

# Benefits At A Glance

Plan Year 2018

**Your Insperty benefits package** includes the benefits summarized in this document. Actual benefits are subject to the provisions and limitations of the agreements between Insperty and its carriers/vendors. Detailed benefits information is available online at [portal.insperty.com](http://portal.insperty.com).

**Eligibility Rules for the health and welfare benefits plans listed below:** Employees must generally be working 30 or more hours per week, on average (20 hours per week in Hawaii), or meet the requirements for continuing eligibility during an approved leave of absence, to be eligible for health and welfare benefits plans\*. Certain individuals are excluded from participation in the Insperty plans. Please refer to Summary Plan Descriptions and other benefits information online for additional details on eligibility requirements.

\*The Employee Assistance Program is available to all employees with no hourly requirement. Eligibility requirements for the “Additional Programs” listed below may vary – see descriptions for details.

HEALTH BENEFITS	VENDOR	DESCRIPTION
<p>GROUP HEALTH PLAN <b>Medical Benefits</b></p>	Various insurance carriers	<p>A summary of the medical coverage options available in this benefits package are provided later in this document.</p> <p><b>NOTE:</b> Most of Insperty's medical coverage options include telemedicine (or virtual visit) providers for the treatment of minor illnesses, except where currently prohibited by state law. When available with your coverage option, a telemedicine visit generally costs less than a physician's office visit or urgent care. Access telemedicine providers through your insurance carrier's member website.</p> <p>A variety of wellness services and programs can also be found on your insurance carrier's member website (or by calling the toll-free number on your insurance ID card).</p>
<p><b>Insperty Health Care Flexible Spending Account (FSA) Plan</b></p>	UnitedHealthcare	<p>Employees who are eligible to make pretax contributions may set aside a portion of current earnings (up to an annual maximum of \$2,600) for reimbursement of qualifying health care expenses incurred during the plan year (and only while a participant under this Health Care FSA). Incurred expenses are eligible for reimbursement only when not otherwise covered by a health plan.</p> <p><b>NOTE:</b> Employees who make contributions to a health savings account (HSA) are not eligible to participate in the Insperty Health Care FSA Plan. Participation in the Insperty Health Care FSA Plan at any time during the calendar year will render an employee ineligible to participate in the Insperty HSA Program during the same calendar year.</p>
<p><b>Insperty Health Savings Account (HSA) Program</b></p>	Tango Health	<p>Employees who enroll in an Insperty high deductible health plan (HDHP) medical coverage option have the opportunity to establish an individual health savings account (HSA) through the Insperty HSA Program and make contributions – up to established annual federal limits – via convenient payroll deduction. HSA contributions through the Insperty HSA Program are made on a pretax basis (for employees who are eligible to make pretax contributions) or a post-tax basis (for all other employees). There are no federal taxes on pretax contributions made to an HSA, and money from an HSA is tax free when used for qualified medical expenses.</p> <p><b>NOTE:</b> Employees who make contributions to a general-purpose Health Care FSA, including the Insperty Health Care FSA Plan, are not eligible to participate in the Insperty HSA Program.</p>
<p><b>Employee Assistance Program</b></p>	Optum®	Available to all Insperty employees, with no hourly eligibility requirement. Confidential counseling and support program. Most services available at no cost to employee.
WELFARE BENEFITS	VENDOR	DESCRIPTION
<p>WELFARE BENEFITS PLAN <b>Basic Life &amp; Personal Accident Insurance [100% employer-paid]</b></p>	Cigna	<p>Employee only coverage. <b>Premiums paid by Insperty.</b> Limitations may apply if you are age 65 or older.</p> <p><b>Basic Term Life Insurance</b> ..... Amount equal to 1x employee's <b>covered annual earnings</b> (\$15,000 minimum; \$50,000 maximum)</p> <p><b>Basic Personal Accident Insurance</b> .... Amount equal to 1x employee's <b>covered annual earnings</b> (\$15,000 minimum; \$50,000 maximum)</p> <p><b>Covered annual earnings</b> include base or estimated annual earnings plus amounts received as commissions, piece work and fee-based pay (as paid by Insperty), but exclude bonuses, overtime, special pay or any other form of extra compensation. Coverage amounts based on covered annual earnings are rounded to the next higher \$1,000.</p>
<p>WELFARE BENEFITS PLAN <b>Voluntary Group Universal Life Insurance [100% employer-paid]</b></p>	Cigna	<p>Optional coverage for employees and their families; premiums 100% paid by employee. Full details, including rates, are provided in the Cigna Voluntary Benefits booklet available online at <a href="http://portal.insperty.com">portal.insperty.com</a>.</p> <p><b>Employee</b> ..... 1x to 6x <b>covered annual earnings</b> (defined below), up to a maximum of \$2.5 million</p> <p><b>Spouse/Domestic Partner</b> ... \$10,000, \$20,000, \$30,000, \$40,000, \$50,000, \$100,000, \$150,000, \$200,000</p> <p><b>Child(ren)</b> ..... \$5,000/child, \$10,000/child</p> <p><b>Evidence of insurability (EOI)</b> is required for employee coverage of more than <b>3x covered annual earnings</b> or \$500,000, whichever is less. EOI is required for spouse coverage over <b>\$20,000</b>. EOI is required for ANY amount of coverage if employee or spouse elects voluntary (employee-paid) Group Universal Life (GUL) coverage AFTER the initial 30-day eligibility period.</p> <p><b>Covered annual earnings</b> include base or estimated annual earnings plus amounts received as commissions, piece work and fee-based pay (as paid by Insperty), but exclude bonuses, overtime, special pay or any other form of extra compensation. Coverage amounts based on covered annual earnings are rounded to the next higher \$1,000.</p>

