



## TRINET SIGNATURE BENEFITS

We're proud to offer you and your family a comprehensive package called TriNet Signature Benefits (TSB). From medical care to life insurance, you and your family will be ready to enjoy a comprehensive portfolio of benefits comparable to those offered by Fortune 500<sup>®</sup> companies.

TriNet wants to make sure you have the information you need to explore all of your benefits options. When it comes to selecting your benefits, knowledge is power. It's important that you take the time to learn about all of the plans and services that can go to work for you and your family.

You also have the opportunity to enroll in other "voluntary" benefits designed to serve you and your family. You can always visit HR Passport via [www.hrpassport.com](http://www.hrpassport.com) for more details on all of your benefits choices, including cost information on your coverage.

TriNet Signature Benefits  
July 1, 2008 – June 30, 2009

ELIGIBILITY & ENROLLMENT	5
Eligibility	5
Initial Enrollment	5
Confirmation Statement	5
Default Enrollment Process	6
No Double Dipping	6
Insurance Premiums	6
Newborn Children	7
Over Age Dependents	7
Student Dependents	7
When Coverage Ends For Student Dependents	7
Disabled Children	7
Domestic Partner	8
Open Enrollment	8
Confirmation Statement	9
MEDICAL TERMS	10
Helpful Benefits Terms to Know	10
MEDICAL PLANS	13
Plans By State	13
Newborns' and Mothers' Health Protection Act	17
Notification of Rights under the Women's Health and Cancer Rights Act	17
DENTAL GROUP PLANS	19
The Dental Preferred Option Plan (The "DPO" Plan) or Preferred Dental Program (The "PDP" Plan)	19
The Delta Care DMO/PMI Plan (The "PMI" Plan)	20
Getting an Estimate Before Treatment	21
How to Enroll	21
Helpful Dental Terms to Know	21
GROUP TERM LIFE AND AD&D INSURANCE	24
Group Term Life Insurance	24
Accidental Death & Dismemberment (AD&D) Insurance	24
Effective Date	24
Beneficiaries	24
Group Term Life Benefits (Employee)	25
Accidental Death & Dismemberment (AD&D)	25
Supplemental (additional) Accidental Death & Dismemberment (AD&D)	25
Accelerated Life Benefits	26
Conversion to an Individual Policy	26
Life Insurance Terms	26
Helpful Life Insurance Terms to Know	26
YOUR LONG-TERM DISABILITY COVERAGE	28
How the LTD Plan Works	28
What's Not Covered	29
Do you Live in a State that Offers Disability Insurance?	29
STRETCHING YOUR DOLLARS: FLEXIBLE SPENDING ACCOUNTS	31
How the Plans Work	31
Certain rules apply to both Health Care and Dependent Day Care FSAs:	32
Health Care Expenses	34
Dependent Day Care Expenses	34
Overcoming the Fear of Forfeiting	33
How to File Claims	35
Deadline for Filing Claims	36
FSAs While On Unpaid Leave of Absence (LOA)	37
ALL ABOUT RETIREMENT PLANS	38
Administering Your Retirement Plan	38
How Retirement Plans Work	38
Retirement Investing	39
Contribution Limits	40
TAKING A BREAK: PTO, LOA, FMLA	40
Paid Time Off (PTO)	40
Leaves of Absence (LOA)	40
Family and Medical Leave Act (FMLA)	40

WORK/LIFE SOLUTIONS	43
Employee Assistance Program	43
Work/Life Service	43
Child Care / Parenting Consultation and Referral	43
Adoption Consultation and Referral	44
Educational Resources: K-12 and Higher Education	44
Elder Care and Dependent Adult Care Consultation and Referral	44
Pre-Retirement Information	44
Legal Consultation and Referral Services	44
Financial Consultation and Referral Services	45
LifeCycle Connect Health Management Services	46
AN OVERVIEW OF VOLUNTARY BENEFITS	47
Aflac	47
MetLife Voluntary Benefits:	47
Optional Dental Plan	48
Optional Vision Plan	48
Optional Long-Term Disability Insurance	48
Supplemental (Additional) Accidental Death & Dismemberment (AD&D) Insurance	48
Group Variable Universal Life (GVUL)	48
The Health & Healing Card	49
Pre-Tax Commuter Benefits	49
Corporate America Family Credit Union	49
FEI EMPLOYEE ASSISTANCE PROGRAM (EAP)	50
Optional Vision Service Plan	50
Using a VSP Provider	50
USING A PROVIDER OUTSIDE THE VSP NETWORK	51
Limitations and Exclusions	51
How to Enroll	51
Annual Eye Exams	52
Vision Terms	52
Helpful Vision Terms to Know	52
OPTIONAL DENTAL PLANS	54
The Dental Preferred Option Plan (The "DPO" Plan) or Preferred Dental Program (The "PDP" Plan)	54
THE DELTA CARE DMO/PMI PLAN (THE "PMI" PLAN)	55
Getting an Estimate Before Treatment	56
How to Enroll	56
Helpful Dental Terms to Know	56
SUPPLEMENTAL ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE	59
Cost to Have the Plan	59
Table of Covered Losses and Benefit Amounts	59
AD&D Payment Exclusions	60
OPTIONAL HEALTH & HEALING CARD	61
Who Benefits from this Plan	61
Health & Healing Card Coverage Overview	61
How to Become a Member	62
TIME TO TRANSITION: YOUR COBRA COVERAGE	63
COBRA	63
ELIGIBILITY	63
NOTIFICATION	64
ENROLLMENT	64
COBRA PLANS	65
COVERAGE PERIOD	65
DISABLED COBRA APPLICANTS	66
Cal-COBRA	66
LIFE STATUS CHANGE	67
PAYMENTS	67
CONTINUATION COVERAGE RIGHTS UNDER COBRA	69
NOTICE OF PRIVACY PRACTICES	72
Effective Date	72
Our Responsibilities	72

Special Situations	73
Required Disclosures	75
Other Disclosures	75
Your Rights	76
Complaints	77

## Eligibility & Enrollment

As a TriNet employee, you're eligible for TriNet's Signature Benefits, provided you're regularly scheduled to work 30 or more hours a week. Refer to the TriNet Signature Benefits guidebook section on Optional Benefits for more information.

### Eligibility

The following individuals are eligible for coverage in TriNet's Signature Benefits:

- Employee
- Employee's spouse/domestic partner
- Employee's spouse's/domestic partner's unmarried dependent children (including adopted children or children placed with you for adoption) who are under age 19 or under age 25 if a student; age 26 in UT (student status is not required due to state laws in CO, TX and in MA where they qualify to age 26 or 2 years after the loss of dependent's status, whichever comes first)
- Dependent children covered by a Qualified Medical Child Support Order (QMCSO)
- Other unmarried dependent children who meet all of the following requirements:
  - They are under age 19, or under age 25 if a student; age 26 in UT (student status is not required in CO, TX and in MA - age 26 or 2 years after the loss of dependent's status, whichever comes first)
  - They receive all of their support and maintenance from you or your spouse/domestic partner
  - They reside with you
  - You or your spouse/domestic partner is the court-appointed guardian

### Initial Enrollment

When you're first eligible for benefits, you will receive a welcome email from TriNet with instructions on how to enroll online through [www.hrpassport.com](http://www.hrpassport.com). You have 30 days from your first date of eligibility to actively enroll in or opt out of health benefits. Within that 30-day period you may revise your enrollment decisions as many times as you like; only your final enrollment will count as a binding decision for the current plan year. Your initial enrollment becomes effective on your eligibility date and stays in effect until the end of the plan year. TriNet's plan year ends on June 30<sup>th</sup>.

If you are not actively at work on the first workday your new benefits are scheduled to begin, your new coverage will not start until you return to work as a regular, full-time employee.

### Confirmation Statement

Once you complete the online enrollment process and electronically send your final benefits election to TriNet, that's it - you're finished. Your coverage will become effective from your first date of eligibility. When completing the enrollment, you can request an email from TriNet confirming your benefits. A confirmation statement will also be mailed to your home address.

Once you receive your confirmation statement, immediately report any errors to TriNet's Solution Center by phone (800-638-0461, 6 a.m.-6 p.m., M-F, Pacific Time) or email [employees@trinet.com](mailto:employees@trinet.com). Remember – outside of your initial 30-day window for benefits eligibility, you cannot make any changes to your benefit

coverage unless it's during TriNet's annual open enrollment period, or you experience a qualified life status change.

### **Default Enrollment Process**

If you have other group-sponsored medical coverage, you may opt out of TriNet's Signature Benefits by making an active election online to waive your health benefits. Following 30 days from your benefits eligibility date, if you haven't made an active election or actively waived your health benefits online, TriNet will enroll you by default into a TriNet-sponsored health plan available where you live (based upon your home zip code).

For New Hires on or after 7/1/07 who do not make an enrollment or waiver election within their 30 days of TriNet benefit eligibility, there are two regional considerations:

For CA Employees: Blue Shield Standard PPO – Employee only coverage

For all other states: Aetna Standard PPO – Employee only coverage

- Dental – MetLife Preferred Dentist Program (PDP) (if your company offers group dental)
- Vision – Vision Service Plan (if your company offers group vision)
- Life insurance – the basic coverage level your company provides
- Disability insurance – the basic coverage level (if your company provides group disability)

Any employee costs for these plans will be deducted from your paycheck following the default enrollment process. If your initial enrollment is defaulted, coverage will be for employee only – no dependents may be enrolled. In addition, Flexible Spending Accounts (FSA's) will not be available to you until the next open enrollment period.

### **No Double Dipping**

If your spouse, domestic partner, or dependent is also a TriNet employee, you cannot have dual coverage. This means that you cannot enroll yourself as an employee and be receiving coverage as a dependent through another TriNet employee at the same time.

For example, if you and your spouse/domestic partner are TriNet employees and you have one dependent child you wish to cover, you or your spouse/domestic partner could waive health coverage and one of you enroll in employee plus family coverage.

Another way of enrolling could be for you or your spouse/domestic partner to enroll in employee only coverage and one of you enrolls in employee plus one dependent child coverage. Both of these approaches result in each person only being covered once – not twice.

### **Insurance Premiums**

Your benefits are "retroactive" to your first date of eligibility. This means that you should pick your benefits within your 30-day window as early as you can. If you don't, you may find a large premium amount taken from your paycheck as a retroactive benefits payment. In addition, delaying your enrollment also delays the receipt of your ID card. Service providers could require you to pay for benefits costs out-of-pocket until the card arrives. Once your benefits are in effect, you can download a claim reimbursement form from [www.hrpassport.com](http://www.hrpassport.com) and submit it for costs incurred during that period of time.

You have 30 days from your benefits eligibility date to enroll in benefits online at [www.hrpassport.com](http://www.hrpassport.com).

However, if you experience a qualifying Life Status Change (LSC) during the plan year, you may be eligible for a special enrollment period providing you notify TriNet within 30 days of your life status event. Refer to the TriNet Signature Benefits guidebook section on Life Status Changes for more information.

**Newborn Children**

A newborn dependent may be covered from the moment of birth. The employee must submit a completed life status change and benefit enrollment form to TriNet within 31 days of the newborn's birth. Unless you have actively enrolled them in your TriNet Signature Benefits, newborn children will lose their coverage at the end of the initial 31-day period. Refer to the TriNet Signature Benefits guidebook section on Life Status Changes for more information.

**Over Age Dependents**

When an enrolled child reaches age 19, the child's coverage will end. The child may continue coverage under the employee's coverage if he or she is:

- Unmarried; and
- Between age 19 and age 25, age 26 in UT; and
- Enrolled as a full-time student at an accredited educational institution; (student status is not required in CO, TX and in MA age 26 or 2 years after the loss of dependent's status, whichever comes first)

**Student Dependents**

To continue coverage for student dependents, the member must provide student verification in an acceptable form directly to TriNet. When asked to provide student verification updates, the member has a duty to cooperate in a timely and appropriate manner in the administration of benefits.

**When Coverage Ends for Student Dependents**

Student dependent coverage ends when the student dependent:

- Reaches age 25 (age 26 in MA, & UT); or
- Marries; or
- Graduates; or
- Takes a leave of absence due to a serious illness or injury that prevents the student dependent from continuing as a student dependent; or
- Stops full-time study

**Disabled Children**

An enrolled child can continue to be covered after age 19 under the employee's family coverage if he or she:

- Is unmarried; and
- Became permanently physically or mentally disabled before age 19 (or before losing eligibility as a student dependent;); and
- Is incapable of supporting himself or herself due to disability; and
- Is chiefly financially dependent on the employee; and
- Lives with the employee or spouse/domestic partner; and
- Was covered under the employee's coverage immediately before reaching age 19 (or before losing eligibility as a student dependent;); or has had other group health coverage at all times since the disability began

### Domestic Partner

If you experience a Life Status Change, that requires the addition of a domestic partner, you must complete a TriNet Declaration of Domestic Partnership form from TriNet's HR Passport (log in at [www.hrpassport.com](http://www.hrpassport.com)). Mail the original, completed TriNet declaration, or mail a copy of your domestic partnership certificate from your state or local registry to TriNet, 9805 Double R Boulevard, Suite 200, Reno, NV 89521-2946.

If you remove a domestic partner from your benefits coverage, changes will take effect the first day of the month following TriNet's receipt of your declaration.

Domestic partnership means a long-term committed relationship of indefinite duration with a person, which meets the following criteria:

- a) You and your domestic partner share an intimate and committed relationship of mutual caring;
- b) You and your domestic partner share the same principal residence;
- c) You and your domestic partner are not related by blood or a degree of closeness which would prohibit marriage in the law of the state in which you reside;
- d) You and your domestic partner are at least 18 years of age and mentally competent to consent to contract;
- e) You and your domestic partner are not currently married to or in a domestic partnership with another person under either statutory or common law;

### Taxation of Domestic Partner Benefits

This section explains the basic tax issues employees should consider when enrolling their domestic partner.

#### *What are the tax differences between health care benefits for spouses and domestic partners?*

When employers provide health care benefits for the spouse and/or dependents of their employees, the Internal Revenue Code allows the money paid by the employer for these benefits to be excluded from the employee's gross income. (Internal Revenue Code §105, §106.) No such exclusion exists for benefits given to an employee for his or her domestic partner, or the dependents of a domestic partner.

#### *Who is responsible for paying the tax?*

The employee is responsible for paying the tax on domestic partner benefits. To the extent the law requires the employer to withhold tax on the income paid to its employees, the tax on domestic partner benefits must also be withheld.

#### *How is the tax calculated?*

While there is no Internal Revenue Service (IRS) code specifically addressing this issue, private letter rulings issued by the IRS require that an employer withhold tax from their employees' income on the fair market value of the health benefit paid in excess of the amount paid by the employee for that benefit. The fair market value to be included in the employee's gross income equals the cost of the premium minus the amount paid by the employee. This is called imputed income.

#### *What about other taxes, such as FICA and FUTA?*

To the extent that the fair market value of domestic partner benefits is considered taxable as income, it also will be treated as wages subject to inclusion in the Federal Insurance Contributions Act (FICA) and the Federal Unemployment Tax Act (FUTA) tax calculations.

### Open Enrollment

During TriNet's annual open enrollment period in the spring, all benefits eligible employees have the opportunity to review available plans and select the benefits strategy that will work best for themselves and their family.

Each year TriNet offers open enrollment to every benefits eligible employee no matter when he or she was hired. It's online for the most dependable, accurate, timely, and easy-to-use process possible. During this annual event, you can re-elect or change some of your benefit options and coverage levels for the

next plan year. Your coverage will become effective on July 1 and stay in effect for the next 12 months (through June 30).

**Confirmation Statement**

Once you complete the online open enrollment process and electronically send your final benefits selections to TriNet, that's it - you're finished. When completing the enrollment, you can request an email from TriNet confirming your benefits. Your open enrollment selections will become effective on July 1st. A confirmation statement will also be mailed to your home address.

Once you receive your confirmation statement, immediately report any errors to TriNet's Solution Center by phone (800-638-0461, 6 a.m.-6 p.m., M-F, Pacific Time) or email [employees@trinet.com](mailto:employees@trinet.com). Remember – outside of your annual open enrollment period, you cannot make any changes to your benefit coverage unless you experience a qualified life status change.

Disclaimer: This guidebook is intended to provide a convenient summary of your benefit plans. If there is any inconsistency between the information in this guidebook and the plan documents or contracts, the plan documents and contracts will prevail. Please log on to HR Passport at [www.hrpassport.com](http://www.hrpassport.com) to view a Summary Plan Description (SPD), which will provide more information about each benefit plan.

# Medical Terms

## Helpful Benefits Terms to Know

Here's a list of terms used in summary fashion to explain health benefits information posted on HR Passport ([www.hrpassport.com](http://www.hrpassport.com)), as well as answers to frequently asked questions in TriNet's "Ask Benefits" knowledgebase.

