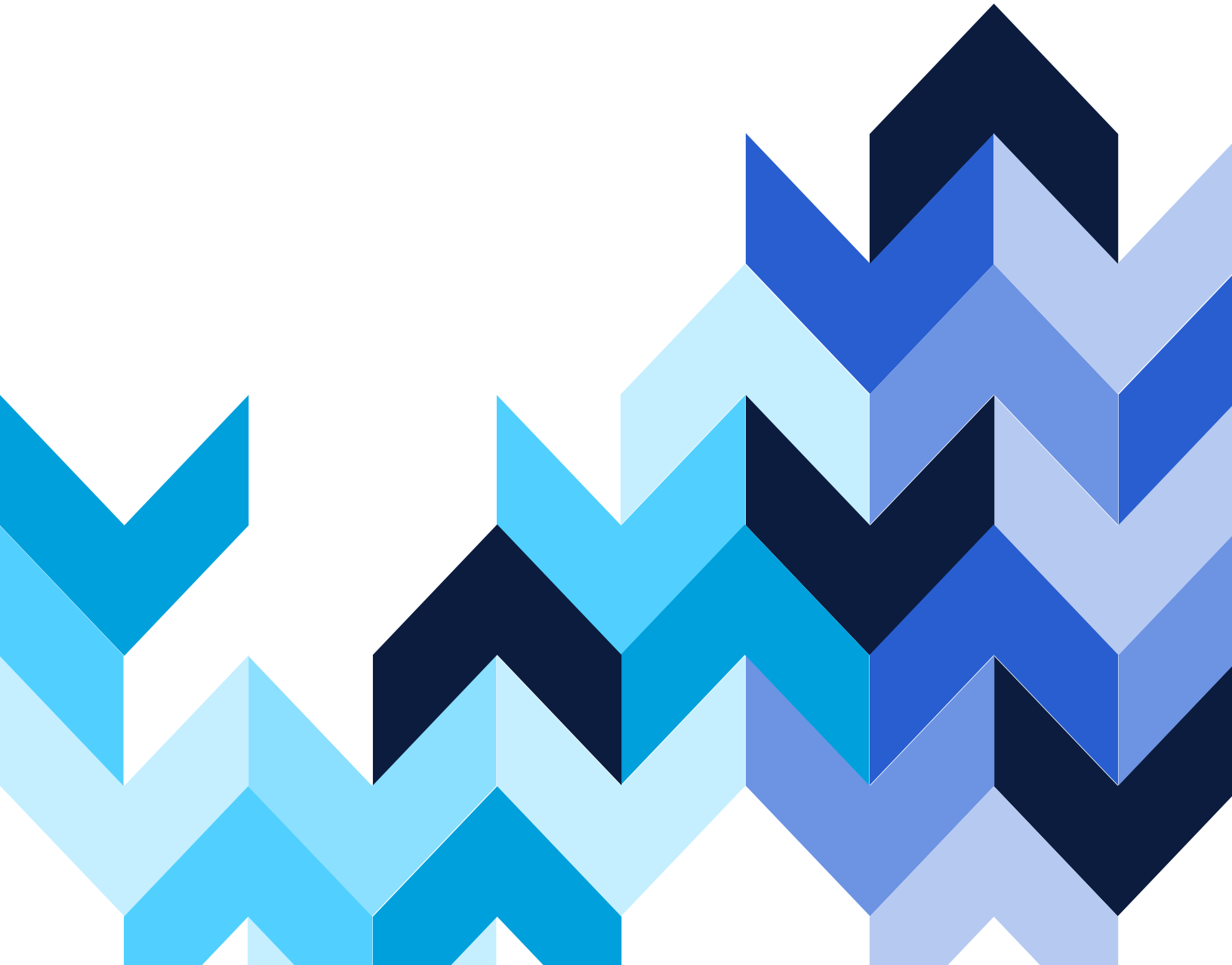
Example.com

20xx

Summary of Benefits



Example.com

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WELCOME TO YOUR BENEFITS!

The investment in employee benefits is a very important way in which Client is able to care for you and your family. We are pleased to provide a comprehensive benefits package centered around four important areas of wellness:

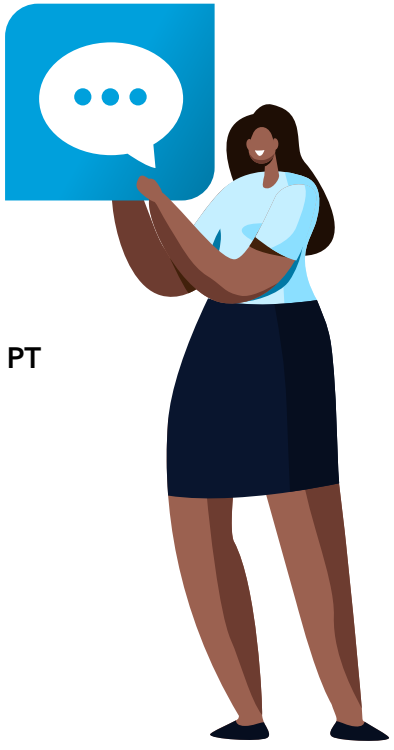
HEALTH CARE | PRE-TAX BENEFITS | FINANCIAL SECURITY | WORK-LIFE BALANCE

This document provides a high level overview of the benefits available so that you can review your options for enrollment. Individual carrier documents provide more detail regarding coverage and benefits. These documents supersede any information provided here.

CLIENT + THE VITA TEAM

The Vita Concierge Team is here to help! Client has partnered with the Vita to assist you with your benefits needs. We can support you with a multitude of issues including those outlined below:

- Benefit plan enrollment
- Plan design inquiries
- ID cards and eligibility issues
- Health and pre-tax claims assistance
- Accessing pre-tax funds
- Enrollment advice



Vita's Concierge Team may be reached Monday – Friday 8:00 a.m. – 5:00 p.m. PT via phone, (650) 966-1492 or email, help@vitamail.com.

Making sure your request is resolved to your satisfaction is our top priority.

Please be aware that Vita complies with all Federal HIPAA privacy and security regulations to ensure your information is safe.

SIGNING UP AND MAKING CHANGES

ELIGIBILITY

Full-time regular employees working 30 or more hours per week are eligible for all benefits on the first of the month following date of hire. For life, disability, and FSA coverages, employees must be actively working on the date coverage begins. Please see 401(k) section for 401(k) eligibility.

ELIGIBLE DEPENDENTS

You may enroll spouses/registered domestic partners and children up to age 26 in your medical, dental, and vision plans. If enrolling a non-registered domestic partner, you must meet the criteria outlined in the "Affidavit of Domestic Partnership". A completed affidavit must be submitted to HR prior to your enrollment being approved.

