PAX TECHNOLOGY, INC.



EMPLOYEE BENEFIT GUIDE

December 1, 2021 through November 30, 2022

Brown & Brown INSURANCE®

EMPLOYEE BENEFITS

This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.

TABLE OF CONTENTS

WELCOME TO THE 2021 - 2022 PLAN YEAR!

Your Employer has partnered with Brown & Brown of Florida, Inc. in order to provide you with the following information. We are pleased to provide you and your family with a comprehensive benefits package that addresses your personal health, medical and financial well-being.

The following pages will introduce your benefits and provide a brief overview of each coverage.

Please do not hesitate to contact us should you have any questions.

WHO IS ELIGIBLE?

You are eligible to enroll in our benefit plans if you are a Full-Time Team Member working an average of 25 or more hours per week.

Your benefits will begin on your date of hire.

Should you leave employment or experience a status change, your benefits will end on your date of termination.

Eligible Dependents for our benefits plan include the following:

- ♦ Legally Married Spouse
- ♦ Dependent Child

⇒ To age 26 on Dental and Vision, with no stipulations
⇒ To age 30 (covered until the end of the calendar year) for Medical with stipulations:

- Full-Time or Part-Time Student
- Unmarried
- Has no children
- Not eligible for Medicare
- Not eligible for any other group coverage

⇒ To age 14 days to 23 on Life Insurance or 25 if Full-Time Student

DISCLAIMER

Please read this booklet carefully, since understanding the options available to you can help ensure that you choose the right benefit options for you and your family. This Benefits at a Glance Booklet is designed to provide basic information to employees on the benefit plans and programs available at your employer. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs documented in the carrier contract, the Summary of Benefits and Coverage (SBC), or the Summary Plan Description (SPD). This booklet does not constitute a SPD, SBC, benefit summary, or Plan Document as defined by the Employee Retirement Income Security Act (ERISA). You can obtain the referenced documents via your insurance carrier, your HR department or from Brown & Brown.

PRE-TAX BENEFITS

The elections you make during open enrollment are locked in for the policy year.

It is very important to remember that you may only make changes to these benefit plans at open enrollment or within 31 days of a Life Status Event. Some Life Events are depicted in the pictures to the right.

The following coverages are taken from your paycheck on a pre-tax basis and are governed by the IRS through a Section 125 Cafeteria Plan:

- Medical
- Dental
- Vision

POST-TAX BENEFITS

The following coverages are taken from your paycheck on a post-tax basis:

- Short-Term Disability
- Long-Term Disability
- Voluntary Life
- Colonial Life Products

Don't forget to update your Beneficiaries!

This can be done any time.

Should you have to file a claim for these benefits, your claim benefit payment will be tax-free.

COBRA

COBRA allows benefit eligible team members to continue medical, dental and/or vision benefits under certain circumstances. The length of COBRA continuation depends on the qualifying event, as follows:

18 Months:
- Termination of employment
- Leave of absence
- Loss of full-time status

36 Months:
- Death
- Loss of dependent eligibility
- Divorce

It is your responsibility to notify HR within 31 days of any listed occurrence.

Once you give notification, information on how to enroll will be sent to your home, and you will have 60 days to elect coverage. You will be responsible for the total cost of the premium plus a 2% administration fee.

EMPLOYEE NAVIGATOR

You will enroll in your benefits online on the Employee Navigator System.

You must login to Employee Navigator to make your benefit selections or to waive coverage. Elections and changes you make during open enrollment will become effective December 1, 2021.

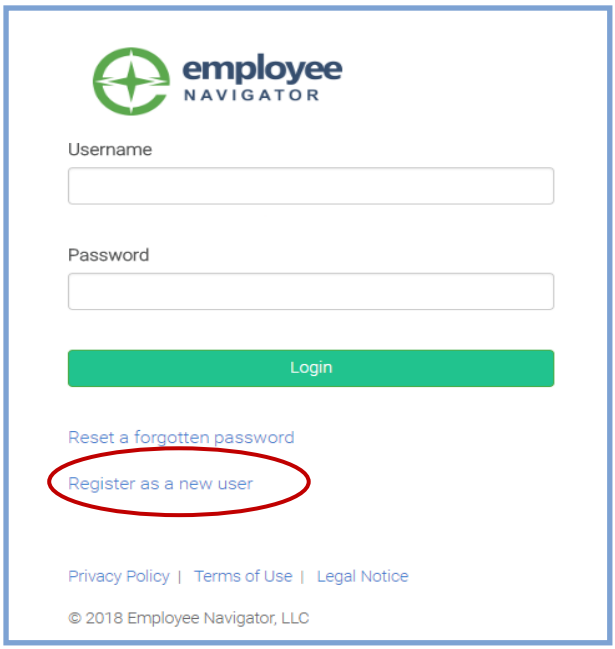
Pax Technology pays for employee only Basic Life/AD&D, therefore ALL employees must add beneficiaries.

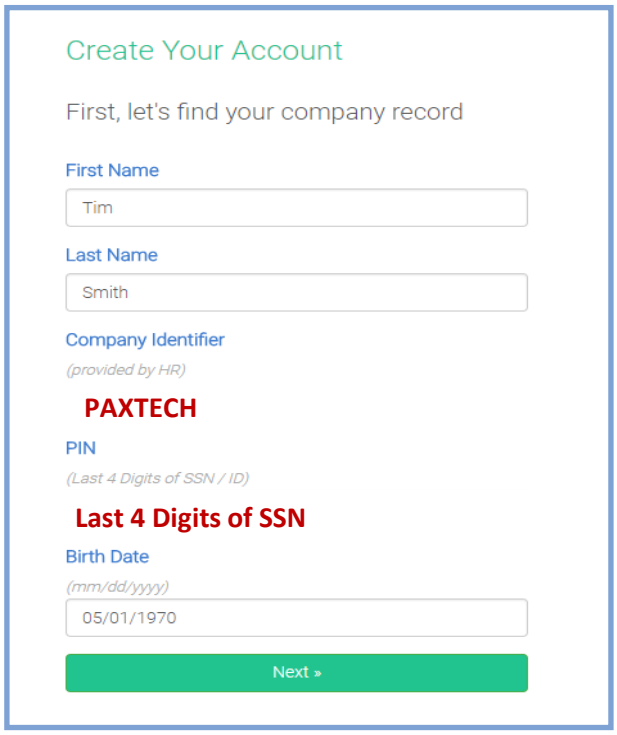
1. To login, please go to:

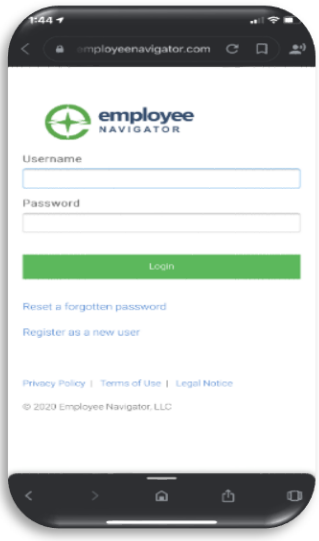
www.employeenavigator.com/benefits/Account/login

(You can do this through your computer or smartphone)

2. Click on "Register as a new user" and input your: First Name, Last Name, Company Identifier which is PAXTECH, the last four of your SSN as your pin, and your birth date and click "Next"







3. Create a username and password and then click "Next."

4. Once logged in, please select the "Start Enrollment" button.

5. Ensure your information and address are correct, then click "Next."

6. Enter any dependents you would like to cover on any of your employee benefits, then click "Next."

7. Select the dependents you want on each plan, and which plan you'd like. If you would like to waive a particular benefit, please select "Don't want this benefit" at the bottom of the page.