### Coinsurance

Coinsurance is the percentage of a medical expense paid by either you or your TriNet medical plan. For example, let's say your plan pays 80% of the cost of a \$1,000 medical procedure. You're responsible for paying the remaining 20%. In this case, the plan will pay coinsurance of \$800 – or 80%; you will pay a coinsurance amount of \$200 – or 20%. The coinsurance amounts apply after you meet your plan's required deductible.

### Copay

The flat fee you pay each time you receive medical care in an HMO or POS plan, or for office visits in a PPO plan. The remaining charges for that care are usually covered in full by your medical plan.

### Deductible

The amount you pay each calendar year toward medical expenses before the health plan begins paying benefits. You may have to meet an individual, per-person deductible, or a family deductible for all of your covered family members combined.

### Durable Medical Equipment

Equipment that is designed primarily to service a medical purpose, can withstand repeated use, generally is not useful to people who are not sick or injured, and is appropriate for use in the home. This includes medically necessary supplies, such as diabetic testing supplies, oxygen, and wheelchairs.

### Eligible Expenses

TriNet's benefits plans recognize eligible expenses that are:

- Medically necessary, not experimental
- Prescribed by a licensed doctor
- Within the plan's usual, customary, and reasonable (UCR) cost levels
- Covered by the plan
- In the case of an HMO or POS plan, prescribed and authorized by your physician or health care provider

### Health Maintenance Organization (HMO)

Requires enrollment with a Primary Care Physician (PCP) who will direct and manage your healthcare services. If you choose an HMO plan, it will generally cover 100% of covered expenses after a copay when you use the HMO's providers. Except in emergency situations worldwide, HMOs do not cover services from non-contracted doctors or hospitals without prior authorization.

**Health Savings Account (HSA)**

A Health Savings Account is a type of tax-favored savings vehicle similar to an Individual Retirement Account (IRA). Amounts in an HSA grow on a tax-deferred basis and, if used for qualified medical expenses, may be distributed on a tax-free basis. In order to contribute to an HSA, an individual must be covered under a High Deductible Health Plan.

**High Deductible Health Plan (HDHP)**

A High Deductible Health Plan is a consumer directed health plan where the decision of how to spend health care dollars rests more with the employee, and his or her health care provider, rather than with the employer or insurance company. In this type of plan, there is a higher deductible than with traditional plans; however, the deductible does not apply to preventive care. Consumer directed health plans are part of an overall initiative to help reign in the rising costs of health care and health insurance by employees as a result of their enhanced decision making responsibility.

**Indemnity Plan**

A traditional health benefits plan that reimburses the patient for covered medical services or pays benefits directly to physicians, hospitals, or other health care providers. The Indemnity Plan is for the very few people who live outside of a TriNet-sponsored HMO, POS, or PPO service area.

**Inpatient**

A person who occupies a hospital bed, crib, or bassinet while under observation, care, diagnosis, or treatment for at least 24 hours.

**Optional Benefits**

If you waive TriNet's group medical plan or your company does not offer group dental, vision, and disability plans, you may enroll in optional dental, vision, and disability plans.

**Out-of-Pocket Maximum**

This is the maximum amount of covered expenses you have to pay in a calendar year, in addition to the deductible. After you have reached the annual out-of-pocket maximum, the plan usually pays the full cost of covered expenses – up to the usual, customary, and reasonable rates – for the rest of the calendar year.

**Outpatient**

A person who visits a clinic, emergency room, or health facility and receives healthcare without being admitted as an overnight patient.

**Plan Year vs. Calendar Year:**

TriNet's plan year begins July 1 and ends June 30 of the following year. This is important because TriNet's Flexible Spending Accounts (FSAs) are in plan years while medical deductibles are in calendar years – which gives you several tactical advantages:

- You don't have to choose your benefits during the busy holidays.
- You can leverage your plan year FSAs in order to pay for calendar year medical expenses.
- Since you enroll for dependent day care FSAs during the summer, it's easier to anticipate school year expenses.

**Point of Service (POS)**

A type of managed care plan that allows members to choose, at the point where care begins, to receive services from a participating or nonparticipating network provider, usually with a financial disincentive for going outside the network.

**Preferred Provider Organization (PPO)**

A network of doctors, hospitals, and other medical professionals commonly referred to as “preferred providers.” You may use any provider you want, but you will save time and money by using one in the PPO network. Being in a PPO plan requires a certain level of responsibility; providers may choose to discontinue their affiliation with a medical plan’s PPO network. You will need to keep current to know whether you are going to a provider who is inside or outside of the PPO network.

**Prescription Drugs – Brand and Generic**

- A brand-name preferred prescription drug is a Food and Drug Administration (FDA) approved drug under patent to the original manufacturer’s branded name.
- A generic prescription is also FDA approved, but its patent protection has expired and it costs less than the brand-name equivalent.

**Primary Care Physician (PCP)**

If you’re enrolling for the first time in a Health Maintenance Organization (HMO) or Point of Service (POS) medical plan, you must select a Primary Care Physician (PCP) for yourself and every covered dependent, except for certain Kaiser Permanente regions. You will need to coordinate all your medical care in advance through your PCP; if you don’t, you may not receive the highest level of coverage from your plan – or any coverage at all. In addition, be aware that doctors in these networks can change plans at any time. It is your responsibility to ensure that your PCP remains part of your HMO or POS network before you access care.

**Prosthetic/Orthotic Appliances:**

Apparatus or device used, usually on a permanent basis, to replace, support, align, or correct a movable body part.

**Usual, Customary, and Reasonable (UCR)**

The customary rates for a medical product or service in your geographic area, or the rates usually charged by your provider, whichever is lower. The insurance carrier determines UCR charges. You’re responsible for paying any charges that exceed UCR. Keep this in mind when you receive care from a provider outside your plan’s network.

## Medical Plans

Your benefits are “retroactive” to your first date of eligibility. This means that you should pick your benefits within your 30-day window as early as you can. If you don’t, you may find a large premium amount taken from your paycheck as a retroactive benefits payment.

There are no exclusions for pre-existing conditions in TriNet’s medical plans. Pre-existing conditions do have some limitations in TriNet’s long term disability plans. See Long Term Disability for more information.

In addition, delaying your enrollment also delays the receipt of your ID cards, requiring you to pay for benefits costs out-of-pocket until they arrive. Once your benefits are in effect, you can download a claim form from TriNet’s HR Passport via [www.hrpassport.com](http://www.hrpassport.com) and submit it for reimbursement of eligible costs incurred during that 30-day window.

## Plans By State

State	Medical Plans
Aetna Nationwide -- excluding HI and Puerto Rico HealthNet Nationwide -- excluding CA/DC/MD/VA/HI and Puerto Rico	Aetna PPOs -- (Platinum (except CA), Gold, Standard, Value, High Deductible Health Plan (Gold, Standard) - HSA compliant) Aetna Indemnity -- (only available where no HMO/POS/PPO networks exist); HealthNet PPOs -- (Platinum, Gold, Standard, High Deductible Health Plan (Gold, Standard) - HSA compliant)
Alabama	
Alaska	
Arizona	Aetna HMOs
Arkansas	
California	Blue Shield PPOs (Platinum, Gold, Standard, High Deductible Health Plan (Gold, Standard) - HSA compliant); Blue Shield HMOs (Gold, Standard); Health Net of CA HMOs (Standard, Gold); Kaiser Permanente HMO
Colorado	Aetna HMOs; Aetna POS; Kaiser Permanente HMO (Colorado Springs, Denver/Boulder)
Connecticut	Aetna HMOs; Aetna POS; Tufts Health Plan HMOs - Limited counties (Gold, Standard)
Delaware	Aetna HMOs
Florida	Aetna HMOs
Georgia	Aetna HMOs; Aetna POS (Agusta); Kaiser Permanente HMO (Metro Atlanta area)
Hawaii	HMSA PPO
Idaho	Group Health HMO (Northern ID)
Illinois	Aetna HMOs
Indiana	
International	CIGNA
Iowa	

Kansas	Aetna HMOs
Kentucky	
Louisiana	
Maine	
Maryland	Aetna HMOs; Aetna POS; Kaiser Permanente HMO; Kaiser Permanente POS
Massachusetts	Aetna HMOs; Aetna POS; Tufts Health Plan HMOs (Gold, Standard)
Michigan	BCBS HMO; Priority Health HMO
Minnesota	
Mississippi	
Missouri	Aetna HMOs
Montana	
Nebraska	
Nevada	Aetna HMOs; Aetna POS (Northern Nevada)
New Hampshire	Aetna POS; Tufts Health Plan HMOs - Limited counties (Gold, Standard)
New Jersey	Aetna HMOs; Aetna POS
New Mexico	
New York	Aetna HMOs; Aetna POS
North Carolina	Aetna HMOs; Aetna POS (Charlotte)
North Dakota	
Ohio	Aetna HMOs
Oklahoma	
Oregon	Kaiser Permanente HMO
Pennsylvania	Aetna HMOs
Puerto Rico	Triple S PPO
Rhode Island	Aetna POS; Tufts Health Plan HMOs - Limited counties (Gold, Standard)
South Carolina	Aetna POS
South Dakota	
Tennessee	
Texas	Aetna HMOs; Aetna POS
Utah	
Vermont	Aetna POS; MVP HMO; Tufts Health Plan HMOs - Limited counties (Gold, Standard)
Virginia	Aetna HMOs; Aetna POS; Kaiser Permanente HMO; Kaiser Permanente POS; Kaiser Permanente PPO (out of POS area)
Washington	Group Health HMO; Kaiser Permanente HMO
Washington D.C.	Aetna HMOs; Aetna POS; Kaiser Permanente HMO; Kaiser Permanente POS
West Virginia	
Wisconsin	
Wyoming	
<b>Note: Assume Aetna and Healthnet PPOs are available in all states unless indicated at top</b>	
<b>Medical Plan</b>	<b>Availability</b>
Aetna HMOs - AZ	Phoenix, Scottsdale, Litchfield Park, and Wittman areas

Aetna HMOs - CO	Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Elbert, El Paso, Fremont, Teller, Jefferson, Larimer, Pueblo, and Mesa areas
Aetna POS - CO	Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Elbert, El Paso, Fremont, Teller, Jefferson, Larimer, Pueblo, and Mesa areas
Aetna HMOs - CT	Monroe, Bridgeport, Brookfield, Danbury, Darien, Fairfield, Wilton, Stamford, Manchester, New Hartford, Clinton, Ansonia, Guilford, New Haven, New London, Hartford, and Hampton areas
Aetna POS - CT	Monroe, Bridgeport, Brookfield, Danbury, Darien, Fairfield, Wilton, Stamford, Manchester, New Hartford, Clinton, Ansonia, Guilford, New Haven, New London, Hartford, and Hampton areas
Aetna HMOs - DC	Washington, D.C.
Aetna POS - DC	Washington, D.C.
Aetna HMOs - DE	Newark area
Aetna HMOs - FL	Most counties have full availability
Aetna HMOs - GA	Woodstock, Marietta, Austell, Powder Springs, Kennesaw, Decatur, Lithonia, Stone Mountain, Cumming, Alpharetta, Roswell, Atlanta, Lawrenceville, Norcross, Duluth, and Buford areas
Aetna HMOs - KS	Kansas City, Stilwell areas
Aetna HMOs - IL	Most counties have full availability
Aetna HMOs - MD	Gambrills, Hanover, Severna Park, Annapolis, Baltimore, Machester, Frederick, Thurmont, Columbia, Bethesda, Rockville, Potomac, Damascus, Germantown, Gaithersburg, and Silver Spring areas
Aetna POS - MD	Gambrills, Hanover, Severna Park, Annapolis, Baltimore, Machester, Frederick, Thurmont, Columbia, Bethesda, Rockville, Potomac, Damascus, Germantown, Gaithersburg, and Silver Spring areas
Aetna HMOs - MO	Kansas City area
Aetna HMOs - NC	Charlotte, Raleigh, Durham, York County areas
Aetna HMOs - NJ	Edgewater, Ridgewood, Weerhawken, Jersey City, South Amboy, Ashbury Park, Belmar, Matawan, Middletown, Ocean Grove, Morris Plans, Somerset, Somerville, Marlton, Vicentown, Cherry Hill, Haddonfield, Audubon, Swedesboro, Pennington, and Trenton areas
Aetna POS - NJ	Edgewater, Ridgewood, Weerhawken, Jersey City, South Amboy, Ashbury Park, Belmar, Matawan, Middletown, Ocean Grove, Morris Plans, Somerset, Somerville, Marlton, Vicentown, Cherry Hill, Haddonfield, Audubon, Swedesboro, Pennington, and Trenton areas
Aetna HMOs - NV	Sparks, Sun Valley, Reno, Washoe Valley areas, Las Vegas
Aetna POS - NV	Sparks, Sun Valley, Reno, and Washoe Valley areas
Aetna HMOs - NY	Bronx, Beacon, Wappingers Falls, Brooklyn, New York City, Newburgh, Carmel, Mahopac, Putnum Valley, Astoria, Rego Park, Jamaica, Staten Island, Suffern, Pearl River, Spring Valley, Valley Cottage, Lindenhurst, Stony Brook, West Sayville, Elmsford, Mount Vernon, Ossining, Pleasantville, Scarsdale, Tarrytown, White Plains, West Harrison, Yonkers, Syracuse, and Albany areas
Aetna POS - NY	Bronx, Beacon, Wappingers Falls, Brooklyn, New York City, Newburgh, Carmel, Mahopac, Putnum Valley, Astoria, Rego Park, Jamaica, Staten Island, Suffern, Pearl River, Spring Valley, Valley Cottage, Lindenhurst, Stony Brook, West Sayville, Elmsford, Mount Vernon, Ossining, Pleasantville, Scarsdale, Tarrytown, White Plains, West Harrison, Yonkers, Syracuse, and Albany areas

Aetna HMOs - OH	Most counties have full availability
Aetna HMOs - PA	Birdsboro, Boyertown, and Reading areas
Aetna HMOs - TX	Available in Austin, Dallas/Fort Worth, Houston, San Antonio
Aetna POS - TX	Available in Austin, Dallas/Fort Worth, Houston, San Antonio
Aetna HMOs - VA	Alexandria City, Arlington, Centreville, Chantilly, Herndon, Fairfax, McLean, Oakton, Springfield, Falls Church, Aldie, Ashburn, Leesburg, Dumfries, Woodbridge, Midlothian, Richmond, Chester, and Mechanicsville areas
Aetna POS - VA	Alexandria City, Arlington, Centreville, Chantilly, Herndon, Fairfax, McLean, Oakton, Springfield, Falls Church, Aldie, Ashburn, Leesburg, Dumfries, Woodbridge, Midlothian, Richmond, Chester, and Mechanicsville areas
BCBS HMO - MI (Blue Care Network)	Mostly in southern Michigan
Group Health HMO (Alliant Select)	Available in Northern, Western, and Eastern Washington areas, including Puget Sound and Northern Idaho
Health Net HMOs - CA	Most counties have full availability
Kaiser Permanente HMO - CA	Most counties have full availability
Kaiser Permanente HMO - CO	Available in Colorado Springs, Denver/Boulder areas
Kaiser Permanente HMO - GA	Available in metro Atlanta area (Counties: Fulton, Barrow, Bartow, Butts, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Newton, Paulding, Rockdale, Spalding and Walton)
Kaiser Permanente HMO - OR/WA	Available in Portland, Salem, Vancouver and Longview areas
Kaiser Permanente HMO - DC/MD/VA	DC: Full availability; MD: Most counties have full availability; VA: Select areas of Northern Virginia
Kaiser Permanente POS - DC/MD/VA	DC: Full availability; MD: Most counties have full availability; VA: Select areas of Northern Virginia
Kaiser Permanente PPO - VA (out of POS area)	Available to employees who live outside the Kaiser Permanente service area
MVP HMO - VT	Available in Addison, Bennington, Caledonia, Chittenden, Essex, Franklin, Grand Isle, Lamoille, Orange, Orleans, Rutland, Washington, Windham and Windsor counties
Priority Health HMO - MI	Available in Charlevoix, Grand Traverse, Emmet, Benzie, Kent, Ottawa, Muskegon and other northwest MI counties
Triple S PPO - Puerto Rico	Preauthorization for treatment in the United States required
Tufts Health Plan HMO - CT/MA/NH/RI/VT	MA: Most counties have full availability; CT, NH, RI & VT: Available in a limited number of counties
CIGNA International	International

**Need Additional help?**

TriNet's benefits eligible employees may call 1-800-638-0461 for additional help. In addition, visit [www.hrpassport.com](http://www.hrpassport.com) to review other available resources online, including Ask Benefits.

