Incredible starts here.

TriNet HR III, Inc. Benefits Guidebook and Summary Plan Description

Benefits Plan Year
January 1, 2020 – December 31,2020

If you have questions about your benefits, please contact the TriNet Solution Center, Monday-Friday 6 a.m.-midnight ET (3 a.m.-9 p.m. PT), by phone (800.638.0461), Live Chat (login.trinet.com > **Contact TriNet> Live Chat**) or email (employees@trinet.com).

Sí usted tiene preguntas sobre sus beneficios, por favor contacte al Centro de Soluciones de Empleados. Usted puede llamar al 800.638.0461 o entrar a TriNet (login.trinet.com) y oprimir Contact TriNet> Live Chat, de 3 a.m. a 9 p.m. Tiempo Pacifico, de Lunes a Viernes o puede enviar un correo electronico a employees@trinet.com

This proprietary communication has been prepared for educational and informational purposes only. The content does not provide and shall not be construed as providing legal, financial, or tax advice on any specific matters. Transmission of this information is not intended to create, and receipt does not constitute, an attorney-client relationship between TriNet and you. TriNet is not an insurance company, but rather is the single-employer sponsor of all its benefit plans. Nothing contained herein constitutes an offer to sell, buy, or procure insurance.

TriNet is the single employer sponsor of all its benefit plans. TriNet makes these plans available to qualifying Worksite employees ("WSEs"), with whom TriNet has established an employment relationship, and who perform services for clients of TriNet in a Professional Employer Organization ("PEO") or service model. Under this model, TriNet incurs all expenses associated with its plan sponsorship and maintenance, and TriNet bills the client for its services. The client has no other financial obligation to TriNet, its other clients, or any of its insurance carriers for TriNet benefit plan sponsorship or provision. TriNet carriers have no recourse against TriNet clients. Other than compliance with TriNet contract terms, clients have no legal responsibilities to TriNet, the WSEs, or any other TriNet client for plan sponsorship or compliance. Federal and state laws may impose obligations on our clients independent of the role of TriNet as the plan sponsor. Because TriNet does not provide tax or legal advice, clients should address the resolutions of these obligations with their advisors.

Any references to "your benefit programs or plans" are not legal terms or terms of art and should not be confused with legal plan sponsorship, participation, or fiduciary compliance. These terms and others, such as "your employees" or "your selections, plan, or investments," are used solely as lay terms of convenience so that you understand we are referring only to the decisions made and TriNet plans available in a specific Worksite or to a specific group of WSEs.

Insurance coverage exclusions and limitations apply. In the event there is a conflict between any of the information contained in any benefits guidance materials provided by TriNet (including but not limited to information contained in any TriNet website, the TriNet Benefits Enrollment Confirmation, any written or electronic pamphlets, letters, emails, text messages, and statements made by TriNet employees) and the TriNet Plan document, the Plan document shall control. Also, if there is a conflict between an official certificate provided by TriNet insurance carrier(s) (the "Carrier Certificate") and either the TriNet Plan document, any TriNet Summary Plan Description, statements made by a TriNet employee, or any other benefits guidance materials provided by TriNet (including but not limited to those described above), the Carrier Certificate shall control.

CONTENTS

PLAN INFORMATION

Name of the Plan
TriNet HR III, Inc. Employee Benefit Plan

Plan Number
501, 502

Type of Plan
The Plan is a welfare plan providing fully insured health, dental, vision, life, accidental death and dismemberment and disability benefits, and self-insured dental, vision and health care and dependent day care flexible spending accounts.

Payment of Plan Expenses
Plan expenses are paid through the TriNet Employee Benefit Insurance Trust and TriNet general assets, which is operated for the exclusive benefit of TriNet employees.

Plan Sponsor and Plan Administrator
The Plan Sponsor and Plan Administrator is TriNet HR III, Inc. TriNet HR III, Inc. is responsible for determining Plan eligibility and the day-to-day management of the plans. Some Plan eligibility determinations may be based on information received from you or your Worksite.

TriNet HR III, Inc.
One Park Place
Suite 600
Dublin, CA 94568
510.352.5000

Service of Legal Process
TriNet agent for service of process is Corporate Creations Network Inc. Corporate Creations Network Inc. has locations across the country.

Corporate Creations Network Inc.
4640 Admiralty Way
5th Floor
Marina Del Rey, CA 90292
800.672.9110

Legal process also may be served properly on the Plan at:

TriNet HR III, Inc.
Attn: Chief Legal Officer
One Park Place
Suite 600
Dublin, CA 94568
510.352.5000

Benefits Plan Year
The benefits plan year begins on January 1, 2020 and ends on December 31, 2020.

CHAPTER 1 – INTRODUCTION, DEFINITIONS AND SUMMARIES OF BENEFITS AND COVERAGE

1.1 Introduction

Welcome to the Benefits Guidebook and Summary Plan Description (the "Guidebook" or "SPD").[1] TriNet provides fully insured medical, dental, vision, and certain voluntary benefits, as well as self-insured dental, vision and flexible spending accounts, to you through TriNet's Employee Benefit Plan, hereafter called the "TriNet Benefits Plan" or the "Plan." The TriNet Benefits Plan is maintained for the exclusive benefit of Plan participants and their eligible dependents.

To the extent applicable, the Plan is qualified under Section 125 of the Internal Revenue Code of 1986, as amended (the "IRC" or "Code"), which allows TriNet to offer you a choice of plans within each benefits option paid for, in many cases, on a pre-tax basis. To maintain its Section 125 qualification, the Plan must maintain certain eligibility and benefits change rules. Those Section 125 rules are contained in this Guidebook to help you maximize the benefits for yourself and eligible dependents.

The Plan is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), which provides certain protections for you and your dependents. This Guidebook, in conjunction with the separate carrier-issued certificates of coverage (the Carrier Certificates) and the Summaries of Benefits and Coverage (SBCs), which are incorporated herein by reference and found on TriNet (login.trinet.com), make up your entire Summary Plan Description, as required under ERISA.

This Guidebook contains information on who is eligible for benefits and how to enroll in and maintain your benefits. The Carrier Certificates contain information that describes the types of covered expenses, amounts covered, exclusions, limitations and other rules that are specific to each benefit offered under the Plan. For example, if you are enrolled in the Aetna PPO plan and you want to know if an MRI is covered, you will need to consult the Aetna-issued Carrier Certificate. The SBCs provide a short, easy to understand uniform summary of the medical benefit plans offered under the Plan.

Every attempt has been made to be as informative as possible about the benefits available under the Plan and the eligibility requirements for those benefits. This Guidebook is intended to provide a summary of the major provisions of the plans in which you are eligible to participate. The information is described as clearly as possible with minimal use of the technical words and phrases normally appearing in the official Plan document ("Official Plan Document"). However, the Official Plan Document, which is available on request, remains the final authority and, in the event of a conflict with this Guidebook, the Official Plan Document shall govern in all cases.

Insurance coverage exclusions and limitations apply. In the event there is a conflict between any of the information contained in any benefits guidance materials provided by TriNet (including but not limited to information contained in any TriNet website, the TriNet Benefits Enrollment Confirmation, any written or electronic pamphlets, letters, emails, text messages, and statements made by TriNet employees) and the TriNet Plan document, the Plan document shall control. Also, if there is a conflict between an official certificate provided by TriNet insurance carrier(s) (the "Carrier Certificate") and either the TriNet Plan document, any TriNet Summary Plan Description, statements made by a TriNet employee, or any other benefits guidance materials provided by TriNet (including but not limited to those described above), the Carrier Certificate shall control except with respect to eligibility to participate in the Plan. It is important to note that although some Carrier Certificates list the dependents that "may" be covered if permitted by the Plan, the dependent eligibility provisions are solely determined by the Plan document and TriNet Benefits Guidebook.

The Plan Administrator has full discretionary authority to interpret the Plan, its provisions, and regulations with regard to eligibility, coverage, benefits entitlement, and general administrative matters. The Plan Administrator's decisions will be binding on all Plan participants and conclusive on all questions of coverage under this Plan.

[1] This Guidebook also serves as the Summary Plan Description ("SPD") required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). We provide the Guidebook and the SPD to you in one integrated form in order to avoid the confusion that can be caused by separate documents. Throughout, we will refer to this document as "the Guidebook" and "the SPD" interchangeably.

TriNet benefit plans claims administration is performed by the carrier, without input from TriNet. TriNet does not have the ability to influence the insurance carrier's decisions with respect to the plans. The following are determined solely by and at the full discretion of the insurance carrier in accordance with their plan rules and underwriting guidelines:

a. Adjudication of claims,
b. Decisions on the existence of pre-existing conditions,
c. Approval of additional benefits,
d. Statement of Health review and approval,
e. Approval for non-standard or experimental treatments, or
f. Outcome of claim appeals.

If you have a health care, life insurance or disability claim issue, your path of appeal is through the insurance carrier. Each carrier describes its appeal process in the Carrier Certificate posted on TriNet (login.trinet.com).

The failure of the Plan Administrator to enforce strictly any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator reserves the right to enforce strictly each and every provision of this Plan at any time, regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

TriNet hopes and expects to be able to continue the Plan indefinitely but reserves the right to make changes in the Plan or to discontinue the Plan at any time in its sole and absolute discretion. TriNet will notify Plan Participants if it amends or discontinues the Plan. Any and all amendments to the Plan shall be in writing and shall be authorized by the signature of the Plan Administrator or its assigned designee.

TriNet cannot anticipate new federal and state regulations concerning group health plans. The Plan is administered to be compliant with legislative mandates. If your eligibility or benefits are impacted by new legislation, TriNet will communicate those changes to you.

You may review the Official Plan Document on file. In the event there is a conflict between any benefits guidance materials provided by TriNet (including, but not limited to written/electronic materials and statements made by a colleague) and this Summary Plan Description, this Summary Plan Description and the Official Plan Document shall control. Again, in the event there is a conflict between this Summary Plan Description and the Official Plan Document, the Official Plan Document shall control. Also, if there is a conflict between a Carrier Certificate and either the Official Plan Document or this Summary Plan Description, the Carrier Certificate shall control.

No person will be refused enrollment or re-enrollment because of race, color, creed, marital status, gender, sexual orientation, medical condition, or age.

1.2 Definitions

The following terms are used within this Guidebook:

"Actively at Work" means you are performing all the usual and customary duties of your job on a full-time basis.

"Affordable Care Act (ACA)" refers to two separate pieces of legislation, however it most commonly refers to the Patient Protection and Affordable Care Act (P.L. 111-148).

"Authorization To Use/Disclose Protected Health Information" is a Health Insurance Portability and Accountability Act (HIPAA) compliant process you can use to authorize another person to discuss your health care benefits information at TriNet. The form can be found on TriNet (login.trinet.com). Complete and return the form to TriNet as indicated on the top of the form.

"Beneficiary" is an individual you have elected to receive life insurance proceeds in the case of your injury or death. See the Chapter subsection entitled *Beneficiary Designation* for help with beneficiary designation. Designating a family member as a beneficiary does not automatically make that individual a dependent or enroll that individual in TriNet benefits. See the definition of a dependent below.

"Benefits Eligibility Date" is the first day you are eligible to participate in the Plan after any applicable waiting period has been satisfied.

"Benefits Effective Date" is the first day a new TriNet client offers benefits to its Worksite employees.

"Benefits Plan" is a component plan, such as medical, dental, or disability, established under the TriNet benefits Plan.

"Calendar Year" is the period beginning January 1 and ending December 31.

"Carrier" means an insurance company that has contracted with TriNet to insure and reimburse eligible claims incurred by you or your eligible dependents.

"Carrier Certificates" are the part of your Summary Plan Description that provide specific detail about covered treatments and services. The insurance carriers of the self-insured and fully insured benefit plans provide a Carrier Certificate for each benefit plan offered by TriNet. You can find a Carrier Certificate for your specific plan on TriNet (login.trinet.com). If you still have questions after reading your Carrier Certificate, call the carrier for more information.

"Client" means an entity that has signed a service agreement with TriNet where TriNet has agreed to provide human resources, payroll, and benefits services in a PEO relationship. The terms "client" and "worksite" will be used interchangeably.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, which provides continuation of medical, dental, and vision coverage, and a health care flexible spending account (FSA) option (as defined below) for eligible employees in certain circumstances.

"Days" means calendar days unless otherwise noted.

"Deductible" means the amount you owe for health care services your plan covers each year before your health insurance or plan begins to pay. For example, if the deductible is $1,000, your plan will not pay anything until you have met the $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. In addition, the deductible may accrue on a calendar year or benefits plan year basis.

An individual deductible is the amount each covered person needs to incur before the plan begins paying the eligible medical bills for the rest of the year. A family deductible is the total amount you and your covered dependents need to incur together before the plan begins paying the eligible medical bills for all covered members for the rest of the year.

Refer to the Carrier Certificate for information on how deductibles apply to the coverage you are enrolled in.

"Dependent" means an individual who is eligible to be enrolled in TriNet health care benefits. See the Chapter entitled *Eligibility* for the eligibility requirements. Once you have verified that an individual is an eligible dependent under the terms of the Plan and have entered the dependent's information, you must also elect which plans (e.g., medical, dental, or vision) this individual will participate in. Merely designating someone as a dependent does not automatically enroll that individual in the benefit plans you elected for yourself.

"Domestic Partner" refers to a relationship that meets all the requirements listed under the Chapter entitled *Eligibility.*

"FSA" means a flexible spending account established to help you pay for eligible out-of-pocket health care expenses or dependent day care expenses on a pre-tax basis.

"Group Benefit Plan" (also known as a group health plan or medical plan)- means an employee welfare benefit plan established or maintained by an employer to the extent that the plan provides medical care (including items and services paid for as medical care) to eligible employees or their eligible dependents directly or through insurance, reimbursement, or otherwise.

"Health Care" means medical, dental or vision coverage provided under the Plan.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Imputed Income" refers to the *value* of certain benefits that are subject to taxation under the IRC. Examples are Worksite-paid group life insurance in excess of $50,000 or the Worksite-paid portion of health care benefits for an individual who is not your IRC-defined tax dependent.

"K-1 Participant" means any individual who has signed the TriNet Terms and Conditions Agreement for Employees Receiving K-1 Distributions.

"Key Employee" is an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

"Month(s)" for any applicable waiting period, a month is counted from one numerical date in the beginning month to the same numerical date in the following month(s). For example, January 8 to February 8 is a month, just as is February 8 to March 8.

"Newly Eligible" is when you initially become eligible for TriNet benefits, either on your date of hire or at the end of a waiting period, because you have been newly hired by your Worksite, your Worksite is a new TriNet client, or your status has changed from part-time to full-time.

"Open Enrollment" is the annual enrollment period when you may make changes to your benefit elections and add or drop eligible dependents.

"Online Enrollment" is a benefits election made via TriNet (login.trinet.com).

"Plan" refers to the TriNet HR III, Inc. Employee Benefit Plan.

"Rehire" means you have been covered under TriNet benefits, your benefits terminate due to loss of employment and you are subsequently rehired by the same Worksite or a related Worksite.

"Spouse" means your legally married husband or wife.

"TriNet (login.trinet.com)" is your primary source for TriNet benefits information. It can be found by logging on to login.trinet.com. You will be prompted to create your own account to enroll or waive when you are first eligible for TriNet benefits. You can find benefits information on the tab marked "Benefits," including but not limited to your current benefit elections, the Ask Benefits tool, and the Carrier Certificates which provide specific detail about covered treatments and services.

"Variable Hour Employee" is an ACA designation that is used for Applicable Large Employers to define Worksite employees for whom the Worksite is unable to determine whether the Worksite employee will be reasonably expected to work an average of at least 30 hours per week.

"Waiting Period" is the amount of time determined by your Worksite that defines the time between your hire date and benefits eligibility date.

"Worksite" means an entity that has signed a service agreement with TriNet where TriNet has agreed to provide human resources, payroll, and benefits services in a professional employer organization (PEO) relationship. The terms "worksite" and "client" will be used interchangeably in this Guidebook.

1.3 Summary of Benefits and Coverage (SBC)

The SBCs provide you with an easy-to-understand summary about each medical plan's benefits and coverage. The SBC regulation is designed to help you better understand and evaluate your health plan choices.

All insurance companies and group medical plans will use the same standard SBC format to help you compare health plans. The SBC form also includes details, called "coverage examples," which are comparison tools that allow you to see what the plan would generally cover in two common medical situations.

If TriNet provides your medical benefits, the SBC for your medical plan is available on TriNet (login.trinet.com). The SBCs are available to you on behalf of your dependents.

1.4 Definition of Terms Used in Summaries of Benefits and Coverage

A uniform glossary is provided by the Department of Labor (DOL) to help you understand the terms used in the SBCs. It is available online here: Glossary of Health Coverage and Medical Terms

CHAPTER 2 – ELIGIBILITY

2.1 Eligibility

You

You are an eligible participant if you:

a. Are either:
   i. Regularly scheduled to work for TriNet or an individual TriNet client and remain actively at work and are paid through TriNet payroll for a minimum of 30 hours a week (20 in Hawaii), unless you are on a TriNet approved leave of absence that provides for benefits continuation.
   ii. A Variable Hour Employee who averaged at least 30 hours a week during the initial or standard measurement period and your Worksite has designated you as a full-time employee for the duration of the subsequent initial or standard stability period; or
   iii. A Worksite employee of a school that is a TriNet client and are regularly scheduled to work and are paid through TriNet payroll for a minimum of 30 hours per week for a minimum of nine months during the plan year.
b. Have completed any applicable waiting period determined by a carrier or your Worksite. If on your benefits eligibility date you are not at work or performing services and being paid by TriNet or have not signed the TriNet Terms and Conditions Agreement for Employees Receiving K-1 Distributions, coverage will begin on the first date you actually perform services compensable by TriNet; provided, however, that for purposes of the TriNet major medical coverage, you will be treated as being actively at work on your benefits eligibility date if you performed services compensable by TriNet on or after your most recent hire date, but are absent on your benefits eligibility date because of a health factor; and
c. Maintain a primary residence or are regularly employed within the geographic scope of an applicable plan or are regularly employed in the service area.

You are ineligible for TriNet benefits if you are:

a. An independent contractor;
b. An employee of a staffing firm;
c. A seasonal Worksite employee;
d. A temporary Worksite employee only if the Worksite is not an ACA Applicable Large Employer;
e. A commissioned Worksite employee that is earning wages or eligible for commissions that will not be paid through TriNet payroll;
f. A business owner, partner or member that is not earning wages paid through TriNet payroll and has not signed the TriNet Terms and Conditions Agreement for Employees Receiving K-1 Distributions;
g. A Worksite employee who is represented by a collective bargaining contract unless the collective bargaining contract or some other written agreement provides for participation.

Your Dependent(s)

Your eligible dependent is an individual who is:
a. Your spouse. A spouse is your legally married husband or wife; or
b. Your domestic partner. A domestic partner is:
   i. A person with whom you have entered into a valid domestic partnership or a valid civil union recognized by state law, including same-sex and opposite-sex couples registered with any state or local government agency authorized to perform such regulations (any requirements for proof of relationship for domestic partnerships are also applied to marriages and domestic partner registry certificates are accepted as fully equivalent to marriage certificates.); or
   ii. You are domestic partners in accordance with **all** of the following criteria:
      - You and your domestic partner share an intimate and committed relationship of mutual caring;
      - You and your domestic partner cohabitate and reside together in the same principal residence and intend to do so indefinitely;
      - You and your domestic partner are not related by blood or a degree of closeness that would prohibit legal marriage in the state in which you legally reside (for example, a parent or sibling is not an eligible domestic partner);
      - You and your domestic partner are at least eighteen (18) years of age and mentally competent to contract;

- Neither you nor your domestic partner is currently married to or in a domestic partnership with another person under either statutory or common law;
- You and your domestic partner are not in this relationship solely for the purpose of obtaining benefits coverage; and
- You and your domestic partner are jointly responsible for each other's common welfare and living expenses.

c. Your, your spouse's, or your domestic partner's natural child, stepchild, adopted child, child placed for adoption, or child for whom you, your spouse, or domestic partner have been appointed legal guardianship, who is:
   - Under age 26, unless extended coverage is mandated under state law;
   - A disabled child;
   - The child of a dependent
     a. This may include grandchildren and great grandchildren if:
        i. The dependents coverage is mandated by state law; and
        ii. The coverage is permitted by the applicable insurance carrier
   - A child named in a Qualified Medical Child Support Order (QMCSO) requiring you to provide health coverage. See the Chapter subsection entitled *Qualified Medical Child Support Order* for more information.