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WELFARE BENEFIT S	VENDOR	DESCRIPTION
<p>WELFARE BENEFITS PLAN</p> <p><b>Voluntary Personal Accident Insurance</b> [100% employee-paid]</p>	Cigna	<p>Optional coverage for employees and their families; premiums 100% paid by employee. Full details, including rates, are provided in the Cigna Voluntary Benefits booklet available online at portal.insperity.com.</p> <p><b>Employee</b> ..... 1x to 6x <b>covered annual earnings</b> (defined below), up to a maximum of \$2.5 million  <b>Spouse/Domestic Partner Only</b> .... 60% of employee coverage amount  <b>Spouse/Domestic Partner &amp; Child</b> ... 50% of employee coverage amount; 10% for each dependent child  <b>Child(ren) Only</b> ..... 15% of employee coverage amount</p> <p><i>Covered annual earnings include base or estimated annual earnings plus amounts received as commissions, piece work and fee-based pay (as paid by Insperity), but exclude bonuses, overtime, special pay or any other form of extra compensation. Coverage amounts based on covered annual earnings are rounded to the next higher \$1,000.</i></p>
<p>WELFARE BENEFITS PLAN</p> <p><b>Voluntary Disability Insurance</b> [100% employee-paid]</p>	Cigna	<p>Optional coverage for eligible employees; premiums 100% paid by employee. Full details, including rates, are provided in the Cigna Voluntary Benefits booklet available online at portal.insperity.com. Limitations may apply.</p> <p><b>Basic Short-Term Disability</b>            Coverage Amount .... Up to 60% of <b>covered weekly earnings</b> (defined below), up to \$2,308 per week            Coverage Begins ..... 15th day of disability            Maximum Period ..... Six continuous months or end of disability, whichever comes first</p> <p><b>Basic Long-Term Disability</b>            Coverage Amount .... Up to 60% of <b>covered monthly earnings</b> (defined below), up to \$10,000 per month            Coverage Begins ..... After you've been disabled six continuous months            Maximum Period ..... Disability beginning age 62 or younger: Up to age 65 or end of disability, whichever comes first. Abbreviated payment schedule applies for disability beginning age 63 or older.</p> <p><i>Covered weekly earnings calculated from an employee's covered annual earnings (defined above), divided by 52.            Covered monthly earnings calculated from an employee's covered annual earnings (defined above), divided by 12.</i></p>
ADDITIONAL PROGRAMS	VENDOR	DESCRIPTION
<b>Adoption Assistance</b>	Insperity	Available to employees who complete at least 180 days of continuous service after obtaining an eligible status. The continuous service requirement must be satisfied prior to the date of the final adoption decree(s). Program reimburses up to \$1,500 per qualified adoption. Qualifying expenses must be incurred through private adoption or licensed adoption agencies.
<b>Commuter Benefits</b>	WageWorks®	Commuter benefits are offered to any employees eligible to make pretax contributions, regardless of number of hours worked per week. Employees who elect to enroll for commuter benefits may pay for job-related mass transit and/or parking expenses with pretax dollars. Employees may enroll for commuter benefits at any time, and may discontinue participation at any time. Employees who do <b>not</b> enroll will be considered to have waived this benefit.
<b>Insperity Pay Options</b>	Insperity	<p><b>Payroll Direct Deposit (with ePayStub):</b> Insperity makes the convenience of payroll direct deposit available to all client companies who choose it. With direct deposit, net pay is deposited automatically, as directed by the employee, in up to four designated checking and/or savings accounts, including 529 College Savings Plan accounts, and it is always on time. Employees may choose to receive their paystubs electronically via ePayStub as well. There is no charge to the employee for direct deposit or ePayStub services.</p> <p><b>Debit Pay Card:</b> A convenient alternative to the traditional paycheck. No bank account required.</p>
<b>Training &amp; Development</b>	Insperity	Available to all Insperity employees with no eligibility requirements. Insperity provides extensive training programs to help employees and supervisors learn new skills, maintain safety or compliance, improve performance and develop in their careers. We can help identify and analyze performance gaps and recommend solutions to help improve productivity. Self-paced resources include over 3,000 courses on topics such as business, desktop, safety, liability management, and advanced IT; more than 20,000 online digital books from industry top authors and publishers in business, and 9 learning portals that target key topic areas. CPE credits area available on select online and classroom courses, PDU credits are available on select online courses.