DOMESTIC PARTNERS

You will pay taxes on the employer paid premium and employee contribution for enrolled domestic partners and/or their children. State level tax exemptions may apply. Please see your tax advisor for more details.

ENROLLMENT

You will receive a Welcome Email from ADP with a link to allow you to establish a password and access to the site. You must complete your initial enrollment within 30 days of your eligibility date.

ADDITIONAL INFORMATION AND RESOURCES

Benefit summaries, detailed plan information, plan certificates, and forms are available through ADP.

SPECIAL ENROLLMENT PERIOD/ADDING NEW DEPENDENTS

You may only enroll or make election changes mid-year if you experience a qualified life event such as marriage, birth or adoption of a new child, divorce, or an involuntary loss of coverage from another group plan. **You must notify HR and submit the request for changes in ADP within 30 days of the life event.**

OPEN ENROLLMENT

Open Enrollment is your annual opportunity to enroll in or make changes to your benefits without a qualified life event. If you or your dependents do not enroll when you first become eligible, you will only be able to enter the plan during Open Enrollment. Open Enrollment is conducted in December each year, for changes to be effective January 1st.

COVERAGE TERMINATION

Medical, dental, and vision benefits terminate on the last day of the month following employment termination. All other benefits end on your last day of employment.

COBRA CONTINUATION

You and your covered dependents have a right to continue medical, dental, vision, and Health FSA coverage for a specified period of time after you terminate employment or for other qualified life events. You will be notified of your rights and responsibilities to continue coverage under Federal COBRA law.

EMPLOYEE COST SHARING

MEDICAL PLANS

- Client pays 90% of the premium for employees and 75% of the premium for eligible dependents.
- Contributions are taken via pre-tax payroll deductions over 24 pay periods.

DENTAL/VISION PLANS

- Client pays 90% of the premium for employees and 75% of the premium for eligible dependents.
- Contributions are taken via pre-tax payroll deductions over 24 pay periods.

LIFE, AD&D AND DISABILITY PLANS

- Client pays 100% of the premium for eligible employees.
- Voluntary Life and AD&D plans are available and 100% employee paid.

HEALTH SAVINGS ACCOUNT (HSA) FUNDING

- If you enroll in the HDHP, you will automatically be enrolled in an HSA.
- If you are not eligible to open and contribute to an HSA, you must notify Client in writing within X days of your eligibility date.
- See HSA section for more details.

EMPLOYEE CONTRIBUTIONS PER PAY PERIOD

	EMPLOYEE ONLY	EMPLOYEE + SPOUSE/DP*	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Cigna HDHP	$X.XX	$X.XX	$X.XX	$X.XX
Cigna PPO	$X.XX	$X.XX	$X.XX	$X.XX
Kaiser	$X.XX	$X.XX	$X.XX	$X.XX
Dental	$X.XX	$X.XX	$X.XX	$X.XX
Vision	$X.XX	$X.XX	$X.XX	$X.XX
Life/Disability	No cost, paid by Client			
Voluntary Life	Age banded rates			
Pre-Tax Benefits	Self-directed up to IRS maximum			
401(k)	Self-directed up to IRS maximum			

ID CARDS

You will receive an ID card for medical coverage only. Your ID card will arrive within 7-10 business days of your enrollment being processed by the insurance carrier. You can also download an electronic version of your ID card by registering directly on the carrier's website.

If you are enrolling in Kaiser and have been a Kaiser member in the past, you will use the same Medical Record Number (MRN) that you used previously. No new ID card will be issued.

Guardian Dental and VSP Vision do not issue ID cards. Eligibility is verified for you and your eligible dependents using your name, date of birth, and last four digits of your social security number. Generic ID cards may be downloaded directly from the carrier's website once you have registered.

HOW TO FIND AN IN-NETWORK PROVIDER

We recommend that you contact your physicians directly to confirm participation in your network prior to seeking services. Locating the provider's name on the carrier's website does not guarantee they are part of the network, as provider participation is subject to change at any time.

CIGNA MEDICAL PLAN

www.mycigna.com

1. Step 1
2. Step 2
3. Step 3
4. Step 4

KAISER MEDICAL PLAN

www.kp.org

1. Click on Doctors and Locations at the top of the page
2. Choose whether to search by Doctors or Locations
3. Select California – Northern under Region
4. Enter your zip code and remaining search criteria

GUARDIAN DENTAL PLAN

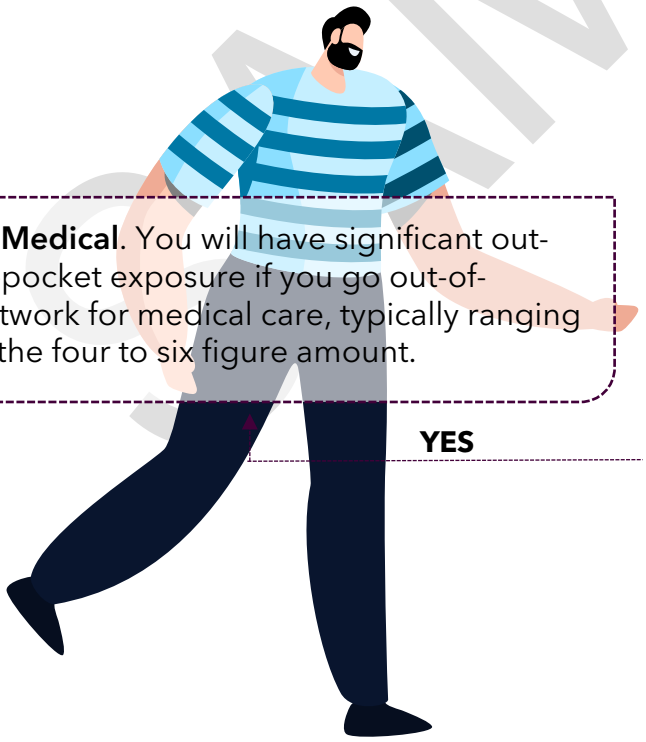
www.guardiananytime.com

1. Step 1
2. Step 2
3. Step 3
4. Step 4

VSP VISION PLAN

www.vsp.com

1. Step 1
2. Step 2
3. Step 3
4. Step 4



Q: IS IT CRITICAL TO STAY IN-NETWORK?

YES

A. **Medical**. You will have significant out-of-pocket exposure if you go out-of-network for medical care, typically ranging in the four to six figure amount.

NO

A. **Dental** and **Vision**. Your dental and vision coverage may be applied to out- of-network expenses, however staying in-network reduces your out-of-pocket costs.

