Employee Benefits Guide

Effective January 1, 2023 to December 31, 2023

For more information, visit zoho.ease.com

We are pleased to provide you and your eligible dependents with a comprehensive employee benefits program that helps you and your dependents stay healthy, feel secure, and maintain a positive work/life balance. We highly value your contribution to ZOHO and we hope that you find these employee benefits a valuable part of your overall compensation package.

This guide is intended to provide a convenient summary of ZOHO's employee benefit plans. It is not intended to be a legal document. If there are any inconsistencies between the information in this brochure and the plan documents or contracts, the plan document and contracts will prevail. All benefits, and your eligibility for benefits, are subject to the terms and conditions of the benefit plans, including group insurance contracts. ZOHO reserves the right to modify or terminate any of the described benefits at any time and for any reason. This guide is not a guarantee of current or future employment or benefits.

For more information about your benefits, including plan summaries and documents, please visit the Ease portal at **zoho.ease.com**.

Important Contacts

Please contact Christian Blood (blood@zohocorp.com), Chelsea Cates (chelsea.c@zohocorp.com), or Dina Ramos (dina.r@zohocorp.com) for assistance or questions regarding your employee benefits.

Carrier Contacts			
Carrier	**Group Number**	**Website Address**	**Important Phone Numbers**
UnitedHealthcare Medical	Choice Plus Premier PPO 250 03U3518-BCX3 Choice Plus Premier PPO 1000 03U3523-BCX5 Choice Plus HSA 2000 09U4570-AE3J	myuhc.com	866.633.2446 Customer Service
Kaiser Permanente Medical (CA Only)	710444	kp.org	800.464.4000 Customer Service 866.454.8855 Appts & Advice
Optum Bank Health Savings Account	N/A	optumbank.com	866.234.8913 Customer Service
MetLife Dental	5924229	metlife.com	800.275.4638 Customer Service
VSP Vision	30053952	vsp.com	800.877.7195 Customer Service
Navia Benefit Solutions Flexible Spending Account Mental Health Resource (EBHRA)	ZHO	naviabenefits.com	800.669.3539 Customer Service
MetLife Short Term Disability Long Term Disability Term Life Insurance	5924229	metlife.com	800.275.4638 Customer Service
MetLife Employee Assistance Program	5924229	metlifeeap.lifeworks.com	888.319.7819 Customer Service
ID Watchdog Identity Theft Protection	N/A	idwatchdog.com	800.970.5182 Customer Service
Fidelity 401k Retirement Plan	N/A	fidelity.com	800.835.5097 Customer Service
Three Bell Capital 401k Plan Advisor/Consultant	N/A	three-bell.com	401k@three-bell.com Email Support

Mindshare Group Contacts			
Name	**Position**	**Phone Number**	**Email Address**
Stephanie McCary	Sr. Account Manager	925.227.9900 ext. 109	stephanie@mindsharegroup.com
Paul Unpingco	Medicare Advisor	925.227.9900 ext. 116	paul@mindsharegroup.com

Eligibility and Cost

Who Is Eligible and When?

- ZOHO employees working **30 hours or more per week** are eligible to enroll in the benefits described in this guide.
- Your spouse or domestic partner and children (up to age 26) are eligible dependents and may be added to your benefits.
- **Coverage is effective on the first day of the month following your date of hire.**

Cost Summary

For exact dollar amounts per pay period please visit the Ease benefits portal.

- **Medical, Dental and Vision Plans** - ZOHO pays **89%** of the premiums for employees, spouse or domestic partner, and eligible dependents.
- **Income Protection Plans** - ZOHO also pays **100%** of the premiums for Short Term Disability, Long Term Disability and Term Life and AD&D Insurance. Additional Voluntary Term Life insurance can be purchased at a discounted group rate. ZOHO pays for **50%** of the ID Watchdog premiums.

Making Changes

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Qualifying events include:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse/domestic partner, child or other qualified dependent
- Spousal loss of other coverage

You can make changes consistent with your life event within 30 days of the event. If you miss the 30 day period, you will have to wait until the next open enrollment to change your benefits.