## Medical Coverage Options At A Glance

Participants are strongly encouraged to receive services from **in-network providers** where possible, as the plan generally pays higher benefits for in-network services. If services are received from out-of-network providers, participant cost-sharing (e.g., deductibles, annual out-of-pocket maximums, and coinsurance) **will be higher**.

Please see also **“What You Need to Know About Group Health Plan Coverage”** for participant responsibilities and obligations, as well as additional group health plan details and information.

MEDICAL (participant costs for <b>non-preventive care</b> services <sup>1</sup> )												PHARMACY	
<ul style="list-style-type: none"> <li>Participant costs when covered services received from <b>IN-NETWORK</b> providers.</li> <li>Participant costs when covered services received from <b>OUT-OF-NETWORK</b> providers. <i>Not all options provide out-of-network benefits</i></li> </ul>												<p><b>IMPORTANT:</b> Pharmacy copays, deductibles and/or coinsurance generally <b>APPLY</b> towards the combined medical + pharmacy annual out-of-pocket maximum, <b>unless otherwise noted</b>.</p>	
<b>Medical Calendar-Year Deductible</b>		<b>Medical+ Pharmacy Combined Annual Out-of-Pocket Max.</b> <i>(unless otherwise noted)</i>		<b>Coinsurance</b>		<b>THE LEGEND BELOW APPLIES ONLY IN THIS SECTION</b>						<b>PER INDIVIDUAL Calendar-yr. Deductible</b>	<b>Prescription (Rx) Copays</b>
This is the amount you owe for certain covered health care services before the plan begins to pay. Not all covered services require this deductible to be met.		This is the most you must pay out of your own pocket during the calendar-year policy period before the plan begins to pay 100% of eligible expenses for covered services.		Where a copay applies, coinsurance generally will <b>not</b> apply.		<ul style="list-style-type: none"> <li>\$ = Participant Copay</li> <li>% = Participant-paid Coinsurance after deductible is satisfied</li> </ul>							
INDIVIDUAL	FAMILY	INDIVIDUAL	FAMILY	PLAN PAYS	YOU PAY	Physician Office Visit <sup>1</sup>	Specialist Office Visit <sup>1</sup>	Outpatient Surgery	Inpatient Hospitalization	Urgent Care Centers	Emergency Room	<b>RETAIL COPAY TIERS</b> <b>MAIL ORDER COPAY TIERS</b>	

**NATIONWIDE** Coverage options listed in this section are generally available to eligible employees nationwide, unless a state-specific set of options are listed.