TriNet reserves the right to conduct dependent eligibility audits or request documentation to verify dependent eligibility. When you enroll a family member in the TriNet Plan, you are representing that:

a. The individual is eligible under the terms of the Plan;
b. You will provide evidence of eligibility on request;
c. Your failure to provide evidence of eligibility will be deemed evidence of fraud or intentional misrepresentation; and
d. You understand that your failure to provide evidence of eligibility may result in the termination of that individual's coverage, which may be retroactive to the date as of which the individual became ineligible for Plan coverage, as determined by the Plan Administrator and subject to the Plan's provisions on rescission of coverage.

For example, if you fail to report a divorce on a timely basis and cannot produce documentation that your former spouse remains eligible for TriNet benefits, TriNet may terminate the (ineligible) former spouse's coverage retroactive to last day of the month in which the divorce occurred.

Documentation might include:

a. A marriage certificate;
b. A birth certificate;
c. Proof of domestic partner registration with a government entity;
d. Verification of disabled child eligibility or claim of dependent as a tax dependent (e.g., IRS transcript of your Form 1040 tax return);
e. Evidence of joint responsibility of significant assets or liabilities (e.g., a bank account statement, mortgage, car loan, lease); or
f. Copies of drivers' licenses, passports, or tax returns showing the same address.

Carrier Certificates and Dependent Eligibility

You should review the dependent eligibility provisions under the applicable Carrier Certificate (for the plan in which you are enrolled) in conjunction with the terms of the Plan document as summarized in this Guidebook. It is important to note that although some Carrier Certificates list the dependents that "may" be covered if permitted by the Plan, the dependent eligibility provisions are solely determined by the Plan document and TriNet Benefits Guidebook.

2.2 Disabled Child

Your child of any age who is incapable of self-sustaining employment as a result of mental or physical disability and is considered eligible for disabled child coverage if all of the following apply:

a. The child is enrolled in the Plan as your dependent and is disabled on the date coverage would otherwise end;
b. The child depends on you for financial support and you claim the child on your IRS tax filing as your dependent and no one else claims the child as their dependent; and
c. Your medical carrier determines that your child meets its definition of a disabled child. Consult the Carrier Certificate for your plan for the carrier's definition of a disabled child. To request an application for a dependent disability extension, call your medical carrier at the number on the back of your insurance ID card.

2.3 Other Relatives

Parents, brothers or sisters, nieces or nephews, other relatives or roommates are generally not eligible for TriNet benefits, even if they qualify as your IRC § 152 tax dependent. There are two possible exceptions:

a. Your elderly parent lives with you and is your IRC tax dependent. Due to a health condition, it is not possible to leave your parent at home alone while you work. You can elect a TriNet dependent day care FSA to pay for day care expenses, but your parent is not eligible for other TriNet benefits.
b. You have a court appointed guardianship to cover a minor child on your TriNet benefits. Contact the TriNet Solution Center for instructions on how to complete a Life Status Change form. Be sure to enclose the court appointed guardianship document when you email the Life Status Change form to employees@trinet.com for approval.

2.4 Tax Dependent

IRC § 152 (as modified by § 105(b)) defines a tax dependent as either a "qualifying child" or a "qualifying relative." The following is a summary of the definition of each. For specific questions about the qualifications for a tax dependent, please consult your lawyer, accountant or other tax advisor.

A "qualifying child" means:

a. Your child (son, daughter, stepchild, sibling or step-sibling, or their descendant), including an adopted child lawfully placed with you;
b. Who lives with you for more than half of the year;
c. Does not provide over one-half of their own support during the year; and
d. Is under age 27 or a child at any age if permanently and totally disabled. This may also include a child who is entitled to coverage under a Qualified Medical Child Support Order (QMCSO).

A "qualifying relative" is an individual who:

a. Bears an IRS-specified familial relationship to you;
b. For whom you provide over one-half of their support for the calendar year; and
c. Who is not the "qualifying child" (for tax purposes) of you or any other individual for the taxable year (i.e., grandchild, grandparent, stepchild, niece or nephew, etc.).

Important Note: Some individuals may qualify as your tax dependents but may not be eligible for TriNet sponsored health care benefits. For example, your elderly mother may qualify as your tax dependent. The IRS allows you to pay for her eligible day care expenses on a pre-tax basis through your dependent day care FSA. However, she is not eligible for TriNet health care benefits.

The definition of a "qualifying relative" is broad enough to cover domestic partners, only if the domestic partner is an individual (other than a spouse) for whom you provide over one-half of their support for the calendar year, who lives with you for the entire taxable year, who is not a "qualifying child" and whose relationship with you does not violate local law.

2.5 Double Coverage

Medical, Dental, and Vision Plans
The Plan does not allow spouses or domestic partners who are both TriNet Worksite employees and elect TriNet health care coverage, even if they work at different Worksites, to cover each other as a dependent. Likewise, dependent children can only be covered under the Plan by one of the parents but not both.

For example, if you work for a TriNet client and your spouse or domestic partner works for a different TriNet client, you may not make multiple elections. See the chart below.

Medical, Dental, and Vision Plans	
Permissible	**Not Permissible**
Each spouse/domestic partner elects Employee Only coverage through their own Worksite	Both spouses/domestic partners elect Employee+ Spouse coverage
One spouse/domestic partner elects Employee Only and the other elects Employee + Children	One spouse/domestic partner elects Employee Only coverage and the other elects Employee + Spouse
One spouse/domestic partner elects Employee + Spouse or Family coverage and the other waives benefits	Both spouses/domestic partners elect Employee + children or Family coverage

If you are eligible for benefits through two or more Worksites, you may only participate once in the medical, dental and vision plans offered by TriNet. Similarly, you may only participate once in a TriNet health care or dependent day care FSA.

Supplemental Life Insurance Plans
You cannot be covered by your own supplemental life insurance and the supplemental life insurance of a spouse/domestic partner. Likewise, dependent children may only be covered under the plan by one of the parents, not both.

Supplemental Insurance Plans	
Permissible	**Not Permissible**
Each spouse/domestic partner elects supplemental life insurance through their Worksite	Both spouses/domestic partners elect their own supplemental life insurance and elect spouse/domestic partner supplemental life insurance for each other
One spouse/domestic partner elects supplemental life insurance and the other elects supplemental life insurance and child life insurance	Both spouses/domestic partners elect their own supplemental life insurance and child life insurance.

CHAPTER 3 – NEWLY ELIGIBLE ENROLLMENT

3.1 Definition of Newly Eligible

You are newly eligible for TriNet benefits either on your date of hire or at the end of your Worksite waiting period if you are enrolling in TriNet benefits for the first time. Examples of this would include if you are newly hired by your Worksite, your Worksite is a new TriNet client or your status has been changed from part-time to full-time. Although the terms "new hire" and "newly eligible" are used interchangeably in TriNet communication materials, both terms refer to your initial TriNet benefits enrollment opportunity.

3.2 When Benefits Begin and Waiting Periods

Benefits Eligibility Date

The benefits eligibility date is the first day when you are eligible to participate in the Plan. Your benefits eligibility date cannot be modified unless the Plan's life status change event rules apply. If you are actively at work benefits will be effective for you on your benefits eligibility date. Employee Assistance Program (EAP) coverage begins on your date of hire.

Immediate Enrollment

If your Worksite selects immediate enrollment in TriNet benefits, your benefits eligibility date is your date of hire. Since benefits coverage and deductions are retroactive to your benefits eligibility date, enrolling early in the election period helps you avoid more than one pay period's worth of deductions from coming out of your paycheck at once.

Waiting Periods

A waiting period is the amount of time determined by your Worksite that defines the time between your hire date and your benefits eligibility date for the benefits described in this Guidebook. A month is counted from one numerical date in the beginning month to the same numerical date in the following month(s). For example, January 8 to February 8 is a month, as is February 8 to March 8.

If your Worksite selects a waiting period, your benefits eligibility date will be the first of the month following the applicable waiting period. For example, if your Worksite has a two-month waiting period and you are hired on November 15 your benefits eligibility date will be February 1. Your Worksite waiting period could be any one of the following:

First of the month coinciding with or after date of hire
First of the month coinciding with or following one month of service
First of the month coinciding with or following two months of service, not to exceed 90 days

If you are unsure if you have a waiting period, how long it may be or what your benefits eligibility date is, please contact the TriNet Solution Center.

If you do have a waiting period, a new hire enrollment link will appear on your TriNet page 30 days before your benefits eligibility date so you can enroll or waive early and avoid retroactive deductions. **Because benefits coverage and deductions are retroactive to your benefits eligibility date, enrolling before or early in the election period will help you avoid having more than one pay period's worth of benefit payments from being deducted from your paycheck at once.**

The waiting period cannot be shortened. If you experience a life status change event that occurs during your waiting period, this event will not allow you to enroll in TriNet benefits any earlier because you are not eligible to participate in the TriNet Plan until you have satisfied your waiting period. For example, if your COBRA coverage is exhausted during your waiting period, you still must wait until your benefits eligibility date to enroll in TriNet benefits.

New TriNet Clients

Your Worksite generally selects the date when TriNet benefits will be made available to you (after satisfying any waiting periods) and such date will be your benefits eligibility date.

Leave of Absence
If you are on an approved leave of absence at the time of your TriNet initial eligibility, unless you are on either Family Medical Leave Act (FMLA) or a state statutory leave, TriNet insurance carriers' rules do not allow enrollment for benefits until you are actively at work and meet the TriNet eligibility requirements.

Life Status Change Event - Change in Status
This eligibility occurs when your Worksite changes your part-time or temporary full-time status to regular full-time status. Your benefits eligibility date will be the later of:

a. The date your Worksite designates you as a full-time employee who meets the minimum hours requirement for full-time status; or
b. The date your Worksite notifies TriNet of your life status change, unless you are still in a waiting period, in which case your benefits eligibility date will be the date your waiting period ends.

For example, if you have already had a year of service with your Worksite on the day they notify TriNet of your change to full-time status, you have already fulfilled the necessary waiting period and you will be immediately eligible for TriNet benefits.

3.3 Quick Start Guide to Enroll or Waive Benefits

ACCESS Log in to TriNet (login.trinet.com). The New Hire enrollment link is on the right -hand side of the page. Because benefits coverage and deductions are retroactive to your benefits eligibility date, enrolling early in the election period will help you avoid having more than one pay period's worth of deductions from coming out of your paycheck at once.

REVIEW your available coverage options, determine if your physicians are in network, and review the associated costs by logging in to TriNet (login.trinet.com). Note that all costs shown are the full amounts that will be deducted from your paycheck each pay-period, so before you make your elections, be sure to do an affordability check. Any Worksite contributions toward your benefit costs are already reflected in the rate amounts shown.

SUBMIT Once you have navigated the entire site and reviewed your elections and per-pay-period costs, ***be sure to click the Submit Benefit Elections button***. If you do not submit your elections (e.g. because you failed to click the submit button), you will not be enrolled in the benefits you elected.

CONFIRM Immediately after you submit your benefit elections, you will receive an email with a confirmation statement. It is recommended that you save or print this confirmation for your records. In the rare case that there is a problem with your election, you will need a copy of the confirmation statement to document your elections. You may review your benefit elections at any time on TriNet (login.trinet.com).

CHANGE If you are still within your 30-day enrollment period and want to change your benefit elections, log back in to TriNet (login.trinet.com) and make the changes. You will receive a new confirmation statement after you have submitted your new elections. For assistance, please contact the TriNet Solution Center.

3.4 Newly Eligible Enrollment Information

When you are eligible for benefits, TriNet will mail a letter to your home address and send various reminder emails to your designated email address on file. The communications contain instructions on how to log in to TriNet (login.trinet.com) and enroll in benefits. On TriNet (login.trinet.com), you will learn which TriNet benefit plans are available in your area, and you will have access to tools that can help you compare plans and benefit rates. Remember, these tools are only a summary of the TriNet benefits and are not a substitute for the Official Plan Document or Carrier Certificates, which govern in the event of any conflict.

To apply for coverage under the Plan, you must:

a. Be an eligible participant or eligible dependent of an eligible participant;
b. Complete enrollment via TriNet (login.trinet.com);
c. Provide any documentation requested by TriNet to determine eligibility; and
d. Provide a valid Social Security or VISA number for each eligible dependent.

Submitting your benefit elections directly on TriNet (login.trinet.com) allows you to consider your benefit options at your convenience, model plans and rates, and discuss your elections with another family member. When you are satisfied with your elections, be sure to **submit** your elections to TriNet. You will know that your submission was successful when you receive an emailed confirmation statement. Make sure that you check your “spam” or “junk mail” folder, in the unlikely event that the emails were sent to one of these folders. If you do not receive an election confirmation email within a few hours, please contact the TriNet Solution Center.

The rules under Section 125 of the IRC require that the benefit elections you make when you enroll or reenroll in the Plan be irrevocable and remain in effect until the end of the benefits plan year. Except for your contributions to a health savings account (HSA), no changes may be made to any benefit elections during the benefits plan year, regardless of whether such benefits are paid on a pre-tax or taxable basis, unless you experience a life status change event and the benefit changes you request are allowable under the TriNet carrier contracts and are consistent with the event.

Benefits Plan Year Elections

Benefit elections that you make when you are a newly eligible Worksite employee are binding through the end of the benefits plan year unless you experience a life status change event. You should carefully consider your benefit elections if your initial elections will be for less than a 12-month period.

Election Period

You have 30 days from your benefits eligibility date, including your benefits eligibility date, within which to elect or waive benefits. Within that 30-day period, you may revise your elections as many times as necessary, and the elections that are last-in-time shall apply and void any prior elections made within the election period. This means that the latest elections submitted by you in TriNet (login.trinet.com) as of the 30th day shall apply and be binding for the remainder of the benefits plan year unless you later experience a life status change event. Be sure to keep a copy of your final confirmation statement for your records.

Because benefits coverage will be effective retroactive to your benefits eligibility date, the deductions for that coverage will accrue retroactive to your benefits eligibility date as well. Therefore, enrolling earlier in the election period could help you avoid having more than one pay period’s worth of deductions from coming out of your paycheck all at once.

You Do Not Live in the State where Your Worksite is Headquartered

Your Worksite may have assigned you to a work location that is in a different location (ZIP code) than your home location. In that case, if you live and work in different states, medical plans may display that are not available for your home location. If you elect a plan that is not available, the medical carrier will not allow enrollment and TriNet will reassign you to the most equivalent and comparable plan for your location which may result in network and carrier changes, higher rates or higher out-of-pocket expenses.

Coverage Categories

When applying for medical, dental or vision coverage, you may elect or waive coverage for yourself or your eligible dependents. You do not need to make the same (coverage category) election for each benefit. For instance, you may elect medical coverage at the Employee plus child level in order to cover your newborn child for the upcoming plan year, but elect Employee only dental coverage because you want to wait until future years to elect dental coverage for your child.

Employee only	Coverage for yourself and no eligible dependents
Employee plus spouse/domestic partner	Coverage for yourself and your eligible spouse or domestic partner
Employee plus child(ren)	Coverage for yourself, your eligible children or your spouse/domestic partner's eligible children
Employee plus family	Coverage for yourself and your eligible dependents (which may include your spouse or domestic partner, your children, and your spouse's or domestic partner's children)

Special Considerations for Employee Paid STD, LTD and Supplemental Life Insurance

Make your employee paid short-term disability and long-term disability elections carefully because your elections may only be changed at Open Enrollment. Important Note: if you do not elect STD, LTD or Supplemental Life Insurance coverage when newly eligible, but decide to elect it at a later time, e.g., during a subsequent Open Enrollment period, such an election will require insurance carrier approval through the Statement of Health process before coverage can be effective.

Social Security Numbers

TriNet must have a Social Security number (SSN) or VISA number for you and each of your dependents for enrollment in a medical benefits plan. Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 created a mandatory data exchange between medical carriers and Medicare. One of the required data elements in this exchange is a SSN for each Plan member. Plan members are defined as Worksite employees and their eligible dependents. Failure to comply with these requirements can result in financial penalties of $1,000 per calendar day to the medical carrier for each incomplete member record. Due to this legislation, the medical carriers have notified TriNet that they will not provide medical coverage for members that have not provided a valid SSN.

Medical carriers allow a 60-90-day window for parents to provide the SSN for a newborn.

Employees who do not provide a valid identification number for each family member enrolled in medical benefits risk having those members dropped from medical coverage by our carriers.

Please be assured that TriNet is bound by strict HIPAA privacy and security policies, and each TriNet colleague is trained to protect your private information under HIPAA, the TriNet Code of Ethics, and data integrity policies. The Health Information Technology for Economic and Clinical Health Act (HITECH Act), part of the American Recovery and Reinvestment Act of 2009 ("ARRA"), imposes even more stringent requirements on all the communications between TriNet and our medical carriers, ensuring the protection of your personal data.

3.5 Automatic Enrollment if You Do Not Submit a New Hire Election

It is very important that you make careful decisions to elect or waive benefits that best meet the needs of your family. For example, some newly eligible Worksite employees have their health care benefits provided through a spouse or parent's employer and prefer to waive TriNet benefits. *You must elect your coverage within your election period*.

If you waive TriNet benefits coverage or do not submit an election, in accordance with strict IRS regulations you will not have an opportunity to elect coverage until your next TriNet Open Enrollment or if you experience certain life status change events. You must submit your elections to TriNet within 30 days of a life status change event (60 days for a birth, adoption, or change in eligibility for a State Children's Health Insurance Program (SCHIP)).

Your election is so important to TriNet that we send emails to your designated email address and mail a letter to your home address to remind you to sign on to TriNet (login.trinet.com) and make your benefit elections.

Under the Plan rules, if you do not submit a benefits election or waiver during your 30-day election period, TriNet shall automatically enroll you in benefits as follows:

Medical	No coverage
Dental	No coverage
Vision	No coverage
Basic life insurance	Worksite paid life insurance, if provided, otherwise, no coverage
Supplemental life insurance	No coverage
Disability	Worksite paid disability insurance, if provided, otherwise, no coverage
Health care or dependent day care FSA	No coverage
Health Savings Account (HSA)	No coverage
Voluntary Benefits	No coverage

3.6 Confirmation Statements

Once you complete the online enrollment process and submit your benefit elections, you will be emailed a confirmation statement for your records. We encourage you to review this statement carefully to check your benefit elections for accuracy and omissions and confirm that you have enrolled your eligible dependents.

The Pay Period Cost listed on your confirmation statement will be deducted from your pay. Please make sure that the TriNet benefits you elected are affordable for you and your family. You will not be able to make changes to your coverage or the cost of your coverage once the Plan year has started unless you later experience a life status change event. While you are an active Worksite employee, you will be responsible for paying the cost of your elected benefits, even if your wages become insufficient to cover the costs. If your payroll schedule changes or deductions are missed, your actual payroll deduction may change and potentially be higher than the per-pay-period cost shown on the confirmation statement.

CHAPTER 4 – BENEFIT REHIRE ENROLLMENT

4.1 Definition of a Rehire

You are a benefit eligible TriNet rehire if you have been covered under TriNet benefits, your benefits were terminated due to loss of eligibility for any reason and you are subsequently rehired by the same or different Worksite. Examples of benefit rehires include:

a. You are on temporary layoff from your Worksite and are called back to work;
b. You leave one TriNet Worksite and are hired by another TriNet Worksite;
c. You are part of a division that is spun off from a TriNet Worksite;
d. Your status is temporarily changed from full-time to part-time; or
e. You return from a leave of absence during which your benefits terminated.

4.2 What You Can Expect as a Rehire*

If your employment terminates and you are subsequently rehired within 30 days by the same Worksite, your prior elections under the Plan will be reinstated back to your date of termination as if you never terminated. You will be responsible for any unpaid benefit costs. If the same benefit options are not available at the time of your reinstatement, you will be automatically reinstated in similar benefits. The similar benefits in which you may be automatically reinstated may have differences in coverage, differences in networks, and higher rates and out-of-pocket expenses.

