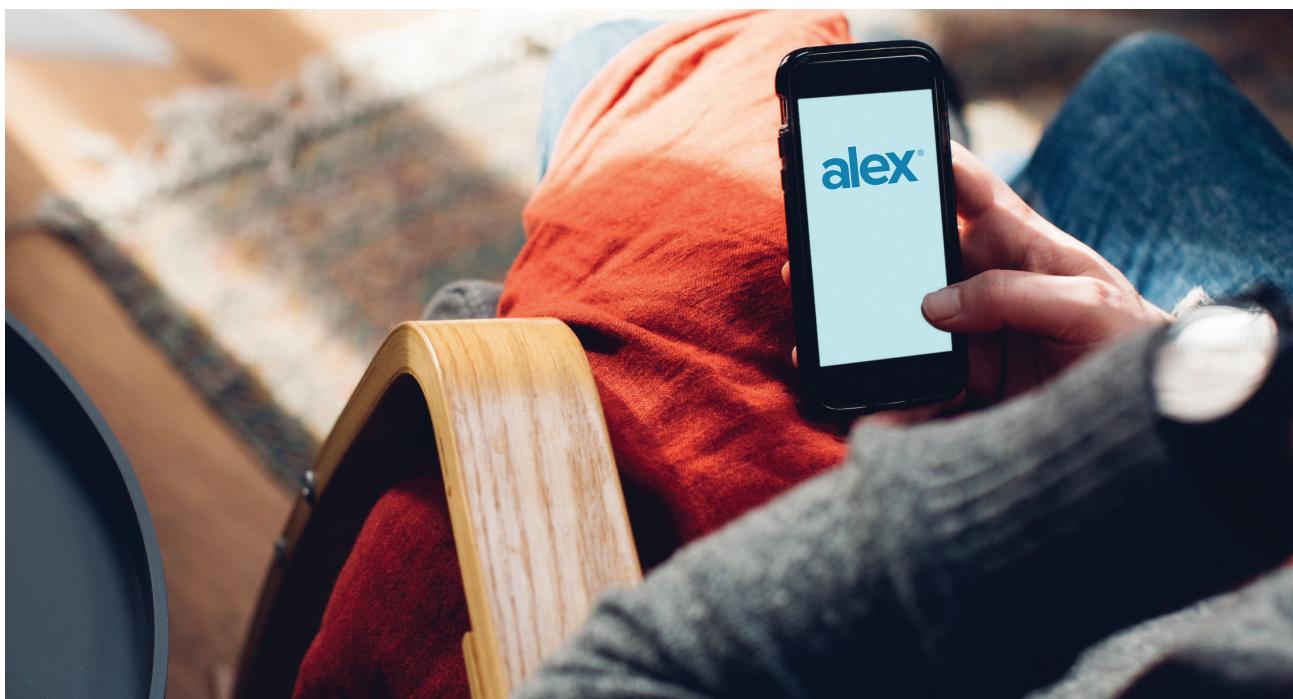
ALEX will ask you to estimate what type of medical care you might need (doctor visits, surgeries, ER visits, prescriptions, etc.), so you may want to tally those up and talk to your family about their needs, but ALEX can also help you come up with some estimates.

How does ALEX know what coverage options will work for me?

ALEX takes the amount each coverage option would cost you (your contribution rate) and adds that to the amount it would cost for the services you might use. Then he'll recommend the least expensive coverage option for your needs.

How do I use ALEX?

You can access ALEX in online benefits enrollment on portal.insperity.com using any computer, tablet or smartphone with a current operating system and web browser. Speakers or headphones are recommended for the full conversation; however, you can select closed captioning if needed.