<b>UHC UnitedHealthcare Choice Plus 500<sup>2</sup></b>	\$500	\$1,500	\$5,000	\$10,000	80%	20%	\$35	\$60	20%	20%	\$75	\$250	\$100 (\$300 max per family)	\$10   \$35   \$60   \$120
	\$1,000	\$3,000	\$10,000	\$20,000	60%	40%	40%	40%	40%	40%	40%			\$25   \$87.50   \$150   \$300
<b>UHC UnitedHealthcare Choice Plus 1000<sup>2</sup></b>	\$1,000	\$3,000	\$4,500	\$9,000	80%	20%	\$35	\$60	20%	20%	\$75	\$250	\$100 (\$300 max per family)	\$10   \$35   \$60   \$120
	\$2,000	\$6,000	\$9,000	\$18,000	60%	40%	40%	40%	40%	40%	40%			\$25   \$87.50   \$150   \$300
<b>UHC UnitedHealthcare Choice Plus 1500<sup>2</sup></b>	\$1,500	\$4,500	\$6,350	\$12,700	80%	20%	\$35	\$60	20%	20%	\$75	\$250	\$100 (\$300 max per family)	\$10   \$35   \$60   \$120
	\$3,000	\$9,000	\$12,700	\$25,400	60%	40%	40%	40%	40%	40%	40%			\$25   \$87.50   \$150   \$300
<b>UHC UnitedHealthcare Choice Plus 2500<sup>2</sup></b>	\$2,500	\$7,500	\$6,850	\$13,700	70%	30%	\$40	\$70	30%	30%	\$75	\$250	\$100 (\$300 max per family)	\$10   \$35   \$60   \$120
	\$5,000	\$15,000	\$13,700	\$27,400	50%	50%	50%	50%	50%	50%	50%			\$25   \$87.50   \$150   \$300
<b>UHC UnitedHealthcare Choice Plus 6000<sup>2</sup></b>	\$6,000	\$13,200	\$7,000	\$14,000	100%	0%	\$40	\$70	0%	0%	\$75	\$500	\$200 (\$600 max per family)	\$10   \$35   \$60   \$120
	\$12,000	\$16,400	\$14,000	\$28,000	70%	30%	30%	30%	30%	30%	30%			\$25   \$87.50   \$150   \$300
♦ <b>UHC Choice Plus HDHP 1500<sup>2, A</sup></b> <i>(HSA-qualified option)</i>	\$1,500	\$3,000	\$4,000	\$7,350	90%	10%	10%	10%	10%	10%	10%	10%	♦	\$10   \$35   \$60   \$120
	\$3,000	\$6,000	\$8,000	\$14,700	70%	30%	30%	30%	30%	30%	30%			\$25   \$87.50   \$150   \$300
♦ <b>UHC Choice Plus HDHP 3000<sup>2</sup></b> <i>(HSA-qualified option)</i>	\$3,000	\$6,000	\$6,650	\$13,300	90%	10%	10%	10%	10%	10%	10%	10%	♦	\$10   \$35   \$60   \$120
	\$6,000	\$12,000	\$13,300	\$26,600	70%	30%	30%	30%	30%	30%	30%			\$25   \$87.50   \$150   \$300
♦ <b>UHC Choice Plus HDHP 5000<sup>2</sup></b> <i>(HSA-qualified option)</i>	\$5,000	\$10,000	\$6,650	\$13,300	80%	20%	20%	20%	20%	20%	20%	20%	♦	\$10   \$35   \$60   \$120
	\$10,000	\$20,000	\$13,300	\$26,600	60%	40%	40%	40%	40%	40%	40%			\$25   \$87.50   \$150   \$300

**CALIFORNIA** Eligible California employees may choose from the UHC options listed above under Nationwide **OR** from those listed in this California section.