HEALTH CARE

UNDERSTANDING YOUR MEDICAL PLAN

Client offers employees a choice of three medical plans. Before making your medical plan election, it is important to understand the differences between each of the plans, including how to access care and what your out of pocket costs will be under each plan.

KEY DEFINITIONS

- **Network Provider:** Physician/provider who has contracted with the insurance carrier and has agreed to a negotiated rate for services.
- **Annual Deductible:** Amount a member pays each calendar year for covered services before the plan's coinsurance (cost sharing) begins. The deductible resets every January 1st.
- **Copayment:** Member's flat dollar payment or "copay" at point of service.
- **Coinsurance:** Cost sharing element of the plan expressed as a percentage. Coinsurance payments are based on negotiated rates.
- **Out of Pocket Maximum (OOP):** Maximum amount a member will pay for covered services in a calendar year. Once met, the plan pays 100% for all covered services when in-network.
- **Preferred Drug List (PDL):** A list (formulary or preferred drug list) that outlines how a particular medication is covered under the different prescription tiers. PDLs change throughout the year, and members are notified by mail when and if a change will affect them.

CONTROLLING YOUR COSTS

Save yourself time and money by knowing where to direct your care!

SYMPTOM	WHERE TO GO	MORE INFORMATION
"I have a minor problem that won't require a test."	Virtual Visit ($)	Cigna: https://www.mdliveforcigna.com/mdliveforcigna/landing_home Kaiser: www.kp.org/mydoctor/videovisits
"I have a minor problem that may require a test/exam but my doctor isn't available."	Convenience Care Clinic ($$)	Find in-network facilities and providers using the How to Find a Network Provider instructions on page 4 or download the Cigna or Kaiser mobile app!
"I want routine care or have a minor, complex, or chronic problem."	Office Visit ($$)	
"It's not life threatening, but I need care quickly."	Urgent Care ($$$)	
"It's life threatening or very serious."	Emergency Room ($$$$)	
"Help! I don't know where to go."	Call the Nurse Help Line	See the back of your medical ID card for phone number

UNDERSTANDING YOUR MEDICAL PLAN (CONTINUED)

KEY PLAN DESIGN DIFFERENCES

	PPO	HMO
How is Kaiser different?	Kaiser requires that you go to a Kaiser facility in your service area. Care outside of Kaiser is only covered in a life threatening emergency.	
Which health providers must I choose?	Whenever possible you should choose doctors, hospitals, and other providers that contract with the PPO network.	You must choose doctors, hospitals, and other providers that contract with the HMO network.
Do I need to have a primary care provider (PCP)?	No. You can receive care from any doctor you choose but you will pay more for out-of-network providers.	Yes. Your HMO will not provide coverage if you do not have a designated PCP or medical group.
How do I see a specialist?	You do not need a referral to see a specialist. However, some specialists will only see patients who are referred to them by a primary care doctor. Also, some PPOs require that you get a prior approval for certain expensive services, such as MRIs.	You need a referral from your PCP to see a specialist (such as a cardiologist or surgeon) except in emergency situations. Your PCP also must refer you to a specialist who is in the HMO network.
Do I have to file an insurance claim?	Not usually for in-network care. However, if you go out-of-network for services you may have to pay the provider in full and then file a claim with the health plan to get reimbursed.	No, unless in an emergency where an outside facility is used.
Can I seek care out of my service area?	Yes. Most PPOs have a nationwide network, meaning that you can find in-network providers in most states.	No. All care must be rendered within your Primary Medical Group, or pre-authorized by them.
Why do we have a High Deductible Health Plan (HDHP)?	An HDHP has a high deductible that you must meet before the insurance will start paying for your office visits, lab tests and prescriptions. The increased deductible helps control costs and therefore usually means a lower premium contribution out of your paycheck. Also, your employer may offset your expenditure by offering a Health Savings Account.	

SIDE BY SIDE MEDICAL PLAN COMPARISON

Following is a very brief side by side comparison of the key benefit features of each plan. **All benefits listed refer to the member's responsibility or cost share after the deductible is met, unless otherwise indicated.** As always, please refer to your carrier's Certificate of Coverage for more details.

PPO OPTIONS	MEDICAL OPTION 1		MEDICAL OPTION 2	
	CIGNA HDHP		CIGNA PPO	
Benefit	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible				
Individual	$2,000	$2,000	$500	$1,000
Family	$4,000	$4,000	$1,000	$2,000
Copays/Coinsurance	10%	50%	$20	30%
Office Visit	10%	50%	10%	30%
Hospital	10%	50%	10%	30%
Prescriptions	$10/$30/$50	Not covered	$5/$30/$50	Not covered
Out-of-Pocket Max				
Individual	$5,000	$10,000	$4,000	$8,000
Family	$10,000	$20,000	$8,000	$16,000
Consider this Plan If…	• you have low medical and prescription utilization • you want to receive employer funding into a Health Savings Account (HSA)		• you are a moderate to heavy user of medical services and prescriptions • you want freedom of choice of providers	

HMO OPTIONS	MEDICAL OPTION 3
	KAISER HMO
Benefit	Kaiser Authorized Care
Deductible	
Individual	None
Family	
Copays/Coinsurance	Various
Office Visit	$20
Hospital	$500 per admit
Prescriptions	$5 / $30
Out-of-Pocket Max	
Individual	$5,000
Family	$10,000
Consider this Plan If…	• you prefer a one-stop location for your medical and prescriptions needs • you prefer simplified copay expenses

OPTION 1: CIGNA HDHP

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Network	Cigna Open Access Plus	
Reimbursement Basis	Cigna's contracted rate	Cigna's allowed amount. All charges in excess of the allowed amount are the member's responsibility.
Deductible	$2,000*/single; $4,000/family *Does not apply if cover 2+ people	$2,000*/single; $4,000/family *Does not apply if cover 2+ people
Out-of-Pocket Maximum	$5,000*/single; $10,000/family *Does not apply if cover 2+ people	$10,000*/single; 20,000/family *Does not apply if cover 2+ people
Office Visit	10%	50%
Virtual Visit	10%	Not covered
Prescriptions (up to a 30-day supply)	$5 / $30 / $50	Not covered
Mail Order Prescriptions (up to a 90-day supply)	$10 / $60 / $100	Not covered
Specialty Prescriptions	20% up to $250	Not covered
Preventive Care	No charge	Not covered
Basic Lab and X-ray	10%	50%
Complex Lab and X-ray	10%	50%
Urgent Care	10%	50%
Outpatient	10%	50%
Inpatient	10%	50%
Emergency Services	$200 + 10%	
Physical Therapy	10%	50%
Chiropractic Services (12 visits max/year)	10%	50%
Acupuncture (12 visits max/year)	10%	50%
Durable Medical Equipment	10%	50%
Infertility	Not covered	Not covered
Lifetime Maximum	Unlimited	
Plan Details	See Additional Plan Notes section	

All benefits listed refer to the member's responsibility or cost share after the deductible is met, unless otherwise indicated. The benefit information above outlines the key components of this medical policy. Please refer to your carrier's Certificate of Coverage for additional details on plan benefits and limitations.