8. Once all benefits have been elected, confirm your selections and click "Sign" on the Enrollment Summary page to complete your enrollment.

ANNUAL OPEN ENROLLMENT

During the annual open enrollment period, you may make changes to your benefit plan elections and/or the family members you cover.

Now is the time to carefully review your plan options. Below is an overview of the changes for the 2021-2022 plan year.

This Guide provides a brief description of the benefit plans available to you and your family members.

WHAT'S NEW?

Medical insurance is staying with CIGNA with no change in plans or rates.

- We are still offering 3 plans.
- We will continue offering an HSA plan this year, with a company contribution to a Health Savings Account.

All ancillary coverage – dental, vision, life, and disability – are moving to Sun Life.

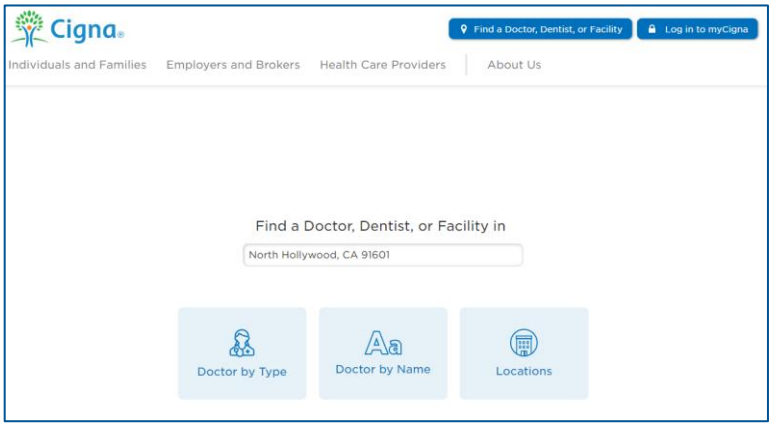
- Dental – you still have access to Network and Non-Network providers. Your benefits are better when you visit In-Network providers.
- Vision – the frame and contact lens allowance is increasing from $130 to $150. The rates are going down!
- Pax will continue to provide a $25,000 life insurance policy with no cost to you!
- You will be able to purchase additional life insurance on you and your family (up to the guaranteed issue amount) for this open enrollment, even if you previously waived coverage.
    - If you already have coverage over the guaranteed amount, you can keep what you have.
    - If you decide to waive this coverage, you will be able to enroll at our next open enrollment but only for yourself and for $10,000 in coverage. If you wish to increase that amount or enroll your family at that time, medical questionnaires will be required, and you are subject to Sun Life's approval.
    - If you enroll this year, you can increase your Employee amount by $10,000 (up to the guaranteed issue amount) at our next open enrollment.
- You are able to purchase voluntary short-term and/or long-term disability coverage. The rates are going down for both of these coverages and no medical questionnaires are required!

HSA, FSA & COBRA Administration are staying with Employee Benefits Corporation.

- You must re-enroll in the FSA each year.
- You cannot contribute to both the HSA and the FSA.

Colonial Life plans are moving from individual to group plans.

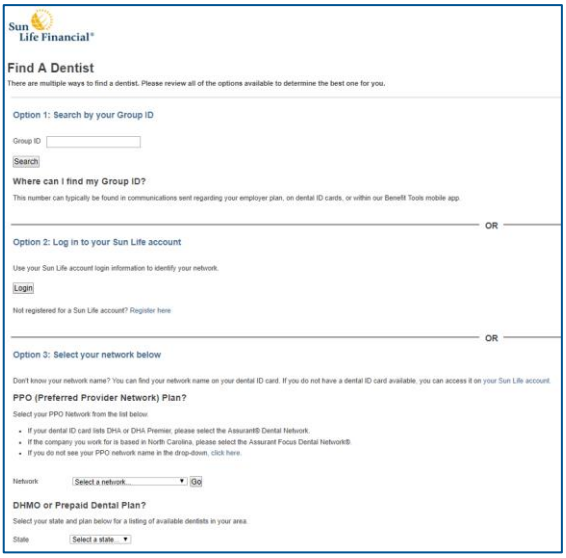
HOW TO LOCATE A PROVIDER



Cigna Medical

cigna.com

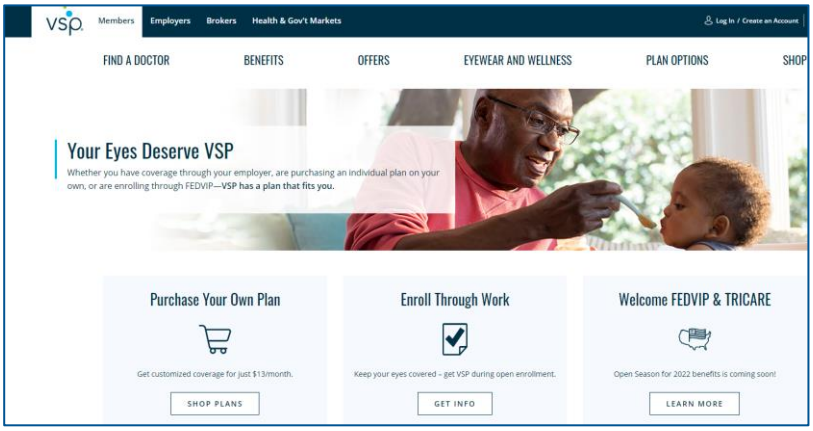
- Click on **Find a Doctor, Dentist or Facility**
- Click on **"Employer or School"**
- Enter your location and choose to search by type, name, or location
- Click **Continue**
- When prompted to Login/Register, click on **Continue as guest**
- Select the network: **Open Access Plus, OA plus, Choice Fund OA Plus**



Sun Life Dental

sunlife.com/findadentist

- Scroll down to **Option 3**
- Click on "**Sun Life Dental Network**"
- Click on "Go"
- Enter your search information



Sun Life Vision through VSP

vsp.com

- Click on **"Find a Doctor"** in the upper left-hand side of the site
- Enter your search information

KNOW WHERE TO GO

With so many options for getting care, how do you know where to go? This chart can help you understand your best options for seeking appropriate medical treatment and how you can save money while still receiving the care you need.