<b>UHC of California Signature Value HMO<sup>3</sup></b>	None	None	\$3,000	\$6,000	100%	0%	\$25	\$50	\$125	\$500	Based on place of service	\$200	N/A	\$10   \$30   \$50 Specialty RX 30% (Max \$200) \$25   \$75   \$125
<b>BCA Blue Shield of California HMO<sup>3</sup></b>	None	None	\$3,000	\$6,000	100%	0%	\$25	\$50	\$150	\$500	Based on place of service	\$200	N/A	\$10   \$25   \$40   Specialty RX 30% (Max \$200) \$20   \$50   \$70
<b>BCA Blue Shield of California Deductible HMO 1000<sup>3</sup></b>	\$1,000	\$2,000	\$6,050	\$12,100	90%	10%	\$35	\$50	10%	10%	Based on place of service	10%	\$100 for certain drugs	\$10   \$30   N/A Specialty RX 30% (Max \$200) \$20   \$60   N/A
<b>KPC Kaiser Permanente HMO<sup>3</sup></b>	None	None	\$3,000	\$6,000	100%	0%	\$25	\$50	\$100	\$250	Based on place of service	\$200	N/A	\$10   \$30   N/A Specialty RX 30% (Max \$150) \$20   \$60   N/A

## Medical Coverage Options At A Glance

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Please see also **“What You Need to Know About Group Health Plan Coverage”** for participant responsibilities and obligations, as well as additional group health plan details and information.

MEDICAL (participant costs for <b>non-preventive care</b> services <sup>1</sup> )											PHARMACY	
<ul style="list-style-type: none"> <li>Participant costs when covered services received from <b>IN-NETWORK</b> providers.</li> <li>Participant costs when covered services received from <b>OUT-OF-NETWORK</b> providers. <i>Not all options provide out-of-network benefits.</i></li> </ul>											<b>IMPORTANT:</b> Pharmacy copays, deductibles and/or coinsurance generally <b>APPLY</b> towards the combined medical + pharmacy annual out-of-pocket maximum, <u>unless otherwise noted</u> .	
Medical Calendar-Year Deductible		Medical+ Pharmacy Combined Annual Out-of-Pocket Max.		Coinsurance		THE LEGEND BELOW APPLIES <b>ONLY</b> IN THIS SECTION						
INDIVIDUAL	FAMILY	INDIVIDUAL	FAMILY	PLAN PAYS	YOU PAY	Physician Office Visit <sup>1</sup>	Specialist Office Visit <sup>1</sup>	Outpatient Surgery	Inpatient Hospitalization	Urgent Care Centers	Emergency Room	
This is the amount you owe for certain covered health care services before the plan begins to pay. Not all covered services require this deductible to be met.		This is the most you must pay out of your own pocket during the calendar-year policy period before the plan begins to pay 100% of eligible expenses for covered services.		Where a copay applies, coinsurance generally will <b>not</b> apply.		\$ = Participant Copay % = Participant-paid Coinsurance after deductible is satisfied					Rx copays apply <b>ONLY</b> after satisfying pharmacy deductible (or HDHP medical deductible), where applicable.	

**CALIFORNIA** (continued) Eligible California employees may choose from the UHC options listed above under Nationwide **OR** from those listed in this California section.

Plan Name	INDIVIDUAL	FAMILY	INDIVIDUAL	FAMILY	PLAN PAYS	YOU PAY	Physician Office Visit <sup>1</sup>	Specialist Office Visit <sup>1</sup>	Outpatient Surgery	Inpatient Hospitalization	Urgent Care Centers	Emergency Room	PER INDIVIDUAL Calendar-yr. Deductible	PHARMACY
KPC Kaiser Permanente Deductible HMO 1000 <sup>3</sup>	\$1,000	\$2,000	\$6,050	\$12,100	70%	30%	\$35	\$50	30%	30%	Based on place of service	30%	\$100 per member for certain drugs	\$10   \$30   N/A Specialty RX 30% (Max \$150) \$20   \$60   N/A
◆ KPC Kaiser Perm. HMO HDHP <sup>3</sup> (HSA-qualified option)	\$2,700	\$5,400	\$5,200	\$10,400	90%	10%	10%	10%	10%	10%	10%	10%	◆	\$10   \$30   N/A Specialty RX 30% (Max \$150) \$20   \$60   N/A

**MASSACHUSETTS** Coverage options listed in this section are available **ONLY** to eligible employees who live in Massachusetts.