If your employment terminates and you are subsequently rehired within 30 days by a different TriNet Worksite, you will be treated as newly eligible for enrollment purposes under the Plan. In this case, you will be subject to all applicable waiting periods and any other restrictions.

If you are rehired by any TriNet Worksite more than 30 days after your termination of employment, you will be treated as newly eligible for enrollment purposes under the Plan and will again be subject to all applicable waiting periods and any other restrictions.

*Special rules and time periods may apply if your Worksite is an Applicable Large Employer under the Affordable Care Act ("ACA").

CHAPTER 5 – CHILD COVERAGE

5.1 Child Coverage (Newborn to Age 26)

A child is your, your spouse's or your domestic partner's natural child, stepchild, adopted child, child placed for adoption or child for whom you have been appointed legal guardian. An eligible child can participate in your active health plan(s) until the end of the month when the child reaches age 26. However, a limited number of states may permit an eligible child to remain on group or individual medical coverage beyond age 26.

Active coverage for dental, vision and supplemental life insurance plans will terminate at the end of the month in which the child reaches age 26.

5.2 Dependent Certification Process

Starting in November of every year TriNet conducts its annual dependent certification process. This process applies to:

a. Any dependent who is, or will have attained, age 26 by the end of the calendar year, and
b. Who is enrolled in a medical plan that provides for state extended medical coverage.

If you are required to complete a dependent certification form, TriNet will mail the form to your home address. Please complete and submit the form to TriNet within the designated time frame. Failure to complete or return the certification form within the allotted time will lead to the termination of dependent benefits effective the last day of the calendar plan year.

5.3 Taxation of Child Medical Rates

If your child is not your IRC-defined tax dependent and your medical plan is issued in a state where the child can stay on your active medical plan beyond the end of the calendar year in which the child reaches age 26, the medical rates you pay on behalf of that child may be taxable income depending on your personal or family tax situation. You may also owe taxes on the value of your Worksite's contribution attributable to the child. Because TriNet cannot provide you with tax advice, you should consult with your tax preparer for more information about these possible tax implications.

Please see **Appendix A** for **Extended Medical Plan Coverage in Certain States**.

CHAPTER 6 – LIFE STATUS CHANGES

6.1 Life Status Changes

If you experience one of the life status change events listed below, you must submit your enrollment to TriNet within 30 days (60 days for a birth, adoption, or State Children's Health Insurance Program (SCHIP) change) of that event to be eligible to make changes to your benefits. If you do not enroll with TriNet within 30 days (60 days for a birth, adoption, or SCHIP event) of your life status change event(s), you may be unable to take advantage of the special enrollment period associated with your event and must wait until the next Open Enrollment to make election changes. Even if you are waiting for proof of the event, submit your elections to TriNet before the deadline to ensure that your event is reported timely. For example, do not wait until a birth certificate is received before you enroll your new child onto your coverage.

In general, depending on the type of event and the day of the event, the effective date of your change in benefits is limited to the date of the life status change event. For instance, if you are married on March 9, your new spouse's benefits will become effective on that date and you may not choose a different effective date.

6.2 HIPAA Special Events

HIPAA allows for a special enrollment period under two circumstances: upon the loss of eligibility for other coverage due to a change in a spouse's (or domestic partner's) employment status and upon certain life status changes. For these HIPAA circumstances only, you may change your plan election as well as add or delete dependents.

If you previously waived enrollment in TriNet benefits for yourself or your dependents (including your spouse or domestic partner) because you enrolled in your spouse/domestic partner's employer group health insurance coverage, you may be able to enroll yourself and your eligible dependents in the TriNet Plan if you or your dependents lose eligibility for that other coverage or if that employer stops contributing toward you or your dependents' coverage. However, you must submit your enrollment within 30 days of the loss of the other coverage or after contributions for the other coverage end.

The following life status changes give rise to special enrollment rights outside of TriNet's normal Open Enrollment period if they are submitted to TriNet **within 30 days** of the event:

a. Marriage or new domestic partnership;
b. Your loss of coverage due to divorce or legal separation with your spouse, or separation from your domestic partner;
c. Your loss of coverage due to the death of your spouse or domestic partner;
d. Your child is no longer a covered dependent under your spouse or domestic partner's plan but qualifies as an eligible dependent under the TriNet Plan;
e. Termination of or other change in employment status for your spouse or domestic partner that causes loss of group benefits eligibility;
f. Your loss of coverage because you no longer live in your HMO's service area: or
g. Your move outside of the United States.

The following life status changes give rise to special enrollment rights outside of TriNet's normal Open Enrollment period if they are submitted to TriNet **within 60 days** of the event:

a. Birth, adoption, placement for adoption or court awarded custody of a child; or
b. Gain or loss of Medicaid or SCHIP eligibility.

TriNet does not pro-rate benefit costs. If you were to add a dependent through a life status change event between the 1st through the 15th day of the month, your coverage will increase beginning on the date of the life status change event and you will be charged rates for the increased coverage for the entire month, versus a portion of the month. If you add a dependent between the 16th and the end of the month, any rate increase will begin the 1st day of the next month.

For example, you elect the HDHP at Open Enrollment. On March 15th, you experience a life status change due to the birth of a baby. The birth of the child gives rise to special enrollment rights under HIPAA and you add the child and change your medical plan to a PPO plan. The PPO plan becomes effective on March 15th. All expenses associated with the birth are paid under the PPO, the plan that was in effect on the date of the child's birth and you will pay rates for the PPO plan at the new coverage level for the entire month.

Summaries of Benefits and Coverage (SBCs) are available to help you make your benefit decisions during a life status change special enrollment. If you need assistance with a HIPAA special enrollment event, please contact the TriNet Solution Center.

6.3 Other Life Status Change Events

For some other life status change events, you may be allowed to add or required to delete dependents from your current coverage, but you are not allowed to change all of your benefit plan elections:

a. Divorce or dissolution of a domestic partner partnership;
b. Legal separation (if the separation is allowed by and consistent with state law);
c. No longer meeting the dependent eligibility requirements, for example, an adult child reaches age 26;
d. Death;
e. A move that results in eligibility or ineligibility in your or a dependent's group health plan;
f. You enroll in Medicare;
g. Your spouse, domestic partner, or dependent's employer terminated contributions to the cost of group health coverage (does not apply to COBRA payments);
h. COBRA coverage is exhausted;
i. If your Worksite makes a change in your group benefit rates midyear, you may change the plan option for the benefit plan(s) that had a significant change in cost. You may **not** change the coverage category. For example, if your Worksite increases your contribution toward your medical plan coverage, you may change your medical plan election. However, you may not change your dental or vision plan options, enroll in or waive any benefit plan except medical, or add or remove dependents from coverage. Note that adjustments made to your group benefit rates do not include adjustments made to your COBRA rates;
j. If TriNet drops a benefit plan during the benefits plan year and you are impacted by that change, you may change your benefits election for that plan only;
k. If you are enrolled in benefits during an ACA stability period and your standard scheduled hours fall below 30 hours per week, you are permitted to terminate your benefits coverage;
l. Your spouse or domestic partner changes their election during the Open Enrollment period of their group health plan, and that plan has a different benefits plan year effective date than the TriNet Plan;
m. Your spouse or domestic partner voluntarily changes their election under their employer's group health plan due to a change in cost or coverage under such plan, so long as the election change is permitted by IRS regulations and their employer's plan (does not apply to COBRA payments). This change does not apply to the health care FSA (although note that other types of changes, such as a loss of coverage under your spouse or domestic partner's employer group health plan, may permit an election change under the health care FSA);
n. You, your spouse, domestic partner and eligible child(ren) lose Marketplace or individual market coverage as a result of plan discontinuation by the insurance carrier or you move outside of the coverage area; or
o. For any other reason as specified in the TriNet benefits Plan document or the IRS or HIPAA regulations.

Failure to timely provide us with the pertinent details of any of the above life status change events may be deemed as fraud and intentional misrepresentation and may result in retroactive termination of coverage. In addition, you may lose your right to elect COBRA continuation coverage if you fail to timely report a qualifying event to TriNet, in writing.

If your life status change falls between the 2nd and the end of the month, coverage and deductions end on the last day of the month in which your life status change occurred. If your life status change occurs on the first day of the month, coverage will end on the last day of the prior month. For example, if you get divorced on June 12, coverage and deductions for your ex-spouse will be continued through June 30 and COBRA will be offered effective July 1. If the divorce occurs June 1, coverage will end May 31 and COBRA will be offered effective June 1.

Some life status change events described in this section permit you to make an election change affecting your health care FSA, but they do not entitle you to cancel your election or to decrease the amount of your election below the amount already reimbursed from or contributed to such account. Some life status change events may allow you to increase your elected amount under the health care FSA on a prospective basis for the remainder of the benefits plan year (subject to the maximum benefit amount for the benefits plan year) and you can otherwise terminate your participation in the health care FSA, as long as it is consistent with IRS regulations.

Under the dependent day care FSA only, you may increase or decrease your FSA contribution only if:
a. You change dependent care providers or your cost for dependent care expenses increases or decreases; and
b. Such cost changes are imposed by a dependent care provider who is not your relative.

Loss of coverage under your spouse or domestic partner's employer group health plan may result in a permitted election change under the health care FSA.

6.4 Events That Are Not Considered Life Status Changes

The following circumstances do not give rise to a special enrollment right:

a. An individual who loses other coverage as a result of either a failure to pay for coverage on a timely basis (for instance, COBRA coverage) or for cause (such as for making a fraudulent claim or an intentional misrepresentation of fact in connection with prior health coverage);
b. Enrollment in or loss of Marketplace or Exchange coverage (except in the case of plan discontinuation by the insurance carrier or you move outside of the coverage area);
c. Voluntary waiver of Medicare after enrolled; or
d. Enrollment in or loss of individually purchased coverage.

6.5 Documentation

TriNet reserves the right to request documentation to verify a life status change event, such as:

a. A marriage certificate;
b. A birth certificate;
c. A divorce decree;
d. Proof of gain or loss of coverage in another group plan;
e. Proof that COBRA coverage has been exhausted;
f. Proof of domestic partner registration with a government entity or on a TriNet Certification form;
g. Verification of claim of dependent as a tax dependent (e.g., an IRS transcript of your Form 1040 tax return);
h. Evidence of joint responsibility of significant assets or liabilities (e.g., a bank account statement, mortgage, lease);
i. Copies of drivers' licenses, passports, or tax returns showing the same address; or
j. Other documentation, as requested.

If you are unable to provide proof of the life status change, the requested benefit changes will not be processed.

6.6 Life Status Change Examples

The following pages contain examples of benefit changes you may make due to a life status change or HIPAA special enrollment event. Note that qualified domestic partners are referred to as "partners" in this chart. These examples apply to active benefits coverage, not COBRA coverage. For a list of COBRA life status change examples refer to the COBRA section of this Guidebook or your COBRA Enrollment Guide.

Changes to your employee paid short-term disability coverage and long-term disability coverage elections are only allowed at Open Enrollment.

Health care and dependent day care flexible spending account (FSA) elections may not be changed to an amount less than the amount already contributed or reimbursed for expenses.

Dependent day care election changes are permitted when there is a change in the number of children or adults being provided with care, the dependent care provider or the cost of services. In no event may you decrease the amount of your elections below the amounts already reimbursed from or contributed to the dependent day care FSA.

New or increased supplemental life insurance elections may require the insurance carrier's approval of your or your spouse's Statement of Health (SOH) application before your election can become effective.

Changes must be consistent with the life status change event.

Life Status Change Event Type	Plan Type	Allowable Changes
Gain of Dependent		
□ Birth or Adoption □ Marriage/Domestic Partnership Established	Medical/Dental/Vision	Enroll (self and dependents) Add or remove eligible dependents Change plan Terminate coverage
	Healthcare FSA	Enroll Increase or decrease existing coverage
	Dependent Day Care FSA	Enroll Increase existing coverage Decrease existing coverage (applies to Dependent Day Care FSA only)
	Supplemental Life	
	Voluntary Benefits	Enroll increase coverage
Loss of Dependent		
□ Divorce/Domestic Partnership Terminated □ Loss (Death) of Dependent	Medical/Dental/Vision	Enroll (self and dependents) Change plan Add eligible dependents who lose coverage under spouse/domestic partner Required to terminate coverage for the dependent
	Healthcare FSA	Enroll Increase or decrease existing coverage
	Dependent Day Care FSA	
	Supplemental Life	Required to terminate coverage for dependent
	Voluntary Benefits	Required to terminate coverage for dependent
Gain of Coverage or Eligibility		
□ Dependent Enrolled in Employer Plan During their Open Enrollment (OE) □ Dependent Becomes Benefits Eligible with their Employer	Medical/Dental/Vision	Enroll Change plan Remove eligible dependents Terminate coverage
	Healthcare FSA	Decrease existing coverage No changes (applies to dependent enrolled during their OE only)
	Dependent Day Care FSA	Increase existing coverage (applies to dependent becomes benefits eligible only) Decrease existing coverage
	Supplemental Life	Enroll Increase/decrease existing coverage No changes (applies to dependent enrolled during their OE only)
	Voluntary Benefits	Decrease Coverage Remove eligible dependents
Gain of Coverage or Eligibility		
□ Newly eligible for premium assistance - SCHIP or Medicaid (60 days to report)	Medical/Dental/Vision	Remove dependents Terminate coverage
	Healthcare FSA	Decrease coverage
	Dependent Day Care FSA	No changes
	Supplemental Life	
	Voluntary Benefits	

Gain of Coverage or Eligibility		
□ Medical Support Order (MSO)	Medical/Dental/Vision	Enroll Required to add dependents listed in MSO Change plans
	Healthcare FSA	Enroll Increase coverage
	Dependent Day Care FSA	No changes
	Supplemental Life	Enroll Increase coverage
	Voluntary Benefits	No changes
Loss of Coverage or Eligibility		
□ Dependent Drops Employer Coverage During their Open Enrollment (OE) □ Dependent Loses Benefits Eligibility with their Employer □ Loss of Marketplace Coverage due to: Plan discontinuation by carrier or moving outside of coverage area. (Voluntary termination of coverage is not a life status change event.)	Medical/Dental/Vision	Enroll Add dependents Change plan
	Healthcare FSA	Enroll Increase/decrease existing coverage No changes (applies to dependent drops employer plan during OE only)
	Dependent Day Care FSA	Enroll Increase/decrease existing coverage
	Supplemental Life	Enroll Increase coverage Change plan (applies to dependent drops employer plan during OE and loss of Marketplace coverage) No changes (applies to OE only)
	Voluntary Benefits	Enroll Increase coverage Change plan No changes (applies to loss of Marketplace coverage only)
□ No Longer eligible for premium assistance - SCHIP or Medicaid (60 days to report) □ Loss of Self/Dependent COBRA - end of coverage period (loss due to failure to pay premiums timely, or voluntary termination of coverage - not a life status change event)	Medical/Dental/Vision	Enroll Add dependents Change plan
	Healthcare FSA	Enroll Increase coverage No changes (applies to SCHIP only)
	Dependent Day Care FSA	No changes
	Supplemental Life	No changes
	Voluntary Benefits	No changes

Loss of Coverage or Eligibility		
□ Dependent ceases to qualify as a dependent on parent's plan	Medical/Dental/Vision	Required to terminate coverage for dependent Terminate coverage Change plan
	Healthcare FSA	Decrease existing coverage
	Dependent Day Care FSA	
	Supplemental Life	Required to terminate coverage for dependent
	Voluntary Benefits	
Residence Changes		
□ Entering the United States	Medical/Dental/Vision	Enroll Add dependents Change plans
	Healthcare FSA	Enroll Increase coverage
	Dependent Day Care FSA	
	Supplemental Life	No changes
	Voluntary Benefits	
□ Leaving the United States	Medical/Dental/Vision	Terminate coverage Remove dependents Change plans
	Healthcare FSA	Decrease coverage
	Dependent Day Care FSA	
	Supplemental Life	No changes
	Voluntary Benefits	
□ Move outside of the HMO coverage area	Medical/Dental/Vision	Terminate coverage Remove dependents Change plans
	Healthcare FSA	No changes
	Dependent Day Care FSA	
	Supplemental Life	
	Voluntary Benefits	
Other Changes		
□ Change in child care providers or cost of care	Dependent Day Care FSA	Increase/decrease existing coverage
□ Worksite makes a change in your benefits mid-year (can only be made for the plan for which the benefit deductions were made)	Medical/Dental/Vision	Terminate coverage Change plans
	Healthcare FSA	No changes
	Dependent Day Care FSA	
	Supplemental Life	
	Voluntary Benefits	

Note - Domestic partner life status changes cannot be initiated online. Log in to TriNet (login.trinet.com) and follow the directions to obtain a paper form. If you remove a domestic partner from your benefits coverage, benefits will end on the last day of the month of your event date.

6.7 Military Leave

When you or your covered family member would otherwise lose coverage due to leave for full-time active duty in the U.S. military, you may ask to extend coverage for up to 24 months or the length of the military service, whichever is shorter, as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA). The Plan's policies and procedures require that you provide notice of any military service within a reasonable period of time in order to be eligible for USERRA continuation coverage. You should provide written notice to TriNet as soon as possible.

If you elect to continue health coverage under the Plan due to qualified military leave, you will be required to pay 102% of the full contribution under the Plan. If you are on active duty for 30 days or less, you cannot be required to pay more than your share of the cost, if any, for the coverage. An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of your military leave.

If you have questions concerning your Plan or your USERRA continuation coverage rights contact the TriNet Solution Center. For more information about your rights under USERRA, contact the Regional or District Office of the U.S. Department of Labor's Veterans' Employment and Training Service (VETS) in your area or contact VETS at 866.4.USA.DOL (866.487.2365) or visit its website at dol.gov/vets.

6.8 Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a type of court order, usually issued as part of a settlement agreement or divorce decree, which provides for health care coverage for a child. If TriNet receives a QMCSO for a child related to you, TriNet is legally obliged to follow the enrollment directions in the Order and deduct the appropriate rates from your pay.

a. If the QMCSO is effective for TriNet benefits, TriNet will set up coverage as directed in the Order, to include enrolling and deducting benefit costs for you and the child(ren) mentioned in the QMCSO. If the QMCSO is received at TriNet on or before the 20th of the month, coverage and benefit costs will begin on the first day of the following month. If the QMCSO is received after the 20th of the month, coverage and benefit costs will begin on the first day of the second following month.

b. TriNet will contact you when the QMCSO is received. You may submit a life status change within 30 days of the QMCSO start date if you wish to elect different benefit plans, but you may not waive any coverage mandated by the QMCSO.

c. Arranging for other coverage for the child(ren) does not negate the court order requiring that TriNet ensure coverage through the Plan. It is your responsibility to contact the court agency and determine if they will accept the alternate coverage and issue a release order. All appeals for relief from the QMCSO should be made directly to the court agency that issued the Order. TriNet cannot assist you.

d. TriNet can only terminate health care coverage for your child(ren) and payroll deductions attributable to a QMCSO when the Plan receives a legally sufficient release from the court or the state agency that issued the order. Termination of coverage and relief from benefit costs will occur on the last day of the month in which TriNet receives the release order.

e. If TriNet has not received a court release and you waive coverage for the child(ren) at Open Enrollment or through a life status change request, TriNet is legally obligated to restore the coverage and deduct any missed deductions from your pay. If your benefits terminate for any reason, TriNet will report the loss of coverage to the court or agency that issued the order.

CHAPTER 7 – OPEN ENROLLMENT

7.1 Open Enrollment

Each year, TriNet offers an Open Enrollment period for all benefits eligible Worksite employees. During Open Enrollment, you may enroll in or make changes to your benefit elections and coverage levels for the next benefits plan year. Open Enrollment generally occurs two months prior to the start of the next benefits plan year and your coverage elections will become effective for the upcoming benefits plan year.

7.2 How to Make Your Elections

TriNet will send an email to your designated email address and mail an Open Enrollment brochure to your home address, which includes instructions on how to enroll online through the Open Enrollment link on TriNet (login.trinet.com) and information you need to make elections for yourself and your eligible dependents.