OPTION 1: CIGNA HDHP ADDITIONAL PLAN NOTES

ALL NON-PREVENTIVE EXPENSES APPLY TO THE DEDUCTIBLE

All benefits listed refer to the member's responsibility or cost share after the deductible is met, unless otherwise indicated. Health Savings Account (HSA) qualified plans require that all non-preventive expenses receive no reimbursement from insurance prior to the deductible being met. With that said, you will still get the benefit of negotiated discounts when using in-network providers.

GOING OUT-OF-NETWORK: "ALLOWED AMOUNT" DEFINED

The "allowed amount" is the amount that Cigna will allow for a participating provider even when the services are rendered out-of-network. Out-of-network charges can be significantly greater than the allowed amount and you will be responsible for the difference between what the out-of-network provider charges and what Cigna reimbursed. These balanced billed charges **do not** accumulate towards your out-of-network deductible or out-of-pocket maximum.

UTILIZATION REVIEW

All hospital confinements and surgeries must be preauthorized by Cigna. You or your physician must call Cigna prior to a hospital admission for non-emergency treatment. If you do not obtain this mandatory authorization, your benefits will be reduced or a penalty payment will apply. Please refer to your ID card for the utilization review phone number and required time frame for reporting.

CLAIMS

In-network providers will submit claims directly to Cigna. If you see an out-of-network provider, you may be required to submit the claim directly to Cigna for reimbursement.

OPTION 2: CIGNA PPO

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Network	Cigna Open Access Plus	
Reimbursement Basis	Cigna's contracted rate	Cigna's allowed amount. All charges in excess of the allowed amount are the member's responsibility.
Deductible	$500/individual; $1,000/family	$1,000/individual; $2,000/family
Out-of-Pocket Maximum	$4,000/individual; $8,000/family	$8,000/individual; $16,000/family
Office Visit	$20 PCP; $40 Specialist	30%
Virtual Visit	$20	30%
Prescriptions (up to a 30-day supply)	$5 / $30 / $50	Not covered
Mail Order Prescriptions (up to a 90-day supply)	$10 / $60 / $100	Not covered
Specialty Prescriptions	20% up to $250	Not covered
Preventive Care	No charge	Not covered
Basic Lab and X-ray	10%	30%
Complex Lab and X-ray	10%	30%
Urgent Care	$40	30%
Outpatient	10%	30%
Inpatient	10%	30%
Emergency Services	$100 + 10%	
Physical Therapy	10%	30%
Chiropractic Services (12 visits max/year)	10%	30%
Acupuncture (12 visits max/year)	10%	30%
Durable Medical Equipment	10%	30%
Infertility	Coverage varies	Not covered
Lifetime Maximum	Unlimited	
Plan Details	See Additional Plan Notes section	

All benefits listed refer to the member's responsibility or cost share after the deductible is met, unless otherwise indicated. The benefit information above outlines the key components of this medical policy. Please refer to your carrier's Certificate of Coverage for additional details on plan benefits and limitations.

OPTION 2: CIGNA PPO ADDITIONAL PLAN NOTES

GOING OUT-OF-NETWORK: "ALLOWED AMOUNT" DEFINED

The "allowed amount" is the amount that Cigna will allow for a participating provider even when the services are rendered out-of-network. Out-of-network charges can be significantly greater than the allowed amount and you will be responsible for the difference between what the out-of-network provider charges and what Cigna reimbursed. These balanced billed charges **do not** accumulate towards your out-of-network deductible or out-of-pocket maximum.

UTILIZATION REVIEW

All hospital confinements and surgeries must be preauthorized by Cigna. You or your physician must call Cigna prior to a hospital admission for non-emergency treatment. If you do not obtain this mandatory authorization, your benefits will be reduced or a penalty payment will apply. Please refer to your ID card for the utilization review phone number and required time frame for reporting.

CLAIMS

In-network providers will submit claims directly to Cigna. If you see an out-of-network provider, you may be required to submit the claim directly to Cigna for reimbursement.

OPTION 3: KAISER HMO

BENEFIT	IN-NETWORK
Network	Kaiser Northern California
Reimbursement Basis	All care must be rendered or authorized by a Kaiser Permanente facility
Deductible	None
Out-of-Pocket Maximum	$5,000/individual; $10,000/family
Office Visit	$20 PCP; $40 Specialist
Virtual Visit	$20
Prescriptions (up to a 30-day supply)	$5 / $30
Mail Order Prescriptions (up to a 90-day supply)	$10 / $60
Specialty Prescriptions	20% up to $250
Preventive Care	No charge
Basic Lab and X-ray	$40/Lab; $80/X-Ray
Complex Lab and X-ray	$300 per procedure
Urgent Care	$40
Outpatient	$350 per procedure
Inpatient	$500 per admit
Emergency Services	$200
Physical Therapy	20%
Chiropractic Services (12 visits max/year)	20%
Acupuncture (12 visits max/year)	20%
Durable Medical Equipment	20%
Infertility	Not covered
Lifetime Maximum	Unlimited
Plan Details	See Additional Plan Notes section

The benefit information above outlines the key components of this medical policy. Please refer to your carrier's Certificate of Coverage for additional details on plan benefits and limitations.

OPTION 4: KAISER HMO ADDITIONAL PLAN NOTES

REFERRALS

All medical treatment must be coordinated by your selected Primary Care Physician (PCP) in order to be covered by the plan. Your PCP will make any referrals to specialists, if needed. No referral is required when:

- Accessing care from an OB/GYN provider within your Primary Medical Group (PMG) for an annual well women's exam
- Accessing chiropractic care as long as you use an ASH provider

You may go to a satellite office of your PMG as long as your PCP authorizes your visit to that facility. Always call your PCP prior to any treatment.

NON-KAISER TREATMENT

If you go to any facility other than Kaiser and it is not based on a referral from a Kaiser physician or an acute life threating emergency, then you will be responsible for all medical expenses you incur.

EMERGENCY TREATMENT

Kaiser defines an emergency as those services required for the alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical condition which, if not treated, would jeopardize or impair your health.