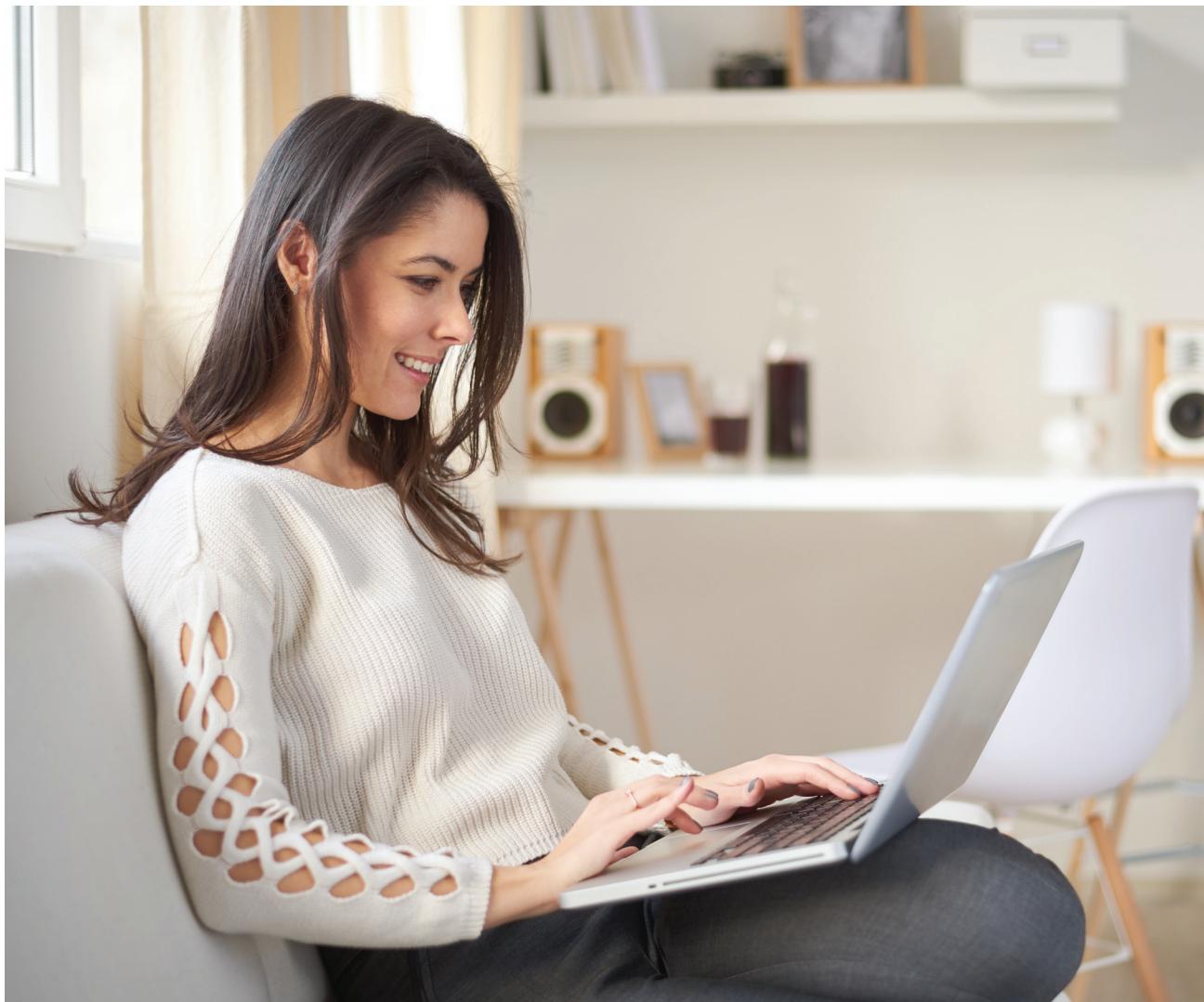


Insperity Group Health Plan ID cards

ID cards are issued for Insperity medical and dental coverage. No ID card is issued or needed for vision coverage. Your ID card will generally be available through your insurer's Member Services website and app within five business days of Insperity receiving your completed enrollment request. If you are not able to register on your insurer's Member Services site after five business days, call the Insperity Contact Center for assistance.