You will be allowed a certain amount of time to make your elections and you may make changes to any election until the last day of the Open Enrollment period. Once the Open Enrollment period closes, your elections are binding for the entire benefits plan year, unless you experience a life status change.

If you need assistance in accessing the Open Enrollment link, please contact the TriNet Solution Center.

7.3 Confirmation Statements

Once you complete the online enrollment process, make sure that you click the Submit Benefit Elections button to electronically transmit your most recent benefit elections to TriNet. If you do not submit your elections, you will lose the benefits you elected and be automatically enrolled as shown in the Chapter subsection entitled *What Happens if You Do Not Submit an Open Enrollment Election*.

You will immediately receive an email confirming your elections. If you do not receive this email, you probably did not submit your elections. Return to the Open Enrollment link, check that your elections are correct and click the Submit Benefit Elections button.

Check your confirmation email carefully for accuracy and omissions. If you need to make a correction, you may return to the Open Enrollment link immediately, make the changes, and submit again. TriNet will process the elections in the last submission you make before the end of the Open Enrollment period.

7.4 What Happens if You Do Not Submit an Open Enrollment Election

TriNet recommends that you make active enrollment elections each benefits plan year. There may be plan changes or cost increases you need to be aware of to determine whether to change your coverage. Your election is so important to you and TriNet that we send reminders and provide online benefit comparisons and other tools to help you make informed decisions. If you do not make a benefits election during the Open Enrollment period, TriNet will automatically enroll you in benefits as follows:

If you do not submit…	Automatic Enrollment
Medical, dental and vision coverage	You will be automatically enrolled in similar benefit plans at your current coverage level.
Life insurance and disability coverage	Your current coverage will continue, subject to Worksite selections and Statement of Health requirements
Health care and dependent day care FSA	Your participation will end
Health Savings Account	Your contributions will stop

Rates, which may increase in the new benefits plan year, will be deducted from your pay. If the plan in which you were enrolled during the previous TriNet benefits plan year is no longer available for the new benefits plan year, you will be automatically enrolled in a similar plan, which may have differences in coverage and networks, and higher rates and out-of-pocket expenses than the benefits in which you were enrolled during the previous TriNet benefits plan year. Unless you experience a life status change event, you may not make benefit changes, including the election of an FSA, until the beginning of the next benefits plan year.

CHAPTER 8 - BENEFIT RATES AND TAXATION

8.1 Your Benefit Costs

You may be required to pay periodic benefit costs for your benefit elections. If costs are required, TriNet is authorized to deduct these benefit costs from your pay. Information about rates will be provided to you when you first enroll, at Open Enrollment, and if you experience a life status change event. Benefit rates are available for comparison purposes by logging in to TriNet (login.trinet.com). The cost that is displayed is on a per-pay-period basis, based on your payroll frequency, so make sure you are evaluating the correct cost of your benefits before you submit your benefit elections.

Payroll Frequency	Number of Deductions Per Month
Weekly	First 4 pay dates
Biweekly	First 2 pay dates
Semimonthly	2
Monthly	1

Your benefits will always start on your benefits effective date, or in the case of a life status change event (that is timely reported), on the event date. However, if your benefits eligibility or life status change event date occurs between the 1st and the 15th of a month, your benefit deductions will begin on the first of that month. If your benefits eligibility date occurs between the 16th through the end of a month, your benefit deductions will begin on the first of the following month.

If you do not pay for a benefits program within 30 days of enrollment, including at the beginning of your benefits eligibility or a new benefit plan year, TriNet reserves the right to terminate your election and you will be ineligible to participate in the benefit plans until the next Open Enrollment period.

8.2 Taxation of Benefits

Rates or contributions for the following benefits may be deducted on a pre-tax basis for you and your dependents who qualify as IRC tax dependents:

a. Medical;
b. Dental;
c. Vision;
d. Health care FSA;
e. Dependent day care FSA; and
f. Health Savings Account (HSA).

Rates for the following benefits will be deducted on an after-tax basis:

Life insurance (both you and your dependents);
AD&D (both you and your dependents);
Short-term disability coverage and Long-term disability coverage; and
Voluntary benefits.

8.3 Taxation of HSA Contributions

You may elect an HSA if you participate in a qualified high deductible health plan (HDHP). Details on how to enroll in an HSA are provided when you enroll in an HDHP. Contributions to your HSA will be deducted on a pre-tax basis when you establish an HSA with a bank affiliated with one of the TriNet sponsored medical carriers that offer an HDHP. It is possible to make additional after-tax contributions to your HSA by setting up direct deposit to your HSA account.

8.4 Taxation of Domestic Partner Benefits

Please note that the following information is intended to provide general information regarding tax treatment of domestic partner benefits. TriNet cannot and does not provide any tax advice. We strongly encourage you to consult with a tax advisor before designating your domestic partner as a tax dependent under Section 152 of the Code. More information can be found here. Benefit deductions for individuals that do not qualify as tax dependents under the Code must be deducted on an after-tax basis and, to the extent such costs are paid by your Worksite, must be imputed as income on your Form W-2.

Unless you certify your domestic partner and their child(ren) as qualified tax dependents, TriNet will deduct their benefit costs on an after-tax basis and any costs paid by your Worksite will be imputed as income.

If your domestic partner or child(ren) are your qualified tax dependents under Section 152 of the Code, your Worksite paid health coverage will be subject to favorable tax treatment. The benefit costs you pay for your domestic partner or your partner's child(ren) can be made on a pre-tax basis and any costs paid by your Worksite on their behalf are not subject to income tax.

If you declare that your domestic partner or domestic partner's child(ren) are tax dependents, TriNet will change the taxation of benefits as follows:

a. If you add a domestic partner or domestic partner's child(ren) who are not currently enrolled in TriNet benefits coverage, your Life Status Change event date will determine the effective date of the requested tax dependent status; or
b. If your domestic partner or domestic partner's child(ren) are already enrolled in TriNet benefits coverage, the tax status change will occur on the first day of the month following the date TriNet receives this form. No retroactive tax refunds are available.

Under Section 152 of the Code, your domestic partner must meet ***all*** of the following criteria to qualify as your tax dependent (as a "qualifying relative"):

a. Is an individual other than a spouse;
b. Is not a "qualifying child" of you or any other taxpayer;
c. Is considered a member of your household for the taxable year and their principal place of abode is your home;
d. You provide more than one-half of your domestic partner's support during the calendar year; and
e. The relationship with you does not violate local law.

In order to qualify as your tax dependent(s), your domestic partner's child(ren) must meet ***all*** of the following criteria to qualify as your "qualifying child"*:

a. Is a child of your domestic partner who did not attain age 26 by the end of the past year;
b. Is not a "qualifying child" of you or any other taxpayer*;
c. Is considered a member of your household and the principal place of abode is your home for more than half of the tax year*;
d. You provide one-half of their support during the calendar year; and
e. Your relationship with the domestic partner does not violate local law.

* If your domestic partner's child(ren) are the qualifying child of your domestic partner, they will not be able to satisfy this provision, but they may instead be your "qualifying relative" and would need to satisfy the same conditions as your domestic partner. Please consult with a tax advisor before making the appropriate declaration or certification.

8.5 Benefit Rates for Self-Employed Individuals

If you are considered self-employed under IRC Section 401(c), you are not eligible to pay for benefits on a pre-tax basis or to participate in the TriNet health care or dependent day care FSAs. The following individuals are considered self-employed for purposes of the Plan, even if they are paid wages through TriNet payroll:

a. Partners in a partnership;
b. More than 2% Shareholders of a Subchapter S Corporation;

c. Members of an LLC who are treated as a partnership for federal tax purposes; and
d. Sole proprietors.

If you are a shareholder or partner, we recommend that you consult your tax advisor. If your tax advisor states that you are not eligible to pay for benefits on a pre-tax basis or to participate in a TriNet flexible spending account, please contact the TriNet Solution Center.

If you report that you are a self-employed individual:

a. Your pre-tax benefit contributions and FSA eligibility will end the last day of the month in which your self-employed employment status changes.
b. Health care FSA contributions and the ability to incur claims will also end the last day of the month in which you become self-employed. You will have until the claims submission deadline to request reimbursement for claims.
c. You will be offered the option to continue your health care FSA under COBRA through the end of the benefits plan year.
d. Dependent day care FSA contributions will also end on the last day of the month in which you report to TriNet that you quality as self-employed. However, you will be able to incur claims and request reimbursement for eligible expenses through the end of the benefits plan year.

CHAPTER 9 – MEDICAL PLANS

9.1 Carrier Certificates and Summaries of Benefits and Coverage (SBCs)

Carrier Certificates and SBCs can be accessed on TriNet (login.trinet.com). Eligibility, enrollment and coverage decisions are subject to the actual terms and conditions of the benefit plans offered by TriNet as described in this Guidebook and in the Carrier Certificates posted on TriNet (login.trinet.com).

9.2 Carrier Certificates and Dependent Eligibility

You should review the dependent eligibility provisions under the applicable Carrier Certificate (for the plan in which you are enrolled) in conjunction with the terms of the Plan document as summarized in this Guidebook. It is important to note that although some carrier certificates list the dependents that "may" be covered if permitted by the Plan, the dependent eligibility provisions are solely determined by the Plan document and TriNet Benefits Guidebook.

9.3 Your Insurance Carrier Website

You can play a proactive role in managing your health care needs. The TriNet insurance carriers have the tools and support available for you to be able to make informed health care choices. To locate your carrier's contact information:

a. Log into TriNet (login.trinet.com) and select **Benefits > Carriers**
b. Gather benefit plan, group number, telephone and website information specific to your carrier

Carrier website features include:

a. View current and past claims;
b. Track deductibles;
c. Request a new ID card;
d. Print temporary ID cards;
e. View eligibility;
f. View networks; and
g. Change your doctor.

Please see **Appendix B** for **Minimum Creditable Coverage for Massachusetts Residents**

Please see **Appendix C** for **Medicare Part D**

CHAPTER 10 – DENTAL

Dental coverage may be available to you in group or optional form, depending on its availability at your Worksite.

10.1 How to Get Specific Dental Plan Information

Refer to the Carrier Certificates posted on TriNet (login.trinet.com). Eligibility, enrollment and coverage decisions are subject to the actual terms and conditions of the benefit plans offered by TriNet as summarized in this Guidebook and in the Carrier Certificates.

10.2 Summary of Plan Benefits

Refer to Ask Benefits for a summary of important plan details, such as copayments, deductibles and other plan features. Log in to TriNet (login.trinet.com).

10.3 Important- MetLife Dental Notice

If you are enrolled in a MetLife dental plan, any references to “at policyholder’s option to pay premiums” in the MetLife Carrier Certificate is not applicable to TriNet. TriNet never exercises the option to pay deductions on behalf of Worksite employees who cease active benefit participation.

CHAPTER 11 – VISION

Vision coverage may be available to you in group or optional form, depending on its availability at your Worksite.

11.1 How to Get Specific Vision Plan Information

Refer to the Carrier Certificates posted on TriNet (login.trinet.com). Eligibility, enrollment and coverage decisions are subject to the actual terms and conditions of the benefit plans offered by TriNet as summarized in this Guidebook and in the Carrier Certificates.

11.2 Summary of Plan Benefits

Refer to Ask Benefits for a summary of important plan details, such as copayments and other plan features. Log in to TriNet (login.trinet.com).

CHAPTER 12 – FLEXIBLE SPENDING ACCOUNTS

Flexible spending accounts (FSAs) help you pay for eligible out-of-pocket health care and dependent day care expenses on a pre-tax basis. You predetermine your projected expenses for the benefits plan year and then elect to contribute a portion of each paycheck into your FSA. When you incur an eligible expense, you can either pay with your FSA debit card or pay the provider or facility directly and then submit a request for reimbursement.

Note that ACA regulations prohibit you from enrolling in the Health Care FSA if you are employed by a Worksite that does not offer TriNet sponsored medical coverage.

12.1 How the Plans Work

After careful planning, decide how much money, if any, you would like to contribute to your health care, limited-use health care, or dependent day care FSAs and enroll online when electing your benefits. TriNet deducts a portion of your FSA election each pay period on a pre-tax basis. Your election is binding for the entire benefits plan year. You cannot change your election until the next Open Enrollment period unless you experience a life status change event that would permit such an election change.

You have two ways to pay for eligible expenses during the benefits plan year. When you receive eligible health care or dependent day care services, you have the flexibility to pay with your FSA debit card or pay out of your pocket and manually submit a claim for reimbursement. Please note that use of the FSA debit card can make certain expenses easier to pay, but it does not relieve you of the requirement to maintain adequate documentation. It is a good idea to save all itemized receipts because you may be required to submit them to satisfy IRS regulations.

For the health care and limited-use health care FSAs, the amount available for reimbursement at any time during the benefits plan year is the total amount of your election for that year less any reimbursements you have already received. For the dependent day care FSA, the amount available for reimbursement at any time during the benefits plan year is limited to the total amount you have already contributed to your dependent day care FSA at the time of your reimbursement request, less any reimbursement you have already received.

Contribution Limitations

If your spouse contributes to a dependent day care FSA through an employer, the combined maximum you and your spouse may contribute to both dependent day care FSAs cannot exceed $5,000 each calendar year.

Your maximum dependent day care FSA contribution is limited to the lesser of your earned income or your spouse's earned income or $5,000. If your spouse is a full-time student or is disabled, your spouse is deemed to have an income of $250 per month if you have one eligible dependent or $500 per month if you have two or more eligible dependents.

FSA Type	2020 Minimum Contribution	2020 Maximum Contribution
Health Care	$200	$2,750
Dependent Day Care	$200	$5,000*

* You may contribute up to the maximum amount of $5,000 ($2,500 for a married individual who files a separate income tax return) to your dependent day care FSA, regardless of how many dependents you have.

Incurring Eligible Expenses

You may incur eligible expenses on or after the date your FSA is effective through the last day of the benefits plan year unless your benefits are terminated. Expenses are incurred on the date the service is provided, not when you pay for the service. If you lose eligibility before the benefits plan year ends, your FSA coverage will end on the last day of the month in which you first become (or became) ineligible for TriNet benefits. You will not be reimbursed for health care FSA expenses incurred after that date unless you elect to continue your health care FSA through COBRA. For guidance on eligible expenses, please refer to the "Health Care Expenses" and "Dependent Day Care Expenses" sections.

Special Health Care FSA Grace Period Extension

If you are **actively participating** in your health care FSA as of the last day of the benefits plan year, you will qualify for a two and a half-month grace period extension after the end of the benefits plan year to incur qualified expenses.

If you have an available balance in the health care FSA from the previous benefits plan year, you may use your FSA debit card for expenses incurred during the grace period, but **all** debit card purchases during the grace period will be applied first to the remaining prior benefits year balance. When that balance is used (or after the end of the grace period), FSA debit card purchases will begin to be applied to the new benefits plan year election. The grace period extension does not apply to dependent day care FSA.

Claims Submission Deadlines

Health care and dependent day care claims must be submitted no later than the last day of the fourth month after the end of the Plan Year. If you do not file a claim for reimbursement by the deadline, you will forfeit any amounts remaining in your health care or dependent day care FSA account.

12.2 FSA Rules – Key Points to Remember

Because of the tax-free treatment of these benefits, the IRS regulations place special restrictions on health care, limited-use health care and dependent day care FSAs. Before you decide to contribute to an FSA, you should carefully review the rules.

"Use It or Lose It." IRS regulations require that any remaining money not used to incur eligible expenses by the end of the benefits plan year (including any grace period for health care FSA) will be forfeited. You must request reimbursement of eligible expenses on or before the claims submission deadline, as described above. Because of the special tax advantages that FSAs provide, you are not permitted to carry over balances from one benefits plan year to the next or receive a refund of unused amounts. There are no exceptions to this rule.

Health Savings Account (HSA) Participation – Limited-Use Health Care FSA. If you are enrolled in a high deductible health plan (HDHP) and you or your Worksite contribute to an HSA, you are limited to participation in the limited-use health care FSA, which covers only out-of-pocket dental and vision expenses.

Self-Employed Individuals Are Not Eligible. If you are considered self-employed under IRC Section 401(c), you are not eligible to participate in the health care or dependent day care FSA.

Service Date. For purposes of determining whether an expense is eligible for reimbursement, the service date is the date a service is provided, not the date you pay for the service, regardless of whether payment is made before, on or after the service date. You cannot be reimbursed for services provided prior to the start of the benefits plan year or the date your FSA participation is effective, if later, even if you pay for the service during the benefits plan year.

Health Care and Dependent Day Care are Separate Accounts. IRS restrictions prohibit transfers from a health care FSA to a dependent day care FSA – or vice versa. Also, you cannot use your dependent day care FSA to pay for your dependent's health care expenses.

Domestic Partner Participation. FSA tax benefits only extend to domestic partners and their children if these individuals qualify as your federal tax dependent(s).

Contribution Restrictions May Apply. IRS regulations may place restrictions on how much certain individuals may contribute to either the health care or dependent day care FSAs.

Consult with Your Tax Advisor

TriNet cannot provide tax or legal advice. Please consult with your tax advisor for information on the tax implications of participating in an FSA.

12.3 Qualified Health Care FSA Expenses

Generally, you can be reimbursed for services or supplies needed to prevent or treat an illness or medical condition. Limited-use health care FSAs can only be used to reimburse out-of-pocket vision and dental services. Some services or

supplies may require a letter of medical necessity to document that they are being used to treat a specific medical condition or they will not be reimbursable. Any expense incurred strictly for cosmetic reasons is not reimbursable.

Over-the-counter (OTC) medicines or drugs require a physician's prescription (except for insulin). A "prescription" is a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state. A receipt for payment with the name of the patient, the name of the medication and a physician's prescription must be submitted with the claim for reimbursement. Although a Letter of Medical Necessity (LMN) may be required for some medicines, it cannot be accepted in place of a physician's prescription.

Expenses that are not eligible for reimbursement under the limited-use health care FSA may be reimbursable through your HSA account. You can research eligible HSA expenses at irs.gov/pub/irs-pdf/p502.pdf or consult your tax advisor with further questions.

12.4 Annual Fee (Concierge) Medicine

A concierge medical practice typically involves charging an annual fee in exchange for better access, longer appointments and other medical perks. Typically, the portion of the concierge fee not related to medical care is not an expense covered for medical plan or FSA reimbursement. The portion of the concierge fee that relates to medical services (such as a physical exam) may be a qualified medical expense. Documentation from the provider must clearly itemize each of the fee components and the date of service. For the portion that represents medical care, the care must actually be incurred. For instance, the patient must actually have had the physical exam.

12.5 Dependent Day Care Expenses

The dependent day care FSA allows you to pay for qualified, employment-related, out-of-pocket day care expenses (or qualified evening care expenses) on a pre-tax basis, as long as you (and your spouse) require these services to work or look for work.

You may enroll if you have an eligible dependent and you fall into one of the following categories:

a. You are a working single parent;
b. You and your spouse are both employed;
c. You work, and your spouse is disabled and unable to provide dependent day care; or
d. Your spouse is a full-time student at least five months during the year.

Eligible Dependents

Eligible dependents for the dependent day care FSA must be claimed as a dependent on your federal tax return and must live with you for more than half of the tax year. Children must be under age 13 and be a son, daughter, stepchild, sibling or step-sibling, or the child or grandchild of any of these relatives, including an adopted child lawfully placed with you or a child for whom you have been appointed legal guardianship pursuant to a valid court order.

Under IRS rules, your spouse, dependent parent or other tax dependent of any age must be physically or mentally incapable of self-care to be an eligible dependent. In addition, your dependent parent or any other tax dependent not your spouse or child must regularly spend at least eight hours per day in your home if services are received outside of the home.

Eligible Caregivers

Services covered by your dependent day care FSA may be provided inside or outside your home by:

a. Licensed dependent day care centers for your disabled dependents. The center must meet local regulations, charge a fee for its service, and provide care for at least six people, not including anyone who lives at the center;
b. Licensed nursery schools and day care centers for children; or
c. Responsible adults, including your relatives over age 19 whom you do not claim as a dependent on your federal income tax return.