Monthly Plan Costs

	Monthly Premiums & Employee Cost		
	Premium	ZOHO Pays	Employee Cost
Medical Plan 1: UHC Choice Plus Premier PPO 250			
Employee Only	$765.36	$681.17	$84.19
Employee + Spouse	$1,683.79	$1,498.57	$185.22
Employee + Children	$1,415.92	$1,260.17	$155.75
Full Family	$2,449.15	$2,179.74	$269.41
Medical Plan 2: UHC Choice Plus Premier PPO 1000			
Employee Only	$741.20	$659.67	$81.53
Employee + Spouse	$1,630.64	$1,451.27	$179.37
Employee + Children	$1,371.22	$1,220.39	$150.83
Full Family	$2,371.84	$2,110.91	$260.93
Medical Plan 3: UHC Choice Plus H.S.A. 2000			
Employee Only	$607.36	$540.55	$66.81
Employee + Spouse	$1,336.19	$1,189.21	$146.98
Employee + Children	$1,123.61	$1,000.01	$122.60
Full Family	$1,943.55	$1,729.76	$213.79
Dental Plan 1: MetLife Low PPO Plan			
Employee Only	$44.47	$39.58	$4.89
Employee + Spouse	$90.47	$80.52	$9.95
Employee + Children	$96.42	$85.81	$10.61
Full Family	$152.04	$135.32	$16.72
Dental Plan 2: MetLife High PPO Plan			
Employee Only	$65.48	$58.28	$7.20
Employee + Spouse	$133.31	$118.65	$14.66
Employee + Children	$142.70	$127.00	$15.70
Full Family	$224.85	$200.12	$24.73
VSP Vision Plan			
Employee Only	$13.22	$11.77	$1.45
Employee + 1	$20.54	$18.28	$2.26
Employee + 2 or more	$32.57	$28.99	$3.58

Enrollment

When to Enroll

New employees are encouraged to enroll as soon as possible. Your coverage is effective on the **first of the month following your date of hire**.

Existing employees may elect or change benefit options only during the open enrollment period or due to a qualifying event.

How to Enroll - New Employees

Ease is your personal benefits portal and can be accessed at **zoho.ease.com**. Ease allows you to view your benefit options and make benefit elections for you and your dependents. You can view plan details, coverage amounts, and costs. Your family's information only needs to be entered once, in one place, and all carrier application forms will automatically be completed.

STEP 1: You will receive an email to register and access Ease. Click the blue "Sign Up" button within the email message.

STEP 2: You will be prompted to set up a password. Once complete, click the blue "Sign Up" button.

STEP 3: After you have logged in, click on the blue "Start" button to begin your enrollment.

STEP 4: Verify your personal information is correct and enter any dependent information.

STEP 5: Make your benefit selections by either clicking the check mark for Enroll or the x for Waive. Click "Continue" to proceed to the next benefit.

STEP 6: Follow the prompts on each page to complete your benefits enrollment. Click "Continue" to proceed to the next section.

STEP 7: You will be prompted to provide any missing data. Once you have done this, you will be able to review and sign any required forms using your mouse or mobile device. Click "Sign Forms". Click "Finish Signing" at the top right of the page and then you can choose to provide feedback. To complete enrollment, click "Finish" in the top right corner.

Open Enrollment

To review your benefits, log onto the Ease benefits portal or download the mobile app. If you have logged in before, you will need to enter your email address or username and your password. If you are logging in with your mobile phone, select log in with mobile phone.

ID Cards

After you enroll, you will receive ID cards from the medical plan provider you select. When you receive your ID card, confirm that all information is accurate. If not, contact HR or the carrier.

Most dental and vision carriers do not issue ID cards. When you access care, your provider should be able to verify coverage using your social security number. If you register at the carrier websites, you can go online and create your own ID card.

Should you lose your ID card/s, go online to the carrier website or call the member services number for your insurance carrier to request a new one. There is a list of contacts located on the 'Important Contacts' page of this guide.

401 (k) Enrollment and Account Access

To enroll in the 401(k) plan, make contribution changes, and elect your investment choices, please visit: **Fidelity.com** or call Customer Service at 800.835.5097 (5:30 AM - 5:30 PM PST).

ZOHO has added 401(k) plan advisory services through Three Bell Capital. For 401(k) plan investment consultations, please contact Three Bell by email at: 401k@three-bell.com.

Medical Insurance

Plan Types*

PPO – Preferred Provider Organization

A type of health plan that contracts with medical providers, including physicians, specialist, hospitals and other facilities, to create a broad network of participating Preferred Providers.

- Freedom to seek care from any medical provider, but you will pay less if using Preferred Providers that belong to the plan's contracted network
- A primary care physician is not required
- No referral needed to see specialists

HSA-Qualified High Deductible Health Plan (HDHP)

A type of health plan that is often coupled with a Health Savings Account (HSA). Similar to a PPO, there are In-Network and Out-of-Network benefits. However, under a HDHP, you pay for all healthcare services - including prescriptions - until you meet the calendar year deductible.