ID cards will also be mailed to the address Insperity has on file for you. Check the home and email addresses on your Insperity Premier™ profile and update them as needed to ensure you receive your ID cards and other time-sensitive benefits information.

Your coverage will be effective as of your eligibility date. If you have an eligible expense before you are active in your insurer's system, you may need to pay out-of-pocket and file a claim for reimbursement.



If you decide not to enroll

You are not required to enroll in the Insperity Group Health Plan if you do not want coverage. If you decide not to enroll, these state-specific requirements may apply to you. The states and municipality listed on this page have passed health care insurance ordinances that require employees who do not enroll in group health coverage to complete a specific waiver of coverage form.

Hawaii

If you live or work in Hawaii and you elect to waive your employer-provided group health plan coverage, you must complete and return the Hawaii Form HC-5 (employee notification to employer) to Insperity upon your initial eligibility for enrollment and each year thereafter in which coverage is waived. Please note that failure to complete the waiver form for Hawaii will cause you to be automatically enrolled in coverage. (The Hawaii Form HC-5 is not required if you work fewer than 20 hours per week.) You can find a blank copy of this form online at portal.insperity.com. The Insperity Contact Center can also assist you in obtaining a paper form; call 866.715.3552 or email contactcenter@insperity.com.

The Hawaii Form HC-5 must be completed and returned to Insperity no later than 30 days after your initial or open enrollment period ends. If you do not return the Form HC-5 within that time, you will be automatically enrolled in HMSA BlueCross BlueShield of Hawaii HMO employee-only coverage and any required employee contributions will be deducted from your paycheck.

San Francisco

If you work in San Francisco and you elect to waive group health coverage, you may complete an Employee Voluntary Waiver of Coverage at the time of your initial enrollment opportunity and each year thereafter when coverage is waived.

The Employee Voluntary Waiver form applies only if your client company is subject to or covered under the San Francisco Health Care Security Ordinance. Please ask your client company for more information. Your client company will maintain these forms in their records; you are not required to submit a copy for Insperity's records.

Vermont

If you work in Vermont and you elect to waive your employer-provided group health coverage, you may be required to complete a Vermont Department of Labor Declaration of Health Care Coverage at the time of your enrollment opportunity and each year thereafter in which coverage is waived.

Please ask your client company if you are required to complete this form. Your client company will maintain these forms in their records; you are not required to submit a copy for Insperity's records.

Understanding your medical coverage

Annual out-of-pocket maximum (OOPM)

This is the most a participant must pay out of their own pocket during the calendar year before the plan begins to pay 100% of eligible expenses. Medical calendar-year deductibles, copays and coinsurance (including prescriptions, unless otherwise noted) generally apply toward satisfying the annual out-of-pocket maximum. Insperity coverage options with embedded deductibles will have embedded OOPMs; HDHP coverage options with aggregate deductibles will have aggregate OOPMs.

Calendar-year deductible

This is the amount owed for certain covered health care services before the plan begins to pay benefits. Not all covered services require this deductible to be met (e.g., office visit copays under non-HDHP coverage options). All Insperity coverage options cover in-network physician office visits for preventive care services (as defined in the applicable Certificate of Coverage) at 100% with no copay or coinsurance, regardless of whether any deductible has been met.

Except as otherwise noted for certain HDHP-type coverage options, Insperity coverage options generally have “embedded” calendar-year deductibles and OOPMs. For family coverage under the embedded design, each covered family member needs to satisfy only an individual calendar-year deductible (not the entire family deductible) before the individual member can receive covered medical services or prescription drugs at copay or coinsurance levels. Individual family members are responsible for their own out-of-pocket covered medical expenses up to the individual-level OOPM. Combined individual out-of-pocket covered medical expenses for a family will never exceed the family-level OOPM.