Eligible Dependent Day Care Expenses
Expenses are considered incurred when the service is performed, not when it is paid. For example, if a day care provider charges for services on a monthly basis in advance, you cannot submit the expense for reimbursement until the month of service is completed.

Save All Itemized Receipts
IRS regulations require that TriNet confirm that all FSA payments are used for eligible FSA expenses, including debit card transactions. In many cases you will be required to submit supporting documentation for your debit card purchases. Therefore, save all your itemized debit card receipts. This is not a requirement specific to the TriNet Plan, but rather an IRS requirement for all FSA plans. TriNet must comply with this requirement in order for eligible expenses to be reimbursed on a tax-free basis.

If you do not submit documentation when requested by TriNet, you will be obligated to repay the amount to your FSA. Failure to do so could result in suspension or revocation of the debit card. For more details, see the Cardholder Agreement that came with your debit card.

12.6 How to Use Your FSA Debit Card
Your FSA debit card gives you easy access to the funds in your health care and dependent day care FSA. Worksite employees actively participating in the plan and their spouses (if applicable) will automatically receive initial debit cards free of charge.

Your FSA debit card works just like a bank debit card with some important differences. Your FSA debit card use is limited to specific merchants and purchases, including health care medical providers (for example, hospitals or outpatient labs), doctors and non-medical health care providers (such as grocery stores and pharmacies) that are IRS compliant. You may also use your debit card for dependent day care providers. If you are enrolled in a limited-use health care FSA, you may only use the FSA debit card for out-of-pocket dental and vision services that are eligible under the plan.

12.7 How to Submit a Request for Reimbursement
When you have paid for a dependent day care or health care expense out-of-pocket, you may submit your FSA reimbursement request to TriNet online. Log in to TriNet (login.trinet.com).

You will need to submit the following documentation with your reimbursement request:

Health Care FSA: An Explanation of Benefits from your insurance company or an itemized statement from the provider that includes the service date, patient name, amount paid and a description of the service.

Dependent Day Care FSA: A third-party bill or itemized statement showing the service date(s), dependent name, dependent date of birth, description of services, amount paid, and the care provider's tax identification number or social security number.

You may upload an electronic version of the receipt when you submit your reimbursement request to TriNet (login.trinet.com) by selecting "Add Receipt", or once you have entered your claim(s) and submitted them, you can print the claim form and fax your receipt(s) with the form to 877.723.0150.

CHAPTER 13 – HEALTH SAVINGS ACCOUNTS

13.1 Health Savings Accounts (HSAs)

This section provides summary information from IRS Publication 969. Available on the IRS website.
Publication 969 provides detailed guidance on your eligibility and responsibilities when you open an HSA account.

A health savings account is a tax-advantaged health care savings account available to you if are enrolled in a medical high deductible health plan (HDHP) and are not enrolled in Medicare, enrolled in a general-purpose FSA, covered by another health plan, or claimed as a dependent on someone else's tax return. The funds contributed to the account are not subject to federal income tax. Unlike a flexible spending account (FSA), funds in your HSA may roll over and accumulate year to year if not spent.

Contributions to an HSA may be made by you, your Worksite or any other person. All deposits to an HSA become your property, regardless of the source of the deposit. If you terminate participation in HDHP medical coverage, you lose eligibility to make further pre-tax deposits to your HSA, but funds already in the HSA remain available for qualified medical expenses. Your HSA funds stay accessible to you, even if you are no longer employed or if you retire.

Depending on your HSA bank rules, the funds may be withdrawn via a debit card, checks, or a reimbursement process. Investment earnings are sheltered from taxation until the money is withdrawn.

If you are enrolled in an HDHP and (1) you or your Worksite contribute to an HSA and (2) you participate in a health care FSA, your participation in the health care FSA is limited to out-of-pocket dental and vision expenses.

13.2 Your Responsibilities as an HSA Account Holder

If you open an HSA, it is your responsibility to determine whether you are eligible to contribute and how much you may contribute for the year. There are many detailed requirements regarding your eligibility to contribute to an HSA. For example, there are federal rules regarding your eligibility to open an HSA if you were previously enrolled in a health care flexible spending account (FSA) that included a grace period. TriNet's role is limited to forwarding your elected contribution to your HSA bank. TriNet has no further responsibility to administer or manage your HSA.

In addition to determining your eligibility to open an HSA, you are responsible for the calculation of your annual pre-tax election and monitoring your HSA account to ensure that your pre-tax contributions do not exceed the federal calendar year contribution limits. (Pre-tax contributions include any made by your Worksite.)

YEAR	SINGLE CONTRIBUTION LIMIT	FAMILY CONTRIBUTION LIMIT	SINGLE AND FAMILY CATCH-UP CONTRIBUTION (AGE 55 OR OLDER)
2020	$3,550	$7,100	$1,000

If you or your spouse are age 55 or over, you may make an additional "catch-up" contribution to your HSA, above the annual maximum. The catch-up contribution limit is $1,000 per calendar year. If your spouse is 55 or over and would like to make catch-up contributions, they may not be made to your HSA account. Your spouse must make those contributions to an individual HSA account in your spouse's name.

Keep receipts for all withdrawals from your HSA account. TriNet does not determine if your HSA expenses are allowable; you do. Expenses that are not qualified expenses could be subject to income taxes and a 20% penalty. There are special rules if you are older than age 65.

It is your responsibility to open an HSA account before your payroll or Worksite contributions begin. Due to payroll cycles, allow up to 60 days following your benefits eligibility date for your payroll contributions to begin. Your HSA contributions are transmitted weekly but may take up to 1–2 weeks to be posted to your HSA.

Factors to consider as you calculate your annual election include how much your Worksite or any other person contributes, your tax status, if you are 55 or older, any pre-tax calendar year HSA contributions previously made through another employer, and whether you elected individual or family coverage in the HDHP. Please consult with your tax advisor before making an election.

It is your responsibility as the HSA account holder to monitor your HSA to ensure that all contributions to your HSA do not exceed federal guidelines. Please contact your HSA bank if you have made contributions that are above the federal guidelines.

You may enroll in an HSA or change or stop your HSA deductions at any time during the year. The HSA Payroll Change form is available on TriNet (login.trinet.com). Your HSA election is for the benefits plan year. If you start or change your HSA payroll contributions after the plan year begins, consider that you are making a partial year election.

Important note: If you have a general use health care FSA balance on the last day of the benefits plan year, due to the grace period and IRS rules, you must wait until the first of the month following the end of the FSA grace period to begin HSA contributions.

Please see **Appendix D** for **TriNet HSA Information**.

13.3 Over-the-Counter (OTC) Medication Reimbursements

Over-the-counter medicines or drugs are only eligible health care expenses if you, your spouse, or eligible dependent obtains a prescription for the medicine or drug. A “prescription” is a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

CHAPTER 14 – LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

14.1 How to Get Specific Life Insurance or AD&D Plan Information

This section provides an overview of the TriNet life insurance and AD&D plans. For specific terms and conditions, please refer to the Carrier Certificate for your plan(s). The Carrier Certificates may be accessed on TriNet (login.trinet.com). You may view your level of coverage, if any, on TriNet (login.trinet.com) under **Benefits > Overview**.

14.2 Types of Life and AD&D Insurance

There are two types of TriNet life insurance and AD&D coverage:

Basic Life Insurance Paid for by Your Worksite	**Supplemental Life Insurance Paid by You**
Life Insurance and AD&D	Supplemental Life Insurance Spouse/Domestic Partner Life Insurance Child Life Insurance Supplemental AD&D

14.3 Base Annual Earnings

The term Base Annual Earnings is used interchangeably with ABBR (Annual Benefit Base Rate), multiple of salary and multiple of earnings. It is defined as:

a. Your annual salary if you are a newly eligible Worksite employee;
b. Twelve times (12x) your regular monthly rate of pay on a date generally calculated five months prior to the first day of each benefits plan year (excluding overtime and any amounts not paid through TriNet payroll), plus bonuses or commissions paid in the rolling calendar year prior to the calculation date.

If you are a partner or S-Corporation shareholder, Base Annual Earnings means your compensation from the prior tax year. Your compensation is determined by adding the amounts as reported on the Schedule K-1, Schedule C, Form W-2 and S-Corporation federal income tax return. You are responsible for timely reporting these amounts to TriNet.

14.4 Worksite Paid Insurance

Basic Life Insurance

Basic life insurance and AD&D insurance is provided at no cost to you. If you die while you are covered for basic life insurance, the insurance company will pay your beneficiary(ies) the amount of basic life insurance that is in effect on the date of your death. You can confirm your basic life insurance coverage by logging in to TriNet (login.trinet.com).

Basic AD&D Insurance

The amount of basic AD&D coverage is the same coverage amount as your basic life insurance. If the insurance carrier determines that your death was due to an accident, your beneficiaries will receive the full amount of coverage. If you lose a limb or permanent use of a body part, you may be paid between 25–100% of your coverage amount, depending on your injuries.

Effective Date

Basic life insurance and AD&D will become effective on your benefits eligibility date, provided you are actively at work as a Worksite employee. If you are not actively at work on the date you are benefits eligible, your benefits will become effective on the first date that you return to active, full-time, benefits-eligible status.

If you work at more than one Worksite, and you meet the eligibility requirements at each Worksite, you will be covered for Basic Life Insurance at each Worksite. However, the maximum amount of Basic Life Insurance you may be covered for at all Worksites combined cannot exceed $1,000,000.

Basic Life and AD&D Insurance Age Reductions – Multiple of Salary Plans Only

If your basic life and AD&D insurance is a multiple of salary plan (1x, 2x, or 3x) your coverage will be automatically reduced on your birthday when you reach age 65 or 70. The cost adjustment for the applicable rate reduction will occur in the pay period that contains your birthdate. Please refer to the Carrier Certificate for specific details.

You can see the amount of your basic life and AD&D insurance after any age reductions by logging in to TriNet (login.trinet.com) and selecting **Benefits > Overview**. If you have questions about the amount of your life insurance, contact the TriNet Solution Center. The carrier will contact you about your conversion rights for the portion of basic life insurance you lose due to age reduction.

Death Benefit

Your Worksite may provide either a flat dollar death benefit (e.g. $20,000) or a benefit based on a multiple of salary. If the latter, the basic life and AD&D insurance death benefit is calculated on the annual salary or wages plus any bonuses and commissions paid through TriNet payroll for the 12 months immediately preceding the date of death, but exclusive of overtime and any other special payments. The age reduction rules will apply if you are age 65 (and again at 70).

Accelerated Benefits Option

You may be eligible to receive a portion of your basic life insurance proceeds in the event that you become terminally ill and are diagnosed with less than 12 months to live. See the Carrier Certificate for more information.

Tax Obligations for Basic Life Insurance Plans

The IRS requires that you pay taxes on the *value* of any basic life insurance in excess of $50,000 (does not apply to employer-paid AD&D). Log in to TriNet (login.trinet.com) to access your most recent Earnings Statement and look under EMPLOYER PAID BENEFITS for *Life & AD/D. The amount shown to the right of that notation (if any) is the value of the excess life insurance and the amount added to your taxable income.

Conversion when Your Benefits Terminate

You may generally purchase individual life insurance benefits from the carrier when your TriNet benefits coverage terminates (for example, if your leave of absence results in the termination of your group life insurance benefits) or due to the age reduction described above. More information can be found on TriNet (login.trinet.com).

If you are a resident of Minnesota on the date your eligibility for TriNet life insurance ends, you are eligible to continue TriNet basic life insurance for up to 18 months if you elect coverage within 60 days of your benefits termination date and make required payments timely. For additional information, please contact the TriNet Solution Center.

IMPORTANT: Pursuant to carrier rules, the insurance carrier must receive a completed conversion application form from you within 31 days after the date your life insurance ends. You are **solely** responsible for meeting this deadline if you wish to continue your policy. Refer to the Carrier Certificate for instructions and information.

Any references to "at policyholder's option to pay premiums" in the Carrier Certificate is not applicable to TriNet. TriNet never exercises the option to pay deductions on behalf of Worksite employees who cease active benefit participation.

There is not a conversion option for basic or supplemental AD&D coverage. Your AD&D benefit will end on your TriNet benefits termination date.

14.5 Supplemental Life Insurance

If you want extra protection for yourself and your eligible dependents, you have the option to elect and pay for supplemental life insurance at your benefits eligibility date, Open Enrollment, or at certain life status change events.

The Plan does not allow spouses or domestic partners who both are Worksite employees and who elect coverage through TriNet supplemental life programs to cover each other. Likewise, dependent children may only be covered under the supplemental life insurance plan by one of the parents, not both.

Effective Date

Supplemental life insurance becomes effective on your benefits eligibility date, subject to carrier underwriting guidelines, provided you are actively at work as a Worksite employee. If you are not actively at work on the date you are benefits eligible or the date coverage is approved by the insurance carrier, your benefits will become effective on the first date that you return to active, full-time, benefits eligible status. If your dependent is hospitalized when your spouse/domestic partner or child coverage begins, the benefits start date will be delayed until he or she is no longer hospitalized and meets all other eligibility requirements.

Benefit Deductions

TriNet determines your deductions for each benefits plan year based on your ABBR and your age on the first day of the benefits plan year. If you experienced a birthday divisible by five in the prior benefits plan year, the cost of your supplemental life insurance will increase.

Death Benefit

The supplemental life insurance death benefit is calculated on your annual salary or wages plus any bonuses and commissions paid through TriNet payroll for the 12 months immediately preceding the date of death, but exclusive of overtime and any other special payments. There is no circumstance in which your death benefit will exceed an amount that is subject to the guaranteed issue rules that has not been approved by the insurance carrier.

Conversion or Portability when Your Benefits Terminate

You may generally purchase individual life insurance benefits from the carrier when your TriNet benefits coverage terminates (for example, if your leave of absence results in the termination of your group life insurance benefits). More information can be found on TriNet (login.trinet.com).

IMPORTANT: Pursuant to carrier rules, the insurance carrier must receive a completed conversion application form from you within 31 days after the date your life insurance ends. You are **solely** responsible for meeting this deadline if you wish to continue your policy. Refer to the Carrier Certificate for instructions and information.

Any references to "at policyholder's option to pay premiums" in the Carrier Certificate is not applicable to TriNet. TriNet never exercises the option to pay deductions on behalf of Worksite employees who cease active benefit participation.

There is not a conversion option for basic or supplemental AD&D coverage. Your AD&D benefit will end on your TriNet benefits termination date.

14.6 Beneficiary Designation

A beneficiary is the person you choose to receive death benefits paid by your life insurance or AD&D policies. If you have basic or supplemental life insurance or AD&D, you must designate a beneficiary or beneficiaries for your coverage. You are always the beneficiary for spouse or child life or AD&D coverage.

The designation of primary and contingent beneficiaries determines the order in which beneficiaries become eligible to receive death benefits. Primary beneficiaries will be first to receive any available death benefits. Contingent beneficiaries will receive death benefits if no primary beneficiary survives you (or are not eligible to receive payment).

If you name two or more persons as beneficiaries in one category (primary or contingent), payment will be made in equal shares to the beneficiaries in that category, unless you specify percentages for each beneficiary. If you specify percentages, the total percent of benefit for each category of beneficiaries (primary and contingent) listed must equal 100%. If you are designating a trust as beneficiary, please be sure to provide the exact name of the trust and the name and address of the trustee.

Considerations for Designating Your Beneficiaries

Although TriNet cannot provide legal, tax, or estate planning advice, here are some considerations you may want to take into account when naming your beneficiaries. TriNet encourages you to consult with a qualified and trusted legal or financial advisor when deciding whom to name as your beneficiaries.

In general, you should consider naming specific people who you want to directly receive the coverage proceeds rather than having proceeds go to your estate. Listed below are some items to consider:

a. Are your children under age 18? Naming a minor as a beneficiary could present some complicated issues and delay benefit payments.
    a) If you die while your children are minors, a number of legal complications may arise because minors generally cannot receive or control proceeds.
    b) In most jurisdictions, state law determines when children are entitled to receive the insurance proceeds, which may be as young as 16 or as old as 18.
    c) You should consult with a trusted legal or financial advisor about the advantages and disadvantages of setting up a trust for your minor children.
b. Consider naming one or more contingent beneficiaries in case you outlive all your primary beneficiaries. (You can also change your primary beneficiaries at any time, but you must remember to do it.)

It may be helpful to review and update your beneficiary designations whenever you experience a life status change event. Note that updating the beneficiaries named in your will does not update the beneficiaries of your life insurance policy, i.e., you must update the beneficiary designation for your insurance policies as well.

Beneficiary Designation Changes

You may change your beneficiary designations at any time by completing and submitting a Beneficiary Designation Form, available on TriNet (login.trinet.com). Each new Beneficiary Designation Form replaces the previous designation on record. TriNet will always honor the most recent Beneficiary Designation Form, provided it's properly executed and submitted.

TriNet does not and will not automatically update beneficiary designations to reflect life status changes, including marriage, divorce, domestic partnership, or new dependents. You are solely responsible for updating the designation of your beneficiaries. To change your beneficiaries, you must submit a new Beneficiary Designation Form. A new beneficiary designation is not effective until TriNet receives it.

14.7 Supplemental AD&D Insurance

You may elect supplemental AD&D insurance as a new hire, at Open Enrollment, or at certain life status change events. If the insurance carrier determines that your death was due to an accident, your beneficiaries will receive the full amount of coverage. If you lose a limb or permanent use of a body part, you may be paid between 25–100% of your coverage

amount, depending on your injuries. AD&D Insurance does not have a continuation feature. See the Carrier Certificate for more information.

AD&D coverage provides no benefit for death or loss of bodily function due to causes other than an accident. For instance, if a death is due to a medical condition such as heart disease or cancer, no benefit will be paid through AD&D coverage.

CHAPTER 15 – DISABILITY INSURANCE

TriNet disability insurance provides you with partial income when you are unable to work due to an eligible illness or injury. Your Worksite may pay for disability benefits, or you may have the option to elect employee paid disability benefits.

15.1 How to Get Specific Disability Plan Information

This chapter highlights the features available in the TriNet disability plans. For specific terms and conditions, please refer to disability information available when you are initially eligible or during Open Enrollment and the Carrier Certificates located on TriNet (login.trinet.com). You may view your level of coverage, if any, on TriNet (login.trinet.com) under **Benefits > Overview**. For help with certain questions about your disability plan, please call the TriNet Solution Center.

15.2 Disability Definitions

Plans

There are two TriNet disability plans:

Short-term disability (STD) is for a temporary disability due to an eligible non-occupational illness or injury or an eligible disabling pregnancy-related condition.

Long-term disability (LTD) can provide coverage for an eligible disabling condition after the end of the elimination period. The covered conditions may be occupational or non-occupational and can be the result of illness or injury, or related to a disabling pregnancy-related condition.

Base Annual Earnings

Base Annual Earnings are used to calculate your disability payments.

The term Base Annual Earnings is defined as:

a. Your annual salary, if you are a newly eligible Worksite employee;
b. Twelve times (12x) your regular monthly rate of pay on a date generally calculated five months prior to the first day of each benefits plan year (excluding overtime and any amounts not paid through TriNet payroll), plus bonuses or commissions paid in the rolling calendar year prior to the calculation date.

If you are a partner or S-Corporation shareholder, Base Annual Earnings means your compensation from the prior tax year. Your compensation is determined by adding the amounts as reported on the Schedule K-1, Schedule C, Form W-2 and S-Corporation federal income tax return. You or your Worksite are responsible for timely reporting these amounts to TriNet.

Determination of Disability and Benefits Calculation

Eligibility for disability benefits is determined solely by the carrier in accordance with its underwriting guidelines. If the carrier approves your claim, benefits will be calculated according to the language found within the applicable Carrier Certificate. TriNet cannot and does not influence or affect the carrier's determination in any way. There are carrier eligibility requirements, conditions, pre-existing conditions, and limitations for STD or LTD coverage that are contained in the Carrier Certificate. All questions about your eligibility for disability benefits should be directed to the carrier.