HSA dollars may be used for qualified medical, dental and vision expenses outlined within IRS Section 213(d). Once the insurer has confirmed the amount you owe, your HSA dollars can be used to pay your out-of-pocket expenses, including copays, deductible and coinsurance amounts billed by the physician, facility or pharmacy. Or, you can choose to save your HSA dollars for a future medical expense.

HMO – Health Maintenance Organization (CA Only)

A type of health plan that limits coverage to care from the specific medical group of your Primary Care Physician (PCP), which includes other contracted specialists, hospitals and other facilities which are contracted through that same medical group.

- Requires you to select a primary care physician who will provide all your basic health services and give you a referral to see a specialist within the same medical group
- Generally defined copayments for office visits and hospital stays
- Except for emergencies, generally will not cover out-of-network care
- May require you to live or work within the HMO service area

Choose Wisely

Your health plan affects many things, including how much choice you have in health care providers, what kind of care you receive, where you receive care, and how you will pay for your care.

It is vital that you evaluate your health plan options carefully and choose the one that best fits your needs. Here are some key elements to consider:

- Does the plan have the doctors and hospitals I want or need?
- What do current members or co-workers think of the health plan?
- Does the plan meet my budget?

*For basic benefits information via short videos, visit **mindsharegroup.com/education.**

Medical Insurance PPO

These tables provide an overview of the benefits and coverage for each plan. For more detailed information, including prescription drugs (Rx)*, please review the carrier plan summary and SBC available online.

	UnitedHealthcare Choice Plus Premier PPO 250	
	In-Network	**Out-of-Network**
Individual Deductible (ded)	$250	$5,000
Family Deductible	$500	$10,000
Individual Out-of-Pocket Max	$1,750	$10,000
Family Out-of-Pocket Max	$3,500	$20,000
Primary Care/Specialist	$20/ SP-$20 (Designated Network), $40 ded waived	30% after ded
Preventive Care	No charge	30% after ded
Lab/X-Ray (Non-Hospital)	$0/$0	30% after ded
Chiropractic Care	$20/visit (ded waived), 20 visits/yr	30% after ded
Mental Health Outpatient	$20 ded waived	30% after ded
Urgent Care	$75 ded waived	30% after ded
Emergency Room	$300 ded waived	Paid as in-network
Inpatient Hospital	$0 after ded	30% after ded
Prescription Drugs (Rx)*		
Tier 1 (Most Generics)	$10	$10 + cost difference
Tier 2	$35	$35 + cost difference
Tier 3	$60	$60 + cost difference

Log in to Ease for specific plan and cost details.

Medical Insurance PPO

These tables provide an overview of the benefits and coverage for each plan. For more detailed information, including prescription drugs (Rx)*, please review the carrier plan summary and SBC available online.

	UnitedHealthcare Choice Plus Premier PPO 1000	
	In-Network	**Out-of-Network**
Individual Deductible (ded)	$1,000	$5,000
Family Deductible	$2,000	$10,000
Individual Out-of-Pocket Max	$2,500	$10,000
Family Out-of-Pocket Max	$5,000	$20,000
Primary Care/Specialist	$25/ SP-$25 (Designated Network), $50 ded waived	30% after ded
Preventive Care	No charge	30% after ded
Lab/X-Ray (Non-Hospital)	$0/$0	30% after ded
Chiropractic Care	$25/visit (ded waived), 20 visits/yr	30% after ded
Mental Health Outpatient	$25 ded waived	30% after ded
Urgent Care	$75 ded waived	30% after ded
Emergency Room	$300 ded waived	Paid as in-network
Inpatient Hospital	$0 after ded	30% after ded
Prescription Drugs (Rx)*		
Tier 1 (Most Generics)	$10	$10 + cost difference
Tier 2	$35	$35 + cost difference
Tier 3	$60	$60 + cost difference

Log in to Ease for specific plan and cost details.

Health Savings Account (H.S.A.)

Overview

- A specialized tax-free account to save and pay for your share of healthcare expenses
- You own it forever – balance rolls over each year
- Works with your HSA-qualified high deductible health plan
- Participants cannot be covered under another medical plan that is not a qualified HDHP

Why Should I Elect a HDHP with HSA?

Cost Savings

- Lower health insurance premium costs
- Triple tax benefits: HSA contributions are excluded from federal income tax.* Interest and earnings are tax-deferred. Withdrawals for eligible expenses are exempt from federal income tax*.

Eligible Expenses

HSA dollars may be used for qualified medical, dental and vision expenses outlined within IRS Section 213(d). A list of qualified medical expenses can be found at qualifiedmedicalexpenses.pdf.