Plan Name	INDIVIDUAL	FAMILY	INDIVIDUAL	FAMILY	PLAN PAYS	YOU PAY	Physician Office Visit <sup>1</sup>	Specialist Office Visit <sup>1</sup>	Outpatient Surgery	Inpatient Hospitalization	Urgent Care Centers	Emergency Room	PER INDIVIDUAL Calendar-yr. Deductible	PHARMACY
THP Tufts CareLink Advantage PPO 500 <sup>2</sup>	\$500	\$1,500	\$5,000	\$10,000	80%	20%	\$35	\$35	20%	20%	Based on place of service	\$250	N/A	\$10   \$35   \$60 \$20   \$70   \$120
	\$1,000	\$3,000	\$10,000	\$20,000	60%	40%	20%	20%	40%	40%	40%			
THP Tufts CareLink Advantage PPO 1000 <sup>2</sup>	\$1,000	\$3,000	\$4,500	\$9,000	80%	20%	\$35	\$35	20%	20%	Based on place of service	\$250	N/A	\$10   \$35   \$60 \$20   \$70   \$120
	\$2,000	\$6,000	\$9,000	\$18,000	60%	40%	20%	20%	40%	40%	40%			
THP Tufts CareLink Advantage PPO 1500 <sup>2</sup>	\$1,500	\$4,000	\$6,350	\$12,700	80%	20%	\$35	\$35	20%	20%	Based on place of service	\$250	N/A	\$10   \$35   \$60 \$20   \$70   \$120
	\$3,000	\$8,000	\$10,000	\$20,000	60%	40%	20%	20%	40%	40%	40%			
◆ THP Tufts CareLink Advantage Saver PPO HDHP 1500 <sup>2, A</sup> (HSA-qualified option)	Combined In- & Out-of-Network				90%	10%	10%	10%	10%	10%	10%	10%	◆	\$10   \$35   \$60 \$20   \$70   \$120
	\$1,500	\$3,000	\$4,000	\$7,350	70%	30%	30%	30%	30%	30%	30%			
◆ THP Tufts CareLink Advantage Saver PPO HDHP 3000 <sup>2, A</sup> (HSA-qualified option)	Combined In- & Out-of-Network				90%	10%	10%	10%	10%	10%	10%	10%	◆	\$10   \$35   \$60 \$20   \$70   \$120
	\$3,000	\$6,000	\$4,000	\$7,350	70%	30%	30%	30%	30%	30%	30%			
THP Tufts Value HMO <sup>3</sup>	None	None	\$3,000	\$6,000	100%	0%	\$25	\$40	\$100	\$500	Based on place of service	\$250	N/A	\$10   \$30   \$60 \$20   \$60   \$90
THP Tufts Advantage Deductible HMO 1000 <sup>3</sup>	\$1,000	\$2,000	\$5,000	\$10,000	100%	0%	\$25	\$40	0%	0%	Based on place of service	\$250	N/A	\$15   \$30   \$60 \$30   \$60   \$100
THP Tufts Advantage Deductible HMO 2000 <sup>3</sup>	\$2,000	\$4,000	\$6,350	\$12,700	100%	0%	\$30	\$45	0%	0%	Based on place of service	\$250	N/A	\$15   \$30   \$60 \$30   \$60   \$100
◆ THP Tufts Adv. Saver HMO HDHP 1500 <sup>3, A</sup>	\$1,500	\$3,000	\$4,000	\$7,350	90%	10%	10%	10%	10%	10%	10%	10%	◆	\$10   \$35   \$60 \$20   \$70   \$120
◆ THP Tufts Adv. Saver HMO HDHP 3000 <sup>3, A</sup> (HSA-qualified option)	\$3,000	\$6,000	\$4,000	\$7,350	65%	35%	35%	35%	35%	35%	35%	35%	◆	\$15   \$30   \$60 \$30   \$60   \$150

# Medical Coverage Options At A Glance

Participants are strongly encouraged to receive services from **in-network providers** where possible, as the plan generally pays higher benefits for in-network services. If services are received from out-of-network providers, participant cost-sharing (e.g., deductibles, annual out-of-pocket maximums, and coinsurance) **will be higher**.