Employee Paid STD and LTD

Employee paid disability benefits are available if your Worksite does not choose to pay for disability benefits. You will pay for coverage on an after-tax basis. TriNet determines your benefits plan year costs at initial benefits eligibility and at the start of each benefits year based on your Base Annual Earnings and your age on that date. If you experienced a birthday divisible by five in the prior benefits plan year, the cost of your disability plan will increase the following benefits plan year.

Disability Elections

Benefits Eligibility Date
The New Hire link will automatically display employee paid LTD or STD options compatible with any disability benefits that your Worksite has selected from the TriNet offerings. If you do not elect an employee paid disability plan at your benefits eligibility date, your next opportunity to elect disability coverage will be during Open Enrollment and the carrier will need to approve your election.

Open Enrollment
You may elect, increase, decrease, or drop your employee paid disability elections during Open Enrollment. If you newly elect employee paid disability or elect to increase employee paid disability (e.g., from 50% to 60%), it will not become effective until the carrier approves your Statement of Health. The carrier will contact you if you need to complete a Statement of Health.

If you are required to complete a Statement of Health, the carrier will contact you at the email address you provided after you submit your Open Enrollment election and provide instructions for completing the online application. If you think you should have received a Statement of Health notification but did not, contact the carrier for a replacement.

Approval of your Statement of Health will be determined solely by the carrier in accordance with its underwriting guidelines. TriNet cannot and does not influence or affect the carrier's determination in any way. If the carrier approves your elected coverage amount, such coverage and the associated rate increase will be effective on the date the carrier approves the Statement of Health (the date the carrier issues the approval letter).

Long Term Disability Pre-Existing Conditions
No benefit will be payable for any disability under the LTD plan that is caused by or contributed to by a "pre-existing condition." Please refer to the Carrier Certificate for more information.

Conversion When Your Benefits Terminate
If you have been continuously covered for at least 12 consecutive months with your Worksite and meet all other eligibility criteria, you may generally purchase individual LTD insurance benefits from the insurance carrier when your TriNet LTD benefits coverage terminates (for example, if your leave of absence results in the termination of your LTD disability insurance benefits). More information can be found on TriNet (login.trinet.com).

IMPORTANT: Pursuant to carrier rules, the insurance carrier must receive a completed conversion application form from you within 31 days after the date your LTD group insurance ends. You are **solely** responsible for meeting this deadline if you wish to continue your policy. Refer to the Carrier Certificate for instructions and information.

There is no conversion option for STD coverage. Your STD benefit will end on your TriNet benefit termination date.

CHAPTER 16 – EMPLOYEE ASSISTANCE PROGRAM (EAP)

16.1 How to Contact Your EAP

You, your household members and your dependent children have access to these resources and additional helpful information anytime. The employee assistance program provides such benefits as employee counseling programs and various online resources. To explore more about how your EAP can assist you log in to TriNet (login.trinet.com).

CHAPTER 17 – VOLUNTARY BENEFITS

Voluntary benefit plans are offered by Aflac or MetLife and are not ERISA-covered group health insurance plans. Enrollment is completely voluntary. If you enroll in a plan you must deal directly with the insurance company to request assistance or submit a claim.

17.1 Aflac Voluntary Benefits

Enrollment in Aflac voluntary benefits is restricted to the 30-day enrollment period after your initial TriNet benefits eligibility date, during annual Open Enrollment or if you experience a Life Status Change event.

Accident Insurance

Group Accident Insurance helps with out-of-pocket costs that arise when you have a covered accident.

Critical Illness Insurance

Group Critical Illness Insurance can help with the treatment costs of covered critical illnesses, such as heart attack or stroke, allowing you to focus less on your wallet and more on getting better. Cash benefits come directly to you (unless otherwise specified), which gives you flexibility to pay bills related to treatment or everyday living expenses.

Hospital Indemnity Insurance

The Group Hospital Indemnity Insurance plan helps with the out-of-pocket costs associated with a covered hospital stay, including benefits for hospital admission, confinement and intensive care. It provides financial assistance to enhance your current coverage if you are hospitalized due to a covered accident or sickness.

17.2 MetLife Voluntary Benefits

Home and Auto Insurance

Provides you with competitive rates on auto and home insurance. Enrollment in this benefit can occur any time during the year and is processed directly by the carrier.

Pet Insurance

Provides you with competitive rates on pet insurance. Enrollment in this benefit can occur any time during the year and is processed directly by the carrier.

Legal Plan

Provides you with access to a network of attorneys to assist with basic legal needs. Enrollment in the legal plan is restricted to the 30-day enrollment period after your initial TriNet benefits eligibility date, during annual Open Enrollment or for a Life Status Change event.

CHAPTER 18 – COMMUTER BENEFITS

18.1 Commuter Benefits

Commuter benefits is a pre-tax benefit program that is used to pay for public transit and qualified parking expenses as part of your daily commute to work. Two types of qualified commuter benefits are offered.

1. One is a public transportation and vanpool account. This account lets you set aside pre-tax money to pay for public transit, vanpooling and alternate forms of transportation.
2. And, the public parking account lets you set aside pre-tax money to pay for qualified parking expenses.

18.2 How the Program Works

The amount you elect for each type of commuter benefit will be deducted automatically from your paycheck on a pre-tax basis, up to the IRS limits, which can be found on IRS Publication 15-B. These limits are subject to change each calendar year. The deduction may be taken from your first or second paycheck each month, depending on when TriNet receives and processes your enrollment election from the carrier.

Key Point to Remember

Because of the tax-free treatment of these benefits, the IRS regulations place special restrictions on commuter benefits. Before you decide to enroll in commuter benefits, you should carefully review the rules. For more information about commuter benefits log in to TriNet (login.trinet.com) and select **Benefits > Commuter Benefits**.

CHAPTER 19 - BENEFITS WHILE ON A LEAVE OF ABSENCE (LOA)

19.1 Initial TriNet Notification

TriNet will send you a letter that will document your LOA and describe what you can expect regarding your benefits. If you are granted an Extended Leave of Absence that is not covered under a state or federal leave plan (such as FMLA or California PDL), your benefits coverage may continue as if you are an active Worksite employee for 30 days. After those 30 days, coverage will continue until the end of the month in which the 30th day occurs. Your Employee Handbook also describes your benefits if you qualify for FMLA, PDL or other state-required leaves.

19.2 FSA While on Unpaid Leave of Absence

Health Care FSA While on Paid Leave of Absence

If you go on a paid leave of absence that provides for continuation of your TriNet health benefits, your health care FSA participation will continue and eligible expenses you incur after the start of your paid leave are eligible for reimbursement. Benefits plan year payroll deductions will continue during paid leave.

Health Care FSA While on Unpaid Leave of Absence

If you go on an unpaid leave of absence that provides for continuation of your TriNet health benefits, you have the following choices regarding your health care FSA.

Your health care FSA participation will continue, and your payroll contributions will be on hold status, unless you notify TriNet that you would like to elect one of the options listed below. Eligible expenses you incur after the start of your unpaid leave are eligible for reimbursement. Upon your return to work, your FSA payroll contributions will resume if you return to work in the same benefits plan year. Your remaining benefits plan year payroll contributions will be adjusted to make up for the contributions you missed during your unpaid leave.

a. You may submit a life status change form to elect to stop your health care FSA participation and contributions. Expenses you incur after the start of your unpaid leave will not be eligible for reimbursement. Upon your return to work, your health care FSA payroll contributions will resume if you return in the same benefits plan year. Your annual health care FSA election will be reduced by the total amount of payroll contributions you missed during your unpaid leave.

b. You may notify TriNet that you would like to contribute through a lump sum pre-tax salary reduction payment before the unpaid leave commences and continue to incur eligible expenses during your leave. This option is only available with an advanced 30-day notice prior to the commencement of your leave date. Upon your return to work, your health care FSA payroll contributions will resume if you return in the same benefits plan year. Your remaining benefits plan year payroll contributions will be adjusted to account for your lump sum contribution.

If you go on an unpaid leave of absence that does not provide for continuation of your TriNet health benefits, you will be offered COBRA continuation coverage. If your unpaid leave lasts more than 30 days, upon return to work you may submit a new health care FSA election.

Dependent Day Care FSA While on Leave of Absence

If you elected dependent day care FSA, day care expenses you incur after the first two weeks of your period of paid or unpaid leave are not eligible for reimbursement. Payroll deductions will be on hold status during your leave of absence. Upon your return from leave you will be automatically re-enrolled in dependent day care FSA and your remaining payroll contributions will be recalculated and increased to make up for the contributions you missed during your leave so that your total FSA election will equal what you originally elected for the year.

19.3 Continuation of Benefits While on Leave of Absence

If you take any type of approved leave of absence (including, but not limited to, a workers' compensation leave), you will be permitted to continue your active medical, dental, vision, disability and life insurance coverage under the Plan on the condition that applicable law requires such coverage to be maintained. You will then be offered COBRA continuation coverage. Importantly, the law does not require the continuation of regular benefits for every type of leave of absence. Furthermore, any offer of COBRA continuation coverage that TriNet makes to you is not a guarantee of such coverage, as

you are solely responsible for making timely payments and otherwise complying with the eligibility requirements for COBRA under the TriNet benefits Plan and applicable federal or state law.

If Your Benefits Terminate While you are on Leave

Medical, Dental and Vision Plans
You will receive a COBRA notice and you must timely elect and pay for COBRA coverage if you want to continue benefits during your leave.

Basic, Supplemental, Spouse/Domestic Partner and Child Life Insurance
The insurance carrier only allows 31 days after the termination of benefits for you to submit an application to continue your basic life insurance or supplemental life insurance coverage for yourself, your spouse/domestic partner or your child(ren). If your leave results in the termination of life insurance benefits, pursuant to the carrier's rules, the carrier must receive a completed conversion or portability application form from you within 31 days after the date your group life insurance coverage ends. If you have not received a conversion application, you should contact the carrier immediately. You are **solely** responsible for meeting this 31-day conversion deadline if you wish to continue your policy.

Disability Benefits
Please refer to your plan's Carrier Certificate for information on disability coverage continuation.

19.4 Life Status Change Events
If you have a life status change event while you are on an approved LOA, report it to TriNet within 30 days (60 days for a birth, adoption, or SCHIP event). If you are on COBRA, slightly different rules may apply. For assistance, please contact the TriNet Solution Center.

19.5 Return to Work

Return to Work Within 30 Days of Your Benefits Termination
If you return to work within 30 days of your benefits termination, with the exception of your FSA benefits, and unless you elected TriNet COBRA, your prior elections under the Plan will be reinstated effective to the date your benefits terminated, and you will be responsible for any costs that are due. Repayment will be collected via payroll deductions unless other arrangements with your Worksite were made. TriNet will send you a letter documenting your leave and benefits reinstatement.

Return to Work More Than 30 Days after Your Benefits Termination
If you return to work more than 30 days* after termination of your benefits, you will be re-enrolled into the plans you had prior to the termination of your benefits and be given the opportunity to make changes to your health plan benefits, within 30 days of your return to full-time regular work. If you participated in an FSA benefit, see the Chapter subsection entitled *FSA While on Unpaid Leave of Absence* for more information. TriNet will send notification and instructions on how to complete your new enrollment.

*Special rules may apply (e.g., no waiting period requirement) if your Worksite is an Applicable Large Employer in accordance with the ACA.

CHAPTER 20 – WHEN BENEFITS END

20.1 Benefit Costs When Benefits Terminate

Your TriNet benefits coverage and rate responsibility extends through the last day of the month in which you first become (or became) ineligible for TriNet benefits. For instance, if your employment ends on the 14th of the month, your benefits coverage extends through the last day of the month. Benefit costs for the entire last month of coverage will be deducted from your pay. You have the same responsibility in the case of a divorce or an adult child who is no longer eligible under the plan, as benefits and deductions extend through the last day of the benefit month. You are responsible for, and may experience, greater deductions than your customary periodic benefit deductions in your final paycheck for such prospective benefit coverage which extends until the last day of the month in which you first become (or became) ineligible for TriNet benefits.

20.2 For You

Your participation in the TriNet benefits Plan will terminate on the last day of the month in which any of these events occur:

a. You cease to be employed by TriNet or your Worksite ceases to be a TriNet client or fails to meet the participation requirements;
b. Your employment as a full-time regular Worksite employee ends;
c. The Plan or any benefits program terminates;
d. Any benefits program (e.g., medical, dental, vision) is no longer available in your service area;
e. Unless federal or state law dictates otherwise, you fail to continue to meet each of the eligibility requirements under the Plan or any benefits program (for example, if the law does not require active benefits to be continued during your leave of absence); or
f. Your participation in the Plan is terminated for cause or any other reason.

20.3 For Your Dependents

If your dependent's participation under the Plan ends, TriNet benefits coverage and your financial responsibility extend through the last day of the month in which the dependent is no longer eligible. For instance, if your divorce is final or your child ceases to meet the Plan's eligibility requirements on the 10th of the month, the benefits coverage and your financial responsibility will extend through the last day of that month.

Dependent coverage will terminate as a result of the following:

a. You are no longer eligible for coverage;
b. The dependent loses or is no longer eligible to receive benefits under the Plan due to one of the following reasons:
    - Divorce or dissolution of domestic partnership;
    - Child ceases to satisfy the dependent eligibility requirements under plan (e.g., age limit);
    - Loss of student status; or
    - Your death.

20.4 Other Reasons for Termination of Participation

If any of the following events occurs, participation may be terminated for cause:

a. Fraud or intentional misrepresentation for eligibility or in requesting benefits;
b. For medical coverage only, violations of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007; or
c. Your refusal to allow TriNet to transmit your social security or VISA number to the medical carrier.

21 – COBRA CONTINUATION COVERAGE

If you or your covered dependents are no longer eligible for health care coverage through the TriNet Plan, under certain circumstances you and they may be eligible to continue coverage under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

It is important to remember TriNet does not guarantee COBRA continuation coverage. Your ability to continue participating in any COBRA continuation coverage provided by TriNet is subject to your (and your eligible dependents, if applicable) continued eligibility for COBRA pursuant to applicable federal or state law, Plan rules and continued timely payment of the correct rates.

21.1 Other Affordable Coverage Options

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options available through the Health Insurance Marketplace, Medicare, or other group health plan coverage options through what is called a "special enrollment period." In the Marketplace, you could be eligible for a tax credit that lowers your monthly rates right away, and you can see what your financial responsibility, deductibles, and out-of-pocket costs will be before you decide to enroll. Being eligible for COBRA does not limit your eligibility for coverage or for a tax credit through the Marketplace. For more information about health insurance options available through a Health Insurance Marketplace, visit healthcare.gov. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

21.2 COBRA Continuation Coverage

COBRA is a temporary continuation of Plan coverage when benefits would otherwise end because of a life event known as a "qualifying event." COBRA may be offered to each person who is a "qualified beneficiary." Qualified beneficiaries pay the entire cost of COBRA coverage.

TriNet administers its COBRA program within the strict guidelines of COBRA as amended, and subject to the interpretation of the Department of Labor.

21.3 Qualified Beneficiary

A qualified beneficiary generally may be an individual covered on your group health plan on the day before a qualifying event who is an eligible participant, the eligible participant's spouse, a dependent child, or, under some circumstances, an eligible participant's domestic partner. In addition, any child born to or placed for adoption with a covered eligible participant during the period of COBRA coverage is considered a qualified beneficiary. COBRA provides independent election rights to all qualified beneficiaries.

21.4 Qualifying Events

The Plan may offer COBRA to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. To be eligible, you or your dependents must be covered under TriNet's health care plans on the day before the qualifying event occurs.

You

You will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events occur:

a. Your hours of employment are reduced; or
b. Your employment with your Worksite ends for any reason other than your gross misconduct.

Your Spouse or Domestic Partner

If you are the spouse or domestic partner of a Worksite employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occur:

a. Your spouse becomes a qualified beneficiary;
b. Your spouse dies; or

c. You become divorced, legally separated from your spouse, or your domestic partnership ends.

If you reduce or eliminate your group health coverage for your spouse at Open Enrollment in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for your spouse even though group health coverage was reduced or eliminated before the divorce or separation. Your spouse's qualifying event date for COBRA continuation will be the date of the divorce or legal separation.

Although TriNet generally offers COBRA continuation coverage to domestic partners in the same way it offers such coverage to eligible spouses, COBRA legislation does not require that domestic partners be covered, and some plans may not allow domestic partner coverage due to current state law. Please refer to the Eligibility, Benefit Rates and Taxation, and Newly Eligible Enrollment chapters in this Guidebook for more domestic partner coverage information.

Your Dependent Children

Your dependent child will become a qualified beneficiary if any of the following qualifying events occur:

a. You become a qualified beneficiary;
b. A child who is born to you, adopted by you, or becomes your responsibility by a court order after your COBRA coverage commences;
c. You die;
d. Your child loses coverage due to your divorce, legal separation, or dissolution of domestic partnership. For example, if your child was enrolled on your spouse's health plans and lost that coverage due to your divorce, your child will become a qualified beneficiary; or
e. Your child loses dependent status under the Plan's eligibility rules.

For birth, adoption and marriage, the coverage will begin on the date of the event. For events other than birth, adoption and marriage, each qualified beneficiary who elects COBRA will be covered starting on the first of the month following the month in which the qualifying event occurs.

21.5 Qualifying Event Notification

Notify TriNet

When the qualifying event is termination of employment from your Worksite, reduction of hours of employment or your death, your Worksite must notify TriNet of the qualifying event.

In the case of a divorce, legal separation, termination of a domestic partner relationship, or loss of dependent status, you are responsible for notifying TriNet within 30 days of the event.

For timely delivery of your Notice of TriNet COBRA Eligibility, be sure that TriNet has your (and your dependents', if applicable) current mailing address. To provide us with the latest information, please contact the TriNet Solution Center. Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA coverage will be offered to each of the qualified beneficiaries.

Important: Please note that your COBRA rights may be adversely affected by a failure to timely notify the Plan of the qualifying event. You may lose all rights to elect COBRA continuation coverage in the event of a prolonged failure to report the qualifying event.

Notice Mailed to You

After TriNet receives timely notification of your qualifying event, a Notice of COBRA Eligibility and COBRA Election Form will be mailed to you and your eligible dependents, which will give instructions on how to elect COBRA coverage.

21.6 Enrollment

Your COBRA package will contain a Notice of COBRA Eligibility, a COBRA Election Form, and a TriNet COBRA Guide. Your COBRA election must be postmarked on or before the 60th day after the date on your COBRA notice or the COBRA effective date, whichever is later.

If you do not include your initial payment with your election form, you have 45 days from the postmark date on your election form to postmark your full initial payment. **Full payment must include benefit costs retroactive to your COBRA effective date.**

Once the initial election form and payment have been submitted, all future payments (no other correspondence) must be sent to the address listed on your COBRA Election Form.

21.7 COBRA Benefits

Health Care Benefits

You or your eligible dependents may elect COBRA independently for medical, dental and vision benefits. You may continue medical, dental and vision coverage in any combination. However, if you decide to waive coverage or drop a plan, you cannot re-elect the waived or dropped plan until the next Open Enrollment period.

Flexible Spending Account (FSA)

If you are currently participating in the health care FSA plan, and if you have a positive account balance, you may elect to continue participating in the health care FSA until the earlier of the date you stop making COBRA payments or the end of the benefits plan year. You will have the opportunity to make that election on your TriNet COBRA Election Form.

The IRS regulations do not allow you to (1) continue health care COBRA FSA beyond the end of the current benefits plan year or (2) continue participation in the dependent day care FSA through COBRA. Although dependent day care FSA participation under COBRA is not permitted, you may continue to submit claims for any eligible expenses incurred through the remainder of the Plan Year until the available balance is exhausted.

COBRA Periods of Coverage

COBRA coverage is a temporary continuation of benefits that can last up to 18, 29 or 36 months, depending upon the following criteria:

Medical, Dental and Vision Benefits

Qualifying Event	Beneficiary	Coverage
Termination of employment from your company or reduced hours	Eligible participant, spouse/domestic partner, dependent child(ren)	18 months
Divorce, termination of domestic partnership, or legal separation	Spouse/domestic partner, dependent child(ren)	36 months
Worksite employee's death	Spouse/domestic partner, dependent child(ren)	36 months
Loss of dependent child status	Dependent child(ren)	36 months
Worksite employee enrolled in Medicare ***before*** qualifying event	Spouse/domestic partner, dependent child(ren)	36 months of coverage from the date of your Medicare enrollment*
Social Security Disability Extension of COBRA	Eligible participant, spouse/domestic partner, dependent child(ren)	29 months

*Worksite employee or eligible dependent must notify TriNet if this qualifying event applies and must provide the date of the Worksite employee's Medicare enrollment.