When Do I Use my HSA?

After visiting a physician, facility or pharmacy, your medical claim will be submitted to your HDHP for payment. Once the insurer has confirmed the amount you owe, your HSA dollars can be used to pay your out-of-pocket expenses, including copays, deductible and coinsurance amounts billed by the physician, facility or pharmacy. Or, you can choose to save your HSA dollars for a future medical expense.

You can also use your HSA debit card to access your HSA funds.

Contributions

ZOHO funds $1,000 annually for individuals and $2,000 annually if enrolling a spouse or domestic partner and/or dependents.

You can make additional tax-exempt contributions to your HSA or a family member or anyone else can deposit dollars on your behalf, subject to the annual contribution limits.

HSA MAXIMUM CONTRIBUTION	
	2023
Individual	$3,850
Family	$7,750
Catch-Up Contributions (Age 55+)	$1,000

Note: These contribution limits include employer contribution

Do Funds Roll Over Year to Year?

Yes! Contributions roll over from year to year and the account is portable. This allows you to save for future medical expenses. Unused money is held in an interest-bearing savings or investment account. You control your HSA dollars and use them when you want.

Special Note - Medicare

Due to more recent IRS rules, you are NOT eligible to contribute to a HSA if you are enrolled in Medicare Part A. In these circumstances, signing up for Part A is NOT recommended.

** California and other states have not passed legislation to provide favorable state tax treatment for HSAs. Therefore, amounts contributed to HSAs and interest earned on HSA accounts in CA and other states will be included on your W-2 for state income tax purposes.*

Medical Insurance H.S.A.

These tables provide an overview of the benefits and coverage for each plan. For more detailed information, including prescription drugs (Rx)*, please review the carrier plan summary and SBC available online.

	UnitedHealthcare Choice Plus H.S.A. 2000	
	In-Network	**Out-of-Network**
Individual Deductible (ded)	$2,000	$5,000
Family Deductible	$4,000 (Aggregate)	$10,000 (Aggregate)
H.S.A. Funding from ZOHO	$1,000 annually / individual $2,000 annually / family	
Individual Out-of-Pocket Max	$3,000	$10,000
Family Out-of-Pocket Max	$6,000 (Aggregate)	$20,000 (Aggregate)
Primary Care/Specialist	$0/$0 after ded	30% after ded
Preventive Care	No charge	30% after ded
Lab/X-Ray (Non-Hospital)	$0 after ded	30% after ded
Chiropractic Care	$0 after ded; 20 visits/yr	30% after ded
Mental Health Outpatient	$0 after ded	30% after ded
Urgent Care	$0 after ded	30% after ded
Emergency Room	$0 after ded	Paid as in-network
Inpatient Hospital	$0 after ded	30% after ded
Prescription Drugs (Rx)*		
Tier 1	$10 after ded	$10 after ded + cost difference
Tier 2	$35 after ded	$35 after ded + cost difference
Tier 3	$60 after ded	$60 after ded + cost difference

Finding a Doctor

Finding a Doctor or Facility with UnitedHealthcare

Staying in network is key to limiting your costs on your health plan. To look up an in-network provider, follow the steps below:

STEP 1: Go to myuhc.com.

STEP 2: Click on “Find a Provider”

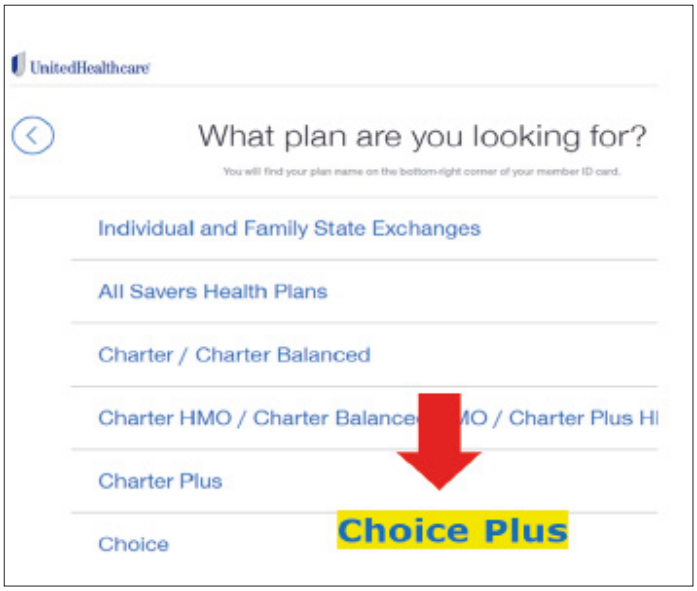
STEP 3: Select “Medical Directory”

Medical Directory

STEP 4: Select “Employer and Individual Plan"

Employer and Individual Plans

STEP 5: Scroll down the list of plans/networks and click on "Choice Plus":



STEP 6: Follow the search instructions to look for contracted doctors, specialists or facilities.