Certain Insperity HDHP coverage options have “aggregate” (non-embedded) deductibles and OOPMs. For family coverage under the aggregate design, the entire family calendar-year deductible must be met before copays or coinsurance will apply for any individual family member. Only after the full family deductible is met will any family member be able to receive covered medical services or prescription drugs at copay or coinsurance levels. A family is responsible for all its members’ out-of-pocket covered medical expenses up to the family-level OOPM.

Coinsurance

This is your share of the cost of a covered service, calculated as a percent of the allowed amount for the service. Coinsurance (where applicable) applies after the participant satisfies any applicable calendar-year deductible. Also, coinsurance generally will not apply where a copay applies.

Copays

A fixed amount you pay for a covered service from an in-network provider. Generally, whenever a medical copay applies, coinsurance will not apply, and you are not required to first satisfy any applicable medical calendar-year deductible.

High deductible health plan (HDHP) options

HDHP coverage options generally do not cover any medical expenses other than preventive care until the applicable calendar-year deductible is met. All medical and pharmacy expenses apply to the applicable calendar-year deductible and OOPM. These expenses are the participant’s responsibility until the deductible is met. All Insperity HDHP coverage options are HSA-qualified.

Understanding your medical coverage

In-network

Providers and facilities that contract with your health insurance carrier are considered in-network; you will pay in-network copays, deductibles and coinsurance rates for eligible expenses from network providers.

Out-of-network

Providers and facilities that do not contract with your health insurance carrier are considered out-of-network. If your coverage option does not include out-of-network coverage, no benefits will be paid for services received from out-of-network providers, except for emergency medical treatment.

If your elected coverage option pays benefits for services received from out-of-network providers, your financial responsibility will likely be much greater. It is important to understand how your specific insurance carrier reimburses for out-of-network services, and it is your responsibility to pay any cost difference between what the out-of-network provider charges and what the plan covers (i.e., what the insurance carrier pays). In addition, the cost difference, which could be substantial depending on the cost of the care received, does not apply to the OOPM.

Limitations and exclusions

Certain health services have notification requirements and limitations that may vary based upon coverage option, insurance provider or state mandate. It is your responsibility as a participant to confirm that the services you plan to receive are covered health services, and to determine what precertification and/or notification requirement or limitations may apply.

Also, some Insperity Group Health Plan coverage options (at the discretion of the health insurance carrier) require covered individuals to designate a Primary Care Physician (PCP) who will be responsible for coordinating the covered individual's care. If your selected coverage option requires a PCP designation, you will receive more information at enrollment.

For each coverage option available to you, specific limitations and exclusions may apply, as outlined in the Certificate of Coverage (COC) for that option. These, along with the Insperity Group Health Plan Summary Plan Description (SPD) and Summary of Benefits and Coverage (SBC) for each option, can be viewed on the Insperity Premier™ platform at portal.insperity.com. They are also available upon request by calling Insperity. Should there be a discrepancy or conflict between the information presented here and the actual Plan documents and insurance contracts, the Plan documents and insurance contracts will govern.

Important notices

Insurance policies

Insperity provides medical, dental and vision benefits and life, personal accident and disability insurance through fully insured group insurance policies. Insperity does not self-fund these benefits.

Governing documents

As sponsor of the Insperity Group Health and Welfare Benefits Plans (Plans), Insperity provides employees with a Summary Plan Description (SPD) prepared by Insperity, as well as the Certificate of Coverage prepared by the insurer. Together, these documents describe eligibility requirements, the benefits available under the Plans, and other important rights and obligations of enrolled individuals. At the end of each year, Insperity also provides enrolled individuals with a Summary of Material Modifications (SMM) that describes changes to the Plans for the upcoming year.

Insperity also makes available Summaries of Benefits and Coverage (SBCs) for each medical coverage option in your package as well as a Glossary of Health Coverage and Medical Terms. The SBCs contain important coverage details presented in a standardized format to help you compare different options, and the glossary provides definitions of commonly used medical terms found in the SBC and other Plan documents.