In the case of a life threatening emergency, obtain care immediately. After care is obtained, you must contact Kaiser within 24 to 48 hours after the onset of the emergency. A family member, co-worker, etc. may make this call on your behalf. In the case of a non-life threatening emergency, regardless of where you are, call Kaiser prior to receiving care. If you do not consult a physician at Kaiser first, you will be responsible for all charges for non-life threatening, but acute emergency services.

SELECTING A CLINIC

You may visit any of the Kaiser Permanente clinics or hospitals in the Northern California service area. You are encouraged, but not required, to select a PCP for yourself and each dependent. Only care provided by Kaiser physicians and hospitals are covered under the plan.

DENTAL BENEFITS: GUARDIAN

OVERVIEW

The Guardian dental plan includes a network of preferred dentists. If you receive treatment from a preferred dentist, you will receive enhanced benefits. However, you do have the option of receiving treatment from the dentist of your choice, even if the dentist is not within the preferred network. Benefits for treatment from non-preferred dentists will be paid at a lower reimbursement level and may be subject to benefit limitations.

BENEFIT	PREFERRED DENTISTS	NON-PREFERRED DENTISTS
Deductible • Waived for preventive care	$25 per member; 3 per family	$25 per member; 3 per family
Maximum Annual Benefit	$2,000 per covered member	
Preventive Care • Includes routine exams, teeth cleanings, x-rays, etc. • Cleanings covered twice per calendar year	0% (covered at 100%)	0% (covered at 100% of UCR)
Basic Care • Includes fillings, endodontics, periodontics, extractions, etc.	20% (covered at 80%)	20% (covered at 80% of UCR)
Major Care • Includes crowns, bridges, dentures, onlays, etc.	20% (covered at 80%)	20% (covered at 80% of UCR)
Orthodontia • Covers children to age 19 and adults • Separate lifetime maximum of $1,500 per member	50% (covered at 50%)	50% (covered at 50% of UCR)

USUAL, CUSTOMARY, AND REASONABLE (UCR) DEFINED

Non-preferred benefits are based on the member's geographic location. Guardian pays non-preferred dentists based on the 90th percentile, or what nine out of ten dentists charge for a procedure in a given geographic location. If you receive services from a non-preferred dentist, you are responsible for any charges that exceed the recognized UCR amounts.

MAXIMUM ROLLOVER ACCOUNT (MRA)

Your dental plan has a Maximum Rollover Account (MRA) feature. Guardian will automatically rollover a portion of each covered member's unused annual maximum benefit into their own MRA. The MRA will be used in future years if a member ever reaches the annual plan maximum. To qualify, you must incur at least one claim during the calendar year and you cannot exceed the claims threshold, illustrated below.

ANNUAL PLAN MAXIMUM	CLAIMS THRESHOLD	ROLLOVER AMOUNT	ROLLOVER AMOUNT (PREFERRED DENTISTS ONLY)	MRA LIMIT
$2,000	$500	$250	$350	$1,500

VISION BENEFITS: VSP VIA GUARDIAN

OVERVIEW

The VSP vision plan includes a network of optometrists and ophthalmologists. If you receive treatment from an in-network optometrist/ophthalmologist, you will receive enhanced benefits. While you do have the option of receiving treatment from out-of-network optometrists or ophthalmologists, you will only receive a limited reimbursement.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK REIMBURSEMENT
Network	VSP Signature	
Vision Exam	One exam covered every 12 months	
	$10 copay	Up to $45
Prescription Glasses: Lenses	One new set of prescription lenses covered every 12 months	
	$25 materials copay (lenses and frames) for single vision, lined bifocal, and lined trifocal lenses	Single vision: up to $30 Lined bifocal: up to $50 Lined trifocal: up to $70
Prescription Glasses: Frames	One new set of frames covered every 12 months	
	$150 allowance + 20% discount on amount in excess of allowance	Up to $105
Contact Lenses	You may choose to purchase contact lenses in lieu of glasses every 12 months (same as glasses lens schedule)	
	Up to $60 copay for exam (fitting and evaluation) $150 allowance	Up to $105
Laser Vision Correction	Laser vision correction surgery can be performed for substantial discounts when using a VSP certified provider. See VSP's website for more details.	
Buy-Up Options	VSP may offer additional allowances or discounts for lens options such as: • Blended lenses • Oversize lenses • Progressive lenses • Photochromatic or tinted lenses other than Pink 1 or 2 • Coated or laminated lenses	
Exclusions	The following services and supplies are not covered: • Orthoptics or vision training • Nonprescription lenses • Medical or surgical treatment of the eyes • Two pairs of glasses in lieu of bifocals • Lost or broken glasses will not be replaced except at the normal intervals	

Example.com

PRE-TAX BENEFITS

HEALTH SAVINGS ACCOUNT (HSA) FACT SHEET

OVERVIEW

Participation in the combination of a High Deductible Health Plan (HDHP) and a Health Savings Account (HSA) allows you to save premium dollars and create a personally owned, tax advantaged savings account for your future medical expenses.

Your HSA balance rolls over year to year. If you terminate employment with Client, this account is yours to take with you. If, at a later date, you are no longer qualified to make contributions into the HSA, you can still use HSA funds for the reimbursement of medical expenses.

ELIGIBILITY RESTRICTIONS

In order to be eligible to make contributions into an HSA, you must meet all of the following criteria:

- Covered by a qualified High Deductible Health Plan (HDHP)
- Not covered by any other health coverage, including a regular Flexible Spending Account (FSA)
- Cannot be claimed as a dependent on another person's tax return
- Not entitled to benefits under Medicare, including Medicare Part A

LIMITED PURPOSE HEALTH FLEXIBLE SPENDING ACCOUNT (HEALTH FSA)

If you participate in the HDHP and HSA and elect a Health FSA, your Health FSA is a Limited Purpose account. This means that eligible expenses for the health care FSA include dental and vision expenses, but cannot be used for medical expenses until you've met a portion of the plan deductible. Once you've met $1,600 of the deductible (individual coverage) or $3,200 of the family deductible, your FSA account can then be used for medical expenses such as additional deductibles or coinsurance.

MAXIMUM CONTRIBUTIONS

Contribution maximum limits are determined each year by the IRS and are inclusive of both employer and employee funding. The 2024 HSA contribution limits are as follows:

- **Single**: $4,150
- **Family**: $8,300

If you are age 55 or turn age 55 during the calendar year, you may make an additional $1,000 "catch-up" contribution.

If you enroll in an HSA qualified HDHP plan after January 1 and contribute to the HSA, you may only contribute up to the IRS maximum if you will be covered by the plan for at least 13 consecutive months. If you will not be enrolled in an HSA qualified HDHP plan for at least 13 consecutive months, your maximum election is prorated. Your maximum election would be 1/12 of the annual election multiplied the number of months you are covered by the HDHP.