Where to get care	What it is	Type of Care		Cost
Virtual Visit 	A virtual visit lets you see a doctor via your smartphone, tablet or computer.	• Allergies • Bladder infections • Bronchitis • Cough/colds • Diarrhea • Fever	• Pink eye • Rashes • Seasonal flu • Sinus problems • Sore throats • Stomach aches	$
Convenience Care Clinics 	Visit a convenience care clinic when you can't see your doctor and your health issue isn't urgent. These clinics are often in stores.	• Common infections (e.g. strep throat) • Minor skin conditions (e.g. poison ivy) • Vaccinations • Pregnancy tests • Minor injuries • Ear aches		$$
Primary Care Physician 	Go to a doctor's office when you need preventive or routine care. Your primary doctor can access your medical records, manage your medications and refer you to a specialist, if needed.	• Checkups • Preventive services • Minor skin conditions • Vaccinations • General health management		$$
Urgent Care 	Urgent care is ideal for when you need care quickly, but it is not an emergency (and your doctor isn't available). Urgent care centers treat issues that aren't life threatening.	• Sprains • Strains • Small cuts that may need a few stitches	• Minor burns • Minor infections • Minor broken bones	$$$
Emergency Room 	The ER is for life-threatening or very serious conditions that require immediate care. This is also when to call 911.	• Heavy bleeding • Large open wounds • Sudden change in vision • Chest pain • Sudden weakness or trouble talking	• Major burns • Spinal injuries • Severe head injury • Breathing difficulty • Major broken bones	$$$$

myCigna.com & CIGNA MOBILE APP

Register on myCigna.com

Once you do, you can log in anytime, just about anywhere to:*

- **Manage** and track claims
- **View** ID card information
- **Find** in-network doctors and compare cost and quality ratings
- **Review** your coverage
- **Track** your account balances and deductibles
- **Order** your Cigna Home Delivery Pharmacy℠ prescriptions online and view order history

The myCigna app uses one-touch access, making it easy to personalize, organize and access your health information on the go. This app is a must-have for Cigna members. You can use the myCigna mobile app to help you:

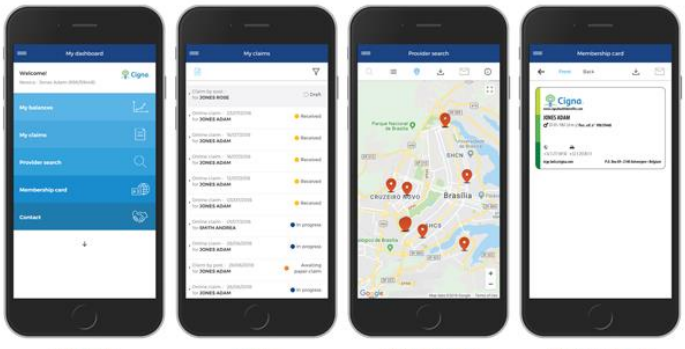
- View your ID cards
- Search for a doctor, specialist, lab, urgent care or hospital close by
- Track your deductible and out of pocket maximums
- View and manage claims
- Manage prescription benefits: Check the cost of drugs, get refills or switch to our home delivery program
- Look up common procedures and compare costs of providers
- View your plan coverage and details
- Connect to Cigna customer service

Download the Mobile App: Just search for Cigna in your app store. Can't get the app? You can use many of the same features on the Cigna website at www.cigna.com

Register today! Visit **myCigna.com** or download the myCigna® App.**

GET IT ON Google play | Download on the App Store | amazon apps Available on kindle fire

Go to myCigna.com to go paperless!
After you register, you can set up paperless communications. Just log in to myCigna.com and select "Go Paperless".



The medical plans are arranged by **Cigna.**

Open Access Plus Network

The Open Access Plus (Broad Network) plan gives you flexibility. Each time you need care, you can choose your providers and hospitals from Cigna's network. Or you can choose to receive care and services from health care providers outside of the network. However, your out-of-pocket costs will be higher if you go out-of-network.

HSA Compatible Plans

HSA plans offer you the advantage of lower per pay costs and the ability to set aside money out of your paycheck on a pre-tax basis for medical, dental, vision, and other qualified health expenses. Unused money in your HSA account rolls over every year and can be taken with you should you switch plans or leave Pax. You may always use the money in your account for qualified health expenses, but you must be enrolled in a High Deductible Health Plan to be able to contribute.

To help with your out-of-pocket costs associated with this plan, **Pax Technology will generously contribute $500 annually to Employees enrolled individually and $900 to employees enrolled with dependents. If you choose to contribute your own dollars to an HSA plan, Pax will also match up to the first $500 for individuals and the next $900 for those with dependents enrolled. All employer HSA contributions will be pro-rated based off your effective date of coverage and contributions will stop if you are no longer employed or no longer enrolled on the HDHP HSA health plan.**

	Cigna Open Access Plus (OAP) HDHP HSA Advantage A Plan
Bi-Weekly Payroll Deductions (26)	
Employee Only	$55.00
Employee + Spouse	$170.00
Employee + Child(ren)	$145.00
Family	$270.00
Employer Annual Contribution to your HSA: **Individual: Pax will contribute $500 per year, plus $500 match of the first $500 you contribute** **Family: $900, plus $900 match of the first $900 you contribute**	
Benefits	*In-Network Shown*
Annual Deductible (1/1 – 12/31)	$3,000 Individual $6,000 Family
Coinsurance (Paid by Plan / You)	70% / 30%
Annual Out of Pocket Maximum (Includes Deductible, Coinsurance & Copays)	$6,000 Individual $12,000 Family
Preventive Care	Plan pays 100%
Virtual Office Visit	Up to $49
Physician Office Visit	Deductible + 30%
Specialist Office Visit	Deductible + 30%
Outpatient Surgery	Deductible + 30%
Inpatient Hospitalization	Deductible + 30%
Emergency Room	Deductible + 30%
Urgent Care	Deductible + 30%
Lab ***at the contracted lab**	**LABCORP & QUEST** Deductible + 30%
X-Ray ***outside of a hospital**	Deductible + 30%
Advanced Imaging (MRI, PET, CT) ***outside of a hospital**	Deductible + 30%
Prescription Drugs Tier 1 Tier 2 Tier 3 Mail-Order	**Medical Deductible Applies First, then**: $10 copay $60 copay $100 copay 3 x copay

HSA Contribution Examples:

Individual Coverage with **no** employee contribution:
Pax: $500
Employee: $0 =
Total Annual HSA Contribution:
$500

Individual Coverage **with** employee contributions:
Pax: $500
Employee: $500 + Pax $500 =
Total Annual HSA Contribution:
$1,500

Employee w/Dependents Coverage with **no** employee contribution:
Pax: $900
Employee: $0 =
Total Annual HSA Contribution:
$900

Employee w/Dependents Coverage **with** employee contribution:
Pax: $900
Employee: $900 + Pax $900 =
Total Annual HSA Contribution:
$2,700

Individual Coverage **with** employee contribution:
Pax: $500
Employee: $300 + Pax $300 =
Total Annual HSA Contribution:
$1100

HEALTH SAVINGS ACCOUNT

For benefit eligible associates, Pax Technology is pleased to offer a Health Savings Account to you and your families to help with your out-of-pocket health expenses throughout the year**. You must be enrolled in the HSA-Compatible HSA Advantage A Plan health plan to open/contribute to a Health Savings Account.** Pax Technology generously contributes to your Health Savings Account, for you and your family, and we encourage you to make contributions on top of our employer portion. **Contributions can be made to the HSA OR the Health Care FSA; not both. There is a limited purpose FSA option for dental & vision expenses if you enroll in an HSA.**

What is a Health Savings Account?

A Health Savings Account is an individually-owned, tax-free savings account that works with your health plan to help you pay for out-of-pocket, qualified health expenses. The money that you contribute into your account is deposited tax free. Any unused money in your account will roll over to next year to continue to help you pay for out-of-pocket expenses. HSA funds must be in your account before you can use them.

What can I use my funds for?

- Office visits
- Prescription drugs/medications with a prescription
- X-Rays or lab work
- Walk-In clinics and urgent care centers
- Dental visits
- Vision exams
- Eyeglasses or contacts

A full list of eligible expenses can be found in **IRS Publication 502**, accessed by visiting www.irs.gov.