**Newborns' and Mothers' Health Protection Act**

On September 26, 1996, a Federal law known as the Newborns' and Mothers' Health Protection Act of 1996 ("Newborns' Act") was enacted to include new protections for mothers and their newborn children with regard to the length of the hospital stay following childbirth. This notice is intended to inform you, in a summary fashion, of your rights under the law.

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.)

If your state has a law that provides similar hospital stay protections and your plan offers coverage through an insurance policy or HMO, then you may be protected under state law rather than the Newborns' and Mothers' Health Protection Act.

**Notification of Rights under the Women's Health and Cancer Rights Act**

On October 21, 1998, a Federal law (H.R. 4328) known as the Women's Health and Cancer Rights Act of 1998 ("Women's Health Act") was enacted requiring group health plans and insurance companies that provide coverage for mastectomies to provide certain mastectomy-related benefits or services to plan participants or beneficiaries. This notice is intended to inform you, in a summary fashion, of your rights under the law.

Under the law, a group health plan participant or beneficiary who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with the mastectomy, is entitled to coverage for the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Coverage for these benefits or services will be provided in a manner determined in consultation with the participant's or beneficiary's attending physician.

If you are a covered member or qualified dependent under the TriNet Employee Benefits Insurance Trust Plan #501, and are currently receiving, or in the future receive, benefits under the plan in connection with a mastectomy, you are entitled to coverage for the benefits and services described above in the event

that you elect breast reconstruction. Your qualified dependents are also entitled to coverage for those benefits or services on the same terms.

Coverage for the mastectomy-related services or benefits required under the Women's Health Law will be subject to the same deductibles and coinsurance or co-payment provisions that apply with respect to other medical or surgical benefits provided under the TriNet Employee Benefits Insurance Trust Plan #501.

## Dental Group Plans

TriNet has 3 dental carriers: Aetna, Delta Dental and MetLife. Our dental plans provide more choice at lower costs than most dental plans. You can visit dentists in-network or out-of-network in the DPO plan. However, you can save time and money by seeing an in-network dentist. With 3 carriers to choose from, finding a provider in-network is easier than ever. For out-of-network visits, the DPO plans pay a lower rate of co-insurance up to the usual, customary and reasonable (UCR) charges.

When you enroll in one of TriNet's DPO plans, you won't have to worry about an ID card. You will receive one. However, you can simply give your name, TriNet's name, and your Social Security number to the provider of your choice.

Our other group dental plan is Delta Care DMO/PMI (The "PMI" Plan.) Coverage is available in California, Florida, Georgia, Nevada, New York, Pennsylvania, Texas, Utah and Washington, DC. In the PMI plan, a Primary Care Dentist (PCD) must be selected from the PMI plan network. No benefits are available outside the PMI plan network without plan authorization.

If you enroll in the PMI dental plan, you will receive a PMI plan membership packet, including an identification card and an Evidence of Coverage booklet that fully describes the benefits of the PMI plan.

### **The Dental Preferred Option Plan (The "DPO" Plan) or Preferred Dental Program (The "PDP" Plan)**

The DPO or PDP plan is really about choice. You may visit any licensed dentist, and can change dentists at any time without notifying the plan.

In terms of choosing a dentist, you have an open choice designed to fit your specific needs.

Firstly, If you prefer, you may choose to visit one of the thousands of network dentists who accept your provider's insurance. Using one of these network dentists will help to reduce your portion of the total bill because their rates are negotiated to keep your costs as low as possible.

Secondly, you may choose your own licensed dentist outside the network. Keep in mind that this freedom of choice may cost you more because the coinsurance and deductible are higher and your coverage is based on the usual, customary and reasonable charges. Your out-of-pocket expenses may be higher outside the network; so, of course, the choice is yours.

#### **Using the DPO Plan**

To use the program, call the dental office of your choice and make an appointment. If you go to a network dentist, he or she will have billing forms in the office and will complete and submit the forms to the appropriate carrier.

Our dental carriers pay network dentists directly. You are responsible only for your share of the bill.

If you go to a non-network dentist, you are responsible for the dentist's entire bill, and the carrier reimburses you directly after you submit a completed claim form.

When you go to a dentist who is not contracted with the plan which you have joined, payment will be calculated on a schedule of allowances or on the prevailing fee (the fee charged by no fewer than half of the plan dentists). If your non-contracted dentist's fees exceed that level, you must pay the difference above your regular out-of-pocket charges. You may also have to pay the non-contracted dentist in advance for the entire bill.

#### **How to locate a DPO or PDP dental plan provider:**

<http://www.aetna.com> (Nationwide)

<http://www.deltadentalca.org> (Nationwide)

<http://www.deltadentalva.com> (Virginia only)

<http://www.metlife.com/dental> (Nationwide)

### **The Delta Care DMO/PMI Plan (The “PMI” Plan)**

The PMI dental plan is really about cost. You get a “big” plan for a “small” premium. It doesn’t give you as much choice as the DPO plan, but it will still help you keep smiling.

The PMI dental plan is available in California, Florida, Georgia, Nevada, New York, Pennsylvania, Texas, Utah and Washington, DC. It works a lot of like a medical plan HMO, in that using one of the PMI dental plan dentists *is required* for all services and/or referrals to specialists. PMI dentist rates are preset to keep your costs as low as possible.

When you enroll in the PMI dental plan, be sure to indicate a dental facility (from the list of contract dental facilities participating in the PMI dental plan) for both yourself and your eligible dependents. You may collectively select up to a maximum of three contract dental facilities, or you may all receive care from the same place.

#### **Using the Delta Care PMI Plan**

When you enroll in the PMI dental plan, you will select a contract dentist to provide services to you and your family. The PMI dental plan network consists of private practice dental facilities that had to pass stringent reviews for quality, access, and safety before they were allowed to join the PMI plan network.

Your selected PMI plan dentist will take care of your dental care needs. If you require treatment from a specialist, your PMI plan dentist will handle the referral for you.

After you have enrolled, you will receive a membership packet, including an identification card and an Evidence of Coverage document that fully describes the benefits of your dental program. Also included in this packet are the name, address, and phone number of your PMI plan dentist. Simply call the PMI plan dentist to make an appointment.

Under the PMI dental plan, many services are covered at no cost while others have copayments (the amount you pay your dentist) for certain benefits. Ask your PMI Plan dentist for a list of copayments and services.

Please note: Dental services that are not performed by your PMI plan dentist, or are not covered under provisions for emergency care, must be pre-authorized to be covered by your DeltaCare PMI plan.

#### **How to locate a PMI dental plan provider:**

<http://www.deltadentalca.org/pmi>

*Note: The DMO plan is often referred to as the “PMI Dental Plan” on the web site. Please remember to look for the PMI abbreviations when researching information and choosing a primary dentist.*

## Getting an Estimate Before Treatment

If you need dental work done that may cost more than \$300 or that requires crowns or bridges, you should always get a predetermination before starting treatment. A predetermination does not guarantee payment; rather, it's an estimate of the amount your plan will pay if you're eligible and meet the plan's requirements when you complete treatment.

## How to Enroll

Enroll in a TriNet Signature Benefits medical plan and then choose either a DPO/PDP plan or the DHMO (PMI) dental plan. You can also sign up dependents separately as you complete your benefits enrollment. If you enroll in the DHMO dental plan, include the name and ID number for the primary dentist(s) you choose for you and your dependents.

If you waive a medical plan, the Group Dental plans will not be available to you and your dependents. You may, however, elect to enroll in and pay for an optional dental plan as described in the "Optional Benefits" section of this guidebook.

## Disclaimer

These benefit descriptions are not part of a summary plan description. They do not serve as evidence of coverage for the program. If you have specific questions regarding the benefit structure, limitations or exclusions, contact the individual plan.

# Helpful Dental Terms to Know

## Basic Services

Basic services typically include

- extraction
- filling
- oral surgery
- periodontal cleaning and scaling
- periodontal surgery
- office visit after regularly scheduled hours
- office visit for observation
- limited occlusal adjustment
- endodontics
- therapeutic drug injection
- treatment of post-surgical complications (unusual circumstances)
- general anesthesia and I.V. sedation in conjunction with covered oral surgery services

## Coinsurance

Coinsurance is the percentage of a dental expense paid by either you or your TriNet dental plan. For example, let's say your plan pays 80% of the cost of a \$1,000 dental procedure. You're responsible for paying the remaining 20%. In this case, the plan will pay coinsurance of \$800 – or 80%; you will pay a coinsurance amount of \$200 – or 20%. The coinsurance amounts apply after you meet your plan's required deductible.

## Deductible

The amount you pay each calendar year toward dental expenses before the dental plan begins paying benefits. You may have to meet an individual, per-person deductible, or a family deductible for all of your covered family members combined.

**Denture**

an artificial replacement of one or several of the teeth (partial denture), or all of the teeth (full denture) of either or both jaws

**DHMO**

Similar to a medical Health Maintenance Organization, a Dental Health Maintenance Organization requires enrollment with a member dentist. All care must be given by your assigned member dentist.

**Diagnostic and Preventive Services**

Diagnostic and Preventive services typically include

- bitewing X-rays
- cleanings (dental prophylaxis)
- diagnostic casts in conjunction with subsequent orthodontic treatment
- emergency treatment of dental pain
- examination of biopsied tissue
- fluoride treatments
- full mouth X-rays
- routine oral exam
- sealant
- space maintainers
- specialist consultation

**DPO or PDP**

A Dental Provider Organization is similar to a PPO medical plan, and is a term used by Aetna and Delta Dental. Each plan has a network of preferred dentists. You may use any provider you want, but you will save time and money by using one in the DPO network. Being in a DPO plan requires a certain level of responsibility; providers may choose to discontinue their affiliation with a plan's DPO network. You will need to keep current to know whether you are going to a provider who is inside or outside of the DPO network. MetLife calls their similar plan a PDP, or Preferred Dental Program.

**Endodontics**

Endodontics is the branch of dentistry that deals with diseases of the tooth root, dental pulp, and surrounding tissue, including root canals.

**Inlays**

A solid filling, as of gold or porcelain, fitted to a cavity in a tooth and cemented into place

**Major Services**

Major services typically include

- cast restoration

- construction or repair of fixed bridges, partial dentures and complete dentures if provided to replace missing, natural teeth
- crowns
- denture reline
- denture repair
- dentures
- inlays
- jackets
- onlays

**Occlusal**

Of or relating to the contacting surfaces of opposing teeth, especially the biting or chewing surfaces.

**Onlays**

On onlay is a cast, usually made of gold, attached to the occlusal surface of a tooth.

**Orthodontics**

Orthodontics is the branch of dentistry dealing with the prevention and correction of irregular teeth, as by means of braces.

**Periodontics**

Periodontics is the branch of dentistry dealing with diseases of the gums and other structures around the teeth.

**Usual, Customary, and Reasonable (UCR)**

The customary rates for a medical product or service in your geographic area, or the rates usually charged by your provider, whichever is lower. The insurance carrier determines UCR charges. You're responsible for paying any charges that exceed UCR. Keep this in mind when you receive care from a provider outside your plan's network.

## Group Term Life and AD&D Insurance

TriNet Signature Benefits offers Group Term Life insurance and Accidental Death and Dismemberment (AD&D) insurance at no cost to you.

### Group Term Life Insurance

If you die while you are covered for group term life benefits, MetLife will pay to the beneficiary the amount of Group Term Life benefits that is in effect on your life on the date of your death.

### Accidental Death & Dismemberment (AD&D) Insurance

AD&D provides coverage for death or dismemberment resulting directly from accidental causes. AD&D provides benefits in the event of loss of life, limbs or eyesight as the result of an accident.

If you die as a result of an accident, your beneficiaries will receive the full amount of coverage. If you lose a limb or use of a body part, you may be paid anywhere from 25-100% of your coverage amount depending on your injuries.

### Effective Date

Your employee benefits will become effective on your benefits eligibility date provided you are then actively at work as an employee. If you are not then 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.

### Beneficiaries

#### Primary

A primary beneficiary is the person or persons you choose to receive any benefit payable because of your death. You make the choice in writing upon enrollment. Your employer may not be named as a beneficiary.

#### Contingent

A contingent beneficiary is an alternate person or persons you choose to receive any benefit payable due to the death of the primary beneficiary or some other contingency. You make the choice in writing upon enrollment.

#### Estate

If a will was completed, once the will has been probated, the appropriate court located in the state of residence of the deceased will issue a certified document appointing an executor of the estate. A certified copy of these estate papers is required before payment can be made.

If no will was completed, the appropriate court located in the state of residence of the deceased will issue a certified document appointing an administrator of the estate. A certified copy of these estate papers is required before payment can be made.

#### Living Trust

If the trustee of the living trust is a bank, the signature of an authorized representative of the bank on the Claimant's Statement is required. A copy of the living trust is required before payment can be made.

If the trustee of the living trust is an individual, the signature of the trustee on the Claimant's Statement is required with a notarized statement from the trustee that the trust is still in effect. A copy of the living trust is required before payment can be made.

If the trustee of the living trust is named in a will, a court order appointing that trustee is required. If no such court order has been or will be issued, a copy of the will that sets up the living trust, and evidence of probate is required before payment can be made.

**Minor**

An employee may name a minor child as a beneficiary. However, MetLife generally cannot distribute the proceeds to the minor directly. MetLife will deposit the proceeds into a "blocked" Total Control Account ® until the attainment of the age of majority by the minor.

If a person of legal age has petitioned the court, and has been appointed as guardian of the "estate" of the minor, the proceeds may be released to that person in his/her capacity as guardian. A copy of the court order that appoints the guardian of the "estate" of the minor is required before payment can be made.

**Assignment of Benefits**

Anyone contemplating making an absolute assignment of Group Term Life insurance should first secure legal advice from his or her own attorney as your rights are irrevocably transferred under an absolute assignment and may not be amended at a later time. MetLife does not allow for collateral assignments as security to obtain a bank loan primarily because group term life insurance has no cash value to act as collateral.

**Changing Your Beneficiary**

A Beneficiaries Change Request form is available on HR Passport at [www.trinet.com](http://www.trinet.com) to add or change your beneficiary designation in writing. To be in effect, complete and fax this form to TriNet, Supplemental Life Department, at (510) 352-6480.

**Group Term Life Benefits (Employee)****Basic Life**

\$50,000. All coverage is guaranteed issue (no statement of health required).

**Accidental Death & Dismemberment (AD&D)**

An amount equal to your Group Term Life benefits

**Supplemental (additional) Accidental Death & Dismemberment (AD&D)**

Increments of \$10,000, up to a maximum benefit of \$500,000. All coverage is guaranteed issue (no statement of health required)

To increase or delete existing Supplemental (additional) Accidental Death & Dismemberment (AD&D) insurance for you, complete and fax a Life/AD&D Insurance Coverage Request to TriNet, Supplemental Life Department, at (510) 352-6480. Once received, the "current benefits" in HR Passport will be updated to reflect the new coverage amount and payroll deductions will begin. No Statement of Health form is required.

## Accelerated Life Benefits

If your life span is drastically limited, and you are expected to die within 6 months without any chance to recover, you may be eligible for accelerated benefits while your Group Term Life benefits are in effect.

Payment of accelerated benefits will reduce your Group Term Life benefits and the amount available for you to convert to a personal policy of life insurance. The amount of accelerated benefits payable is up to 50% of your Group Term Life benefits, reduced by administrative costs. In no event will your accelerated benefits exceed \$250,000 for Group Term Life Insurance.

### Exclusions

Accelerated benefits will not be payable if you have assigned your Life Benefits, or the amount of your Life Benefits is less than \$10,000.

## Conversion to an Individual Policy

### Employee

MetLife will issue an individual Life Insurance policy without disability or accidental death benefits to you if you apply for it in writing during the application period. MetLife does not require proof that you are insurable during the application period. The application period is the 31 day period after: the date your Term Life benefits end because your employment ends; you are no longer in a class which remains eligible for Term Life benefits; or the date your Term Life benefits end because this Plan ends.

## Life Insurance Terms

### Helpful Life Insurance Terms to Know

Here's a list of terms used throughout the Group Term Life and AD&D section:

**Actively at Work** means that you are performing all of the material duties of your job with your Employer where these duties are normally carried out.

**Assignment of benefits** means the signed transfer of certain benefits by the insured person to a third party.

**Basic Annual Earnings** means your gross annual rate of pay as determined by your Employer, excluding overtime and other extra pay. "Basic Annual Earnings" for you includes commissions and/or bonuses, which shall be averaged over the previous 12-month period.

**Basic Group Term Life** means Employer sponsored term life.

**Beneficiary** means a person named by the participant in an insurance policy to receive any benefits provided by the plan if the participant dies.

**Benefits Eligibility Date** means the date benefits commence.

**Contingent Beneficiary** means an alternate beneficiary. One whose rights under a contract are dependent upon the death of the original beneficiary or some other contingency.

**Conversion** means a privilege given to a participant to convert to an individual policy on termination of group coverage without evidence of good health.