Please see also **“What You Need to Know About Group Health Plan Coverage”** for participant responsibilities and obligations, as well as additional group health plan details and information.

MEDICAL (participant costs for <b>non-preventive care</b> services <sup>1</sup> )											PHARMACY		
<ul style="list-style-type: none"> <li>Participant costs when covered services received from <b>IN-NETWORK</b> providers.</li> <li>Participant costs when covered services received from <b>OUT-OF-NETWORK</b> providers. <i>Not all options provide out-of-network benefits</i></li> </ul>											<b>IMPORTANT:</b> Pharmacy copays, deductibles and/or coinsurance generally <b>APPLY</b> towards the combined medical + pharmacy annual out-of-pocket maximum, <b>unless otherwise noted</b> .		
Medical Calendar-Year Deductible		Medical+ Pharmacy Combined Annual Out-of-Pocket Max.		Coinsurance		THE LEGEND BELOW APPLIES <b>ONLY</b> IN THIS SECTION						PER INDIVIDUAL Calendar-yr. Deductible	<b>Prescription (Rx) Copays</b> Rx copays apply <b>ONLY</b> after satisfying pharmacy deductible (or HDHP medical deductible), where applicable.  <b>RETAIL COPAY TIERS</b> <b>MAIL ORDER COPAY TIERS</b>
INDIVIDUAL	FAMILY	INDIVIDUAL	FAMILY	PLAN PAYS	YOU PAY	Physician Office Visit <sup>1</sup>	Specialist Office Visit <sup>1</sup>	Outpatient Surgery	Inpatient Hospitalization	Urgent Care Centers	Emergency Room		

**HAWAII** Coverage options listed in this section are available **ONLY** to eligible employees who live in Hawaii.

Plan Name	Individual Deductible	Family Deductible	Medical-Only Deductible	Medical-Only OOP Max	Coinsurance (Plan/You)	Physician Office Visit	Specialist Office Visit	Outpatient Surgery	Inpatient Hospitalization	Urgent Care Centers	Emergency Room	Pharmacy Deductible	Pharmacy Copays	
<b>BHI HMSA BCBS of Hawaii HMO<sup>3</sup></b>	None	None	\$2,500 <sup>4</sup>	\$7,500 <sup>4</sup>	90% / 10%	\$20	\$20	10%	10%	Based on place of service	\$100	N/A	\$7   \$30   \$30 + \$45   Specialty Rx \$100   \$200 <b>\$11   \$65   \$65 + \$135</b>	
<b>KPC Kaiser Permanente HMO<sup>3</sup></b>	None	None	\$2,000	\$6,000	100% / 0%	\$20	\$20	\$20	\$50 per day	Based on place of service	\$50	N/A	\$5   \$20   Not covered <b>\$10   \$40   Not covered</b>	
<b>UHC Options PPO<sup>2</sup></b>	Combined In- & Out-of-Network				90% / 10%	10%	10%	10%	10%	10%	10%	10%	N/A	\$10   \$15   \$30 <b>\$20   \$30   \$60</b>

**OUT-OF AREA** Indemnity options available **ONLY** to eligible employees who live in a ZIP code service area **NOT** served by a carrier network contracted with the Insperty Group Health Plan. **No** network limitations apply.