You, as the employee, own the HSA. You take the account with you after you terminate employment.

ADDITIONAL INFORMATION

For detailed information, rules, and restrictions on Health Savings Accounts, see IRS Publication 969 (https://www.irs.gov/pub/irs-pdf/p969.pdf).

HEALTH SAVINGS ACCOUNT (HSA) ADMINISTRATION

ADMINISTRATOR
Vita Flex

ELIGIBILITY
If you and your eligible dependents choose to participate in the High Deductible Health Plan (HDHP) *and* are not covered by other disqualifying coverage, you are eligible to establish an HSA through Client.

EFFECTIVE DATE
Your HSA becomes active as of the effective date of your enrollment into the HDHP plan offered by Client. You are eligible to incur qualified health-related expenses any time on or after this date.

EMPLOYER FUNDING
If you are eligible to open and contribute to an HSA, Client will make a monthly contribution to your HSA on your behalf. If you do not open an HSA within 60 days of your eligibility date, by the end of the calendar year in which you are first eligible, or prior to your termination date (whichever comes first), you will forfeit the employer contributions.

Each employee's HSA is personally owned by the employee. Deposits made by Client into the account are tax-free under federal law. Once deposited into your HSA, these funds may be used at any time to fund eligible medical expenses on a tax preferred basis. Deposit amounts are as follows and are determined by Client each January 1.

HSA COVERAGE TIER	MONTHLY CONTRIBUTION FROM CLIENT
Employee Only	$xxx
Employee + Spouse	$xxx
Employee + Child(ren)	$xxx
Employee + Family	$xxx

EMPLOYEE CONTRIBUTIONS
You have the option to fund your HSA through pre-tax payroll contributions. The pre-tax deductions will begin on the next available payroll date. Your HSA contribution may be changed at any time.

ACCESSING FUNDS
There are three ways to access funds from your HSA to pay for eligible expenses. Expenses must be incurred on or after the effective date of the account.

- **Debit Card**: Use at time of service or to pay bills
- **Online**: Submit a claim for reimbursement online at www.vitaflex.net
- **Mobile App**: Upload claims for reimbursement through the VitaFlex mobile app

FLEXIBLE SPENDING ACCOUNTS (FSA): VITA FLEX

OVERVIEW

A Flexible Spending Account (FSA) enables tax-free reimbursement of health-related or dependent care expenses. You decide how much you want to set aside for the year and a portion of that amount is deducted from your paycheck before taxes. When you or your dependents incur an eligible expense, you may be reimbursed for that expense with the money that you have put aside.

EFFECTIVE DATE

Your election becomes effective on either the date that you become benefits eligible or the date that you complete your enrollment, whichever is later.

ANNUAL ELECTION

The election that you make is irrevocable for the Plan Year (January 1 – December 31). This means that, in general, you cannot adjust or stop your contributions once the Plan Year has begun. It is important to note that elections do not carry forward year-to-year. You must actively make a new election during each Open Enrollment period, or your account will be made inactive.

PAYCHECK DEDUCTIONS

Your election is made as an annual election for the Plan year. Your annual election is then divided by the total number of paychecks during the Plan Year or by the number of remaining paychecks in the Plan Year if you are hired mid-year.

MID-YEAR CHANGES

You may only change your election mid-year in certain limited circumstances, and even then, changes are subject to restrictions. In order to change your election mid-year, you must experience a qualified status change (birth, marriage, etc.) or other approved exception. All change requests must be made within 30 days of the status change date.

TERMINATION

Medical expenses are only eligible to the extent that they are incurred prior to or on your date of termination. The exception to this rule is that if you elect COBRA coverage for your Health FSA and continue to make contributions to your FSA (on a post-tax basis), claims may be incurred as long as the COBRA coverage is active. Dependent care expenses may be reimbursed after your termination date without electing COBRA, as long as the expense occurred in the current Plan Year.

USE IT OR LOSE IT

Under IRS guidelines, FSAs are subject to a "use it or lose it" provision. If your eligible expenses are not sufficient to exhaust your full FSA election, any unused funds are forfeited. In order to protect yourself against this, carefully consider your medical and dependent care expenses prior to making your election.

Your employer's plan includes a rollover feature. This feature allows up to $640 of unused funds (those left over after the claims submission deadline) to roll over into the new Plan Year as of March 31 of the following year (e.g. 3/31/2025). If your Health FSA balance is greater than $640 as of the deadline, any amount in excess of that figure is forfeited under the "use it or lose it" rule. Note that there is no rollover provision for the Dependent Care FSA.

LIMITED PURPOSE HEALTH FSA

If you participate in the HDHP and HSA and elect a Health FSA, your Health FSA will be deemed a Limited Purpose account. See Health Savings Account (HSA) Fact Sheet for more information.

FLEXIBLE SPENDING ACCOUNTS (CONTINUED)

	HEALTH FSA	DEPENDENT CARE FSA
Plan Year	January 1st through December 31st	
Minimum Election	$240/year	$240/year
Maximum Election	$3,200/year (per employee)	$5,000/year (per household)
Claims Incurred Deadline	December 31 or your employment termination date	December 31
Claims Submission Deadline	March 31st after Plan Year ends	
Rollover	Yes, up to $640	No
Eligible Dependents	• Yourself • Your spouse • Your children under age 26 (or who have not attained age 27 as of the end of the tax year)	• Children under age 13 • A spouse or dependent (age 13 or older) who is physically or mentally incapable of caring for himself/herself
Filing Claims	Full annual election available immediately • Debit Card (save your receipts!) • Online: www.vitaflex.net • Mobile: Vita Flex (app store download) • Email: claims@vitamail.com (claim form required) • Fax: (650) 964-3539 (claim form required)	Funds available as contributed • Online: www.vitaflex.net • Mobile: Vita Flex (app store download) • Email: claims@vitamail.com (claim form required) • Fax: (650) 964-3539 (claim form required)
Common Eligible Expenses	• Medical and prescription copays and coinsurance • Over-the-counter items (may need prescription) • Dental expenses including orthodontia • Vision copays, prescription glasses and contacts • Chiropractor, acupuncture and physical therapy	• Licensed day care provider • Pre-school • In-home day care • Nanny care • After-school care custodial/recreational • Summer day camps custodial/recreational • Mental health with medical diagnosis
Common Ineligible Expenses	• Vitamins/herbal supplements • Toiletries • Massage therapy for general health (without diagnosis) • Cosmetic dentistry	• Tutoring/language programs • Lessons for piano, gymnastics, etc. • Sports classes or leagues • Overnight camps

COMMUTER BENEFITS: VITA FLEX

OVERVIEW

Set aside pre-tax payroll deductions to pay for eligible commuting expenses. You will receive a debit card that will be loaded with funds each pay period for your elected transit and/or parking amounts. Elections may be modified at any time throughout the year and will be effective the month following the date of the election change.