How does my HSA Work?

1. Choose your per pay/annual contribution amount - this is what will be taken out of your paycheck and put into your HSA account
2. You will receive a debit card in the mail from EBC, our HSA Administrator. You will need to activate this card. Card is administered by Avidia Bank.
3. Simply swipe your card to pay for qualified health expenses. Money must be in your account for you to use it.
4. You may check your HSA account balances online at www.ebcflex.com
5. Enjoy tax-fee savings
   - You never pay taxes on withdraws for qualified medical expenses
   - Your contributions are tax-free and reduce your overall taxable income

Pax Technology's Annual Contribution to Your HSA

Individual HSA	**$500 + $500 EE Match**
Family HSA	**$900 + $900 EE Match**

If you are enrolled in the **HSA Advantage A Plan** plan, you will receive this contribution to help with your out-of-pocket, qualified health expenses.

All employer HSA contributions will be pro-rated based off your effective date of coverage and contributions will stop if you are no longer employed or no longer enrolled on the HDHP HSA health plan.

What Happens If I Leave Employment?

You can take your Health Savings Account and all the funds in the account with you! You must be enrolled in another HSA compatible health plan in order to contribute to an HSA, but you can always spend the money that is in your account.

HSA Contribution Limits

	2021	2022
Self-Only	$3,600	$3,650
Family	$7,200	$7,300
Age 55+ Catch Up Provision	Additional $1,000	Additional $1,000

Our contribution to your Health Savings Account is included in the maximum amount above, so your individual funds in addition to our employer funds cannot exceed the contribution limits.

HSA funds stay in your account and should be used for qualified health expenses. At age 65, you can use these funds to pay for Medicare premiums.

If you use funds for non-qualified health expenses, there is a 20% penalty and taxes will apply.

You may not contribute to a Health Savings Account if you are age 65 or older and enrolled in Medicare.

COPAY MEDICAL PLAN OFFERINGS

The medical plans are arranged by **Cigna.**

Open Access Plus Network The Open Access Plus (Broad Network) plan gives you flexibility. Each time you need care, you can choose your providers and hospitals from Cigna's network. Or you can choose to receive care and services from health care providers outside of the network. However, your out-of-pocket costs will be higher if you go out-of-network.

Traditional Copay Plans Traditional plans have a higher per pay cost, but they provide you with copays or fixed charges for several of your day-to-day services. This means you can often budget for services prior to going in for your actual service. Additionally, unlike the HSA plans, there is no deductible tied to your pharmacy drug card, so you have copays for covered prescriptions as of day one of the plan start date.

	Cigna Open Access Plus (OAP) Low Plan	**Cigna Open Access Plus (OAP) High Plan**
Bi-Weekly Payroll Deductions (26) Employee Only Employee + Spouse Employee + Child(ren) Family	 $94.50 $257.25 $220.50 $409.50	 $130.00 $348.40 $301.60 $551.20
Benefits	*In-Network Only*	*In-Network Shown*
Annual Deductible (1/1 – 12/31)	$3,000 Individual $6,000 Family	$1,500 Individual $3,000 Family
Coinsurance (Paid by Plan / You)	90% / 10%	90% / 10%
Annual Out of Pocket Maximum (Includes Deductible, Coinsurance & Copays)	$3,000 Individual $6,000 Family	$1,500 Individual $3,000 Family
Preventive Care	Plan pays 100%	Plan pays 100%
Virtual Office Visit	$10 copay	$10 copay
Physician Office Visit	$30 copay	$30 copay
Specialist Office Visit	$60 copay	$60 copay
Outpatient Surgery	Deductible + 10%	Deductible + 10%
Inpatient Hospitalization	Deductible + 10%	Deductible + 10%
Emergency Room	$300 copay	$300 copay
Urgent Care	$80 copay	$75 copay
Lab ***at the contracted lab**	**LABCORP & QUEST** Plan pays 100%	**LABCORP & QUEST** Plan pays 100%
X-Ray ***outside of a hospital**	Plan pays 100%	Plan pays 100%
Advanced Imaging (MRI, PET, CT) ***outside of a hospital**	$300 copay	$300 copay
Prescription Drugs Tier 1 Tier 2 Tier 3 Mail-Order	 $15 copay $45 copay $85 copay 3 x copay	 $10 copay $50 copay $80 copay 3 x copay

*10% Coinsurance (no deductible) applies to the cost of Infusion Therapy drugs administered at home.

SAVE SOME MONEY

Virtual Visits

Use virtual visits when:

- Your doctor is not available
- You become ill while traveling
- You are considering visiting a hospital emergency room for a non-emergency health condition

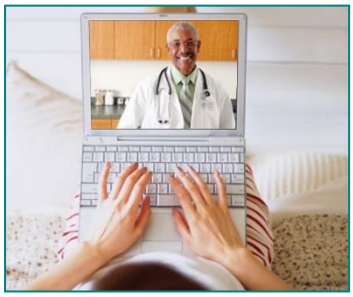
Not good for:

- Anything requiring an exam or test
- Complex or chronic conditions
- Injuries requiring bandaging or sprains/broken bones

Conditions commonly treated through a virtual visit

Doctors can diagnose and treat a wide range of non-emergency medical conditions, including:

- Bladder infection/ Urinary tract infection
- Bronchitis
- Cold/flu
- Fever
- Migraine/headaches
- Pink eye
- Rash
- Sinus problems
- Sore throat
- Stomach ache



Signing up is easy!

- Set up and create an account with MDLive
- Complete your medical history
- Download the MDLive app for easy use
- MDLiveforCigna.com or (888) 726-3171

Preventive Care

Your plan offers preventive care at no cost to you. When scheduling, make sure you tell your doctor you're coming in for a preventive visit. The following is a list of some of the services covered at 100%. Please note that many of the following in-network covered expenses are subject to age and frequency schedules:

- Annual Preventive Exam
- Annual Well Woman Exam
- Well Baby/Child Screening
- Breast Cancer Screening (mammography)
- Colorectal Cancer Screening
- Vaccines
- And More!

Cigna Behavioral Health

For covered services related to mental health and substance abuse, you have access to the Cigna Behavioral Health network of providers.

- Go to mycigna.com to search for a video telehealth specialist
- Call to make an appointment with your selected provider.

Telehealth visits with Cigna Behavioral Health network providers cost the same as an in-office visit.

Cigna Healthy Rewards Program

Healthy Rewards is a discount program available to Cigna members covered under our medical and/or dental plan. Visit cigna.com for more information. You can save on health and wellness programs, including:

- Monthly gym fees
- Weight management programs
- Vitamins
- Vision/Hearing care
- Massage
- Acupuncture

Pharmacy

Take advantage of low cost and free prescriptions:

- Publix – Free 14 day supply of common antibiotics
- Publix - Discounted Diabetic Supplies/free Metformin
- Walmart, Target, Sam's Club - $4 generics/30 day supply
- Walmart, Target, Sam's Club -$10 generics/90 day supply
- Kroger - $4 generics, Easy Drug Card for discounts
- Use your Brown & Brown Prescription Drug discount card
- GoodRx.com

DENTAL PLAN

The dental plans are arranged through **Sun Life.**

It is a **PPO Dental** plan, which allows you to use any dentist of your choice. However, when you use an out-of-network provider, you will be balance billed for any amount that Sun Life does not pay.