**Current Benefits** means a summary of your most current benefits listed on HR Passport at [www.trinet.com](http://www.trinet.com) under My Benefits.

**Dependent** means your spouse or domestic partner, or your unmarried child(ren).

**Domestic Partner** means each of two people, one of whom is an Employee of the Employer who represent themselves publicly as each other's domestic partner.

**Employee** means a person who is employed and paid for services by the Employer on a full-time basis.

**Employer** means TriNet.

**Group Term Life insurance** means employer-paid life insurance coverage at little or no tax cost. It does not provide paid-up insurance, or loan or cash values.

**Disclaimer**

These benefit descriptions are not part of a summary plan description. They do not serve as evidence of coverage for the program. If you have specific questions regarding the benefit structure, limitations or exclusions, review the Summary Plan Description (SPD) on HR Passport at [www.trinet.com](http://www.trinet.com).

## Your Long-Term Disability Coverage

If an illness or injury prevents you from working more than 3 months, you may be eligible for long-term disability (LTD) benefits through MetLife. As long as you remain disabled under the terms of the plan, this benefit can last until you reach age 65.

Group LTD is provided at no cost if you're eligible for TriNet Signature Benefits. You don't need to enroll. Coverage is automatic

You should, however, read on to have a good understanding of what kinds of injuries and illnesses count, when benefits kick in, and what you might have to do to ensure benefits continue if you're permanently disabled.

### Comprehensive Income Protection Coverage Overview

Plan	Your Waiting Period	Percentage of Your Income Replaced	Your Maximum Benefit	Maximum Benefit Duration
Group Long-term Disability	3 months	60%	Up to \$10,000 a month	Up To age 65

### How the LTD Plan Works

If an illness or injury prevents you from working for more than 3 months, you may be eligible for long-term disability (LTD) benefits. Your illness or injury must prevent you from earning more than 80% of your pre-disability monthly earnings while performing your own occupation.

You will be paid a monthly benefit if MetLife determines that you are disabled and have become disabled while covered under the plan. Your monthly benefit is calculated based on your base annual earnings. Base annual earnings include your regular gross salary or wages including commissions and bonuses as of the day before your disability began. Overtime pay is excluded when calculating your base annual earnings.

Your monthly benefit will not be affected by the termination of the plan, your coverage, or any other plan change that is effective after you become eligible to receive disability benefits.

Group LTD insurance replaces up to 60 percent of your income up to \$10,000 a month. In some cases, the plan may pay more than 60 percent of your income if you participate in an approved rehabilitation program or a partial return to work, though your benefit will never exceed 100 percent of your pre-disability earnings.

### Other Disability Benefits

Your LTD benefits will be reduced by any other disability income benefits you receive or are entitled to receive. These include, but aren't limited to:

- Benefits from state disability or workers' compensation unemployment or sick time pay
- Benefits from any other group insurance coverage
- Social Security disability or retirement benefits for you or your dependents

### Pre-existing Conditions

The LTD plan does not provide benefits for any disability caused by, contributed to by, or resulting from a pre-existing medical condition - unless the disability begins after you have been covered under the plan for 12 months in a row.

What does "pre-existing condition" mean? It's an illness or injury for which you received medical advice or treatment during the three month period immediately preceding your effective date of coverage. MetLife will give consideration towards continuous time you were covered under a plan that the TriNet's plan replaced in order to satisfy the 12-month requirement.

### **Filing a Claim for Disability Benefits**

Contact TriNet's Employee Solution Center via phone (800.638.0461, 6 a.m.-6 p.m., M-F, Pacific Time) or e-mail ([employees@trinet.com](mailto:employees@trinet.com)) if you expect to be disabled for at least three months. TriNet will work with you to complete all the claim forms and submit those forms to MetLife, the claims administrator.

MetLife must certify that you will be disabled for at least 3 months. You must be under the continuous care of a physician, who will provide information on your condition directly to MetLife.

### **Benefit Payment and Duration**

Benefit checks are issued once a month by MetLife. Once you have received LTD benefit payments for 24 months, you will be considered disabled only if you cannot perform with reasonable continuity the duties of your own job or any job for which you're reasonably qualified by training, education or experience, age, and physical and mental capacity. Exceptions to this rule are made for certain employment classes.

### **Taxes**

As a new hire and during open enrollment, the TriNet Group disability plan allows you to choose if you would rather be taxed now rather than when disability benefits are paid. The names of the options refer to pay-out of the disability should you become disabled.

Here's an example:

The tax-free plan means the disability check will not be taxed as the employee will pay taxes now on the cost of the premium to the employer. If the premium is \$20 a month, the employee's taxable earnings are increased by this amount and taxed, but his disability check will have no deductions taken from it,

The taxable plan means that the disability check would be taxed as the employee is opting to not pay any taxes on the premiums now. With this option, no adjustments are made to their taxable earnings now, but should they become disabled, the full gross amount of the check will be taxable for all taxes.

If you choose to have your premiums applied on a pre-tax basis, your disability benefits will be taxable income if you are approved for a claim. If you choose to have your premiums applied after tax, your disability benefits will not be considered taxable income if you are approved for a claim.

### **What's Not Covered**

The LTD plan does not cover any illness or injury resulting from:

- War or any act of war declared or undeclared
- Active participation in a riot
- Attempted suicide or self inflicted injuries
- Committing or attempting to commit an assault or felony

### **Do You Live in a State that Offers Disability Insurance?**

If yes, check out these links for more information:

- California – <http://www.edd.ca.gov/direp/dipub.htm>

- Hawaii – <http://www.hawaii.gov/labor/dcd/abouttdi.shtml>
- New Jersey – <http://www.state.nj.us/labor/tdi/tdiindex.html>
- New York – [http://www.wcb.state.ny.us/content/main/offthejob/IntroToLaw\\_DB.jsp](http://www.wcb.state.ny.us/content/main/offthejob/IntroToLaw_DB.jsp)
- Rhode Island – <http://www.dlt.state.ri.us/tdi/>

**Disclaimer**

These benefit descriptions are not part of a summary plan description. They do not serve as evidence of coverage for the program. If you have specific questions regarding the benefit structure, limitations or exclusions, contact the individual plan.

## Stretching Your Dollars: Flexible Spending Accounts

TriNet Signature Benefits provides an easy pre-tax way to help you pay for health care and dependent day care expenses while cutting your tax bill.

Flexible Spending Accounts (FSAs) – often referred to as Health Care or Dependent Day Care spending accounts – help you pay for eligible out-of-pocket expenses that your insurance plans don't cover. You determine what your expenses for the year might be and then ask TriNet to set aside a portion of each paycheck into a special FSA account. When the eligible expenses come up, you pay them – then submit the documentation to TriNet for reimbursement.

Claims, as low as \$50 or as high as \$5,000, are processed within 10 business days after receipt, and paid by direct deposit or live check sent by mail.

### How the Plans Work

The IRS allows certain expenses to be reimbursed through the FSA accounts. However, you cannot request reimbursement for an expense that occurred before you joined the plan. Similarly, if you stop participation before the plan year ends, you cannot request reimbursement for an expense that occurs after you leave the plan, unless you have elected to continue your Health Care spending account through COBRA.

After careful planning, you decide how much money – if any – to put into each FSA. You then enroll in FSAs when you choose your benefits online. Your election is binding for the entire Plan Year. You can't change your election until the next Open Enrollment period unless you have a "Qualified" Life Status Change. Each pay period a portion of your annual election is withheld from your paycheck, on a pre-tax basis and put into your FSA account(s).

When you receive a bill for an eligible health care or dependent day care expense, you pay the provider – your doctor, hospital, babysitter, day care center, and so on – for the service. Then you file your claim online for reimbursement with TriNet. You do this by logging into HR Passport and go to Myself - My Benefits - Flexible Spending Accounts. There is a tutorial available to walk you through the process.

Your claim will be processed within 10 business days if you submitted all the necessary documentation, and if your claim is approved. TriNet will then direct deposit your reimbursement amount, or mail you a live check for the amount of your FSA reimbursement.

- For dependent day care, you'll be reimbursed up to the amount of the expense, but not more than the aggregated amount in your account, minus any amount you were already reimbursed.
- For health care, you'll be reimbursed up to the amount you committed to contribute for that Plan Year, minus any amount you were already reimbursed.

You have 90 days from the end of the month in which you were terminated or until October 15, (if you actively participated in the plan through June 30) to submit claims for reimbursement.

Any amount left in your Dependent Day Care FSA at the end of the TriNet Plan Year (June 30) and not claimed by October 15, will be forfeited according to IRS regulations.

Your Health Care FSA plan allows a "Grace Period" with a two-and-a-half month extension to incur claims and receive reimbursement for amounts remaining in the Health Care FSA account as of June 30. You must be **actively participating** in your Health Care FSA as of June 30, to qualify for the "Grace Period" extension. The "Grace Period" is from July 1, to September 15. The claims submission deadline is October 15, and there will be no exception to this deadline. At the end of each Plan Year and throughout the "Grace Period," Health Care FSA claims will be processed on a first in, first out basis. If a claim is received and there is an available balance in the Health Care FSA account, the claim will be applied to

the previous Plan Year, regardless if the expense was incurred during the Plan Year (July 1 to June 30) or the "Grace Period" (July 1 to September 15).

### **Certain rules apply to both Health Care and Dependent Day Care FSAs:**

For both Health Care and Dependent Day Care FSAs, you can contribute from \$200 to \$5,000 for the Plan Year. No matter when you enroll, the Plan Year lasts from July 1 to June 30. You can put up to the maximum amount in your Dependent Day Care FSA regardless of how many dependents you have.

**Rehire/Reinstatement.** When an employee is rehired or reinstated in the same plan year with TriNet as a full-time employee within 30 days, your contributed/reimbursement FSA amounts transfer to your new employer. You can not reduce your election lower than what you have contributed or lower than what has been reimbursed to you within that plan year, whichever amount is higher.

**Elections are for the Plan Year.** TriNet's FSA Plan Year lasts from July 1 to June 30. Once you enroll, you may not change your election or contribution levels for the rest of the Plan Year unless you have a "Qualified" Life Status Change.

**"Use It or Lose It," says the IRS.** Plan your expenses carefully. You may not carry over balances from one plan year to the next. Because of the special tax advantages that FSAs give you, you cannot receive a refund of the unused amounts.

**No Retroactive Claims.** If you join an FSA after the plan year begins, you can't request reimbursement for an expense that occurred before you joined the plan.

**No Post-Participation Claims.** If you stop participation before the plan year ends, you can't request reimbursement for an expense that occurs after you leave the plan, unless you have elected to continue your Health Care FSA through COBRA.

**No Health Care expenses from the Dependent Day Care FSA.** The name "Dependent Day Care FSA" may suggest to you that you can take your child to the doctor and then reimburse the costs through your Dependent Day Care FSA. This is not the case. Only the Health Care FSA can pay for health care expenses; your Dependent Day Care FSA is used for daycare-related expenses only.

**Accounts are Separate.** You can't transfer money from a Health Care account to a Dependent Day Care account – or vice-versa. This isn't a TriNet rule; it's an IRS restriction.

**No Health Care Premium Reimbursement for TriNet plans.** You can't claim either your health care premium expenses or your spouse's health care premium expenses through the TriNet Health Care FSA.

**Account or Tax Deduction, Not Both.** You may not claim a tax deduction for any expense paid from your Health Care FSA and/or Dependent Day Care FSA.

**Keep Your Dates in Order.** Please note that the date of an expense is the date a service is rendered, not the billing or payment date. It's an important distinction to remember in order to file your reimbursement claims on time.

**Some Restrictions May Apply.** The IRS may put restrictions on how much certain employees can put into either the Health Care or Dependent Day Care FSAs.

**Social Security Benefits.** If your taxable income – what's left after you put money in the FSAs – is less than the Social Security wage base, your future Social Security benefits may be reduced slightly.

## Overcoming the Fear of Forfeiting

Use it or lose it. No one wants to forfeit money they earned and saved. However, you can still come out ahead even if you don't spend all the money in your account. Here's how:

Let's say you're in a 36 percent tax bracket for federal income and Social Security taxes. If you put \$200 in a FSA but are only reimbursed for \$175, you still save money. Why? Though you give up \$25, you save about \$68 in taxes. You're still ahead by \$43.

With careful planning – such as keeping a diary of expenses and keeping your original receipts (not just copies) – you can reduce the risk of forfeiting. Don't let the potential for forfeitures stop you from considering the advantages of the FSA.

## Health Care Expenses

Generally, you can be reimbursed for services or supplies needed to prevent or treat an illness or medical condition.

Specifically, covered expenses include:

- Acupuncture - if to treat a medical condition
- Adoption – medical expenses incurred before the adoption is finalized
- Amounts not covered, or not paid in full, by any medical, dental, or vision plans
- Amounts you pay for professional services and prescription drugs
- Contact lenses and other prescription vision care products
- Counseling for learning disabilities (but not marriage counseling)
- Deductibles, co-payments and co-insurance, or the amount you pay before some health care plans pay certain benefits
- Hearing care examinations and hearing aids
- Medically necessary weight-loss expenses (not gym dues!)
- Orthodontia treatment
- Over-the-counter drugs and non-prescription medication used to treat illness or injury

The IRS does not allow these expenses to be reimbursed through the Health Care FSA:

- Athletic club or gym membership fees
- Cosmetic surgery
- Dietary supplements and vitamins
- Diet pills or appetite suppressants
- Insurance premiums, including COBRA
- Over-the-counter cosmetics and toiletries
- Teeth whitening

Here are some frequently asked questions about health care expenses:

**Allergy treatment products and household improvements to treat allergies (e.g. filters, pillows, and special vacuums)** generally can't be reimbursed if the product is one that would be owned even without allergies, such as a pillow or vacuum. However, an air purifier or water filter necessary to treat a specific medical condition may be allowable.

**Dental treatment** may be reimbursed for fees such as X-rays, fillings, braces, extractions, dentures, and most other procedures.

**Diapers or diaper services** may not be reimbursed unless the amounts are paid to relieve the effects of a particular disease.

**Fertility treatments (such as surgery, GIFT, etc.)** can be reimbursed. Expenses paid to or for an in vitro surrogate may not be reimbursed unless the surrogate is a tax dependent.

**Eye Surgery** may be reimbursed. You can include in medical expenses the amount you pay for eye surgery to treat defective vision, such as laser eye surgery or radial keratotomy.

**Massage therapy** may not be reimbursed, unless prescribed by a physician to treat a specific injury or trauma. Stress or depression treatments do not qualify.

**Nutritional supplements** may not be reimbursed unless they can only be obtained legally with a physician's prescription.

**Over-the-Counter Drugs** and non-prescription medication used to treat illness or injury may be reimbursed.

**Physical therapy** may be reimbursed as long as it's required for a specific medical condition.

**Smoking cessation programs** may be reimbursed, as well as prescribed drugs that are only available by prescription. Over-the-counter drugs such as nicotine patches and gum may be reimbursed even without a physician prescribing them.

### More Information

TriNet does not give tax or legal advice. Please see your professional financial or tax advisor for information on the tax and legal implications of a Health Care FSA. In addition, visit [www.irs.gov](http://www.irs.gov) to review other available resources, including *IRS Publication #502*. Publication 502 is written solely for the purpose of helping taxpayers determine which medical expenses can be deducted on their taxes. It isn't designed to address the special rules of Health Care FSAs. Care should be exercised in relying on Publication 502, because some expenses that are listed as deductible medical expenses may not be reimbursed under a health FSA. For example, insurance premiums are not reimbursable under health FSA.

### Dependent Day Care Expenses

The Dependent Day Care FSA allows you to save pre-tax money for eligible expenses – as long as you (and your spouse) need these services to allow you to work .

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

- You are a working single parent
- You and your spouse both work outside the home
- Your spouse is disabled and unable to provide dependent day care
- Your spouse is a full-time student at least five months during the year

If you're divorced or legally separated, you can use this FSA to help pay for the day care of dependents who are either under age 13 or disabled, as long as you provide more than half of their financial support and claim them as a dependent on your federal tax return.

Eligible dependents for this FSA must be claimed as dependents on your federal tax return and are either:

- Under age 13
- Mentally or physically unable to care for themselves, regardless of age (individuals are considered mentally or physically disabled if they cannot dress, clean, or feed themselves; or they require constant attention to prevent them from injuring themselves or others)

### Eligible Dependent Day Care Expenses

The types of care that can be reimbursed do *not* include medical or health care expenses for dependents. That's the scope of your Health Care FSA. Rather, eligible dependent day care expenses tend to include some form of day care or provider care such as:

- After-school care

- Care at a licensed day care facility
- Care at a professional facility to look after a sick or disabled child
- Care at an unlicensed facility caring for fewer than seven people
- Day camp
- In-home babysitting services
- Practical nursing care for an adult

### **Ineligible Dependent Day Care Expenses**

The IRS will not allow reimbursements for:

- Care provided by anyone you claim as an exemption on your federal income tax return
- Care provided by your dependents living in your home and who can be claimed as dependents on your federal income taxes
- Days you are not working or do not otherwise meet the eligibility requirements
- Deposits, Registration, or School Tuition for grades Kindergarten and higher
- Household services (such as a housekeeper, maid, etc.) where incidental to childcare
- Meals
- Overnight camps
- Residential nursing home care
- Transportation, clothes, or entertainment
- Tuition and education expenses unless they are provided by the nursery school or day care center as part of its dependent day care services
- Dependent Day Care services outside of the U.S.