Where you can find Plan documents

All of the important documents described here are available online at portal.insperity.com. You may request that a copy of the SBC and other documents specific to your benefits be sent to you free of charge by calling Insperity at 866.715.3552.

If you enroll in medical coverage, a copy of the SBC describing your current medical coverage option will also be provided at your annual open enrollment opportunity. Once you are enrolled, further information is available on portal.insperity.com, including access to your insurer's website.

Enrollment and special enrollment

You and your eligible dependents may become enrolled in the Insperity Group Health Plan or Insperity Health Care Flexible Spending Account Plan only during certain designated enrollment periods. As a newly eligible employee, you may first enroll for coverage (including coverage for your eligible dependents) during the 30-day period following the date you become eligible. This 30-day period is called your initial enrollment period. In addition, as an eligible employee you may enroll for coverage during your annual open enrollment period. Insperity will tell you when your annual open enrollment period occurs. Outside of your initial enrollment period or annual open enrollment period, you may enroll for coverage only if a special enrollment event or other mid-year election change event (described under "Changing your coverage") occurs. See portal.insperity.com for more information.

A special enrollment event may occur if you decline Plan coverage for yourself or your eligible dependent(s) (including your spouse) because of other health insurance or group health plan coverage and eligibility for that coverage is later lost (or the employer stops contributing to or otherwise terminates that coverage). A special enrollment event may also occur if you or your eligible dependent(s) lose Medicaid or State Children's Health Insurance Program (CHIP) coverage, or become eligible for a premium assistance subsidy for such coverage.¹ In addition, a special enrollment event may occur if you gain a new dependent as a result of marriage, birth, adoption or placement for adoption. Refer to the Plan's SPD for more details about special enrollment events. If a special enrollment event occurs, you and your eligible dependents must request enrollment during the 30-day^{1,2} period following the date of the special enrollment event.

Changing your coverage

Once enrolled, your election will usually continue for the remainder of your coverage period unless canceled or changed. You can cancel or change your election only during your open enrollment period or if you experience a mid-year election change event. The election change rules under the Plan determine whether you have experienced a mid-year election change event (examples include

marriage, divorce, death of a dependent and certain changes in employment status).

If you experience a mid-year election change event (including a special enrollment event as described above), your election change must generally be consistent with that event and made within 30 days^{1,2} of the event. Refer to the Plan's SPD for a summary of the events that may enable you to change your election mid-year and additional rules that apply.

Women's Health and Cancer Rights Act

As required by the Women's Health and Cancer Rights Act of 1998, Plan benefits are payable for covered expenses incurred by a person covered under the Plan for mastectomy-related services in a manner determined in consultation with the attending physician and 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; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema.

These benefits are subject to the Plan's regular copayments and deductibles.

¹The special enrollment period related to Medicaid and SCHIP is 60 days. ²Or any longer period as required under a state insurance law that applies to your coverage.

Notice of privacy practices for protected health information

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

Insperity Holdings, Inc. sponsors the Insperity Group Health Plan and the Insperity Health Care Flexible Spending Account Plan (individually a "Plan" and collectively the "Plans"). Each Plan is a covered entity under the Health Insurance Portability and Accountability Act's ("HIPAA's") privacy regulation ("privacy rule"). The privacy rule

regulates each Plan's use and disclosure of protected health information ("PHI") about you. Together, the Plans constitute an organized health care arrangement ("arrangement") under the privacy rule.

In this notice, we sometimes refer to a Plan that is included in the arrangement as "we" and sometimes as the "Plan." When we say "you" or "your" in this notice, we mean any person entitled to benefits under a Plan. This notice describes how each Plan (as listed above) and the arrangement may use and disclose your PHI, as permitted by the privacy rule. This notice also describes your individual rights concerning your PHI. Under the privacy rule, PHI generally means information that: (i) relates to your past, present or future physical or mental health condition or health Plan coverage and (ii) may identify you. The documents governing each Plan determine eligibility for benefits. Nothing in this notice gives you any new or expanded rights to eligibility for benefits under any of the Plans.