Plan Name	Individual Deductible	Family Deductible	Medical-Only Deductible	Medical-Only OOP Max	Coinsurance (Plan/You)	Physician Office Visit	Specialist Office Visit	Outpatient Surgery	Inpatient Hospitalization	Urgent Care Centers	Emergency Room	Pharmacy Deductible	Pharmacy Copays
<b>UHC UnitedHealthcare PP1 Out-of-Area 500</b>	\$500	\$1,500	\$6,350	\$12,700	80% / 20%	20%	20%	20%	20%	20%	20%	\$100 (\$300 max per family)	\$10   \$35   \$60   \$120 <b>\$25   \$87.50   \$150   \$300</b>
<b>◆ UHC PP1 Out-of-Area HDHP 1500<sup>A</sup></b> <i>(HSA-qualified option)</i>	\$1,500	\$3,000	\$4,000	\$8,000	80% / 20%	20%	20%	20%	20%	20%	20%	◆	\$10   \$35   \$60   \$120 <b>\$25   \$87.50   \$150   \$300</b>
<b>◆ UHC PP1 Out-of-Area HDHP 3000</b> <i>(HSA-qualified option)</i>	\$3,000	\$6,000	\$6,650	\$13,300	80% / 20%	20%	20%	20%	20%	20%	20%	◆	\$10   \$35   \$60   \$120 <b>\$25   \$87.50   \$150   \$300</b>
<b>◆ UHC PP1 Out-of-Area HDHP 5000</b> <i>(HSA-qualified option)</i>	\$5,000	\$10,000	\$6,650	\$13,300	80% / 20%	20%	20%	20%	20%	20%	20%	◆	\$10   \$35   \$60   \$120 <b>\$25   \$87.50   \$150   \$300</b>

◆ Denotes a high deductible health plan (HDHP)-type coverage option, which offers **NO** coverage (other than certain preventive care) until the **applicable** deductible is met. All Insperty HDHP-type coverage options are HSA-eligible. With HDHP coverage, Rx copays apply **only** after the **applicable** HDHP medical calendar-year deductible is met. As a result, HDHP coverage options generally do not have a separate pharmacy deductible. (See also the HDHP explanation on the next page.)

- <sup>1</sup> In-network office visits for **preventive care services** (as defined in the Certificate of Coverage that applies to a specific Insperty coverage option) are paid at 100% and **not** subject to any deductible, coinsurance or copay. Applies to all Insperty coverage options.
- <sup>2</sup> Choice Plus and PPO-type coverage options provide **BOTH** in- and out-of-network benefits.
- <sup>3</sup> HMO-type coverage options provide **ONLY** in-network benefits, and generally **require** participants to designate a **Primary Care Physician (PCP)**.
- <sup>4</sup> For the **HMSA BlueCross BlueShield of Hawaii HMO** coverage option only, a **pharmacy-only** annual out-of-pocket maximum applies, which must be met separately from the medical-only annual out-of-pocket maximum before the plan will begin paying 100% of eligible pharmacy expenses. No participant out-of-pocket pharmacy expenses will apply towards the medical-only annual out-of-pocket maximum.
- <sup>A</sup> Denotes a high deductible health plan (HDHP) coverage option that has **“aggregate” (non-embedded) deductibles and out-of-pocket maximums (OOPMs)**. For family coverage under the aggregate design, the entire family calendar-year deductible must be met before copays or coinsurance will apply for any individual family member. Only after the full family deductible is met will any family member be able to receive covered medical services or prescription drugs at copay or coinsurance levels. A family is responsible for all its members' out-of-pocket covered medical expenses up to the family-level OOPM. **In contrast, all other Insperty coverage options have “embedded” calendar-year deductibles and OOPMs.** For family coverage under the embedded design, each covered family member needs to satisfy only an individual calendar-year deductible, not the entire family deductible, before the individual member can receive covered medical services or prescription drugs at copay or coinsurance levels. Individual family members are responsible for their own out-of-pocket covered medical expenses up to the **individual-level** OOPM. Combined individual out-of-pocket covered medical expenses for a family will never exceed the **family-level** OOPM.

Actual benefits are subject to the provisions and limitations of the agreements between Insperty and its benefit providers. In the event of a conflict between the information in this schedule and the Certificate of Coverage, the Certificate of Coverage will be the controlling document.

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