People

Doctors, medical groups, and other professionals by specialty

Places

Hospitals, clinics, labs, imaging centers, medical suppliers

Health Plan Resources for UnitedHealthcare Members

Health4Me®

The UnitedHealthcare (UHC) Health4Me® app is designed to make managing health care a lot simpler. You can access your ID card, benefit amounts, account balances and Personal Health Records.

You can also manage claims, estimate costs, search drug pricing and find nearby providers and quick care facilities anytime and anywhere. If you can't find the answer you are looking for, the app can connect you with a helpful professional through Talk With Us.

Virtual Visits

With a Virtual Visit, you can see and talk to a doctor via a mobile device or computer 24/7, no appointment needed.

You can use a virtual visit for these minor medical needs: bladder/urinary tract infection, bronchitis, cold/flu, fever, pinkeye, rash, sinus problems, sore throat and stomachache. To get started, go to uhc.com/virtualvisits.

Healthiest You

The Healthiest You Program offers the following:

- 24/7 unlimited doctor access - the physician network can diagnose, treat, and prescribe, anytime, anywhere. Registering and using the service is designed to be simple. The program also offers rescription savings - a geo-based prescription search engine that can save you up to 85% on a prescription and will often beat a co-pay.

AppleFitness+

UHC plans include a 1-year subscription to Apple Fitness+, a $79 value (can be shared with up to 5 family members).

Access on-demand workouts on your iPhone, iPad and Apple TV.

Real Appeal

This program provides up to a full year of support for weight loss. It combines clinically proven science with engaging content and easy-to-understand principles that teach how to eat healthier and be active and helping to achieve and maintain weight-loss goals.

The program includes the following:

- A success kit
- Weekly group classes
- Transformation coach
- Digital support and tracking
- Entertaining and inspirational messaging

One Year Peloton Digital Membership

Your health benefits plan includes the option to purchase Peloton equipment at special pricing ($100 savings), and a 1-year Peloton App membership — a $155 value — available at no additional cost.

The Peloton App gives you: access to thousands of fitness classes, the flexibility to get active anytime and anywhere, and lots of ways to help you have fun and stay motivated!

To get started, sign in to myuhc.com/peloton, then go to Coverage & Benefits to get your access code.

UnitedHealthcare Mental Health Services

Overview

If you or a loved one has feelings of anxiety, stress, isolation of depression, you are not alone. How you feel matters; and the way you learn to cope matters too. Mental health and behavioral health programs and resources are available to help you feel better and help you get back to being you.

You can sign into your health plan account or call the number on your member ID card to determine if you may be eligible for specific mental health care services, including virtual visits and well-being resources.

Mental health providers offer a range of services to address various issues, including:

- Anxiety
- Depression
- Addiction and substance abuse
- Various other disorders (personality, mood, eating or trauma)

Find a Provider to Support Your Mental Health

Under UnitedHealthcare, mental healthcare can be delivered two ways: in person or virtually. The best way to search for providers for face-to-face or virtual visits is by going to:

- myuhc.com
- Click on the “Find a Provider”
- Under Type of Provider, click on “Behavioral Health Directory”
- Select "Employer and Individual Plan"
- Under what type of mental health care, and location, search by: provider, service or condition; or click on type: Psychiatrist, Psychologist, Telemental Health Providers, or Anxiety
- Those providers with a Telemental Health Designation are available for virtual visits. You can call the provider directly to make an appointment.

Optum Behavioral Health, a UnitedHealthcare company, can also help guide you through this process. You can call 800.552.9951 for assistance. If you have a provider who is out of network, you should contact Optum Behavioral Health for prior authorization before accessing care.

Say Hello to Sanvello

With your UnitedHealthcare plan, you have access to tools, at no cost to you, to support your mental health, such as the Sanvello App.

SANVELLO

Sanvello offers clinical techniques to help dial down the symptoms of stress, anxiety, and depression - anytime. Visit sanvello.com for more information, or to download the app.

Mental Health Support (EBHRA)

Overview

In support of mental health expenses that are not fully covered by your selected medical plan, ZOHO provides a Supplemental Benefits Plan specifically for Mental Health Support.