Section 1. Plan duties

Federal law says that we must maintain the privacy of your PHI, give you notice of our legal duties and privacy practices concerning your PHI and notify you of a breach (as defined in the privacy rule) of your unsecured PHI. We must follow the terms of this notice, as currently in effect. However, we have the right to change the terms of this notice at any time and to make the new notice provisions effective for all PHI that we have then or will later have. We will give or send you a revised notice at work or by mail if we make material changes to our privacy practices.

Section 2. How and when the Plan may use/disclose PHI

Sections A and B describe the different ways in which a Plan in which you are entitled to benefits may use or disclose your PHI without your written authorization.

A Plan must have your written authorization for any other uses and disclosures. For example, subject to certain exceptions described in the privacy rule, we must obtain your authorization for: (i) a use or disclosure of your psychotherapy notes, (ii) a use or disclosure of your PHI for marketing and (iii) any sale of your PHI. You may revoke your authorization at any time, but only if you make the request

to revoke in writing and give or send it to the Plan's privacy office at the address in section 5. Your revocation of an authorization will not apply to any action a Plan has already taken in reliance on such authorization.

A. Primary uses and disclosures of PHI

Required disclosures. The privacy rule says we must disclose your PHI to you when you ask to inspect or amend it, or if you ask for an accounting of certain types of disclosures. We must also disclose your PHI to the Secretary of the Department of Health and Human Services without your authorization for an investigation of our compliance with the privacy rule.

Treatment. We may disclose PHI about you for the treatment activities of a health care provider, as permitted by the privacy rule. These activities include a health care provider's providing, coordinating or managing your health care and related services, health care providers' consulting with one another about you, and referrals by one provider to another. For example, we may disclose your Plan enrollment status to a hospital in connection with a planned admission without your authorization.

Payment. We may use or disclose your PHI for our payment activities and those of other covered entities and health care providers, as permitted by the privacy rule. For example, we may disclose your PHI in order to collect your premiums or reimbursement for providing health care to you. In the same way, we may also disclose your PHI to another covered entity or a health care provider for its payment activities, such as to a health care provider who has filed a claim for payment for health care services provided to you.

Health care operations. We may use or disclose your PHI for our own health care operations activities, as permitted by the privacy rule. We may also disclose your PHI to another covered entity for its own health care operations activities. Health care operations activities for this purpose include: (i) quality assessment and improvement activities, (ii) population based activities relating to reducing health care costs, (iii) case management and care coordination, (iv) evaluating health Plan performance, (v) underwriting, enrollment, premium rating and similar activities and

(vi) the general business management and general administrative activities of the entity for whom the health care operations activities are performed. For example, we may use or disclose information about your claims to project future benefit costs or audit the claims processing functions. We will not use or disclose your genetic information for underwriting purposes.

To the Plan's sponsor. We, or a health insurance issuer or HMO with respect to the Plan, may disclose your PHI to the sponsor of the Plan, as permitted by the privacy rule. For example, we may disclose your PHI to the Plan's sponsor so that it may evaluate Plan design changes.

Within the arrangement. Each Plan may share PHI with the other Plans that make up the arrangement, as necessary to carry out the treatment, payment and health care operations activities (as described above) relating to the arrangement. For example, we may share your PHI with the arrangement for general administrative activities such as auditing or cost analysis of the arrangement as a whole.

B. Other uses and disclosures of PHI

Disclosures required by law. We may use or disclose your PHI when required by law, as permitted by the privacy rule.

For public health activities. We may disclose your PHI for certain public health activities, as permitted by the privacy rule, such as: (i) activities to prevent or control disease, injury or disability (including reporting a disease), (ii) the conduct of public health surveillance, public health investigations and (iii) public health interventions.