It is recommended that any services in excess of $300 be sent to Sun Life for pre-determination before services are rendered.

To find providers in your network, refer to page 6 of this booklet.

Benefits	PPO Plan	
	In-Network	Out-of-Network [1]
Have to Select a Provider?	No	
Annual Deductible (1/1 – 12/31)	$50 per individual and $150 per family Deductible is waived for Preventive	
Annual Plan Maximum	$1,500 per individual	
Orthodontia Lifetime Maximum	$1,000 per child	
Type I: Preventive Services		
Routine Exam	Plan pays 100%	Plan pays 100% [1]
Teeth Cleaning	Plan pays 100%	Plan pays 100% [1]
Panoramic X-rays	Plan pays 100%	Plan pays 100% [1]
Type II: Basic Services		
Fillings	Plan pays 80%	Plan pays 80% [1]
Simple Extractions	Plan pays 80%	Plan pays 80% [1]
Type III: Major Services		
Dentures	Plan pays 50%	Plan pays 50% [1]
Crown	Plan pays 50%	Plan pays 50% [1]
Root Canal/Endodontic	Plan pays 50%	Plan pays 50% [1]
Periodontal Scaling	Plan pays 50%	Plan pays 50% [1]
Complex Oral Surgery	Plan pays 50%	Plan pays 50% [1]
Type IV: Orthodontic Services		
Treatment - Child to age 19	Plan pays 50%	Plan pays 50% [1]
Payroll Deductions	**Bi-Weekly (26)**	
Employee Only	$12.32	
Employee + Spouse	$24.03	
Employee + Child(ren)	$27.34	
Family	$41.68	

1 If you use a non-network provider, you are responsible for paying the difference in cost between the non-network provider's charges and the allowed amount.

VISION PLAN

Our vision plan is offered to you through **Sun Life using the VSP network.**

You have the option of using in-network or out-of-network benefits on this PPO plan, however, it is always less expensive to stay in-network. Out-of-Network requires you to Pay for your services upfront and then submit a claim for reimbursement. Reimbursement amounts will be "up to" the amounts below, not necessarily the full amount.

To find an In-Network provider, refer to page 6 of this booklet.

BENEFITS	VSP VISION PLAN	
NETWORK	**In-Network**	**Out-of-Network**
Eye Exams	$10 Copay	Up to $45
	Eyeglass Lenses and Frames	
Single Standard Lenses	$25 Copay	Up to $30
Bifocal Standard Lenses	$25 Copay	Up to $50
Trifocal Standard Lenses	$25 Copay	Up to $60
Frames	$150 Allowance and then 20% off balance **$80 Allowance at Walmart and Costco*	Up to $70
	Contact Lenses (In Lieu of Glasses)	
Fitting & Evaluation	$60 Copay	Included in reimbursement for Conventional Lenses
Conventional Lenses	$150 Allowance	Up to $105
	Frequency	
Eye Exam	Once every 12 months	
Lenses—Eyeglasses or Contacts	Once every 12 months	
Frames	Once every 24 months	
	Plan Enhancements	
Laser Correction Surgery	Up to 15% off the regular price or 5% off promotional price *Only available through contracted facilities*	
Payroll Deductions	**Bi-Weekly (26)**	
Employee Only	$2.58	
Employee + Spouse	$5.15	
Employee + Child(ren)	$5.66	
Family	$8.24	

FLEXIBLE SPENDING ACCOUNT

Flexible Spending Accounts (FSAs) allow benefit eligible associates to save pre-taxed dollars to use on eligible health care and/or dependent care expenses every year. Pax Technology offers an FSA account administered by EBC.

Please note that you cannot have both an HSA and a traditional FSA. If you are enrolled in an HSA account, you may contribute to a Limited Purpose FSA for dental and vision expenses only.

What is an FSA?

An FSA allows you to save on your eligible health care and/or dependent care expenses every year by using pre-tax dollars. Consider how much you spend on health care and/or dependent care expenses for you and your qualified dependents in one year:

- Medical/dental office visit copays
- Virtual visits
- Prescription drugs/medications with a prescription
- Eye exams and prescription glasses/lenses
- Vaccinations
- Certain over-the-counter medications (with a prescription)
- **Dependent Care:** Daycare tuition - children under age 13

A full list of eligible expenses can be found in **IRS Publication 502**, accessed by visiting www.irs.gov.

How You Save:

You can also plan for large health care expenditures, like surgery, because you choose how much to put pre-tax into your FSA account. You make your election each year at Annual Enrollment, so you can change the contribution amount every year. Choose your amount wisely!

2021 Maximum Contributions
Health Care: $2,750

Dependent Care: $5,000
($2,500 if married filing separately)

2022 Maximum Contributions
Health Care: $2,750

Dependent Care: $5,000
($2,500 if married filing separately)

Who is Eligible to Use Your FSA Dollars?

You may use your Health FSA dollars towards out-of-pocket expenses for you, your spouse, and children regardless if they participate on your group medical plan.

Adult children are eligible as long as they can be claimed as a tax dependent or if the child is permanently or totally disabled. Please refer to **IRS Publication 969** for more information.

IMPORTANT CONSIDERATIONS:

Unlike your HSA, FSA Funds are considered **"Use or it Lose it."** It is important to be conservative in making elections because any unused funds left in your FSA at the end of December are not refundable to you. You are urged to take precautionary steps to avoid having funds remaining in your account at year-end.

Health care FSA: Per IRS guidelines, you will be able to roll over $500 of your remaining funds to the next plan year.

Dependent care FSA: There is no rollover on dependent care FSA, but there is a grace period to continue incurring claims through 3/15/22.

There is a run-out period to file claims incurred before 1/1/22 for both health care FSA and dependent care FSA through 3/31/22.

HSAs & FSAs: WHAT'S THE DIFFERENCE?

Provisions	Health Savings Account (HSA)	Flexible Spending Account (FSA)
Plan Requirements	HDHP	None
Other Requirements	Cannot be enrolled in any other health insurance including an FSA	None
Account Owner	You	Employer
Qualified Expenses	· Unreimbursed medical, dental and vision expenses · Some insurance premiums: Medicare, long term care and COBRA	Unreimbursed medical, dental and vision expenses
OTC Medicines	Only with a prescription	Only with a prescription
2021 Annual Contribution Limits	$3,600 individual $7,200 family Plus $1,000 catch-up at age 55	$2,750
2022 Annual Contribution Limits	$3,650 individual $7,300 family Plus $1,000 catch-up at age 55	$2,750
Access to Funds	Available balance only	Up front availability
Ability to Use Funds for Non-Qualified Expenses	Yes, but taxable and subject to a 20% penalty (no penalty after age 65)	No
Ability to Change Contribution	Same as all direct deposit banking	Open Enrollment only unless qualified event
Rollover of Funds	Yes	No
Recordkeeping	Retain receipts in case of IRS audit	Submit receipts when requested by Plan Administrator
Eligible Dependents	Legal spouse and dependent children (IRC Section 152)	Legal spouse and dependent children (IRC Section 152)

LIFE / AD&D INSURANCE

The life insurance plans are offered to you through **Sun Life.**

Pax Technology provides term Life Insurance and Accidental Death and Dismemberment (AD&D) insurance to all eligible full-time employees in the amount of $25,000. *Age reductions apply, see below.* **There's no cost to you!**

ALL FULL TIME EMPLOYEES	BENEFIT AMOUNT
Life Insurance	$25,000
Accidental Death & Dismemberment	$25,000

VOLUNTARY LIFE / AD&D INSURANCE

You have the option to purchase additional life insurance through **Sun Life.** Accidental Death & Dismemberment coverage is automatically included with the Voluntary Life Insurance. *Age reductions apply, see below.*

You must purchase coverage for yourself in order to purchase coverage for your family. Should you decline coverage when you are first eligible, you will be able to enroll in $10,000 of Employee coverage at our next open enrollment. If you decide you want a higher amount or want to cover your family, you (and/or your family members) will have to complete a Sun Life Evidence of Insurability Form (EOI) (medical questionnaire) and are subject to Sun Life's approval. Approval is not guaranteed so we encourage you to consider purchasing the insurance when it is first offered. If electing coverage when you first become eligible, you can get up to the Guaranteed Issue amount without having to answer any medical questions.