Please forgive the repetition, but the Dependent Day Care FSA is not for your dependents' health care expenses. To pay for those expenses, enroll in the Health Care FSA.

### **Eligible Caregivers**

Services covered by your Dependent Day Care FSA may be provided inside or outside your home by:

- 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
- Licensed nursery schools and day care centers for children
- Responsible adults – including your relatives over age 19 whom you do not claim as an exemption on your federal income tax return

You're required to report the name, address, and Social Security number or Tax ID number of your dependent day care provider on your federal tax return, *IRS Form 2441*. Otherwise, the amount of your reimbursements shown on your annual W-2 Earnings Statement may become taxable income.

### **Contribution Limits**

Generally, you may not contribute more than \$5,000 per family, per *calendar year*, to your Dependent Day Care FSA. This may take a little extra planning, because your participation in the Dependent Day Care FSA Plan Year is July 1 through June 30.

### **More Information**

TriNet does not give tax or legal advice. Please see your professional financial or tax advisor for information on the tax and legal implications of a Dependent Day Care FSA. In addition, visit [www.irs.gov](http://www.irs.gov) to review other available resources, including *IRS Publication #503*.

### **How to File Claims**

When you have a dependent day care or health care expense, submit your claim online for reimbursement with TriNet. You do this by logging into HR Passport and go to Myself - My Benefits -

Flexible Spending Accounts. There is a tutorial available to walk you through the process. After submitting your claim online, you will need to email the reimbursement form to yourself for printing. You will then fax the form and your supporting documentation to TriNet @ 510-352-6480 to complete the process.

### **Minimum Claim Amount**

You may submit a claim any time you reach a minimum of \$50 in eligible expenses. At the end of the Plan Year, reimbursements for less than \$50 will be allowed so you can claim any money that remains in your FSA.

### **Claims for Your Dependent Day Care Expenses**

When you file a claim for dependent day care expenses, you must fill out the form completely, including the:

- Amount of expenses
- Type of services provided
- Name(s), age, and grade level (if applicable) of the dependent(s) who received the day care
- Signature of the provider and the date the provider signed the form (not required if you are including a receipt)
- Date of expenses (which must be for days you and your non-disabled spouse were working, or for days your spouse qualified as a full-time student)
- Name(s) and Social Security or Tax ID number of the person or organization providing the service

You will be reimbursed up to the amount currently in your Dependent Day Care FSA. If there is not enough money in your FSA to pay the full expense, you will receive a partial reimbursement. The remainder of the claim will be paid as more money is credited to your FSA each pay period.

### **Claims for Your Health Care Expenses**

When you file a claim for health care expenses you must fill out the form completely.

- For expenses for services not covered under your health insurance, attach the original itemized statement of services that includes the amount charged, the date of service, patient name, the type of service, the provider name, and the amount paid. Unfortunately, canceled checks won't count.
- For expenses covered under an insurance plan, you'll get your reimbursement faster if you attach the carrier's *Explanation of Benefits (EOB)*. There are other acceptable forms of documentation you can submit, but the EOB will expedite your reimbursement.
- For HMO copays, an EOB may not be available. In that case, attach a receipt or copy of your bill indicating dates of service, patient name, the type of service, the provider name, the provider address, and the amount paid.
- For reimbursement of expenses for orthodontia, attach a copy of the orthodontia contract, a dated receipt for charges you paid, and if applicable, an EOB from your dental insurance company. Reimbursement may be made for orthodontia claims in full at the beginning of treatment, following banding, rather than over the entire orthodontia treatment period.
- For reimbursement of prescription drug expenses, please provide pharmacy receipts indicating the date filled, the prescription name, patient name, and your co-payment amount. Cash register receipts are not sufficient documentation.

You will receive up to the full amount you have committed to contribute to your Health Care FSA during the Plan Year – minus any amount already paid. The plan will not reimburse you for more than you have elected to contribute to your FSA.

### **Deadline for Filing Claims**

If you quit or lose your job before the Plan Year ends, you have 90 days from the end of the month in which your employment ends to file a claim for reimbursement.

Otherwise, any amount left in your Dependent Day Care FSA at the end of the TriNet Plan Year (June 30) and not claimed by October 15, will be forfeited.

Your Health Care FSA plan allows a “Grace Period” with a two-and-a-half month extension to incur claims and receive reimbursement for amounts remaining in the Health Care FSA account as of June 30. You must be **actively participating** in your Health Care FSA as of June 30, to qualify for the “Grace Period” extension. The “Grace Period” is from July 1, to September 15. The claims submission deadline is October 15, and there will be no exception to this deadline. At the end of each Plan Year and throughout the “Grace Period,” Health Care FSA claims will be processed on a first in, first out basis. If a claim is received and there is an available balance in the Health Care FSA account, the claim will be applied to the previous Plan Year, regardless if the expense was incurred during the Plan Year (July 1 to June 30) or the “Grace Period” (July 1 to September 15).

## FSA While On Unpaid Leave of Absence (LOA)

### Dependent Day Care FSA

If you go on an unpaid leave of absence – contributions into your Dependent Day Care FSA stop with your last paycheck. Any claims for reimbursement must be for services incurred during the period of active participation (from the first period contributions were made to the period covering the last contribution) in the FSA. Upon your return to work, you can re-elect your pre-tax contributions for the remainder of the Plan Year. Your remaining contributions will be adjusted by the remaining number of pay periods in the Plan Year.

### Health Care FSA

If you go on any unpaid leave of absence, or have any other absence during which you’re not receiving a paycheck – you have three choices regarding your Health Care FSA.

- You can stop contributing and not submit claims for expenses you incur after the start of your unpaid leave. The amount you initially agreed to contribute to your account will be subject to revocation in whole or in part, and reset to the amount actually contributed through the last paycheck deduction. Any claims for reimbursement must be for services incurred during the period of active participation (from the first period contributions were made to the period covering the last contribution) in the FSA. Upon your return to work, your pre-tax contributions will resume if you return in the same Plan Year. Your remaining contributions will be adjusted to include any remaining pay periods for the Plan Year.
- You can continue after-tax contributions by personal check or money order through COBRA and continue to file claims for expenses you incur during your unpaid leave. Any claims for reimbursement must be for services incurred during the period of active participation (from the first period contributions were made to the period covering the last contribution) in the FSA. Upon your return to work, your pre-tax contributions will resume if you return in the same Plan Year. Your remaining contributions will be adjusted to account for your post-tax contributions and any remaining pay periods for the Plan Year.
- You can contribute through a lump sum pre-tax salary reduction payment before the unpaid leave commences, and continue to file claims for expenses you incur during your leave. This option is only available with an advance 30-day notice prior to the commencement of your leave date. Any claims for reimbursement must be for services incurred during the period of active participation (from the first period contributions were made to the period covering the last contribution) in the FSA. Upon your return to work, your pre-tax contributions will resume if you return in the same Plan Year. Your remaining contributions will be adjusted to account for your pre-tax contribution and any remaining pay periods for the Plan Year.

## All About Retirement Plans

Many of TriNet's worksite employers provide employee retirement plans such as 401(k)s and Simple IRAs.

If your company sponsors a retirement plan, chances are you can take a pre-tax portion of your paycheck (called an elective salary deferral) and save it in an account that's not taxed until you take the money out. The investment earnings are also tax-deferred until withdrawn.

### Administering Your Retirement Plan

TriNet takes care of your elective salary deferrals, but we don't sponsor the retirement plan itself. As a result, most of your questions about your plan will have to be answered by your company's internal HR representative or plan sponsor. Please contact your company's internal HR representative or plan sponsor if you have questions about

- Choosing an elective salary deferral percentage versus a flat dollar amount contribution
- Coordinating plan rollovers
- Enrolling in your retirement plan
- Finding out about plan fees
- Finding your account balance
- Making elective salary deferral changes or changing your investment fund options
- Suspending your contributions
- Taking out a loan from your vested account balance

Still, we can tell you this much: by putting money in a retirement plan, you're also lowering your taxes right now. And just in case you need additional incentive to talk with your company about your retirement options, keep reading.

### How Retirement Plans Work

The specifics may differ between plans, but the basics usually apply to all of them.

**It's Tough to Forget to Invest.** Contributions are automatic, which means you can concentrate harder on work (or other life-affirming activities). Every payday, TriNet removes from your salary the exact percentage you requested *before* it's taxed. The money is deposited by your plan provider or administrator in each investment fund you selected, in exactly the proportions you desire.

**Compounding Interest.** Save a dollar in a retirement plan, and it magically manufactures more money to do the hard work for you. How? Your investments earn money over time.

**It really adds up.** For example, save \$3.33 a day for 25 years. Out of pocket that's just over \$30,000. If your investments earn an average of nine percent a year, you should have around \$112,000 waiting for you.

**You Get More, the IRS Gets Less.** The money you contribute up to the calendar year maximum – as well as all the money your investments earn – is not taxed by the government until you start withdrawing it. Not only that, but the investments in your account grow faster than taxable investments earning the same rate of interest.

As an example, let's look at an annual \$2,000 investment returning eight percent a year. After 30 years, the taxable investment would be worth about \$153,000 assuming a 31 percent tax rate every year. The tax-deferred investment would have grown to \$245,000, and would be taxed at the rate in effect at the

time of withdrawal. Even if that rate is the same 31 percent, the tax-deferred investment would still be worth \$15,000 more after it had been taxed.

## Retirement Investing

Here's a primer on retirement investing. Keep in mind that this isn't legal or investment advice; you'll need to consult with an appropriately trained lawyer or financial planner in order to get the whole story. Rather, consider it a little light reading before you read all the plan's materials, talk to the right people, and *then* enroll.

1. **Choose an investment strategy.** That means deciding what kind of investor you really are.
  - **Conservative investors** prefer money market funds and other low-return, high-security investments – often because these investors are inches away from or actually in retirement.
  - **Moderate investors** prefer bonds or fixed-income funds and equities – often because they have a few years before retirement.
  - **Aggressive investors** want funds featuring companies with growth potential, so they prefer mostly domestic and foreign equities – often because they have several years, even decades, before their golden years.
2. **Diversify your investments.** If you spread your contributions among several funds options and across several fund categories, you'll have a better chance to a) avoid a big loss if one sector of the market tanks, and b) earn enough to beat inflation over the long haul.
3. **Invest consistently.** Easy enough with retirement plans, because TriNet automatically deducts a pre-selected amount from each paycheck to deposit in them. Bonus: if the stock market slips, you buy more shares of your selected funds at a lower price – automatically.
4. **Get in and keep it up.** The earlier you start investing, the more investment income you may earn, which itself earns even more interest.

## Contribution Limits

Certain federal limits have been placed by the IRS on the amount of contributions that employees can elect in salary deferrals to a retirement plan during the calendar year.

The annual limits may change from year to year. Refer to [www.401khelpcenter.com](http://www.401khelpcenter.com) for the current year maximum limits.

This amount includes any previous contributions made to another plan during the calendar year. It is the employee's responsibility to make sure that their elective salary deferrals do not exceed the annual federal maximum or plan imposed restriction by advising your company representative upon enrollment of any previous contributions for the plan.

## Disclaimer

These benefit descriptions are not part of a summary plan description. They do not serve as evidence of coverage for the program. If you have specific questions regarding the benefit structure, limitations or exclusions, contact the individual plan.

## Taking a Break: PTO, LOA, FMLA

PTO. LOA. FMLA. This alphabet soup represents the three major forms of time off you have available outside the income protection provided through TriNet Signature Benefits.

**Paid Time Off (PTO).** Generally, you earn (or accrue) paid time off (PTO) through the number of hours you work in a given pay period. Your company has a specific PTO policy, which should provide the details about how much you earn, bank, and can spend over time and for what reasons. When you take PTO, your benefit levels and coverage do not change.

**Leave of Absence (LOA).** A leave of absence (LOA) can be paid or unpaid depending on the company and the circumstance. Again, each company's policy is different, so check with your manager for more information on the specifics of your program. LOAs can change your benefits level and coverage.

**Family and Medical Leave (FMLA).** The Family and Medical Leave Act (FMLA) is a federal law that provides eligible men and women up to 12 weeks of unpaid leave for certain family or medical reasons. An absence under the FMLA will not reduce your benefits under most, but not all, circumstances.

Depending on the nature of your absence, any number of combinations of paid and unpaid leave may be available to you – along with any number of benefit changes.

### Paid Time Off (PTO)

If you need time off – for a personal day, vacation, floating holiday, mild illness, jury duty, bereavement, etc. – chances are you'll be dipping into your PTO. To make use of your PTO, contact your manager and make your wishes known. Your manager will include the relevant information when transmitting your payroll hours to TriNet.

If you intend to extend your PTO longer than originally requested, please coordinate with your manager or see below for extended leave information, if applicable. If you take PTO for an illness, and are absent longer than three days, your company may request a physician's verification to allow you to return to work.

### Leaves of Absence (LOA)

Let's say you're not taking a vacation. Rather, you need a leave of absence that lasts seven days or longer. It could be for medical disability you have or a family member has, a pregnancy leave, a military leave, or personal leaves your company deems compelling. (Personal leaves are not vacations.)

For these kinds of leaves, you need to complete the two-page *Request for Leave of Absence over 7 Days*, available for download via HR Passport (log in at [www.trinet.com](http://www.trinet.com)). You finish the first page, which includes information about the leave. Your manager needs to finish the second page, which indicates how your benefits will be continued during your leave. Your manager then faxes the form to 510.352.6480. Please write "TriNet LOA" on the form. TriNet will review the form and manage your benefit coverage accordingly.

### Family and Medical Leave Act (FMLA)

If the absence you have from work is for a medical condition – either yours or a family member – you may be eligible for leave under the Family and Medical Leave Act. The FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for certain family and medical reasons.

## Eligibility

Employees eligible for leave under FMLA are those who:

- Have completed at least 12 months of service with the company, and
- Have a minimum of 1,250 hours of service during the 12 month-period immediately preceding the commencement of the leave, and
- Are employed at a company that employs 50 or more employees within 75 miles.

What if you've already used FMLA leave before, or you think you may use it again in the near future? You may wonder if you still have FMLA leave available to you. TriNet uses a "rolling 12 months" measured backwards from the date an employee uses any FMLA leave. In other words: you'll look at the end date of your requested FMLA leave, then look back 12 months to determine if you're still entitled to any of your 12-week FMLA leave within that period.

## Qualifying Reasons

If you're eligible, you can take unpaid FMLA leave:

- To care for your child after birth
- To care for a child placed with you for adoption or foster care
- To care for your spouse, child, or parent who has a serious health condition
- When a serious health condition leaves you unable to perform your job

## PTO, STD, LTD, and SDI Concerns

Before taking unpaid leave through the Family and Medical Leave Act (FMLA), the following kinds of time off might first apply to your situation:

- PTO – paid time off may be available, which your company can require you to use up before taking unpaid leave
- STD – short-term disability insurance may cover you for certain kinds of illnesses or accidents, if your company provides it through TriNet Signature Benefits. (If your company doesn't provide it, it may come from the state. Check with your HR contact for more information.)
- LTD – long-term disability insurance may cover you for certain kinds of illnesses or accidents – after you have exhausted the benefits of your STD coverage – if your company provides LTD through TriNet Signature Benefits
- SDI – state disability insurance may require you to first use earned, or accrued, PTO before SDI is available.

Also, just to clarify: a leave starts the first day you are unable to work even if you use PTO time during the waiting period for STD, LTD, or SDI. A leave does not start after you've used all your accrued PTO.

## Applying for FMLA Leave

To request FMLA leave, you need to:

- Provide at least 30 days advance notice (when the leave is foreseeable) by completing the *Request for Leave of Absence over 7 Days* form. If the leave is unforeseeable, please provide the form as soon as possible.
- Present medical certification to support FMLA leave because you or a family member has a serious health condition. Use TriNet's *Certification from Health Care Provider*, available for download by logging into HR Passport.
- If requested, get a second or third opinion – at the company's expense – on health conditions.
- If the leave was for a serious health condition, you must submit a doctor's release before you return to work.