Health Care FSA
Continuation of coverage under the health care FSA terminates on the earlier of the date you stop making COBRA payments or the end of the benefits plan year in which the qualifying event occurs.

21.8 Changes to Your COBRA Coverage

Open Enrollment
Each year, TriNet offers an Open Enrollment period for all COBRA beneficiaries. During this annual event, you may re-elect or change some of your benefit options and coverage levels for COBRA. You will receive an Open Enrollment notification to your home address with instructions on how to enroll.

Life Status Changes
You may drop COBRA coverage for a dependent at any time without providing a reason by sending notice to TriNet. No retroactive or mid-month terminations or refunds will be permitted. However, you may only add an eligible dependent to your COBRA coverage during Open Enrollment or if you experience a life status change event.

A life status change event allows you to add eligible dependents to your COBRA coverage. Examples are birth, adoption, death, marriage, divorce or loss of other coverage. Should you become eligible for COBRA coverage you will receive a TriNet COBRA Guide with additional information on life status changes. You may report life status changes to the TriNet Solution Center. You must submit your enrollment within 30 days (60 days for a birth, adoption, or SCHIP event) if you experience a life status change.

Second Qualifying Events
Your spouse/domestic partner and dependent children who experience a second qualifying event may be entitled to a total of 36 months of COBRA coverage if the event is reported within 60 days. Second qualifying events may include your death, divorce, legal separation or the dissolution of domestic partnership, your enrollment in Medicare benefits (see discussion below on special rules for Medicare eligible COBRA participants), or a dependent child becomes ineligible for coverage as a dependent under the group health plan. The following conditions must be met for a second event to extend a period of coverage:

a. The initial qualifying event is the covered Worksite employee's termination, or reduction of hours of employment, which calls for an 18-month period of continuation coverage;
b. The second event that gives rise to a 36-month maximum coverage period occurs during the initial 18-month period of continuation coverage (or within the 29-month period of coverage if a disability extension applies);
c. The second event would have caused a qualified beneficiary to lose coverage under the plan in the absence of the initial qualifying event;
d. The individual was a qualified beneficiary of the first qualifying event and is still a qualified beneficiary at the time of the second event; and
e. The individual meets any applicable requirement in connection with a second event, such as notifying the Plan Administrator of a divorce or a child ceasing to be a dependent under the Plan within 60 days after the event.

If all conditions associated with a second qualifying event are met, the period of continuation coverage for the affected qualified beneficiary (or beneficiaries) is extended from 18 months (or 29 months) to 36 months.

Social Security Disability Extension of COBRA Coverage
If a qualified beneficiary is determined under Title II or XVI of the Social Security Act to be disabled, then that qualified beneficiary and all qualified beneficiaries on COBRA coverage may be able to extend COBRA continuation coverage for up to an additional 11 months, not to exceed 36 months. An individual who has been determined to have been disabled before the first day of COBRA continuation coverage is considered to be disabled within the first 60 days of COBRA continuation coverage.

Qualified beneficiaries may lose all rights to the additional 11 months of coverage if notice of the determination is not provided within 60 days after the latest of:

a) The date of the Social Security disability determination letter;
b) The date of the qualifying event (i.e. your benefits termination or a second qualifying event); or
c) The date of the COBRA initial notice

In each of these cases, notice of the determination must be provided to TriNet before the expiration of the 18-month COBRA period.

A qualified beneficiary who is disabled or any qualified beneficiaries in their family may notify TriNet by emailing a copy of the determination letter together with a cover letter stating the name of the principal COBRA holder, employee ID number (and, if applicable, the name of the qualified beneficiary other than the principal COBRA holder who is disabled) to employees@trinet.com.

In accordance with the COBRA regulations, TriNet will charge 150% of the applicable group rate during the 11-month extension. You must notify TriNet within 30 days upon the determination that the Qualified Beneficiary is no longer disabled under Title II or XVI of the Social Security Act.

For information about the Social Security Disability COBRA extension, please contact the TriNet Solution Center.

21.9 Special COBRA Rules Pertaining to Medicare

If Your Medicare Enrollment Occurs Before a COBRA Qualifying Event

A special rule for dependents provides that, if you enroll in Medicare benefits (either Part A or Part B) ***before*** experiencing a qualifying event (i.e., while actively at work without experiencing a reduction of work hours), the period of coverage for your spouse/domestic partner and dependent children ends (1) 36 months after the Worksite employee enrolls in Medicare, or (2) 18 or 29 months (whichever applies) after your termination of employment from your company or reduction of employment hours, whichever occurs later. You or your eligible dependent(s) are responsible for notifying TriNet of the date you enrolled in Medicare.

NOTE: Becoming Medicare eligible while actively at work, and without any reduction in hours, is not a qualifying event that triggers COBRA because being eligible for Medicare does not result in a loss of coverage for the Worksite employee's dependents. Thus, the 36-month coverage period would be part regular plan coverage and part continuation coverage. In other words, irrespective of when the qualifying event occurs, a spouse/domestic partner or child can never have more than a total of 36-months of COBRA coverage.

If You Become Medicare Eligible While on COBRA

If you enroll in Medicare during the period that you are a COBRA participant, you may choose to terminate your COBRA coverage; however, your dependent(s) can remain on COBRA coverage as a qualified beneficiary for the remainder of the term not to exceed 36 months, provided your dependents are also not eligible for Medicare. If you choose to remain enrolled in COBRA coverage, your Medicare benefits will become primary and COBRA coverage benefits will become secondary.

21.10 Early Termination of COBRA Coverage

COBRA coverage will expire at the end of the applicable COBRA period, which normally is either 18, 29 or 36 months, depending on the circumstances. However, COBRA coverage will be terminated early for any of the following reasons:

a) A required full payment is not received in a timely manner;
b) The qualified beneficiary enrolls in Medicare and terminates COBRA coverage. The spouse/domestic partner and children, however, may remain on COBRA as qualified beneficiaries up to 36 months if a second qualifying event occurs; or
c) The qualified beneficiary becomes covered, after the date of COBRA coverage election, under a group health plan maintained by another employer that does not exclude or limit coverage for a qualified beneficiary's pre-existing condition and the coverage is comparable coverage to what the qualified beneficiary is receiving under COBRA.

21.11 COBRA Payments

After you have remitted your initial payment, COBRA payments are due on the first day of each month**.** You are granted an additional 30-day grace period after each due date to send in payment that must be postmarked within this timeframe. Payments postmarked after the grace period will lead to the termination of COBRA benefits retroactive to midnight on the last day of the month of your last timely (and fully) paid remittance. If you receive health care treatment during a month in which you have not paid your COBRA payment on time or in full, you will be responsible for your health care costs.

You will not receive an invoice when payments are due. TriNet does provide coupons to simplify your COBRA payments, but it remains your responsibility at all times to remit your COBRA payments timely. TriNet recommends you pay your own COBRA payment. Even if you rely on a third party to pay your monthly COBRA payments, it remains **your sole responsibility** to make certain that payments are remitted timely with good and clear funds.

Non-payment, payments not received, underpayment, late payment, non-negotiable checks or checks returned for insufficient funds (NSF), even if deposited into our automated deposit system, will result in termination of coverage retroactive to the end of the month of your last full payment. If you incur medical, dental, or vision expenses during a month in which you have not paid your COBRA payments on time or in full, you will be responsible for your health care costs because your COBRA continuation coverage will be terminated. Any insufficient or late payments deposited into our automated deposit system (1) does not constitute acceptance of such payment, (2) is no indication that your coverage has been reinstated and (3) will be returned to you. It is the sole responsibility of the COBRA participant to make certain that payments are remitted timely with good and clear funds.

In the event that TriNet does not timely receive your COBRA payment, it is your duty to show sufficient written proof of mailing (that TriNet may choose to accept in its sole discretion). Therefore, TriNet recommends that you use methods of delivery with written proof of mailing, such as certified mail, to send all COBRA payments.

In the event that your COBRA coverage terminates for any reason listed above and you choose to appeal this decision, you must submit a request for COBRA reinstatement to TriNet in writing.

If you decide to modify or terminate your coverage, TriNet will refund any payments that you have already submitted for coverage in future months. No mid-month terminations or refunds will be allowed.

Payments include a 2% administrative fee, as permitted by law.

If you elect more than one TriNet COBRA benefit and you timely submit substantial payment which is less than the total due, your payment will be applied to benefits in the following order: medical, dental, vision, and health care FSA. Underpayment of the required COBRA payment for any of those benefits will result in termination of such coverage.

21.12 Extended State Mandated COBRA Coverage

Several states mandate that medical insurance carriers offer continued COBRA coverage after federal COBRA ends. You may be eligible if:

a. You are enrolled in a TriNet sponsored medical plan issued in a state with a COBRA continuation mandate
b. You complete 18 months of TriNet federal COBRA coverage

Please refer to **Appendix E** for **State Mandated COBRA Coverage**.

21.13 Special Rules if Your Worksite Terminates Its Relationship with TriNet

Termination of the service agreement between your Worksite and TriNet does not always constitute a TriNet COBRA qualifying event. Whether you are entitled to COBRA depends on any number of factors. In general, the following describes instances where you may or may not be eligible for COBRA continuation coverage. If you are enrolled in healthcare plans, you will receive a letter from TriNet informing you whether you are eligible to elect TriNet COBRA.

Active Worksite Employees

You are considered an active employee if your benefits terminate on the last day of the month in which your Worksite terminates its service agreement with TriNet. If TriNet COBRA is not offered to active Worksite employees for any reason, and your employment terminated earlier in the month and your benefits coverage continued through the end of the month, you will be ineligible for TriNet COBRA coverage.

If the Worksite determines that they want TriNet to assist in fulfilling its COBRA obligation, generally they must notify TriNet, in writing of their intent to offer COBRA continuation coverage upon client termination. For any questions surrounding COBRA offerings, consult with your Worksite for further information regarding COBRA.

Former Worksite Employees and Dependents

Former Worksite employees whose active TriNet benefits coverage terminated prior to the last day of the month in which the Worksite terminates its TriNet service agreement and who are either in their TriNet COBRA election window or who have elected TriNet COBRA, will have the option of staying on TriNet COBRA or obtaining COBRA coverage from their Worksite's new plan.

21.14 Additional Information

For more information about your rights under COBRA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

CHAPTER 22 – BENEFIT APPEALS

22.1 Medical, Dental, Vision, Life, AD&D or Disability Claims Appeals

TriNet offers fully-insured medical, dental, vision, life insurance, AD&D and disability benefit plans, and self-funded dental and vision plans. All claims administration is performed by the carriers, without any input from TriNet. TriNet does not have the ability to influence the carrier's claims and appeals decisions. The following issues are determined solely by the insurance carriers in accordance with their plan rules and underwriting guidelines:

a. Adjudication of claims;
b. Decisions on the existence of pre-existing conditions;
c. Approval for additional benefits;
d. Statement of Health review and approval;
e. Approval for non-standard or experimental treatments; or
f. Outcome of claims appeals.

If you have a medical, dental, vision, life, AD&D or disability claims issue, your path of appeal is through your insurance carrier. Each carrier describes its appeal process in the Carrier Certificates posted on TriNet (login.trinet.com).

IMPORTANT: In accordance with health care reform, carriers must respond to an authorization request for a pre-service "urgent" claim within 24 hours of receipt, unless the claimant fails to provide sufficient information for the carrier to determine whether, or to what extent, benefits are covered or payable under the plan or health insurance coverage.

A pre-service "urgent" claim is a claim that:

a. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
b. In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If a participant or beneficiary believes that an "urgent" claim request, as defined above, is not being timely processed by the carrier, he or she should immediately contact the TriNet Solution Center. TriNet can assist in a limited manner by asking the carrier for a timely response to an "urgent" claim authorization request. However, TriNet cannot influence carrier claim decisions. Claim determinations, including urgent care decisions, are made solely by the carrier.

22.2 Voluntary Benefit Appeals

TriNet has no responsibility whatsoever for voluntary benefits. These plans are not part of the TriNet benefits plan and any issues or appeals should be addressed directly with the carrier.

22.3 TriNet's Internal Appeals Process

Benefit Appeals

The benefit appeals process was established pursuant to federal law requirements to give Worksite employees an avenue of appeal to ensure that decisions regarding the TriNet health care, flexible spending accounts and certain plan eligibility decisions (for example, when an insurance carrier has denied a particular claim for benefits because TriNet has determined that the participant or dependent is not eligible for coverage) are based on Plan requirements, federal and State laws, other regulations and guidelines, and the TriNet insurance contracts. Your benefit appeal will be considered by TriNet representatives appointed by the Plan Administrator who have established reputations as being neutral, independent, fair and thorough. For more information, contact the TriNet Solution Center.

Benefit Appeals Process

If you would like to submit a benefits appeal, you must submit the request to TriNet, preferably in writing. Requests to appeal a benefits decision must be submitted within 180 days of the date you were notified of the benefits decision (e.g., notice of ineligibility/coverage termination).

Your request may be submitted to TriNet in one of the following ways:

a. Creating a case through TriNet (login.trinet.com) containing the appeal and assigning it to the Services: Benefits provider group;
b. Calling the TriNet Solution Center at 800.638.0461, 3 a.m. to 9 p.m. PT, Monday through Friday; or
c. Emailing your appeal to benefitappeals@trinet.com

If available, please include related TriNet case numbers in your request and attach or include all supporting documentation you wish to have reviewed. Your appeal should also include a detailed description of the relevant facts and circumstances that you want the Plan to consider when reviewing your appeal.

Important: Please do not provide any information related to your or your dependent's medical diagnoses or health conditions. TriNet does not require this information in order to review your request.

A TriNet representative will contact you directly at the email address on file to confirm receipt of your request. Requests are reviewed in the order they are received, generally within 15 business days, but no later than 60 days after receipt by TriNet.

TriNet will review your appeal and will consider all statements and supporting documentation that you include with your appeal. TriNet may also review other relevant information, documentation, and recorded phone calls in order to make their decision. The review of your appeal will not be conducted by the individual who made the initial benefits determination or a subordinate of such individual.

A TriNet representative will contact you directly with the appeal decision. In the event that TriNet is unable to render a decision with regard to your appeal within 60 days due to unusual circumstances, the Plan will notify you in writing prior to the end of the 60-day period that an extension of time is needed and will advise you of the date when you can expect a decision on your appeal. The extension of time shall not exceed 60 days.

You will receive any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of final determination is required to be provided, to give you a reasonable opportunity to respond prior to such determination. Before Benefit Appeals can issue a final determination based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final determination is required to be provided, to give you a reasonable opportunity to respond prior to such determination.

Once a decision is reached, you will receive written communication from TriNet outlining its decision on your appeal. Final appeal determinations will include:

a. The determination of your appeal;
b. The specific reason or reasons for the determination;
c. Specific reference(s) to pertinent Plan provisions, laws, or regulations on which the decision was based;
d. A description of any additional material or information necessary for you to perfect your appeal and an explanation of why such material is necessary, if applicable;
e. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your appeal; and
f. A statement of your rights to bring a civil action against the Plan under Section 502(a) of ERISA.

You may request to see or to obtain, free of charge, copies of any documents, records, and communications that are relevant to your case and that were relied on by TriNet in making its decision.

CHAPTER 23 – ERISA STATEMENT OF RIGHTS

As a participant in the TriNet benefits Plan, you are entitled to certain rights and protections under ERISA. It should be noted that these rights do not extend to the dependent day care FSA, any HSA, or any voluntary insurance benefit, which are not ERISA-covered programs. ERISA provides that all Plan participants will be entitled to:

Receive Information about Your Plan and Benefits

a. Examine, without charge, at the Plan Administrator's office and at other specified TriNet locations, such as TriNet field offices, all Plan documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Official Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day, for each day after 30 days that you did not receive the materials, until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. No action at law or in equity may be brought to recover under the plan(s) until the appeal rights provided have been exercised and the plan benefits requested in such appeal have been denied in whole or in part.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

CHAPTER 24 – NOTICE OF PRIVACY PRACTICES

The TriNet sponsored medical plans are fully insured group health plans. With respect to these medical plans, the TriNet Plan does not create or receive protected health information other than summary health information and enrollment and dis-enrollment information. Therefore, this Notice pertains only to protected health information held by the Plan regarding the Plan's administration of the Health Care FSA.

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

This Notice describes the legal obligations of the TriNet benefits Plan and your legal rights regarding your protected health information held by the Plan under HIPAA, and the Health Information Technology for Economic and Clinical Health Act. In this document, the two laws are referred to together as HIPAA. Among other things, this notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you, or created or received by a health care provider, a health care clearinghouse, a health plan, or your Worksite or TriNet on behalf of a group health plan that relates to:

a. Your past, present, or future physical or mental health or condition;
b. The provision of health care to you; or
c. The past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the HIPAA Privacy Officer at 510.352.5000 or One Park Place, Suite 600, Dublin, CA 94568.

Effective Date

This Notice is effective April 2003, as amended on June 2004, February 2007, April 2011 and January 2018.

Our Responsibilities

HIPAA requires us to:

a. Maintain the privacy of your protected health information;
b. Provide you with certain rights with respect to your protected health information;
c. Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
d. Follow the terms of the Notice that are currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by email to your last-known address on file.

Other Uses of Medical Information

Other uses and disclosures of health information not covered by this Notice or the laws that apply to the Plan will be made only with your written permission. This written permission is called an "Authorization." If you provide the Plan with an Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, the Plan will no longer use or disclose health information about you for the reasons covered by your written Authorization. You understand that the Plan is unable to take back any disclosures it has already made with your Authorization, and that the Plan is required by law to retain records of the care that it has provided to you.

How We May Use and Disclose Your Medical Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health

information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, benefit cost rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

For Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide these services, Business Associates will receive, create, maintain, use, or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the Plan, we may disclose protected health information to certain employees of TriNet. However, those employees will use or disclose that information only as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. As with the above list, not every use or disclosure in a category will be listed in this list. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs but only as authorized by, and to the extent necessary to comply with laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health actions. These actions generally include the following:

a. To prevent or control disease, injury, or disability;
b. To report births and deaths;
c. To report child abuse or neglect;
d. To report reactions to medications or problems with products;
e. To notify people of recalls of products they may be using;
f. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
g. To notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official:

a. In response to a court order, subpoena, warrant, summons, or similar process;
b. To identify or locate a suspect, fugitive, material witness, or missing person;
c. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
d. About a death that we believe may be the result of criminal conduct; and
e. About criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are under the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when: (1) the individual identifiers have been removed; or (2) when an institutional review board or privacy board (a) has reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information where the disclosure was for reasons other than for payment, treatment, or health care operations, and where the protected health information was disclosed pursuant to your individual authorization.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). We will disclose your protected health information upon your verbal authorization only in accordance with the law. Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (2) treating such person as your personal representative could endanger you; or (3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the Worksite employee. This includes mail relating to the Worksite employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the Worksite employee's spouse and other family members and information on the denial of any Plan benefits to the Worksite employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose psychiatric notes about you; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to the HIPAA Privacy Officer at TriNet, One Park Place, Suite 600 Dublin, CA 94568. You can also ask us to send your protected health information to a third party. Your request must be in writing and signed, and clearly identify the third party who will receive the information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. Generally, we will respond to your request within 30 days after we receive it; if we need more time, we will notify you within the original 30-day period. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by submitting a written request to the Plan Administrator at TriNet, One Park Place, Suite 600 Dublin, CA 94568.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the HIPAA Privacy Officer at TriNet, One Park Place, Suite 600, Dublin, CA 94568. Generally, we will respond to your request within 60 days. You must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a. Is not part of the medical information kept by or for the Plan;
b. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
c. Is not part of the information that you would be permitted to inspect and copy; or
d. Is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the HIPAA Privacy Officer at TriNet, One Park Place, Suite 600 Dublin, CA 94568. Your request must state a time-period of no longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. Generally, we will respond to your request within 60 days. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request in writing to the HIPAA Privacy Officer at TriNet, One Park Place, Suite 600 Dublin, CA 94568. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply – for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the HIPAA Privacy Officer at TriNet, One Park Place, Suite 600, Dublin, CA 94568. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, trinet.com. To obtain a paper copy of this notice, make your request in writing to the HIPAA Privacy Officer at TriNet, One Park Place, Suite 600, Dublin, CA 94568.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights. To file a complaint with the Plan, contact the HIPAA Privacy Officer at TriNet, One Park Place, Suite 600 Dublin, CA 94568. All complaints must be submitted in writing. A complaint to the Office of Civil Rights should be sent to: Office for Civil Rights, U.S. Department of Health & Human Services, 50 United Nations Plaza – Room 322, San Francisco, CA 94102. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us.