This coverage is portable and has a conversion benefit, should you leave employment for any reason.

Please login to Employee Navigator for your cost of this coverage. Voluntary Life rates will be based on your age and elected amount. **If you currently have more than the Guaranteed Issue amount of life insurance with our previous carrier, your amount will be grandfathered in and honored by Sun Life at this year's open enrollment.**

	Increments of Coverage	Minimum	Maximum	Guarantee Issue Amount
Employee	$10,000	$10,000	$500,000 *Cannot exceed 5 times your Basic Annual Earnings	$100,000
Spouse ***Coverage ends when you turn age 70***	$5,000	$5,000 *Cannot exceed 100% of Employee Amount	$100,000	$50,000
Child(ren) ***Age 6 months to age 25***	$1,000	$1,000 *Cannot exceed 100% of Employee Amount	$10,000 *Age 14 days to 6 months: $500*	$10,000

Age Reductions: 35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80

IMPORTANT REMINDERS

- If you are enrolled in Voluntary Life/AD&D, you can increase your Employee amount by $10,000 at our next open enrollment up to the Guarantee Issued Amount without completing the EOI Form.
- You must be actively at work on the date your insurance takes effect to be covered. If you are not actively at work, coverage will begin when you return to work.

Don't forget to update your Beneficiaries!

This can be done any time.

VOLUNTARY SHORT-TERM DISABILITY

The short-term disability plan is arranged through **Sun Life**.

Disability insurance is most commonly referred to as "paycheck insurance" as it protects your income in the event you become ill or injured off the job and you cannot work for a period of time. Short-Term Disability protects your income in case you are disabled for a **short** amount of time.

Short-Term Disability	
Benefits Begin (Elimination Period)	If you become disabled, there is a 14 day waiting period before benefits are payable for both accidents and illnesses.
Benefit	You may choose your weekly benefit in $50 increments up to $1,000, **not to exceed 60% of your weekly earnings**
Maximum Benefit Period	Short-term disability benefits are available for up to **11** weeks.
Pre-Existing Conditions Limitation (3/12)	Disabilities that occur during the first **12** months of coverage, due to a pre-existing condition during the **3** months prior to coverage, are excluded.
Guaranteed Issue	No Evidence of Insurability (EOI) medical questionnaire is required if you waive this coverage when you are first eligible and wish to enroll during the following open enrollment.
Rates	**Your rates will automatically calculate when you login to make your elections in Employee Navigator.**

VOLUNTARY LONG-TERM DISABILITY

The long-term disability plan is arranged through **Sun Life**.
Long-Term Disability protects your income in case you are disabled for a long period of time.

Long-Term Disability	
Benefits Begin (Elimination Period)	If you become disabled, there is an elimination period before benefits are payable of **90 days** for both accidents and illnesses.
Benefit	**60% of monthly earnings**, not to exceed monthly benefit maximum of **$10,000**
Maximum Benefit Period	Long-term disability benefits are available for up to **Social Security Normal Retirement Age**. 2-year Own Occupation definition applies.
Pre-Existing Conditions Limitation (3/12)	Disabilities that occur during the first **12** months of coverage, due to a pre-existing condition during the **3** months prior to coverage, are excluded.
Guaranteed Issue	**Only when first eligible** If you enroll at a later date, you will be required to complete an Evidence of Insurability (EOI) form and are subject to Sun Life's approval. Approval is not guaranteed.
Rates	**Your rates will automatically calculate when you login to make your elections in Employee Navigator.**

***Disability benefits may be offset by other sources of income.**

EMPLOYEE ASSISTANCE PROGRAM

An Overview of Your GuidanceResources® Program EAP Essential

Call: 800.460.4374
TDD: 800.697.0353
Go online: guidanceresources.com
Your company Web ID: EAPEssential

Personal issues, planning for life events or simply managing daily life can affect your work, health and family. GuidanceResources® provides support, resources and information for personal and work-life issues. GuidanceResources is company-sponsored, confidential and provided at no charge to you and your dependents. This flyer explains how GuidanceResources can help you and your family deal with everyday challenges.

Confidential Counseling

Someone to talk to.

This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. It is staffed by GuidanceConsultants℠—highly trained master's and doctoral level clinicians who will listen to your concerns and quickly refer you to telephone counseling and other local resources for:

- Stress, anxiety and depression
- Relationship/marital conflicts
- Problems with children
- Job pressures
- Grief and loss
- Substance abuse

Financial Information and Resources

Discover your best options.

Speak by phone with our Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including:

- Getting out of debt
- Credit card or loan problems
- Tax questions
- Retirement planning
- Estate planning
- Saving for college

If you should require additional guidance, we can refer you to a financial professional for an initial one-hour in-person consult at no cost to you.

Legal Support and Resources

Expert info when you need it.

Talk to our attorneys by phone. If you require representation, we'll refer you to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call about:

- Divorce and family law
- Debt and bankruptcy
- Landlord/tenant issues
- Real estate transactions
- Civil and criminal actions
- Contracts

Work-Life Solutions

Delegate your "to-do" list.

Our Work-Life specialists will do the research for you, providing qualified referrals and customized resources for:

- Child and elder care
- Moving and relocation
- Making major purchases
- College planning
- Pet care
- Home repair

GuidanceResources® Online

Knowledge at your fingertips.

GuidanceResources Online is your one stop for expert information on the issues that matter most to you...relationships, work, school, children, wellness, legal, financial, free time and more.

- Timely articles, HelpSheets℠, tutorials, streaming videos and self-assessments
- "Ask the Expert" personal responses to your questions
- Child care, elder care, attorney and financial planner searches

Free for you and members of your household.

100% CONFIDENTIAL!

ADDITIONAL VOLUNTARY PRODUCTS

Pax Technology provides benefit-eligible Team Members the opportunity to purchase voluntary products through **Colonial Life**. **It is important to remember that these lines of coverage are supplemental and not a replacement for major medical insurance.** These products provide lump sum cash payments that can be used for both direct medical and indirect non-medical expenses for you and your family.