About victims of abuse, neglect or domestic violence. We may disclose your PHI if we reasonably believe that you are a victim of abuse, neglect or domestic violence. We may only make this disclosure to a government authority (including a social service or protective services agency) authorized by law to receive reports of such abuse, neglect or domestic violence, as permitted by the privacy rule. We will make this type of disclosure only if you agree to the disclosure or if the disclosure is otherwise required or authorized by law.

For health oversight activities. We may disclose your PHI to a public health oversight agency for certain oversight activities authorized by law, as permitted by the privacy rule, such as: (i) audits, (ii) investigations, (iii) inspections, (iv) licensure and (v) other activities generally necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

For judicial and administrative proceedings. We may disclose your PHI in response to a court or administrative order issued in any judicial or administrative proceeding as permitted by the privacy rule. We may also disclose your PHI in response to a subpoena, discovery request or other lawful purpose, without a court or administrative order, but only: (i) if we obtain an order protecting the information requested or (ii) if efforts have been made to tell you about the request for your PHI.

For law enforcement purposes. We may disclose your PHI to a law enforcement official for certain law enforcement purposes, as permitted by the privacy rule, such as: (i) disclosure in response to a court order, subpoena, warrant, summons or similar process and (ii) disclosure made in emergency circumstances to prevent a crime.

To coroners, medical examiners, and funeral directors. We may disclose your PHI to a coroner or medical examiner for the purpose of: (i) identifying a deceased person, (ii) determining a cause of death or (iii) other duties as authorized by law, as permitted by the privacy rule. Also, we may disclose your PHI to funeral directors, consistent with applicable law, as necessary to carry out their duties regarding the decedent.

For organ and tissue donation purposes. We may use or disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation, as permitted by the privacy rule.

For research. We may use or disclose your PHI for research, as permitted by the privacy rule. However, a number of conditions must be met before we use or disclose your PHI for research.

To avert a serious threat to health or safety. We may use or disclose your PHI when necessary to prevent a serious threat to someone's health and safety, as permitted by the privacy rule. We may only make that kind of disclosure, however, to someone able to lessen or prevent the threat.

For specialized governmental functions. We may use or disclose your PHI for specialized governmental functions, as permitted by the privacy rule such as: (i) disclosure of PHI of military personnel for activities deemed necessary by military command authorities and (ii) disclosure to authorized federal officials for lawful national security activities.

For workers' compensation. We may use or disclose your PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault, as permitted by the privacy rule.

For care and notification. We may use or disclose your PHI to your family member, other relative or a close personal friend or other person you identify. Our disclosure will be limited to PHI that is directly relevant to your care or payment related to your care. This includes information about your location, general condition or death, as permitted by the privacy rule.

Incident to a use or disclosure permitted by the privacy rule. We may make a use or disclosure of your PHI if the use or disclosure is incidental to a use or disclosure otherwise permitted by the privacy rule. We will make reasonable efforts to limit PHI used and/or disclosed to the minimum necessary to accomplish the intended purpose of the use and/or disclosure. We have implemented appropriate administrative, technical and physical safeguards in an effort to protect the privacy of your PHI.

Section 3. Your rights

Right to request restrictions on PHI uses and disclosures. You have the right to request that a Plan restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons

identified by you who are involved in your care or in payment for your care, as permitted by the privacy rule. However, the Plan is not required to agree to your request. Your request for restrictions must be in writing to the Plan's privacy office at the address in section 5.

Right to receive confidential communications. You have the right to request that the Plan make certain communications of your PHI to you by alternative means or to alternative locations, if the Plan's traditional means of communication could endanger you. Your request for confidential communications of PHI must be in writing to the Plan's privacy office at the address in section 5. Your request must include a statement that the disclosure of all or part of the information could endanger you.