**Job Benefits and Protection**

During FMLA leave, TriNet maintains your group health plan at the same level and under the same conditions as before the leave. The use of FMLA leave will not result in the loss of any employment benefit that was earned before the start of the leave.

When you return from FMLA leave, you will be restored to your original or an equivalent position with equivalent pay, benefits, and other employment terms.

## Work/Life Solutions

### Services Included

- Employee Assistance Program
- Work/Life Consultation and Referral Services
- LifeCycle® Connect (online interactive resources)

### The Employee Assistance Program

We all face expected, or unexpected, challenges in our lives as well as everyday stress associated with personal, family, relationship, health or work-related issues. The Employee Assistance Program (EAP) is available to you and your family members at no cost, to assist you during those times. EAP services include:

- A toll free, dedicated phone number: **1-800-847-6034**
- Licensed, professional counselors
- In-person appointment within 2 business days or sooner in emergency
- Assistance for personal, family and work-related concerns, such as:
  - Stress, grief, anger, anxiety, depression
  - Marriage, family and other relationship issues
  - Substance abuse and addictive disorders
  - Traumatic events, domestic violence
  - Work related stress, conflicts or other issues

### *How It Works*

- Calls are answered 24 hours a day, 7 days a week by a professional counselor
- Level and type of need is determined
- Telephone or in-person counseling is provided
- Transfers made to Work/Life specialists when required
- Referrals made to affiliated counselors near your work or home for in-person counseling
- Legal and financial referrals provided when appropriate

### Work/Life Service

The Work/Life Service offers you comprehensive assistance for family care issues spanning the life cycle. Services include help for employees to balance work responsibilities and family care needs. Your benefit offers unlimited phone consultation, information and referral resources for:

### **Child Care / Parenting Consultation and Referral**

- Explain available child care options
- Provide verified referrals to local providers
- Includes before and after school care, summer programs, emergency care and more

**Adoption Consultation and Referral**

- Information about adoption choices, costs and referrals to local adoption agencies

**Educational Resources: K-12 and Higher Education**

- Resources for the college planning process, career research, college and scholarship searches
- Searches for schools, tutors, financial aid

**Elder Care and Dependent Adult Care Consultation and Referral**

- Information about providers, programs, services and policies
- Verified referrals to local providers including in-home care, community care, transportation, and other support services

**Pre-Retirement Information**

- Resources and referrals for retirement planning

***How It Works***

- Call the toll free number **1-800-847-6034** and ask to speak with a work/life specialist who will conduct a phone assessment of your needs. This call may take about 10 – 15 minutes
- You can also contact them via the on-line intake form at [www.TriNet.WorkLifeConnect.com](http://www.TriNet.WorkLifeConnect.com)
- Resource searches will be conducted on your behalf and you will receive an average of three to seven verified referrals within two to three business days
- A personalized resource packet will either be mailed or e-mailed to you based upon your preference
- You will receive a follow-up call or e-mail after each consultation/referral to make sure you are satisfied with the resources given

**Legal Consultation and Referral Services**

Your LifeCycle® Service can help resolve legal matters that you may encounter at different stages of life such as:

- Getting married
- Purchasing a home
- Raising a family
- Preparing a will or trust
- Going through a divorce
- Adopting a child
- Child custody/visitation issues
- Facing traffic, civil, or criminal matters
- Dealing with juvenile matters

- And more...

***What kind of help is available?***

You can call your toll-free number for unbiased telephone consultations with an attorney to discuss any of the above listed issues - Other services include:

- Legal Document Review – includes review and critique of IRS letters, contracts, leases, etc.
- Identity Theft and Fraud Assistance – includes advice on what steps to take should you fall victim to identity theft and fraud
- On-line Legal Content and Programs – provides articles and interactive resources, self-help tools, and cost-saving assistance

***How It Works***

This benefit provides one telephone consultation and/or an in-person 30 minute consultation with a Legal Services attorney per legal matter. There is no limit to the number of consultations you may receive. Should you retain a legal professional through the EAP beyond this benefit, services will be offered at a 25% discount off the attorney's customary fees. You are responsible for the cost of all services beyond this benefit. Consultation is not available for matters pertaining to patents, employment and work-related concerns, second legal opinions, state tax questions and third party questions.

**Financial Consultation and Referral Services**

Your LifeCycle® Service can assist in resolving financial matters that you may encounter at different stages of life such as:

- Managing expenses and debt
- Preparing a realistic budget
- Dealing with tax-related questions
- Planning for retirement
- Wage garnishment issues
- Identity theft
- Investing in a college education
- And much more...

***What kind of help is available?***

You can call the toll-free number for unbiased telephone consultations with a financial advisor to discuss any of the above-listed issues. Other services include:

- Housing Education – provides all aspects of pre-purchase education, as well as early delinquency intervention counseling to homeowners at risk of foreclosure
- Debt Management - provides access to debt counselors who can help develop a realistic plan to pay down debt and get back into a desirable financial position. The maximum cost to the client is no more than \$20.00/month where allowed by state law
- Financial Planning – addresses issues of risk management, investment planning, and retirement planning. No products are sold or endorsed

- On-line Financial Content and Programs – provides articles and interactive resources, self-help tools and cost-saving assistance

### ***How It Works***

This benefit provides one telephone consultation with a Financial Services Representative per financial matter. There is no limit to the number of consultations you may receive. There is no in-person benefit available; however, you will be provided with resources, information and referrals for further assistance if needed. You are responsible for the cost of all services beyond this benefit.

### **LifeCycle® Connect**

LifeCycle® Connect is a work/life and wellness website featuring a collection of resources for all areas of life management. It includes a collection of web-based articles, assessments, calculators, service provider locators, seminars, interactive training modules and other resources covering the following areas:

- Family and care giving
- Emotional well-being
- Health and wellness
- Working smarter
- Daily living

### **LifeCycle® Connect Health Management Services**

Features on-line access for employees and family members to current, reliable and easy to use information to help make more informed personal health care and consumer decisions.

- On-line tools include:
  - Interactive health self-assessments including general health and specialty assessments such as a depression screen
  - Current, reliable information on diseases, conditions, procedures, drug options.
  - Self-search resource databases using MEDLINEPLUS®
  - Life Learning Center with facts, tools, advice, strategies for health and wellness success
  - Tools for a successful nutrition or exercise plan / setting health goals
  - Medication Tracker
  - Medical Encyclopedia
  - Interactive Health Tutorials
  - And much more

To Access LifeCycle® Connect go to: [www.TriNet.WorkLifeConnect.com](http://www.TriNet.WorkLifeConnect.com)

## **An Overview of Voluntary Benefits**

### **Aflac**

TriNet works with Aflac, a Fortune 500 company insuring more than 40 million people worldwide, to provide income protection programs that pays cash benefits directly to you, in addition to any other insurance you may have. Aflac programs are designed to help fill the gaps that medical insurance was not intended to cover.

- Personal Accident Indemnity
- Personal Cancer Indemnity
- Personal Hospital Intensive Care
- Hospital Protector
- Specified Health Event

These benefits are only available at open enrollment. In order to enroll, change, or terminate coverage, you will need to contact Aflac directly. ([Link to Aflac's website here](#)).

### **MetLife Voluntary Benefits:**

MetLife offers a variety of voluntary benefits. There is MetLaw, Auto and Home insurance, Preferred Savings Plus from Metbank, Veterinary Pet Insurance, Long Term Care, and Met Life Retirement Savings.

#### **MetLaw**

With a MetLaw group legal plan, your affordable monthly premium brings you legal advice and assistance in a wide range of areas, from real estate matters, to will preparation, debt problems, family law, and more. You can enroll in this benefit at open enrollment time only. In order to enroll, change or terminate coverage, you will need to contact MetLife directly online on HR Passport under Myself > My Benefits> MetLife Benefits and clicking the MetLife link.

#### **Auto and Home Insurance**

Special group rates and discounts could help you save up to 10% on your auto insurance alone. Plus, you can count on convenient payment options, including payroll and bank account deduction, outstanding customer service, a Guaranteed Repair Program, and valuable coverage for all of your personal property and liability insurance needs. You may enroll at any time during the year. In order to enroll, change or terminate coverage, you must contact MetLife directly online on HR Passport under Myself > My Benefits> MetLife Benefits and clicking the MetLife link.

#### **Preferred Savings Plus from MetLife Bank®**

You can save more money with some of today's highest savings rates, save more time with Automated Savings, and get 24/7 access to funds and account information. You may enroll at any time during the year. In order to enroll, change or terminate coverage, you must contact MetLife directly online on HR Passport under Myself > My Benefits> MetLife Benefits and clicking the MetLife link.

#### **Veterinary Pet Insurance**

With veterinary pet insurance, you can stop worrying about the ever-increasing costs of caring for your pets, because your pets will be covered for more than 6,400 medical problems and conditions, subject to policy terms and conditions. You may enroll at any time during the year. In order to enroll, change or

terminate coverage, you must contact MetLife directly online on HR Passport under Myself > My Benefits> MetLife Benefits and clicking the MetLife link.

### Long-Term Care Insurance

If you suffered an injury or illness that resulted in the need for in-home nursing, assisted living, or other costly services, long-term care insurance could help you to avoid high out-of-pocket costs. You may enroll at any time during the year. In order to enroll, change or terminate coverage, you must contact MetLife directly online on HR Passport under Myself > My Benefits> MetLife Benefits and clicking the MetLife link

MetLife Auto & Home is a brand of Metropolitan Property and Casualty Insurance Company and its affiliates: Metropolitan General Insurance Company, Metropolitan Casualty Insurance Company, Metropolitan Direct Property and Casualty Insurance Company, Metropolitan Group Property and Casualty Insurance Company, Economy Premier Assurance Company, and Metropolitan Lloyds Insurance Company of Texas, all with administrative home offices in Warwick, RI. Coverage, rates, and discounts are available in most states to those who qualify.

Preferred Savings Plus offered by MetLife Bank<sup>®</sup>, N.A., Member FDIC

Veterinary pet insurance is underwritten by National Casualty Company (an A+15 rated company), Madison, Wisconsin, in all states except California. In California, policies are underwritten by Veterinary Pet Insurance Company, Inc., Brea, CA. These companies are not affiliated with Metropolitan Life Insurance Company or its affiliates.

Group Legal Plans provided by Hyatt Legal Plans, Inc., Cleveland, Ohio. In certain states, group legal services plans are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and affiliates, Warwick, RI.

Like most group long-term care insurance policies, MetLife group policies contain certain exclusions, waiting periods, reductions of benefits, limitations, and terms for keeping them in force. This coverage is guaranteed renewable. This means that coverage cannot be canceled due to an increase in your age or a change in your health. Premium rates can only be raised as the result of a rate increase made on a class-wide basis. Long-Term Care Insurance is underwritten by Metropolitan Life Insurance Company, New York, NY Policy forms G.LTC 197, G.LTC 1597, GPNP 99-LTC. For more information about costs and complete details, call MetLife at 1-800-438-6388.

© 20056 MetLife<sup>®</sup> is a registered trademark of Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166.

### Optional Dental Plan

The Delta Optional Dental Plan is available for you and your family if your employer does not provide a group dental plan or if you opt out of the Group Medical Plan.. Your monthly premium will be deducted from your paycheck before it's taxed, saving you even more money. You can change your coverage during Open Enrollment or when you have a Life Status Change.

### Optional Vision Plan

The Optional Vision Service Plan (VSP) is available for you and your family if your employer does not provide a group vision plan or if you opt out of the Group Medical Plan. Your monthly premium will be deducted from your paycheck before it's taxed, saving you even more money. You can change your coverage during Open Enrollment or when you have a Life Status Change.

### Optional Long-Term Disability Insurance

The Optional Long Term Disability Insurance plan (OLTD) is available to you if your employer does not provide an employer group sponsored disability plan. Optional LTD coverage becomes effective when MetLife approves your application. If you enroll within the first 30 days of initial eligibility, no *Statement of Health* form is required. However, you will be required to complete a *Statement of Health* form for enrollments that occur at a later time. Depending upon your responses, additional health data may be requested before MetLife makes a determination of your insurability. Your monthly premium will be deducted from your paycheck after it's taxed, which means you can change your coverage at any time. (This also means you won't be taxed on the benefits you receive.)

### Supplemental (Additional) Accidental Death & Dismemberment (AD&D) Insurance

In addition to the basic AD&D your company sponsors, you may request additional amounts of coverage, up to a maximum of \$500,000. A *Statement of Health* form is not required. Your monthly premium will be deducted from your paycheck after it's taxed, which means you can change your coverage at any time.

### Group Variable Universal Life (GVUL)

The GVUL program offers life insurance protection, combined with a tax-advantaged investment opportunity. The optional tax-advantaged investment feature can be used to help provide for expenses

such as higher education, retirement or post-retirement medical expenses. The GVUL program also offers portable life insurance coverage – As employment circumstances change, you may need to continue your life insurance protection. If you retire or leave TriNet, you will have the option to maintain your GVUL coverage, to age 95.

There is also an optional tax-advantaged investment feature – you may make after-tax contributions that have the potential to grow on a tax-deferred basis. Your contributions can be invested in several variable investment portfolios from nationally-recognized money managers. If you decide to access your cash value, for any reason, withdrawals can be made without surrender charges or early withdrawal penalties – plus any withdrawals up to your cost basis can be made tax-free. Please note, withdrawals will reduce your cash value and death benefit.

You may elect up to \$2,000,000 in coverage in \$10,000 increments for yourself. There is a \$30,000 minimum election requirement.

There is also coverage available to your spouse or domestic partner if you have elected GVUL for yourself. You may elect up to \$100,000 in \$10,000 increments for your spouse or domestic partner. There is a \$10,000 minimum election requirement and this coverage cannot exceed 50% of the employee amount.

You may also purchase \$5,000 of coverage for your dependent child.

In order to enroll, change or terminate coverage, you must contact MetLife directly (link to MyBenefits). If you enroll within the first 30 days of initial eligibility, no *Statement of Health* form is required for amounts up to \$100,000 for your coverage. However, you will be required to complete a *Statement of Health* form for enrollments that occur at a later time or for any amounts in excess of \$100,000 during your first 30 days of initial eligibility. Depending upon your responses, additional health data may be requested before MetLife makes a determination of your insurability.

After your coverage has become effective and you have been issued a certificate/policy number; you will be able to access information about your certificate/policy online on HR Passport under Myself > My Benefits> MetLife Benefits and clicking the MetLife link. You will also receive a GVUL Service Guide.

### **The Health & Healing Card**

HHC, the Health & Healing Card, offers discounts in a network of alternative and complementary health providers. The program costs \$25 a year and covers all family members. You can join any time, and you can start using the services when your card arrives (usually the month after you join). To sign up, log into HR Passport under Myself > My Benefits> Benefits Overview> Health & Healing Card.

### **Pre-Tax Commuter Benefits**

Thanks to new IRS commuting regulations, you can now avoid federal, state, and employment taxes when you pay for parking and public transit – putting as much as 40% of your normal commuting expenses back into your pocket. You can select from a nationwide catalog of thousands of commuter choices, everything from the New York subway to San Francisco's BART, plus a variety of monthly parking options. Transit passes can be delivered right to your home, or you can simply submit monthly receipts for reimbursement.

To sign up, log into [www.HRPassport.com](http://www.HRPassport.com) and click on the "Additional Benefits" section.

### **Corporate America Family Credit Union**

You and family are eligible for membership in Corporate America Family Credit Union. To obtain more information, please visit their website at: [www.cafcu.org](http://www.cafcu.org)

## **FEI Employee Assistance Program (EAP)**

### **How the Plan Works**

FEI offers a completely confidential counseling and referral service for topics that affect, or may affect, your personal life or job performance. FEI can help in many areas, including:

- Alcohol and drug abuse
- Child and elder care resources
- Emotional, personal, and stress-related concerns
- Financial and credit consultation
- Legal consultation
- Marriage, family, and relationship problems

All communications are confidential, except as required by law.

For more information, visit [HRPassport.com](http://HRPassport.com) and click under additional benefits.

### **Employee Discount Club**

As a member, you have access to an ever growing list of discounts. You will find discounts on theme park tickets, movie theater tickets, hotels, and other merchandise.

For more information, log on to [www.HRPassport](http://www.HRPassport) and click on additional benefits.

---

## Optional Vision Service Plan

Look what TriNet Signature Benefits has for you: an optional vision care plan that can cover most of the costs of exams, glasses or contact lenses. Here's how.

The Vision Service Plan, or VSP, offers a nationwide network of vision care professionals. Choose a provider in the network, and you can:

- take your pick from thousands of professionals in thousands of locations;
- receive a thorough exam, including glaucoma and other tests, every 12 months at no cost to you;
- reduce your paperwork; and
- save money on other procedures.