This additional benefit is facilitated through a Health Reimbursement Arrangement (EBHRA), administered by Navia Benefits Solutions. This supplemental plan reimburses you, up to federal-allowed limits, for eligible mental health expenses.

Your HRA account runs on the calendar year, beginning January 1st and continues until December 31st.

EBHRA Benefit

ZOHO contributes a maximum of $1,950 per employee, per year for the following eligible* mental health expenses:

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)
Eligible Expenses
• Licensed Psychiatrist
• Licensed Psychoanalyst
• Licensed Psychologist
• Licensed Psychotherapy

** Per federal guidelines, the above expenses are eligible under 213(d) and can be eligible under an EBHRA. Please note, therapy/ counseling—such as marriage or family counseling—not required for a medical or mental purpose will typically not qualify.*

How it Works

Once you've incurred an eligible expense and your patient responsibility has been determined, you may submit a claim to Navia for reimbursement. If your expense is covered by insurance, you must wait until your insurance carrier has applied your benefits before using the HRA to pay for an remaining patient responsibility.

Using the Program

To set-up your account and register with Navia Benefit Solutions, visit: naviabenefits.com. Click on the "Register" button at the top of the screen.

NOTE: You will need the ZOHO "Employer Code": ZHO to complete your registration.

For Customer Service by phone, call 800.669.3539, or email: customerservice@naviabenefits.com.

Claims Submission Process

- Complete a claim form, itemize your expenses and list the total amount you are claiming.
- Attach an itemized invoice/EOB/receipt that shows the date the service was incurred, the patient responsibility, and the type of service received.
- Submit the claim form and supporting documentation to Navia. The most efficient way to submit a claim is by using the online claim submission tool or the MyNavia smartphone app for Android or iPhone. You may also submit claims via email, fax or mail. Please use only one method per submission. Allow one week for your claim to be reviewed and processed once it has been received.
- Reimbursements are processed weekly on Tuesday. Reimbursements will be directly deposited into your bank account or a check mailed to your home. Direct deposits may take 1-2 days to post to your bank account.

Medical Insurance HMO (CA Only)

KAISER PERMANENTE®

These tables provide an overview of the benefits and coverage for each plan. For more detailed information, including prescription drugs (Rx)*, please review the carrier plan summary and SBC available online.

	Kaiser Platinum 90 HMO 0/10	Kaiser Gold 80 HMO 0/30
	In-Network	**In-Network**
Individual Deductible (ded)	$0	$0
Family Deductible	$0	$0
Individual Out-of-Pocket Max	$3,000	$7,500
Family Out-of-Pocket Max	$6,000	$15,000
Primary Care/Specialist	$10/$20	$30/$50
Preventive Care	No charge	No charge
Most Lab/X-Ray	$20/$40	$30/$40
Chiropractic Care	$15; 20 visits/yr	$15; 20 visits/yr
Mental Health Outpatient	$10	$30
Urgent Care	$10	$30
Emergency Room	$200 (waived if admitted)	$250 (waived if admitted)
Inpatient Hospital	$500/admit	$600/day up to 5 days
Prescription Drugs (Rx)*		
Tier 1 (Most Generics)	$5	$15
Tier 2	$15	$50
Tier 3	$15	$50
Tier 4	10%; $250 max/script	20%; $250 max/script

Monthly premiums and employee costs are age specific for each health plan. Log in to Ease to see your specific costs.