PLAN PROVISIONS

	TRANSIT	PARKING
Monthly Pre-Tax Maximum	$315	$315
	You may elect above the pre-tax maximum as an after tax expense	
Eligible Expenses	• Train and subway • Bus • Ferry • Eligible Vanpool	• Parking near office • Parking near mass transit for commute to work
Accessing Funds	Vita Flex Benefits Card Use the card to purchase eligible passes or load a Clipper Card.	Vita Flex Benefits Card Use the card to pay for eligible parking expenses. Submit reimbursement online via your Vita Flex account within 180 days of expense OR 90 days after you stop being an active participant (whichever comes first).

Attention Caltrain and BART riders: Due to Federal regulations, your debit card will not work at Caltrain and BART terminals. You will need to use your debit card to fund your Clipper card via www.clippercard.com.

Please note: If you've elected a Flexible Spending Account (FSA) and/or a Health Savings Account (HSA), the same debit card will be used for your pre-tax Commute elections. Funds will be pulled from the applicable account based on where the debit card is used and what is being purchased. If you haven't elected an FSA and/or HSA, you will receive a new debit card in the mail following your first election.

MAKING AN ELECTION

Elections are made in Vita Flex. Your election will be a monthly recurring order unless you actively choose to log back into system to change your election to $0. You must elect by the end of the month for the future benefit month (i.e. elect by June 30 for a July benefit month).

TERMINATION

Upon termination, your debit card will be deactivated and you will no longer have access to any unused transit funds. If you are submitting parking expenses for reimbursement, you have up to 60 days from your date of termination to submit expenses incurred prior to your date of termination.

Example.com

FINANCIAL SECURITY

GROUP LIFE AND AD&D BENEFITS: GUARDIAN

BENEFIT

Each employee is covered for term Life and AD&D insurance equal to one times your base annual earnings rounded up to the nearest thousand. The maximum benefit is $500,000. No medical examination or health history disclosure is required for timely applicants.

AGE REDUCTIONS

At age 65, benefits will reduce to 67% of the original amount then to 45% of the original amount at age 70.

BENEFICIARIES

A personal beneficiary of your choosing must be named for the proceeds of your life insurance, however, it is not recommended to list a minor as your beneficiary. You may change your beneficiaries at any time.

NOTE ON TAXATION

The value of up to $50,000 of employer paid group term life insurance is tax exempt. However, the value of any coverage in excess of $50,000 is taxable to the employee per the IRS guidelines. This is called Table I Taxation. The following schedule is used to calculate the taxable benefit of the group term life insurance in excess of $50,000.

AGE BRACKET	COST PER $1,000 PER MONTH
Under 25	$0.05
25-29	$0.06
30-34	$0.08
35-39	$0.09
40-44	$0.10
45-49	$0.15
50-54	$0.23
55-59	$0.43
60-64	$0.66
65-69	$1.27
70+	$2.06

Sue Smith is 33 years old with an annual income of $75,000. Her life insurance benefit is $75,000. The first $50,000 of the group life insurance benefit is tax-free. She has a remaining $25,000 subject to Table I taxation. The monthly taxable amount that will be added to Sue's income is $2.00 [($25,000 x $0.08) / $1,000 = $2.00]. If Sue worked the entire year, she would have $24.00 ($2.00 x 12) add to her W2. Her actual tax would be less than half this amount.

VOLUNTARY LIFE AND AD&D BENEFITS: GUARDIAN

BENEFIT

Each employee can choose to purchase the following:

Employee: You may elect coverage in $10,000 increments up to $250,000, not to exceed 5 times your basic annual earnings.

Spouse: You may elect coverage in $5,000 increments up to $125,000, not to exceed 50% of the employee's election.

Child(ren): You may elect a flat $10,000 for your child(ren). Children are covered from age six (6) months to age 23 (to age 25, if full time student). The benefit for children from 14 days old to six (6) months is $250. Additional children are covered at no additional charge.

You may not elect coverage for your dependent(s) without electing coverage for yourself.

MONTHLY RATES

AGE BRACKET	EMPLOYEE * RATE PER $1,000	SPOUSE RATE PER $1,000
Under 25	$X.XX	$X.XX
25-29	$X.XX	$X.XX
30-34	$X.XX	$X.XX
35-39	$X.XX	$X.XX
40-44	$X.XX	$X.XX
45-49	$X.XX	$X.XX
50-54	$X.XX	$X.XX
55-59	$X.XX	$X.XX
60-64	$X.XX	$X.XX
65+	$X.XX	$X.XX
Child	$X.XX per $1,000	

*Spouse rates based on employee age.

AGE REDUCTIONS

Benefits will be reduced to 65% of the pre-age 70 amount at age 70. Benefits terminate at retirement. Spouse elections terminate when spouse turns age 70.

APPLICATION PROCESS

Any amounts that you apply for up to $100,000 are guaranteed issue (no health questions or exams required) at your initial eligibility period. Amounts over $100,000 for you or amounts over $25,000 for your spouse, or any amount applied for after your initial eligibility period will be subject to medical underwriting. Coverage will only be effective if approved by Guardian.

BENEFICIARIES

A personal beneficiary of your choosing must be named for the proceeds of your life insurance, however, it is not recommended to list a minor as your beneficiary. You may change your beneficiaries at any time.

DISABILITY BENEFITS: GUARDIAN

BENEFIT

These plans provide partial income replacement should you be unable to work due to an illness or injury. The plans integrate with other social sources (State Disability Insurance, Workers Compensation, Social Security, etc.) to provide a combined benefit of 60% of your base annual earnings.

TAXATION

Client pays the premium and the value of the premium is listed as imputed income to employees. This allows for the disability benefits to be paid out tax-free.

	SHORT –TERM DISABILITY	LONG-TERM DISABILITY
Elimination Period	7 days	90 days
Maximum Benefit	The maximum payable benefit from all sources combined will not exceed $2,500 per week.	The maximum payable benefit from all sources combined will not exceed $14,000 per month.
Duration of Benefits	Benefits are payable for a maximum of 13 weeks.	Benefits are payable to Social Security Normal Retirement Age while you continue to be disabled.
Pre-Existing Conditions	None	A disability resulting from any condition that existed, or for which you were treated, during the three (3) months immediately preceding your coverage effective date is **not covered** unless you have been actively at work and continuously covered under the plan for 12 consecutive months.
Special Limitations	None	There is a 24-month lifetime benefit maximum for disabilities resulting from mental/nervous conditions and alcohol or substance abuse.