Use a provider in the network and most of your basic eye care costs will be covered by the plan. (Medical conditions or injuries to your eyes are covered under your medical plan.) Of course, you can still use a provider outside the VSP network and receive benefits. However, you'll have to:

- pay for the services first,
- submit a claim to be reimbursed, and
- pay more than with a network provider.

No matter when you enroll, you won't have to worry about receiving or keeping a VSP ID card. There isn't one. Simply give your name, TriNet's name, and your Social Security number to the provider of your choice.

### Using a VSP Provider

You don't need to contact TriNet to make an appointment. Simply call your provider. If you don't have one, call VSP at 800.877.7195 or visit [www.vsp.com](http://www.vsp.com).

No matter when you enroll, you won't have to worry about receiving or keeping a VSP ID card. There isn't one. When making an appointment, inform the provider that you are a VSP member. You and your covered dependents will simply give your name, TriNet's name, and your Social Security number to the provider of your choice. The provider will contact VSP to verify eligibility and plan coverage. He or she will also request authorization for services and materials. If you're not eligible for services, your provider should let you know.

### Using a Provider Outside the VSP Network

Pick any provider you want and make your appointment. Pay the entire bill and then send your itemized receipts for reimbursement to:

Vision Service Plan  
Out of Area Claims  
PO Box 997105  
Sacramento CA 95899-7105

VSP will review your receipts, compare them to the Non-VSP Provider reimbursement schedule, and send you a check for the appropriate amount. The reimbursement schedule does not guarantee full payment.

---

## Limitations and Exclusions

There are certain limitations when using VSP whether you choose to go in or out-of-network. For instance, you will have to pay the additional cost above the stated lens allowance for optional items you choose, such as but not limited to:

Oversized lenses

Blended lenses

The coating of lens or lenses

Cosmetic lenses

Progressive multifocal lenses

There are no benefits under this plan for professional services and materials connected with but not limited to:

Medical or surgical treatment of the eyes

Corrective vision treatment of experimental nature

Replacement of lenses and frames furnished under this plan, which are lost or broken except at the normal intervals when services are otherwise available.

## How to Enroll

Enroll in a TriNet Signature Benefits medical plan and you'll enroll in the VSP. You can sign up dependents separately as you complete your benefits enrollment via our Benefits Wizard in HR passport.

If you waive a medical plan, the group VSP won't be available to you or your family members through TriNet. You may, however, elect to enroll in and pay for the optional VSP as described in the "Optional Benefits" section of this guidebook.

## Annual Eye Exams

TriNet's Vision plans provide coverage for an annual eye exam. An annual eye exam is important for any adult who wears corrective lenses. The American Optometric Association recommends eye exams every two to three years for adults who don't normally need vision correction, to the age of 40, depending on your rate of visual change and overall health. Doctors often recommend more frequent examinations for adults with diabetes, high blood pressure and other disorders, because many diseases can have an impact on the health of your eyes.

If you are over 40, it's a good idea to have your eyes examined every one to two years to check for common age-related eye problems such as *presbyopia*, *cataracts* and *macular degeneration*.

Because the risk of eye disease continues to increase with advancing age, everyone over the age of 60 should be examined annually. The American Optometric Association provides the general guidelines, by you should ask your *eyecare professional* what interval is right for you.

### Disclaimer

These benefit descriptions are not part of a summary plan description. They do not serve as evidence of coverage for the program. If you have specific questions regarding the benefit structure, limitations or exclusions, contact the individual plan.

## Vision Terms

### Helpful Vision Terms to Know

#### Bifocal Lenses

Bifocal lenses have 2 different portions, one for near and one for far vision.

#### Cataracts

A cataract is a clouding of the eye's natural lens, which lies behind the iris and the pupil.

**Coinsurance**

The percentage of a medical expense paid by either you or your TriNet medical plan. For example, let's say your plan pays 80% of the cost of a \$1,000 medical procedure. You're responsible for paying the remaining 20%. In this case, the plan will pay coinsurance of \$800 – or 80%; you will pay a coinsurance amount of \$200 – or 20%. The coinsurance amounts apply after you meet your plan's required deductible.

**Copay**

The flat fee you pay each time you receive medical care in an HMO or POS plan, or for office visits in a PPO plan. The remaining charges for that care are usually covered in full by your medical plan.

**Deductible**

The amount you pay each calendar year toward medical expenses before the health plan begins paying benefits. You may have to meet an individual, per-person deductible, or a family deductible for all of your covered family members combined.

**Lenticular Lenses**

Lenticular lenses are double convex lenses; they are convex on both sides.

**Macular Degeneration**

AMD, age-related macular degeneration occurs with degeneration of the *macula*, which is the part of the *retina* responsible for the sharp, central vision needed to read or drive. Because the macula primarily is affected in AMD, central vision loss may occur.

Macular degeneration is the leading cause of vision loss and blindness in Americans aged 65 and older. Because older people represent an increasingly larger percentage of the general population, vision loss associated with AMD is a growing problem.

**Presbyopia**

Presbyopia is blurred vision at near points, such as when reading, sewing or working at the computer.

**Trifocal Lenses**

Trifocal lenses have three portions, one for near, one for intermediate, and one for far vision.

**Usual, Customary, and Reasonable (UCR)**

The customary rates for a medical product or service in your geographic area, or the rates usually charged by your provider, whichever is lower. The insurance carrier determines UCR charges. You're responsible for paying any charges that exceed UCR. Keep this in mind when you receive care from a provider outside your plan's network.

## Optional Dental Plans

TriNet has 3 dental carriers: Aetna, Delta Dental and MetLife. Our optional dental plans provide more choice at lower costs than most dental plans. You can visit dentists in-network or out-of-network in the DPO plan. However, you can save time and money by seeing an in-network dentist. With 3 carriers to choose from, finding a provider in-network is easier than ever. For out-of-network visits, the DPO plans pay a lower rate of co-insurance up to the usual, customary and reasonable (UCR) charges.

When you enroll in one of TriNet's optional DPO plans, you won't have to worry about an ID card. You will receive one. However, you can simply give your name, TriNet's name, and your Social Security number to the provider of your choice.

Our other optional group dental plan is Delta Care DMO/PMI (The "PMI" Plan.) Coverage is available in California, Florida, Georgia, Nevada, New York, Pennsylvania, Texas, Utah and Washington, DC. In the PMI plan, a Primary Care Dentist (PCD) must be selected from the PMI plan network. No benefits are available outside the PMI plan network without plan authorization.

If you enroll in the PMI dental plan, you will receive a PMI plan membership packet, including an identification card and an Evidence of Coverage booklet that fully describes the benefits of the PMI plan.

## The Dental Preferred Option Plan (The "DPO" Plan) or Preferred Dental Program (The "PDP" Plan)

The DPO or PDP plan is really about choice. You may visit any licensed dentist, and can change dentists at any time without notifying the plan.

In terms of choosing a dentist, you have an open choice designed to fit your specific needs.

Firstly, If you prefer, you may choose to visit one of the thousands of network dentists who accept your provider's insurance. Using one of these network dentists will help to reduce your portion of the total bill because their rates are negotiated to keep your costs as low as possible.

Secondly, you may choose your own licensed dentist outside the network. Keep in mind that this freedom of choice may cost you more because the coinsurance and deductible are higher and your coverage is based on the usual, customary and reasonable charges. Your out-of-pocket expenses may be higher outside the network; so, of course, the choice is yours.

### Using the DPO Plan

To use the program, call the dental office of your choice and make an appointment. If you go to a network dentist, he or she will have billing forms in the office and will complete and submit the forms to the appropriate carrier.

Our dental carriers pay network dentists directly. You are responsible only for your share of the bill.

If you go to a non-network dentist, you are responsible for the dentist's entire bill, and the carrier reimburses you directly after you submit a completed claim form.

When you go to a dentist who is not contracted with the plan which you have joined, payment will be calculated on a schedule of allowances or on the prevailing fee (the fee charged by no fewer than half of the plan dentists). If your non-contracted dentist's fees exceed that level, you must pay the difference above your regular out-of-pocket charges. You may also have to pay the non-contracted dentist in advance for the entire bill.

### How to locate a DPO or PDP dental plan provider:

<http://www.aetna.com> (Nationwide)

<http://www.deltadentalca.org> (Nationwide)

<http://www.deltadentalva.com> (Virginia only)

<http://www.metlife.com/dental> (Nationwide)

## **The Delta Care DMO/PMI Plan (The “PMI” Plan)**

The PMI dental plan is really about cost. You get a “big” plan for a “small” premium. It doesn’t give you as much choice as the DPO plan, but it will still help you keep smiling.

The PMI dental plan is available in California, Florida, Georgia, Nevada, New York, Pennsylvania, Texas, Utah and Washington, DC. It works a lot of like a medical plan HMO, in that using one of the PMI dental plan dentists *is required* for all services and/or referrals to specialists. PMI dentist rates are preset to keep your costs as low as possible.

When you enroll in the PMI dental plan, be sure to indicate a dental facility (from the list of contract dental facilities participating in the PMI dental plan) for both yourself and your eligible dependents. You may collectively select up to a maximum of three contract dental facilities, or you may all receive care from the same place.

### **Using the Delta Care PMI Plan**

When you enroll in the PMI dental plan, you will select a contract dentist to provide services to you and your family. The PMI dental plan network consists of private practice dental facilities that had to pass stringent reviews for quality, access, and safety before they were allowed to join the PMI plan network.

Your selected PMI plan dentist will take care of your dental care needs. If you require treatment from a specialist, your PMI plan dentist will handle the referral for you.

After you have enrolled, you will receive a membership packet, including an identification card and an Evidence of Coverage document that fully describes the benefits of your dental program. Also included in this packet are the name, address, and phone number of your PMI plan dentist. Simply call the PMI plan dentist to make an appointment.

Under the PMI dental plan, many services are covered at no cost while others have copayments (the amount you pay your dentist) for certain benefits. Ask your PMI Plan dentist for a list of copayments and services.

Please note: Dental services that are not performed by your PMI plan dentist, or are not covered under provisions for emergency care, must be pre-authorized to be covered by your DeltaCare PMI plan.

### **How to locate a PMI dental plan provider:**

<http://www.deltadentalca.org/pmi>

Note: The DMO plan is often referred to as the “PMI Dental Plan” on the web site. Please remember to look for the PMI abbreviations when researching information and choosing a primary dentist.

## Getting an Estimate Before Treatment

If you need dental work done that may cost more than \$300 or that requires crowns or bridges, you should always get a predetermination before starting treatment. A predetermination does not guarantee payment; rather, it's an estimate of the amount your plan will pay if you're eligible and meet the plan's requirements when you complete treatment.

## How to Enroll

Enroll in a TriNet Signature Benefits medical plan and then choose either a DPO/PDP plan or the DHMO (PMI) dental plan. You can also sign up dependents separately as you complete your benefits enrollment. If you enroll in the DHMO dental plan, include the name and ID number for the primary dentist(s) you choose for you and your dependents.

If you waive a medical plan, the Group Dental plans will not be available to you and your dependents. You may, however, elect to enroll in and pay for an optional dental plan as described in the "Optional Benefits" section of this guidebook.

### Disclaimer

These benefit descriptions are not part of a summary plan description. They do not serve as evidence of coverage for the program. If you have specific questions regarding the benefit structure, limitations or exclusions, contact the individual plan.

## Helpful Dental Terms to Know

### Basic Services

Basic services typically include

- extraction
- filling
- oral surgery
- periodontal cleaning and scaling
- periodontal surgery
- office visit after regularly scheduled hours
- office visit for observation
- limited occlusal adjustment
- endodontics
- therapeutic drug injection
- treatment of post-surgical complications (unusual circumstances)
- general anesthesia and I.V. sedation in conjunction with covered oral surgery services

### Coinsurance

Coinsurance is the percentage of a dental expense paid by either you or your TriNet dental plan. For example, let's say your plan pays 80% of the cost of a \$1,000 dental procedure. You're responsible for paying the remaining 20%. In this case, the plan will pay coinsurance of \$800 – or 80%; you will pay a coinsurance amount of \$200 – or 20%. The coinsurance amounts apply after you meet your plan's required deductible.

### Deductible

The amount you pay each calendar year toward dental expenses before the dental plan begins paying benefits. You may have to meet an individual, per-person deductible, or a family deductible for all of your covered family members combined.

**Denture**

an artificial replacement of one or several of the teeth (partial denture), or all of the teeth (full denture) of either or both jaws

**DHMO**

Similar to a medical Health Maintenance Organization, a Dental Health Maintenance Organization requires enrollment with a member dentist. All care must be given by your assigned member dentist.

**Diagnostic and Preventive Services**

Diagnostic and Preventive services typically include

- bitewing X-rays
- cleanings (dental prophylaxis)
- diagnostic casts in conjunction with subsequent orthodontic treatment
- emergency treatment of dental pain
- examination of biopsied tissue
- fluoride treatments
- full mouth X-rays
- routine oral exam
- sealant
- space maintainers
- specialist consultation

**DPO or PDP**

A Dental Provider Organization is similar to a PPO medical plan, and is a term used by Aetna and Delta Dental. Each plan has a network of preferred dentists. You may use any provider you want, but you will save time and money by using one in the DPO network. Being in a DPO plan requires a certain level of responsibility; providers may choose to discontinue their affiliation with a plan's DPO network. You will need to keep current to know whether you are going to a provider who is inside or outside of the DPO network. MetLife calls their similar plan a PDP, or Preferred Dental Program.

**Endodontics**

Endodontics is the branch of dentistry that deals with diseases of the tooth root, dental pulp, and surrounding tissue, including root canals.

**Inlays**

A solid filling, as of gold or porcelain, fitted to a cavity in a tooth and cemented into place

**Major Services**

Major services typically include

- cast restoration

- construction or repair of fixed bridges, partial dentures and complete dentures if provided to replace missing, natural teeth
- crowns
- denture reline
- denture repair
- dentures
- inlays
- jackets
- onlays

**Occlusal**

Of or relating to the contacting surfaces of opposing teeth, especially the biting or chewing surfaces.

**Onlays**

On onlay is a cast, usually made of gold, attached to the occlusal surface of a tooth.

**Orthodontics**

Orthodontics is the branch of dentistry dealing with the prevention and correction of irregular teeth, as by means of braces.

**Periodontics**

Periodontics is the branch of dentistry dealing with diseases of the gums and other structures around the teeth.

**Usual, Customary, and Reasonable (UCR)**

The customary rates for a medical product or service in your geographic area, or the rates usually charged by your provider, whichever is lower. The insurance carrier determines UCR charges. You're responsible for paying any charges that exceed UCR. Keep this in mind when you receive care from a provider outside your plan's network.

# Supplemental Accidental Death and Dismemberment (AD&D) Insurance

You have the option to buy supplemental accidental death and dismemberment (AD&D) insurance for yourself through your basic, employer-paid life and AD&D plan.

AD&D insurance provides a benefit in the event of a fatal accident or an accident that results in the loss of a limb, eyesight or other dismemberment listed below. For benefits to be paid, the death or loss must occur not more than one year from the date of the accident and be a direct result of bodily injury sustained from that accident, independent of all other causes.

You can elect AD&D Benefits during your initial enrollment and our annual Open enrollment via [www.hrpassport.com](http://www.hrpassport.com).

## Summary of Benefits

Optional AD&D Insurance	Employee Only
Available in increments of \$10,000	
Minimum amount	\$10,000
Maximum amount	\$500,000
Statement of Health	Not required

## Cost to Have the Plan

The Monthly Premium for Optional Accidental Death & Dismemberment Rates is \$0.26 per \$10,000 of Coverage.

## Table of Covered Losses and Benefit Amounts

You will be paid a benefit under this plan if you suffer one or a combination of the incidents below.

Covered Losses (Subject to Exclusions)	Benefit Amounts
Life coverage you have elected	Full Amount of
A hand	One-half of the Full Amount
A foot	One-half of the Full Amount
Sight of an eye	One-half of the Full Amount
Any combination of a hand, a foot or sight of an eye	One-quarter of the Full Amount
Thumb and Index finger of same hand	One-quarter of the Full Amount
Speech and hearing	Full Amount
Speech or hearing in both ears	One-half of the Full Amount
Quadriplegia	Full Amount
Paraplegia	One-half of the Full Amount
Full Amount	

Hemiplegia  
Full Amount

One-half of the

## AD&D Payment Exclusions

MetLife not pay for any Covered Loss shown the above if it in any way results from, or is caused or contributed to by any of the following:

1. Physical or mental illness, diagnosis of or treatment for the illness
2. An infection, unless it is caused by an external wound that can be seen and which was sustained in an accident
3. Suicide or attempted suicide
4. Injuring oneself on purpose
5. The use of any drug or medicine
6. A war, or a warlike action in time of peace
7. Committing or trying to commit a felony or other serious crime or an assault
8. Any poison or gas, voluntarily taken, administered or absorbed
9. Service in the armed forces of any country or international authority, except the United States National Guard
10. Operating, learning to operate, or serving as a member of a crew of an aircraft; or while in any aircraft operated by or under any military authority (other than the Military Airlift Command); or while in any aircraft being used for a test or experimental purposes; or while in any aircraft used or designed for use beyond the Earth's atmosphere; or while in any aircraft for the purpose of descent from such aircraft while in flight (except for self preservation)
11. Driving a vehicle while intoxicated as defined by the laws of the jurisdiction in which the vehicle was being operated.