Finding a Doctor

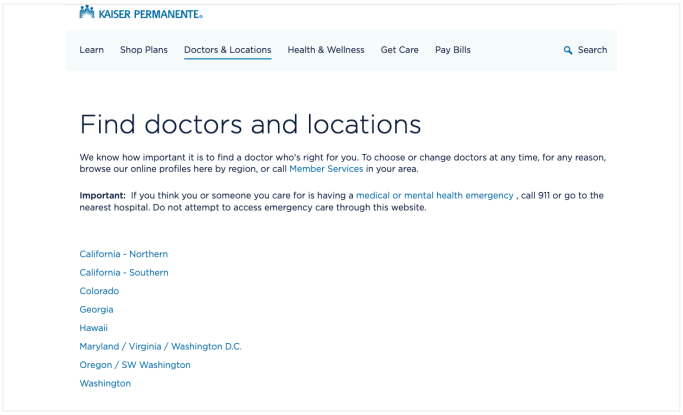
KAISER PERMANENTE®

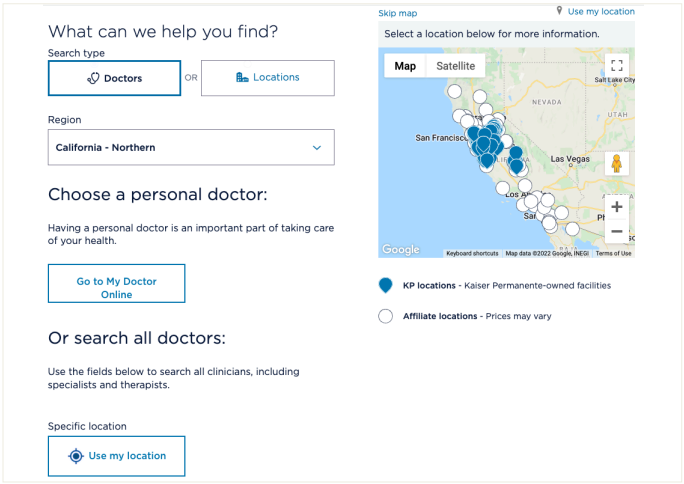
Finding a Doctor or Facility with Kaiser

Whether you are looking for a primary care doctor or a specialist, it's important to find a doctor you can partner with. A strong partnership between you and your doctor is key to getting great care and reducing costs. When you have many doctors, think of them as part of your health care team. Ask your doctors to communicate with each other about your care.

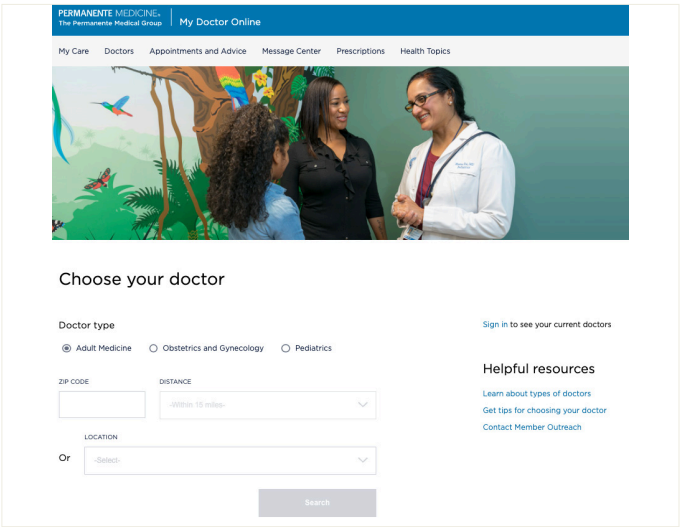
As a member of Kaiser Permanente, you will utilize Kaiser Permanente providers and facilities from The Permanente Medical Group (TPMG).

To choose or change doctors at any time, for any reason, call Member Services in your area or go to: kp.org/doctors and click on doctors and locations tab.





You can search a list of providers or search by provider's name by clicking **"Go to My Doctor Online"** or you can enter your location and search using filters such as specialty, gender, language etc.



Health Plan Resources for Kaiser Members

KAISER PERMANENTE®

Take Charge of your Care with KP.org

When you register, you can securely access many time-saving tools for managing the care you get at Kaiser Permanente facilities. Visit kp.org (or download the Mobile App) anytime, from anywhere, to:

- View most lab results
- Refill most prescriptions
- Email your doctor's office with non-urgent questions
- Schedule and cancel routine appointments
- Print vaccination records

Phone/Video Visits

The next time you schedule an appointment at Kaiser Permanente, you may be offered a phone or video visit with your doctor.

- Convenient access from your home or office
- Secure and easy way to visit your doctor
- Saves travel time and expense

Live Healthy for Less

Members get reduced rates on a variety of health-related products and services through the ChooseHealthy program. These include:

- Acupuncture — up to 25% off regular rates
- Active&Fit Direct — pay $25 per month (plus $25 enrollment fee) for access to a national network of more than 10,000 fitness centers
- Chiropractic care — up to 25% off regular rates
- Massage therapy services — 25% off regular rates

Join Health Classes

All kinds of health classes and support groups are offered at Kaiser facilities. For more information on options available, visit kp.org/classes.

Healthy Lifestyle Programs

With online wellness programs, you'll get advice, encouragement, and tools to help you make healthier choices, improve your wellbeing, and create positive changes in your life. Complimentary programs can help you lose weight, eat healthier, quit smoking, reduce stress and manage ongoing conditions like diabetes or depression. Start with a Total Health Assessment. Visit KP Healthy Lifestyles and select Health & Wellness from the menu.

Wellness Coaching

If you need a little extra support, Kaiser Permanente has wellness coaches available to you by phone, at no cost. You'll work one on one with your personal coach to set a plan to help you reach a wide range of health goals. For more information, please visit: kp.org/wellnesscoach.