Right to inspect and copy PHI. You have the right to request access to inspect or obtain a copy of certain types of PHI that a Plan has about you. Your request for access must be in writing to the Plan's privacy office at the address in section 5. If you ask for a copy of the information, we may charge a fee for the costs of copying, mailing or other charges related to fulfilling your request. The Plan may deny your request for access to inspect or obtain a copy of your PHI in certain circumstances, as permitted by the privacy rule.

Right to amend PHI. If you feel that your PHI that is maintained by a Plan is incorrect or incomplete, you may ask us to amend your information. Your request for an amendment must be in writing to the Plan's privacy office at the address in section 5. Your written request must also specify the basis for the amendment. However, we may deny your request for an amendment in certain circumstances, as permitted by the privacy rule.

Right to receive an accounting of PHI disclosures. You have the right to receive an accounting of certain disclosures of your PHI by the Plan. Your request for an accounting of disclosures must be in writing to the Plan's privacy office at the address in section 5. Your written request must specify the time period for which you are requesting an accounting. That time period may not be longer than six years from the date of your request. Your written request should state the format (paper, electronic, etc.)

in which you want to receive your accounting. The Plan may charge a fee for the costs of responding to more than one accounting request in a 12-month period. The Plan may deny your request for an accounting in certain circumstances, as permitted by the privacy rule.

Right to obtain a paper copy of notice. You have the right to receive a paper copy of this notice from any Plan under which you are entitled to benefits, even if you have agreed to receive this notice electronically. To obtain a paper copy of this notice, please make your request in writing to the Plan's privacy office at the address in section 5.

Section 4. Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, write to the Plan's privacy office at the address in section 5. Your complaint must be submitted in writing. You will not be retaliated against for filing a complaint.

Section 5. Address

If you have any questions about the privacy practices of the Plans identified in this notice or the information contained in this notice, please contact the Plan's privacy office at the address or phone number on the next page. This contact information applies to each Plan within the arrangement.

Insperity Privacy Office
[Group Health Plan or Health Care FSA Plan]
19001 Crescent Springs Drive
Kingwood, Texas 77339-3802
877.804.8978

2020 Medicare Part D notice

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please read this notice for details.

Important notice about prescription drug coverage and Medicare

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

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or a PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some Medicare plans may also offer more coverage for a higher monthly premium.

Creditable coverage information

The prescription drug coverage offered under the Insperity Group Health Plan (Plan) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered "creditable coverage." Because this coverage is "creditable coverage," you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can enroll in a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15 through Dec. 7. If you currently have creditable prescription drug coverage under the Plan and you lose that coverage through no fault of your own, you will also be eligible for a two (2) month special enrollment period to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

Your current Plan coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. Be aware that this Plan's prescription drug coverage is provided in a package with medical coverage, and you cannot drop this Plan's prescription drug coverage without also dropping the medical coverage. If you decide to enroll in a Medicare drug plan and drop Plan coverage (both medical and prescription drug), you may not be able to get this Plan's coverage back later. You may contact us for more information about the consequences of dropping your Plan coverage.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

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

If you currently have creditable prescription drug coverage under the Plan, this means you must enroll in a Medicare drug plan within 63 continuous days after your current coverage ends to avoid a higher premium (a penalty).

Remember to keep this notice. If you currently have creditable coverage and enroll in one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium amount (a penalty).

How to obtain additional information

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You should get a copy of the handbook in the mail every year from Medicare if you are eligible. You may be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your state Health Insurance Assistance Program (see your copy of the “Medicare & You” handbook for the telephone number) for personalized help
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at socialsecurity.gov, or call SSA at 800.772.1213 (TTY 800.325.0778).

You will receive this notice each year. You will also get this notice before the next period you can join a Medicare drug plan, and if this Plan’s coverage changes. You may also request a copy of this notice at any time. You may contact Insperity toll-free at 866.715.3552 for further information about this notice or this Plan’s prescription drug coverage.



portal.insperity.com
866.715.3552