### Disclaimer

These benefit descriptions are not part of a summary plan description. They do not serve as evidence of coverage for the program. If you have specific questions regarding the benefit structure, limitations or exclusions, contact the individual plan.

## Optional Health & Healing Card

The Health & Healing Card (HHC) is a membership program offering significant discounts on a wide array of complementary and alternative health, wellness, and fitness providers. It's offered to all TriNet customers in all fifty United States.

Members simply present their card to a participating HHC product or service provider, and receive discounts ranging from 10 to 50 percent on office visits, product purchases, health classes and much more. (Average discounts range from 20 to 25 percent.) With HHC, there are no office visit limitations, no physician referrals, or benefits restrictions.

For an annual membership fee of \$25, you can cover your entire family.

### Who Benefits from this Plan

Anyone drawn to complementary healthcare practices and fitness services should find the HHC useful. Since many of the HHC member services are typically not covered under your insurance plan, the card cuts your costs for services you may already be using.

The basic products and services covered are outlined below.

### Health & Healing Card Coverage Overview

Network Products and Services	Examples
Complementary and Alternative Therapies	Acupuncture, Applied Kinesiology, Aromatherapy, Ayurveda, Chiropractic, Classical Homeopathy, Flower Essence Therapy, Naturopathic Medicine
Psychotherapy and Counseling	Art Therapy, Biofeedback, Hypnotherapy, Coaching, Motivational Counseling, Psychotherapy
Therapeutic Massage	Acupressure, Bowen Therapy, Deep Tissue, Onsite Massage, Reflexology, Shiatsu, Sports Massage, Swedish/Esalen, Trigger Point, Tui Na, Vibrational Healing Massage
Movement and Bodywork	Alexander Technique, Aston Patterning, Body-Mind Somatic Therapy, Breathwork, Craniosacral Therapy, Energywork, Feldenkrais Method, Hellerwork, Reiki, Rolfing, Rosen Method, Tragerwork
Vitamin and Herbal Supplements	Vitamin, Herb and Homeopathic Medicines, and more.
Health and Fitness Classes	Aerobic Exercise, Healthy Cooking, Nutrition, QiGong, Tai Chi, Yoga
Wellness Consultations	Health Education, Nutritional & Diet Counseling, Personal Training, Smoking Cessation program, Stress Management, Pain Management.

Home Exercise and Massage Equipment	Fitness Equipment, Treadmills, Exercise Bikes, Yoga Mats
-------------------------------------	----------------------------------------------------------

**How to Become a Member**

You can apply and pay for the HHC online. Simply visit the “Additional Benefits” section of TriNet’s HR Passport. You’ll see a link to the Health and Healing Card where you can receive TriNet’s special discount on this service.

The providers and their products, services, and discounts will vary depending on your region. For more information, call toll-free 888.817.5566.

You can also contact HHC to request a practitioner or service provider be added to the program.

**Disclaimer**

These benefit descriptions are not part of a summary plan description. They do not serve as evidence of coverage for the program. If you have specific questions regarding the benefit structure, limitations or exclusions, contact the individual plan.

## Time to Transition: Your COBRA Coverage

If you or your covered dependents are no longer eligible for healthcare coverage through TriNet Signature Benefits, you may be eligible to continue your coverage under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

### COBRA

COBRA continuation coverage (herein referred to as COBRA) is a continuation of Plan coverage when benefits would otherwise end because of a life event known as a “qualifying event.” A qualifying event can be any of the following; the end of employment; reduction of hours of employment; death of the employee; or entitlement of the employee in Medicare (Part A, Part B, or both). COBRA must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you don't elect COBRA coverage by the deadlines explained in the Enrollment section of your TriNet Signature Benefits Guidebook, you will not be eligible for COBRA continuation coverage.

### ELIGIBILITY

The Plan will offer COBRA to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the qualifying event within 30 days of the qualifying event. To be eligible, you or your dependents must be covered under TriNet's healthcare plans on the day before you lose your eligibility for that coverage. You don't need to provide evidence of good health for COBRA.

#### You

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events occurs:

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

#### Your Spouse or Domestic Partner

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

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

COBRA legislation does not require domestic partners be covered, and some plans may not allow domestic partner coverage because of current state law. Please refer to the Medical Plans section of the TriNet Signature Benefits Guidebook for Domestic Partner coverage information.

#### Your Dependent Children

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated;

Your children no longer qualify as dependents under TriNet's healthcare plans for the following examples:

- They reach age 19
- They reach age 25, as a full-time student; (student status is not required in CO, TX; age 26 regardless of student status in UT; in MA age 26 or 2 years after the loss of dependants status, whichever comes first)
- They get married
- Loss of student status
- They are under the custody of your spouse or domestic partner after a divorce or legal separation, unless you're ordered by a court to continue coverage

## NOTIFICATION

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA, coverage will begin on the first of the month following loss of coverage.

After we receive notification of the loss of healthcare coverage, you'll receive a COBRA Notice and Election Form that will inform you how to elect COBRA coverage. Please be sure we have your current mailing address. You can either contact the Employee Solution Center at 1-800-638-0461 (6:00 AM – 6:00 PM Pacific Time), visit HR Passport at [www.hrpassport.com](http://www.hrpassport.com), or email [cobra@trinet.com](mailto:cobra@trinet.com) to give us the latest information.

## ENROLLMENT

1. When the package arrives, it will contain a COBRA Notification Letter and Election Form. You or your eligible dependents may elect continuation coverage independently for medical, dental and/or vision benefits.
2. The response date listed on your COBRA election form is the deadline to complete the election form and return it to:  
TriNet COBRA Department  
9805 Double R. Blvd #200  
Reno, NV 89521
3. If you do not include your initial payment with your election form, you have 45 days from the date you return your election form to remit your full initial payment. Full payment must include premiums **retroactive** to the first date of coverage.
4. With the exception of the election form and initial payment, all future payments must be sent to:

TriNet COBRA  
MS-5  
P.O. Box 11107  
Tacoma, WA 98411-0107

### Annual Open Enrollment

Each year TriNet offers Open Enrollment to every COBRA eligible beneficiary. It's online for the most dependable, accurate, timely, and easy-to use process possible. During this annual event, you can re-elect or change some of your benefit options and coverage levels for COBRA.

Once you complete the online Open Enrollment process and electronically send your final benefits selections to TriNet, that's it-you're finished. You will receive an email from TriNet confirming your benefits, and your coverage will become effective on July 1 and stay in effect for the next 12 months (through June 30) or up to the remaining timeline of your COBRA coverage. A confirmation statement will also be mailed to your home address.

Once you receive your confirmation statement, immediately report any errors to TriNet's Employee Solution Center by phone (1-800-638-0461, 6 a.m.-6 p.m., M-F, Pacific Time) or email [cobra@trinet.com](mailto:cobra@trinet.com). Remember – outside of Open Enrollment, you cannot make any changes to your benefit coverage unless you experience a Qualifying Life Status Change.

## COBRA PLANS

### Healthcare

You or your eligible dependents may elect continuation coverage independently for medical, dental and/or vision benefits. You may continue medical, dental and/or 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. You'll receive a *COBRA Election - Health Care FSA* form as part of your COBRA package, which you can complete and return to TriNet with your COBRA Election form. COBRA FSA coverage ends the last day of the current plan year (June 30).

IRS regulations do not allow you to make new FSA elections for the new FSA plan year or to continue participation in the Dependent Day Care FSA through COBRA.

## COVERAGE PERIOD

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

### 18 Months

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months.

### 29 Months

If you or any qualified beneficiary is determined by the Social Security Administration to be disabled, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that TriNet is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

COBRA coverage will end on the earlier of these two dates:

- The end of the month in which you're no longer disabled
- The end of the 11-month additional COBRA period

**GUIDELINES: DISABLED COBRA APPLICANTS**

Per the Revenue Reconciliation Act of 1989, the monthly premium amounts increase to

**150% of the applicable premium for the 11 additional months of Health Benefit**

**Continuation.**

A Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act to have been disabled, as of the date of termination of employment, reduction in hours or within sixty (60) days after COBRA coverage begins, may be eligible to continue coverage for an additional eleven (11) months (29 months total.) The Qualified Beneficiary **MUST** notify the Plan Administrator within sixty (60) days of receipt of the determination of disability by the Social Security Administration and prior to the end of the 18-month continuation period. The Plan Administrator will charge 150% of the group rate during the 11-month extension. The Qualified Beneficiary **MUST** notify the Plan Administrator within thirty (30) days upon the determination that the Qualified Beneficiary is no longer disabled under Title II or XVI of the Social Security Act.

**36 Months**

Your qualified beneficiaries may receive up to 36 months of COBRA coverage if one of the following situations occurs during their initial 18 months of COBRA coverage, or if your qualified dependents lose benefit eligibility for one of these reasons and we are notified within 30 days of the event:

- You divorce or legally separate
- You end your domestic partner relationship
- You become entitled to Medicare benefits
- You die
- Your child no longer qualifies as a dependent under TriNet's plans

**Cal-COBRA**

California Assembly Bill 1401 amended the California Continuation Benefits Replacement Act (Cal-COBRA) effective January 1, 2003. California residents and those participants whose medical carrier Plans originate in California, even if they reside in a different state; and who started COBRA as of January 1, 2003; and maintained coverage for the entire 18 or 29 months will be entitled to an additional 7 or 18 months of medical coverage administered directly by their health insurance company.

The new law does not apply to anyone who started COBRA/Cal-COBRA prior to January 1, 2003 nor does it apply to participants whose medical carrier Plans do NOT originate in California. If you have questions regarding your eligibility for the Cal-COBRA extension, please contact your insurance carrier.

**SENIOR COBRA: Extended Coverage for Those Age 60 and Older**

This program will only be available to those individuals who qualified prior to January 1, 2005. Anyone in California who qualifies after that date will not be offered a Senior continuation program per California Assembly Bill 254 (AB254) (2004) which does away with the Senior continuation program

Under the California Continuation Benefits Replacement Act, California law provides greater continuation coverage rights than COBRA coverage for certain individuals age 60 and older. In

such cases, these individuals could receive roughly five years of continuation coverage. This part of California law does not specifically apply to dependent children, unlike COBRA. Also, the extended coverage could end early if an individual becomes covered under another employer's group health plan even if that coverage is less valuable than continued coverage.

**GUIDELINES: SENIOR COBRA APPLICANTS**

Per the California Continuation Benefits Replacement Act, the monthly premium amounts for Senior COBRA increase to 213%, (if not adjusted for age), or 110%, (if adjusted for age), of the applicable premium for the additional months of Health Benefit Continuation.

Senior COBRA coverage may be extended to former employees who have: (1) reached age 60 or older on the date employment ends; (2) worked for the employer for the last five years; and (3) elected COBRA or Cal-COBRA coverage.

Individuals must submit their election for Senior COBRA in writing within 30 days of the end of COBRA or Cal-COBRA coverage. A former employee can also elect this coverage for his or her spouse. In addition, surviving spouses and ex-spouses of qualified beneficiaries are eligible for this extension.

The extended coverage ends automatically when: (1) the individual reaches age 65 and becomes covered under any other group health plan (regardless of whether that coverage is less valuable) or entitled to Medicare; (2) the employer ceases to maintain any group health plan; or (3) five years from the date COBRA or Cal-COBRA coverage was scheduled to end for a spouse.

**LIFE STATUS CHANGE**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the status of you and your family members. Birth, adoption, marriage and divorce are examples of events that have impact on both you and your dependent's coverage. You need to notify TriNet within 30 days if you experience a Life Status Change.

Call the Employee Solution Center at 1-800-638-0461 (6 a.m.-6 p.m., M-F, Pacific time) or email us at [cobra@trinet.com](mailto:cobra@trinet.com).

**PAYMENTS**

***You will not receive an invoice or any reminders stating when payments are due.***

- Make checks payable to TriNet and include your Employee ID number on each check.
- If you receive healthcare treatment during a month in which you have not paid your premiums on time or in full, you will be responsible for your healthcare costs.
- After you have remitted your initial payment, COBRA premiums are due on the first day of each coverage month.
- You are granted a 30-day grace period in which the payment must be postmarked.
- No late payments will be accepted after the grace period expires.
- If you submit a partial premium payment, your coverage will terminate as of the end of the month of your last full premium payment.
- It is the sole responsibility of the participant to make certain that payments are remitted according the rules as outlined above.
- If you decide to modify or terminate your coverage, TriNet will refund any premiums that you have already submitted for future months coverage. No mid-month terminations or refunds will be allowed.
- Please note that payments include a 2% administrative fee.

Send your election form and first premium payment to:

TriNet  
COBRA Department  
9805 Double R. Blvd #200  
Reno, NV 89521

Send all subsequent payments to:

TriNet  
COBRA Department  
MS-5  
P.O. Box 11107  
Tacoma, WA 98411-0107

**GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS**  
**APPENDIX TO §2590.606-1**  
**\*\*CONTINUATION COVERAGE RIGHTS UNDER COBRA\*\***

## Introduction

You are receiving this notice because you have recently become covered under the TriNet Employee Benefit Insurance Plan #501 (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description *or* get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is TriNet, 1100 San Leandro Boulevard, Suite 300, San Leandro, California 94577 (510) 352-5000. The Plan Administrator is responsible for administering COBRA continuation coverage.

### COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.

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

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

**For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to TriNet COBRA department, 9805 Double R Boulevard, Suite 200, Reno, NV 89521. You must send a copy of the supporting information or documentation.**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

#### **Disability extension of 18-month period of continuation coverage**

**If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to: TriNet COBRA department, 9805 Double R Boulevard, Suite 200, Reno, NV 89521. You must send a copy of the supporting information or documentation.**

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

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both),

or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child.

**In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the TriNet COBRA department, 9805 Double R Boulevard, Suite 200, Reno, NV 89521. You must send a copy of the supporting information or documentation.**

### **If You Have Questions**

If you have questions about your COBRA continuation coverage, you should contact the TriNet COBRA department, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

### **Keep Your Plan Informed of Address Changes**

**In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members.** You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## **DISCLAIMER**

If you have questions about your COBRA continuation coverage, you should contact the TriNet COBRA department or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

If there are any discrepancies between the TriNet Signature Benefits Guidebook and the plan documents, the plan documents will control.

## **Notice of Privacy Practices**

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 Employee Benefits Insurance Trust group health plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (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 (the "Notice") 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 employer on behalf of a group health plan, that relates to:

- (1) your past, present or future physical or mental health or condition;
- (2) the provision of health care to you; or
- (3) 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 c/o Greg Hammond at (510) 352-5000.

### ***Effective Date***

This Notice is effective April 14, 2003, as amended on June 11, 2004, and February 9, 2007.

### ***Our Responsibilities***

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is 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.

### ***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 of 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 contra indicate 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 pre-certification 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, premium 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.

**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. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/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 only 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. These programs 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:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- 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;
- 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—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person suspected of committing a crime.

**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). 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 employee. This includes mail relating to the 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 employee's spouse and other family members and information on the denial of any Plan benefits to the 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. You may revoke written authorization 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. To inspect and copy your protected health information, you must submit your request in writing to the HIPAA Privacy Officer c/o Greg Hammond, at TriNet, 1100 San Leandro Boulevard, Suite 300, San Leandro, California 94577. 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.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Benefits Appeals Committee, at TriNet, 1100 San Leandro Boulevard, Suite 300, San Leandro, California 94577.

**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 c/o Greg Hammond, at TriNet, 1100 San Leandro Boulevard, Suite 300, San Leandro, California 94577. In addition, 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:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- 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 c/o Greg Hammond, at TriNet, 1100 San Leandro Boulevard, Suite 300, San Leandro, California 94577. Your request must state a time period of not 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. 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.

To request restrictions, you must make your request in writing to the HIPAA Privacy Officer c/o Greg Hammond, at TriNet, 1100 San Leandro Boulevard, Suite 300, San Leandro, California 94577. 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 c/o Greg Hammond, at TriNet, 1100 San Leandro Boulevard, Suite 300, San Leandro, California 94577. 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 if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

**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, [www.trinet.com](http://www.trinet.com).

To obtain a paper copy of this notice, make your request in writing to the HIPAA Privacy Officer c/o Greg Hammond, at TriNet, 1100 San Leandro Boulevard, Suite 300, San Leandro, California 94577.

### **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 c/o Greg Hammond, at (510) 352-5000. 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.