DIRECT MEDICAL EXPENSES	INDIRECT MEDICAL EXPENSES
Deductibles Coinsurance Copays Experimental Treatments Prosthetic Devices Medical Equipment	Transportation Childcare Groceries Mortgage Household Bills

ACCIDENT INSURANCE: Colonial Life sends you a lump sum cash payment for accidental injuries such as sports-related accidental injuries, broken bones, burns, lacerations, concussions, and more. This benefit also pays for initial care, follow-up care, catastrophic accidents, and a wellness benefit.

MEDICAL BRIDGE INSURANCE (GAP): This plan pays indemnity benefits to help cover out-of-pocket expenses associated with your major medical plan. This plan does not coordinate benefits with any other plans you might have. The Medical Bridge pays lump sum cash payments to you for hospital confinement. Additionally, you are able to purchase this coverage for your dependents. Colonial Life will not pay benefits for loss during the first 12 months of coverage, due to a pre-existing condition. **You must be enrolled in medical coverage in order to enroll in Medical Bridge Insurance. However, you do not have to be enrolled in our medical plans.**

CRITICAL ILLNESS INSURANCE: This coverage combines Cancer and Critical Illness into one policy and is available to you and your dependents. Common covered illnesses include but are not limited to:

- ❑ Heart Attack (Myocardial Infarction)
- ❑ Occupational Infectious HIV or Hepatitis B, C or D
- ❑ Stroke
- ❑ Paralysis due to a covered accident
- ❑ Blindness
- ❑ End-Stage Renal (Kidney) Failure
- ❑ Major Organ Failure
- ❑ Coronary Artery Disease
- ❑ Cancer
- ❑ Coma

Rates are available online.

ANNUAL DISCLOSURE NOTICES

FAMILY MEDICAL LEAVE ACT

Employee Rights & Responsibilities

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 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 FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

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

Eligibility Requirements

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

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

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care 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 health care 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 member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care 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 by 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 or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text 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
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor Wage and Hour Division

HEALTHCARE REFORM
Notice of Health Care Reform Changes

As a reminder, the following changes to **Pax Technology's** Medical Plans and are still valid for the 2021-2022 plan year.

- The lifetime benefit limit will be unlimited on essential services.
  - There will be no annual limit on essential benefits. Essential benefits may include:
  - Ambulatory Patient Services
  - Emergency Services
  - Hospitalization
  - Maternity and Newborn Care
  - Mental Health and Substance Abuse Disorders
  - Prescription Drugs
  - Rehabilitative and Facilitative Services and Devices (including durable medical equipment)
  - Laboratory Services
  - Prevention and Wellness Services
  - Chronic Disease Management
  - Pediatric Services, including oral and vision care
- Certain Preventive services are now covered 100% at no charge when you use **Cigna** network providers. These include**:**
  - Routine adult physical
  - Routine Well child Exams
  - Routine Gynecological exams (includes pap and related fees)
  - Colorectal Cancer Screening
  - Routine mammograms
- Most Generic Oral Contraceptive Medications & Products for $0 cost-share. (FDA Approved Contraceptive Methods for women). Items available without a prescription are not covered under the Health Care Reform law.
- Pre-existing Condition exclusions do not apply
- Dependents may be covered until age 26. Dependents under the age of 26 may enroll within 30 days of renewal for coverage effective December 1, 2021.
- Primary care physicians: a participating physician specializing in pediatrics may be selected as the primary care physician for a covered dependent child.
- Gynecological and obstetric services: Authorization or referral for gynecologic or obstetric care will not be required.
- Appeals: Covered persons will have the right to an internal appeal and external review for coverage determinations or claims.

MEDICARE PART D
NOTICE OF CREDITABLE COVERAGE

For Medicare-Eligible employees enrolled in the Cigna Health Plans:

- 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 that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.
- **Your Employer** has determined that the prescription drug coverage offered by your Cigna plan on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you become eligible for Medicare and each year from October 15th through December 7th. This may mean that you have to wait to join a Medicare drug plan and that you may pay a higher rate (a penalty) if you join later. You may pay the higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

In addition, if you lose or decide to leave employer/union-sponsored coverage, you will be eligible to join a Part D plan at the time using an Employer Group Special Enrollment Period.

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.

If you decide to join a Medicare drug plan, your employer coverage will not be affected. If you decide to join a Medicare drug plan and drop your employer sponsored prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

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

Note: You'll get this notice each year. You may also request a copy.

For more information about your option under Medicare prescription drug coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will be mailed a copy from Medicare each year. For more information about Medicare prescription drug coverage:
Visit www.medicare.gov
Call your State Health Insurance Assistance Program (or see "Medicare & You" Guide)
Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying Medicare prescription drug coverage is available. For more information, contact Social Security at 1-800-772-1213 or www.socialsecurity.gov.

Date:	**December 1, 2021**
Name of Entity/Sender:	**Pax Technology, Inc.**
Contact / Position:	**Human Resources**
Address:	**8880 Freedom Crossing Trail, Suite 300** **Jacksonville, FL 32256**
Phone Number:	**904-236-5205**

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

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

PART B: Information about Health Coverage Offered by Your Employer

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

3. Employer name Pax Technology, Inc.	4. Employer Identification Number (EIN) 26-2199262	
5. Employer address 8880 Freedom Crossing Trail, #300	6. Employer phone number 904-236-5205	
7. City Jacksonville	8. State FL	9. ZIP code 32256
10. Who can we contact about employee health coverage at this job? Christy Tse		
11. Phone number (if different from above)	12. Email address Christy.tse@pax.us	

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

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

  ☒ All employees. Eligible employees are:
  All Full-time employees working at least 30 hours per week who have satisfied the new hire waiting period; COBRA Participants

  ❑ Some employees. Eligible employees are:
  All Full-time Eligible Employees who work at least 25 hours a week; COBRA Participants

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:
  Lawful spouse, dependents up to age 26; and dependents who are age 26+ under the guidelines of the State of Florida (FSS 627.6562)

  ❑ We do not offer coverage.

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

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

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

COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage.

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee'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 your Plan Administrator.

COBRA NOTICE CONTINUED

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: Pax Technology, Inc., HR, 8880 Freedom Crossing Trail Ste. 300, Jacksonville, FL 32256, (904) 236-5205

OMB Control Number 1210-0123 (expires 1/31/2023)

NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT (NMHPA)

The Newborns' and Mothers' Health Protection Act (NMHPA) was enacted in 1996 to provide protections to mothers and their newborn children with respect to the length of hospital stays after childbirth. Under the NMHPA, group health plans may not restrict mothers' and newborns' benefits for hospital stays after childbirth to less than:

- 48 hours following a vaginal delivery; and
- 96 hours following a delivery by cesarean section.

A group health plan may also not require a physician or other health care provider to obtain authorization from the plan for prescribing the minimum hospital stay for the mother or newborn. However, the health plan may impose cost sharing, such as deductibles or coinsurance, on hospital stays related to childbirth.

Coverage Requirements

The NMHPA sets limits on benefits that are provided for hospital stays after childbirth. However, nothing in the law or regulations requires a mother to give birth in a hospital or stay in the hospital for a specific period of time after giving birth. Also, the NMHPA does not require group health plans to provide any benefits for hospital stays related to childbirth. However, if the plan provides these benefits, it must comply with the NMHPA's minimum requirements.

Hospital Length of Stay

The final regulations clarify when a hospital stay connected with childbirth begins.

- When a delivery occurs in the hospital, the stay begins at the time of delivery, not at the time of admission or beginning of labor.
- If there are multiple births, the stay begins at the time of the last delivery.
- For deliveries that occur outside of the hospital, the stay begins at the time the mother or newborn is admitted.