CHAPTER 25 – GENERAL INFORMATION

25.1 Provider Choice

Certain medical plans require the designation of a primary care provider. Please refer to your plan's Carrier Certificate or contact your health insurance carrier at the number on the back of your ID card to determine if your plan requires a primary care provider designation.

You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, the medical plan insurer will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact your insurance carrier.

25.2 Obstetrical or Gynecological Referrals are not Required

You do not need prior authorization from TriNet or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology.

The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your medical insurance carrier.

25.3 Pre-Existing Conditions Limitation

Medical Plans

None of the TriNet sponsored medical plans have pre-existing condition exclusions.

All other plans and insurance carriers may have pre-existing condition exclusions on coverage. We recommend that you review the applicable Carrier Certificate, located on TriNet (login.trinet.com), for a list of pre-existing condition exclusions, if any. You may also contact the carrier directly at the number provided on the back of your insurance card or on TriNet (login.TriNet.com). Pre-existing condition limitations are determined solely by the insurance carrier.

25.4 Coordination of Benefits and Subrogation

IMPORTANT: The following provisions regarding coordination of benefits and subrogation will apply in the absence of specific provisions contained in the applicable insurance contracts.

Coordination of Benefits

Coordination of benefits (COB) applies when a person is covered by more than one health plan. When two plans cover the same expense, one of the plans pays benefits first. This is called the "primary plan." The other plan is called the "secondary plan," which pays benefits after the primary plan has paid.

Determining Primary and Secondary Plans

a. A plan with no COB provision is always primary;
b. The plan covering a person as an eligible participant is primary; the plan covering a person as a dependent or on COBRA is secondary;
c. The plan covering a person as an active eligible participant is primary; the plan covering the person as a retired, laid-off, or terminated participant is secondary;
d. When the above rules do not apply, the plan that has covered the person for the longest period of time is primary;
e. For a dependent child covered under the plans of both non-divorced parents, the plan of the parent whose birthday falls first in the year is primary; the other parent's plan is secondary;
f. For a dependent child whose parents are not married, the order of benefits is:

- The plan of the custodial parent; then
- The plan of the spouse of the custodial parent; then
- The plan of the noncustodial parent; then
- The plan of the spouse of the noncustodial parent.

Subrogation

In some cases, another individual, insurance policy, or plan—such as an auto or liability insurance policy or another group medical plan—may be obligated to pay some or all of your health care expenses. In these cases, you or your spouse, domestic partner, or dependent have the right to recover some or all of your eligible expenses from those sources, rather than from the Plan.

In these cases, the Plan is “subrogated’ in your or your spouse, domestic partner, or dependent’s right to recover, and has the right to recover these amounts from you or your spouse, domestic partner, or dependent if such amounts are recovered from the liable third party or its insurer. The Plan (or the applicable insurance carrier) may assert this right independently of you or your spouse, domestic partner, or dependent. You or your spouse, domestic partner, or dependent may request for the Plan to pay benefits for covered expenses, but you or your spouse, domestic partner, or dependent must give written consent for the Plan to recover those expenses from the other insurance policy or plan, and you must agree to pay over to the Plan any amount that you or your spouse, domestic partner, or dependent recover from a responsible party.

You or your spouse, domestic partner, or dependent must also cooperate in all respects with the Plan’s effort to recover, including providing the Plan with any relevant information, signing and delivering any documents the Plan reasonably requests to secure its subrogation claim, and obtaining the Plan’s consent before releasing any party from liability for payment of medical expenses.

If you or your spouse, domestic partner, or dependent receives an amount to compensate for injuries that the Plan has paid for (even if these injuries are not specifically mentioned), you or your spouse, domestic partner, or dependent must repay the Plan. Further, you or your spouse, domestic partner, or dependent will hold these amounts in trust or a constructive trust for the benefit of the Plan. The Plan does not take into account state law doctrines such as limitations on its rights to recover in cases where you or your spouse, domestic partner, or dependent has not been fully compensated for injuries. Furthermore, the Plan will not be responsible for paying any part of your or your spouse, domestic partner, or dependent’s legal fees in connection with recovering any covered expenses.

If another party is legally responsible or agrees to provide any compensation, you or your spouse, domestic partner, or dependent (or legal representatives, estate, heirs, or trusts established on behalf of either you or your spouse, domestic partner, or dependent), must promptly reimburse the Plan for any benefits it paid relating to that illness or injury, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized and regardless of whether you or your spouse, domestic partner, or dependent have been made whole).

The Plan may reduce or deny current or future benefits on the basis of the compensation received or constructively received by you or your spouse, domestic partner or dependent.

In order to secure the rights of the Plan under this section, you or your spouse, domestic partner, or dependent hereby:

a. Grant to the Plan a first priority lien against the proceeds of any such settlement, verdict, or other amounts received by you or your spouse, domestic partner, or dependent;
b. Assign to the Plan any benefits you or your spouse, domestic partner, or dependent may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement; and
c. Agree that you or your spouse, domestic partner, or dependent or representative will hold any compensation in constructive trust for the benefit of the Plan and all its participants who have contributed to the funding of the Plan.

The Plan may reduce or deny current or future benefits on the basis that you or your spouse, domestic partner, or dependent has refused to sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement or refused to reimburse the Plan from the proceeds of your settlement verdict.

If you or your spouse, domestic partner, or dependent enter into litigation or settlement negotiations regarding the obligations of other parties, you or your spouse, domestic partner, or dependent must not prejudice, in any way, the subrogation rights of the Plan under this section.

25.5 Highly Compensated and Key Employees

Under the Internal Revenue Code, highly compensated Worksite employees and key Worksite employees generally are participants who are officers, shareholders, or highly paid.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses, or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key Worksite employees if they as a group receive more than 25% of the total nontaxable benefits provided for under our Plan. Plan experience will dictate whether contribution limitations on highly compensated Worksite employees or key Worksite employees will apply. You will be notified of these limitations if you are affected.

25.6 Mandated Benefits

Women's Health and Cancer Rights Act of 1998

In the case of covered persons receiving medical benefits under their program in connection with a mastectomy who elect breast reconstruction surgery, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

a. Reconstruction of the breast on which the mastectomy was performed;
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
c. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. Deductibles, co-insurance, and copayment amounts will be the same as those applied to other similarly covered medical services, such as surgery and prostheses.

Newborns' and Mothers' Health Protection Act of 1996

For each person covered for maternity and childbirth benefits, inpatient care for the mother and her newborn child will be provided in a health care facility for a minimum of:

a. 48 hours following an uncomplicated vaginal delivery; or
b. 96 hours following an uncomplicated delivery by cesarean section.

The Plan does not require a covered female who is eligible for maternity and childbirth benefits to:

a. Give birth in a hospital or other health care facility; or
b. Remain in a hospital or other health care facility for a minimum number of hours following birth of the child.

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notification of Rights under Michelle's Law

Michelle's Law was enacted to prohibit a group health plan from terminating coverage of an adult child due to a medically necessary leave of absence from, or any other change in enrollment at, a postsecondary education institution that commences while such adult child is suffering from a severe illness or injury and that causes such adult child to lose student status for purposes of coverage. This notice is intended to inform you, in a summary fashion, of the adult child's rights under the law.

Under the law, in order for a leave of absence or reduction in hours to qualify for continued adult child coverage:

a. The leave or reduction must be medically necessary;
b. The leave must commence while the eligible student is suffering from a serious illness or injury;
c. The leave or reduction would cause a loss of eligibility and benefits under the plan;
d. The student's physician must provide certification that the student is suffering from a serious illness or injury that necessitates the leave or reduction in hours.

Such adult children may remain covered under their parent's plan up to the earlier of:

a. One year after the first day of the medically necessary leave of absence; or
b. The date on which such coverage would otherwise terminate under the terms of the plan.

Notification of Rights under the Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, TriNet is asking that you not provide any genetic information when responding to a request to certify a leave of absence under the Family Medical Leave Act or other state or federal law.
"Genetic Information" as defined by GINA, includes an individual's family medical history, the results of an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Special Notice for Connecticut TriNet Worksite Employees

This notice is intended to inform you, in a summary fashion, of your rights under the Connecticut Insurance Bulletin HC-61 law.

Your Worksite has contracted with TriNet to provide outsourced human resources functions as a Professional Employer Organization ("PEO"). A PEO provides integrated services to manage human resource responsibilities and employer risks for clients. The PEO delivers these services by establishing and maintaining an employer relationship with the employees at the client's Worksite and by contractually assuming certain employer rights, responsibilities, and risk including health benefits administration. The PEO relationship involves a contractual allocation and sharing of employer responsibilities between the PEO and the client. This shared employment relationship is called co-employment, and under this relationship, you are considered to be not only an employee of your Worksite but also TriNet.

Small group health insurance laws in Connecticut require insurance carriers who provide small group health insurance to Connecticut Worksites to provide that insurance on a guaranteed issue, guaranteed renewability basis with rates based on community rating. By establishing a co-employment relationship, the health insurance is no longer issued to a small group and those guaranteed benefits are lost. Should the PEO relationship be terminated, health insurance replacement will likely cost considerably more.

Because of this co-employment relationship, your health insurance is now provided to you as a Worksite employee of TriNet. Because your health insurance is provided through a large employer group, defined in Connecticut as 51 or more employees, the small group employer insurance laws and protections no longer apply to your coverage. Specifically, this means the following:

All aspects of the health insurance will be controlled by the PEO, including plan design, carrier selection, eligibility, plan termination, and regulatory compliance. Should the relationship between your small group employer and the PEO terminate, there could be issues with respect to continuation of coverage and transition of care, particularly for those confined on the date of termination. The current benefit plan design may not be available in the small employer market.

Please make certain that you understand your rights and obligations as an employee receiving health insurance through a co-employment relationship. If you have questions, you should ask your Worksite or the TriNet Solution Center.

25.7 Amendments, Plan Termination, and Actions by TriNet

TriNet reserves the right to change or terminate the Plan at any time for any reason, retroactively, and with or without notice to eligible participants or dependents. Therefore, there is no guarantee that you will be eligible for the benefits described in this document for the duration of your employment.

25.8 No Guarantee of Employment

Nothing contained in the Plan will be construed as a contract of employment between any participant and any entity such as TriNet or a client, or as the right of any participant to be continued in the employment of TriNet or a client or as limitation of the right of TriNet or a client to discharge any Worksite employees with or without cause.

25.9 Medicaid and the Children's Health Insurance Program (CHIP)

Medicaid and the Children's Health Insurance Program (CHIP) offer free or low-cost health coverage to children and families.

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health- plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp. htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HI PP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.ht m Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, 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

APPENDIX A

Extended Medical Plan Coverage in Certain States

The state where your medical plan is issued is important because a few states mandate the extension of coverage for child(ren) at or above age 26 if they meet certain eligibility requirements. The following plans are generally written in states that have a mandated extension for dependent child(ren). Coverage can extend through the last day of the year in which the dependent reaches age 30 if certain eligibility requirements are met:

- Aetna;
- Empire;
- Florida Blue; and
- United Healthcare (UHC)

If your plan permits child(ren) to remain on existing medical coverage beyond the age of 26, you will be required to complete the annual dependent certification process starting at the end of the year in which the child turns age 26. To find out where your plan is written contact your insurance carrier or the TriNet Solution Center.

State Adult Child Extension Eligibility Rules

TriNet and the carriers reserve the right to audit child eligibility at any time. It is your responsibility to notify TriNet immediately if your child no longer meets one or more of the eligibility requirements. Failure to timely report ineligibility may be deemed as fraud and intentional misrepresentation and may result in retroactive termination of your child's TriNet benefits and reversal of claim payments.

Medical Plans Issued in Florida

Florida-issued plans allow an adult child to remain on your active medical plan through the end of the year in which the dependent turns 30 if you and your child meet and continue to satisfy all of the eligibility requirements below:

a. You must continue to be an active Worksite employee enrolled in a TriNet sponsored medical plan contracted in Florida;
b. The adult child must be your, your spouse's or your domestic partner's natural child, stepchild, adopted child, child placed for adoption or child for whom you have been appointed legal guardian;
c. The adult child is a Florida resident or a fulltime or part-time student;
d. The adult child is unmarried and does not have a child of their own;
e. The adult child is not covered under any other group or individual medical plan, Medicare or Medicaid;
f. If your adult child is enrolled in your TriNet sponsored medical plan coverage on the last day of the calendar year when the child reaches age 26 and meets the eligibility requirements, their medical coverage can continue on your active plan until the child is no longer eligible;
g. An adult child can be added to an active Florida medical plan if you are newly eligible for TriNet benefits at Open Enrollment, or due to a life status change, provided that your child meets the eligibility requirements above and there is a gap in coverage less than 64 days between the date your child lost other group medical coverage and the date you request coverage. TriNet requires the submission of a Certificate of Creditable Coverage from the prior medical carrier to document the prior group medical benefit termination date.

Medical Plans Issued in New York

New York-issued plans allow an adult child to remain on your active medical plan through to the end of the year in which the dependent turns 30, if your child meets and continues to satisfy all of the eligibility requirements below:

a. Is unmarried;
b. Is 29 years of age or younger (Coverage ends on the last day of the year of the 30th birthday);
c. Is not eligible for comprehensive (i.e., medical and hospital) health insurance through their own employer;
d. Lives in the Northeast/Tri-State service area; and
e. Is not covered under Medicare.

Medical Plans Issued in Texas

Texas-issued plans allow an adult child to remain on your active medical plan through the end of the year in which the dependent turns 30 if you and your child meet and continue to satisfy all of the eligibility requirements below. Note, this is permitted under the insurance carrier policy. It is not a Texas state mandate:

a. You must continue to be an active Worksite employee enrolled in a TriNet sponsored medical plan contracted in Texas;
b. The adult child must be your, your spouse's or your domestic partner's natural child, stepchild, adopted child, child placed for adoption or child for whom you have been appointed legal guardian;
c. The adult child is a Texas resident or a fulltime or part-time student;
d. The adult child is unmarried and does not have a child of their own;
e. The adult child is not covered under any other group or individual medical plan, Medicare or Medicaid;
f. If your adult child is enrolled in your TriNet sponsored medical plan coverage on the last day of the calendar year when the child reaches age 26 and meets the eligibility requirements, their medical coverage can continue on your active plan until the child is no longer eligible;
g. An adult child can be added to an active Texas medical plan if you are newly eligible for TriNet benefits at Open Enrollment, or due to a life status change, provided that your child meets the eligibility requirements above and there is a gap in coverage less than 64 days between the date your child lost other group medical coverage and the date you request coverage. TriNet requires the submission of a Certificate of Creditable Coverage from the prior medical carrier to document the prior group medical benefit termination date.

APPENDIX B

Minimum Creditable Coverage for Massachusetts Residents

The following TriNet sponsored medical plans satisfy the Massachusetts Minimum Creditable Coverage (MCC) requirements:

Aetna	BS California	BCBS NC	FL Blue	Empire	Tufts	UHC	BCBS MN	BS Idaho
EPO 0 MA EPO 1000 EPO 2000 PPO 300 PPO 750 PPO 1000 PPO 2000 Indemnity 1000 NTL	PPO 250 PPO 500 PPO 700 PPO 1000 PPO 1500	PPO 500	PPO 500 PPO 500/80 PPO 1000 PPO 1500 PPO 2000	PPO 500 HDHP 3000	HMO 20 HMO 30 Advantage HMO 2000 PPO 500 PPO 1000 PPO 2000 PPO/HDHP 3000	PPO 0 PPO 500 PPO 1000 PPO 1500 Primary 500 Primary 1500 HDHP 1500	PPO 0 PPO 500 PPO 1000 HDHP 2000	PPO 500

Minimum Creditable Coverage is a provision in Massachusetts health reform law that requires certain minimum benefits coverage that adult tax filers must have to avoid tax penalties. For more information, see: http://www.mass.gov/dor/individuals/taxpayer-help-and-resources/health-care-reform-information/frequently-asked-questions-individuals.html

APPENDIX C

Medicare Part D

If you or a dependent need a Medicare Part D notice to prove that you are enrolled in a medical plan with creditable prescription drug coverage, log in to TriNet (login.trinet.com) Click Benefits > Legal Notices > Medicare Prescription Drug Coverage

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

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year during Medicare's Open Enrollment period, October 15 through December 7. Individuals that lose eligibility for TriNet coverage may be eligible for a Medicare Special Enrollment Period.

Medicare beneficiaries who choose not to sign up at their first opportunity may have to pay more if they wait to enter the program later unless they can prove that they have been covered by a prescription drug plan that is considered to provide "creditable coverage." In general, prescription drug coverage is considered creditable if the expected dollar amount of paid claims under the coverage is at least equal to the expected dollar amount of paid claims under the standard Medicare prescription drug benefit.

As of August 2019, TriNet has determined, based on the Medicare creditable coverage guidelines, that the prescription drug coverage provided under all of the TriNet sponsored medical plans are creditable coverage. In other words, the prescription drug coverage provided under these plans is, on average, at least as good as standard Medicare prescription drug coverage. Coverage under one of these plans will help you avoid a Medicare Part D late enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan you may also continue your TriNet sponsored medical plan coverage. In this case, the TriNet plan will continue to pay primary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop TriNet coverage, Medicare will be your only payer. You can re-enroll in the TriNet sponsored medical plan at Open Enrollment or if you experience a life status change event for the TriNet Plan.

APPENDIX D

TriNet HSA Information

TriNet HDHP and an HSA Account in a Bank Not Sponsored by a TriNet Carrier
TriNet can only make pre-tax contributions to one of our carrier banks listed in the next section. Your TriNet calendar year HSA contribution will be shown on your Form W-2 with code W to aid you in preparing your income tax return. If you prefer to have your HSA account at another bank, you have the option of creating an after-tax direct deposit from your pay to your HSA account.

TriNet HDHPs and HSA Accounts
Each of the medical carriers offering an HDHP partners with a bank for HSA accounts. Using the bank associated with your carrier has several advantages, such as pre-tax contributions from your pay and a link on the carrier website to monitor your claims and HSA account. Each bank has its own rules and conditions. For more information, log in to TriNet (login.trinet.com).

Carrier(s)	Bank	Phone
Aetna Tufts	Citibank (Administered by PayFlex)	888.678.8242
BS CA BCBS NC BCBS MN Blue Cross Idaho Empire Kaiser UnitedHealthcare (UHC)	Optum Bank	844.326.7967
Florida Blue	BNY Mellon Bank	877.472.4200

APPENDIX E

COBRA State Continuation

TriNet only offers COBRA continuation medical coverage issued in the following states that have a COBRA continuation mandate:

Issue State	Duration of Extension	Maximum COBRA Period
California – Cal COBRA	18 months	36 months
New York	18 months	36 months
Texas	6 months	24 months

The Aetna Northeast plans are available to residents of Connecticut, New Jersey and New York. Because these plans are issued in New York, residents of Connecticut and New Jersey enrolled in Northeast plans are eligible for the New York 18-month extension.

If you live in a state that mandates COBRA continuation but are enrolled in a medical plan that is issued in a state without a coverage mandate, you are not eligible for the extension. For example, if you live in Texas and enroll in an Aetna PPO plan which is issued in Florida, there is no extension beyond federal COBRA. For more information, contact the TriNet Solution Center.