LONG TERM CARE (LTC): UNUM

OVERVIEW
Long Term Care provides income replacement to you if you were unable to perform at least 2 out of 6 activities of daily living (bathing, dressing, toileting, continence, and eating) or cognitive impairment.

BENEFIT
Following a 90 day elimination period, the plan provides a monthly benefit of up to $X,XXX for long term care in a facility. See XX for more details.

MONTHLY RATES
See XX for more details.

VOLUNTARY CRITICAL ILLNESS: GUARDIAN

OVERVIEW
If elected, this plan provides cash directly to you to assist with expenses associated with critical illness.

BENEFIT
You may purchase the following:

401(K) PLAN: EMPOWER RETIREMENT

ELIGIBILITY
You are eligible to participate in the 401(k) plan after you have completed 1,000 work hours. After meeting the eligibility requirement, you may begin to participate on the following entry dates: January 1, April 1, July 1, and October 1.

CONTRIBUTIONS
Eligible employees may elect to defer up to 100% of their paycheck, up to the IRS maximum of $18,500 for 2018. If you are age 50 or over, you may elect to defer an additional $6,000 for 2018 in "Catch-up Contributions" as allowed by the IRS.

You may defer your contributions on a pre-tax or a Roth (after-tax) basis.

EMPLOYER MATCH
Client will match 10% of your election up to $2,500 per year.

ADDITIONAL INFORMATION
You may contact Empower Retirement for additional information about the 401(k) Plan. Contact information may be found in the Questions and Help Section of this Summary.

529 PLAN: COLLEGE AMERICA (SPONSORED BY THE STATE OF VIRGINIA)

BENEFIT

This is a tax-advantaged investment account which can be used to fund expenses at any U.S. public or private college.

- Eligible expenses include tuition, fees, room and board
- Funds can be used for undergraduate, graduate, professional or vocational education
- Beneficiaries can include your children, grandchildren, nieces, nephews, friends, or even yourself
- Deductions can be made through your personal bank account

ADDITIONAL INFORMATION

You may contact Vita Planning Group for additional information about the 529 Plan. Contact information may be found in the Questions and Help Section of this Summary.

Example.com

WORK-LIFE BALANCE

EMPLOYEE ASSISTANCE PROGRAM (EAP): WORKLIFEMATTERS

OVERVIEW

Everyone faces difficult periods in their life. Personal problems are part of what it means to be human, and effectively dealing with them makes us better prepared to overcome future ones. When a personal problem is making life difficult for you, it can also affect your job performance. The purpose of the Employee Assistance Program (EAP) is to help you deal with life's rough spots. When you seek help with a personal problem, your home life improves, work goes better and everyone benefits.

Your EAP is a free, professional, ***confidential*** consultation service provided by Guardian's WorkLifeMatters. All counselors and consultants are experienced, licensed professionals who have specialized training in employee assistance consultation. *Everything discussed in consultation is kept completely confidential*. The Employee Assistance Program can be contacted at **(xxx) xxx-xxxx**.

TYPES OF PROBLEMS

- Marriage and family problems
- Work-related problems
- Stress, anxiety, depression and other emotional problems
- Difficulty with relationships
- Loss and death
- Alcohol or drug problems affecting you or your family
- Difficulty adjusting to a new culture or environment
- Any other personal concern which may benefit from a professional consultation

BENEFITS

You may call **(xxx) xxx-xxxx** to seek assistance 24 hours a day. Counselors can assist with any type of personal situation. You are entitled to up to three (3) sessions per issue with the options of face-to-face counseling, telephonic, or web-video. If you choose to pursue additional outpatient consultation, additional benefits may be payable by your medical plan.

LEGAL AND/OR IDENTITY THEFT PROTECTION: ROCKET LAWYER

OVERVIEW

Everyone can use some legal advice at some point in their life, but not all can afford to obtain it. Receive peace of mind knowing that Rocket Lawyer provides you online access to over 3,000 legal documents, allows you to ask an attorney legal questions online and provides free legal consultations for any life event, all at no cost to you. Rocket Lawyer also gives you a 40% discount on attorney fees should you need further legal representation.

TYPES OF PROBLEMS

- Landlord and tenant issues
- Roommate agreement
- Aging parent
- Getting married
- Writing a will
- Buying a house
- Hiring a contractor
- Any personal concern that may benefit from legal consultation

ENROLLMENT

Sign up at www.rocketlawyer.com. You must initially sign up using your @employeremail.com email address in order to register for this benefit at no cost.

PET INSURANCE: FIGO PET INSURANCE

OVERVIEW

You may receive a 10% corporate discount on pet insurance when purchased through Figo.

PRICING AND BILLING

Pricing is based on zip code, age, breed of your cat or dog, and level of coverage selected. You will be billed directly by Figo for the cost of your pet insurance.

ENROLLMENT

You may enroll any time at xxxxxxx.

QUESTIONS AND HELP

Following is a listing of the current contact information for each insurance company/vendor. Many of the websites listed below contain useful information on general health topics as well as information on how the plans operate.

CARRIER/VENDOR	CONTACT INFORMATION
Cigna Medical Plan ***Group #222222***	(888) 888-8888 www.mycigna.com
Kaiser Medical Plan ***Group #333333***	(888) 888-8888 www.kp.org
Guardian Dental Plan ***Group #444444***	(888) 888-8888 www.guardiananytime.com
VSP Vision Plan ***Use Social for ID***	(888) 888-8888 www.vsp.com
WorkLifeMatters EAP ***Username: UN | Password: PW***	(888) 888-8888 www.ibhworklife.com
Figo Pet Insurance	(888) 888-8888 www.figopetinsurance.com
Rocket Lawyer	(888) 888-8888
Empower Retirement ***401(k) advisors***	(888) 888-8888 www.empower-retirement.com
The Vita Companies ***For questions regarding your healthcare benefits, FSA, HSA, or Commuter benefits***	(650) 966-1492 help@vitamail.com

NOTES

NOTE: The initial plan description is intended for general information purposes only; it is NOT to be considered a Summary Plan Description nor is it a contract. It provides only a very brief summary of benefits and does not replace or supersede the actual plan provisions as defined in the master plan documents. It is not all-inclusive and it is not a contract. Every attempt has been made to ensure the accuracy of this summary, but in the event of a discrepancy between this summary and the plan contract, benefits will be governed solely by the respective plan contracts.