The decision of whether a hospital stay is connected with childbirth is a medical decision to be made by the attending provider.

Attending Provider Definition

The regulations provide an exception to the NMHPA's general rule regarding length of hospital stay for situations where the attending provider, in consultation with the mother, decides to discharge the mother or newborn earlier than 48 or 96 hours, as applicable.
The attending provider is "an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child." The final regulations definitively state that the definition of attending provider does not include a plan, hospital, managed care organization or other issuer.

Prohibition on Incentives

The NMHPA contains a number of prohibitions designed to prevent benefits from being improperly limited. The regulations clarify that a group health plan may not deny a mother or her newborn coverage under the plan to avoid the NMHPA's requirements or provide payments or rebates to a mother to encourage her to accept lesser benefits than those provided for by the NMHPA.

Also, a group health plan may not penalize an attending provider for giving care in accordance with the NMHPA or provide incentives to induce an attending provider to discharge a mother or newborn before the end of the required time period. However, a group health plan may negotiate with an attending provider the compensation for care provided for hospital stays related to childbirth in general.

(NMHPA) CONTINUED

Authorization and Cost-sharing

The final regulations state that a plan may not require a physician or other health care provider to obtain authorization for prescribing a hospital stay in accordance with the NMHPA. In addition, a group health plan may not restrict benefits for a portion of a hospital length of stay provided for by the NMHPA in a way that is less favorable than benefits for a previous portion of the stay.

The regulations do not prohibit imposing cost-sharing, such as deductibles or coinsurance, on hospital stays related to childbirth. However, the cost-sharing must be consistent for the entire stay and cannot be higher for a later portion of the mandated length of stay.

Notice Requirements

The notice requirements with respect to the NMHPA differ depending on the type of plan or coverage involved. The regulations explain the differences as follows:

- **ERISA Plans**. ERISA's rules for summary plan descriptions (SPDs) require all group health plans to describe the federal or state law requirements applicable to the plan relating to hospital lengths of stay in connection with childbirth for the mother or newborn. The DOL provided model language regarding the NMHPA in the SPD rules. See below for this model language.
- State and Local Government Plans. Plans that are subject to the NMHPA must provide a notice with specific language describing the federal requirements. The final regulations clarify that the notice can either be included in the plan document that describes benefits or in the type of document the plan generally uses to inform participants and beneficiaries of plan benefit changes. Further, any time a plan distributes one or both of these documents after providing the initial notice, the applicable statement must be included in one or both documents.
- Health Insurance Issuers in the Individual Market. Health insurance issuers in the individual market must also provide notice in the insurance contract containing specific language regarding the federal rules.

State Insurance Mandates

The NMHPA and the final regulations do not apply to health insurance coverage (and group health plans that provide benefits only through health insurance coverage) in certain states that have adopted laws similar to the NMHPA. The final regulations clarify that a state law qualifies for this exception if it requires the health insurance coverage to do one of the following:
Provide for at least a 48-hour hospital length of stay after childbirth (96 hours for a cesarean delivery);
Provide for maternity and pediatric care in accordance with guidelines for care following childbirth established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics or any other established professional medical association; or
Require, in connection with coverage for maternity care, that the hospital length of stay decision is made by the attending provider in connection with the mother or with the mother's consent.

Enforcement

There are no specific penalties for failing to comply with the NMHPA. However, plan participants or the DOL could use ERISA's enforcement scheme to compel compliance with the NMHPA's requirements. For example, a plan participant could bring a lawsuit for benefits due under the NMHPA, and could seek interest and attorneys' fees. In addition, the Internal Revenue Service (IRS) may impose an excise tax of $100 per day on a group health plan that does not comply with the NMHPA, subject to certain limitations and exceptions depending on the nature of the noncompliance.

Model Disclosure for ERISA Plans

> 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).

SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

ANNUAL DISCLOSURE NOTICES

Women's Health and Cancer Rights Act of 1998 (WHCRA)

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; External breast forms that fit into your bra for before or during reconstruction
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, call your plan administrator.

Michelle's Law Notice- Coverage for Dependent Students

Michelle's Law was enacted in 2008 to ensure that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law is named after a New Hampshire college student, Michelle Morse, who continued her studies while battling colon cancer in order to maintain health insurance coverage under her parents' plan. Michelle died of colon cancer in November 2005 at the age of 22.

The Affordable Care Act (ACA) further expanded coverage requirements for dependents, effective for plan years beginning on or after Sept. 23, 2010. Under the ACA, group health plans or insurers that provide coverage for dependent children must continue to make coverage available until a child attains age 26, regardless of student status.

COVERAGE REQUIREMENTS

Michelle's Law allows seriously ill or injured college students, who are covered dependents under group health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status.
Under Michelle's Law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

NOTICE REQUIREMENTS

If a group health plan requires a certification of student status for coverage under the plan, it must send a Michelle's Law notice along with any notice regarding the certification requirement. The Michelle's Law notice must be written in language understandable to a typical plan participant and must describe the terms of the continuation coverage available under Michelle's Law during medically necessary leaves of absence.

IMPACT OF the ACA

The ACA's adult child coverage mandate diminished the impact of Michelle's Law on many health plans. Under the ACA, if a group health plan or insurer provides dependent coverage for children, the plan or insurer must continue to make the coverage available until the child attains age 26, regardless of student status. Thus, the impact of Michelle's Law on group health plans will generally be limited to health plans that provide coverage to dependent students who are age 26 or over.

MEDICAID & the CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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, 2021. Contact your State for more information on eligibility –

FLORIDA – Medicaid
Website:**https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html** Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

To see if any other states have added a premium assistance program since July 31, 2021, 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

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

CONTACT INFORMATION

To speak with a Benefits Counselor, visit:
https://coloniallife.rivs.com/schedule/paxtechnologyinc/

COMPANY NAME	CUSTOMER SERVICE NUMBER	WEBSITE ADDRESS
Brown & Brown INSURANCE EMPLOYEE BENEFITS	**BROWN & BROWN OF FLORIDA** **Kathleen Kam Larsen** Benefits Consultant **Chris Beach** Sr. Account Manager	kkam@bbjax.com (904) 565-8300 cbeach@bbjax.com (904) 565-8289
CIGNA	**MEDICAL & RX** **(800) 244-6224**	www.cigna.com www.mycigna.com
SUN LIFE	**DENTAL** **(800) 786-5433**	www.sunlife.com
SUN LIFE through VSP	**VISION - VSP** **(800) 877-7195**	www.vsp.com
SUN LIFE	**LIFE & DISABILITY** **(800) 786-5433**	www.sunlife.com
GUIDANCE RESOURCES	**EMPLOYEE ASSISTANCE PROGRAM** **(800) 460-4374**	Guidanceresources.com Web ID: EAPEssential
EMPLOYEE BENEFITS CORPORATION	**HSA/FSA** **(800) 346-2126**	www.ebcflex.com
COLONIAL LIFE	**Cancer, Accident, Critical Illness, Medical Bridge** **Ken MacDougall** **(904) 651-9330**	Kenneth.MacDougall@coloniallifesales.com
PAX	**HUMAN RESOURCES** **Heather Summers** **FlexHR**	**hsummers@flexhr.com** **770-814-4225**