Travel Coverage

As a Kaiser Permanente member, you're covered for emergency and urgent care anywhere in the world. It's important to remember that how you get care can vary depending on where you are. So plan ahead and find out what emergency and other medical services are available where you'll be traveling. Go to kp.org/travel for more information. The Kaiser Permanente away from home travel line is 951.268.3900.

Mental Health Services for Kaiser Members

Overview

Millions of people seek mental health services every year. If you are looking for support, you are not alone. You deserve care that supports your total health – mind and body. Health insurance carriers recognize this and have enhanced their mental health services to meet member needs. Mental health parity laws require that health plans cover treatment for mental health under the same terms and conditions as medical and surgical benefits.

Mental health providers offer a range of services to address various issues, including:

- Anxiety
- Depression
- Addiction and substance abuse
- Various other disorders (personality, mood, eating or trauma)

Connected care

Your Kaiser team is connected to each other, so it's easy for Kaiser doctors to consult with one another about your care. Your connected team includes many health professionals, including:

- Psychologists and psychiatrists
- Licensed marriage and family therapists
- Behavioral and addiction medicine specialists, and more

Learn more by visiting: kp.org/mentalhealth/conditions and kp.org/mentalhealth/resources.

Kaiser Mental Health Services

Your personal doctor is your biggest total health advocate. If you're struggling, they can connect you with support and help you access care. Appointments can be in person or virtual. You can also visit www.kp.org to find care near you.

Also on kp.org/selfcareapps, you will find valuable resources and tools to support mental health including free self-care apps such Calm and myStrength.

- **Calm** — an app for meditation, mental resilience, and sleep. It is designed to help lower stress, reduce anxiety, and more. Kaiser Permanente members can access all the great features of Calm at no cost.

- **myStrength** — a personalized program that helps you improve your awareness and change behaviors. Kaiser Permanente members can explore interactive activities, in-the-moment coping tools, community support, and more at no cost.

- **Ginger** — On-demand emotional support through the Ginger app. Ginger's emotional support coaches are available 24/7 to help with stress, low mood, sleep troubles and more.

Dental Plan

In order to take full advantage of your dental plan, verify your dentist's participation in MetLife's network. You can go online to metlife.com/mybenefits or call MetLife at 800.942.0854.

In-Network vs. Out-of-Network

Always use in-network dentists to pay the least out-of-pocket for dental services. If you choose to see an out-of-network dentist, your costs may be higher, and an out-of-network dentist may "balance bill" you for the difference between the Usual, Customary, and Reasonable (UCR) allowance and their fee.

This table provides an overview of the benefits and coverage. For more detailed information, please review the carrier's full Plan Summary, available online via Ease.

	MetLife Low PPO Plan		MetLife High PPO Plan	
	In-Network Dentists	**Out-of-Network Dentists**	**In-Network Dentists**	**Out-of-Network Dentists**
Annual Deductible (waived for preventive)	$50/individual $150/family	$50/individual $150/family	$25/individual $75/family	$25/individual $75/family
Annual Maximum Annual benefit amount paid by the plan	**$2,500 per person**		**$4,000 per person**	
	PLAN PAYS			
	Negotiated Fee Schedule	**99% of UCR***	**Negotiated Fee Schedule**	**99% of UCR***
Preventive and Diagnostic Services Oral exams and cleanings and x-rays	100%	100%	100%	100%
Basic Services Fillings, simple extractions & root canals	90%	90%	90%	90%
Major Services Crowns, dentures & bridges	60%	60%	65%	65%
Orthodontia Adults and Children to age 26	Not Covered	Not Covered	50%	50%
Orthodontia Lifetime Maximum	N/A		**$2,000 per person**	

Limitations and exclusions may apply to some benefits.

** UCR - Usual, Customary and Reasonable: The amount paid for a dental service in a geographic area is based on what providers in the area usually charge for the same or similar dental service.*

Vision Plan

In-Network vs. Out-of-Network

In order to take full advantage of your vision plan and pay the least out-of-pocket, visit a VSP provider. You can find in-network providers online at vsp.com or by calling Customer Service at **800.877.7195**. If you receive services from an out-of-network provider you will be responsible for paying at the time of service, and you may then request the allowed reimbursement from VSP.

This table provides an overview of the benefits and coverage. For more detailed information, please review the carrier's full Plan Summary, available online via Ease.

VSP Choice $10/$25			
Benefit	**Description**	**Copay**	**Frequency**
Well Vision Exam	Focus on your eyes and overall wellness	$10	Every calendar year
Prescription Glasses		$25	
Frame	• $250 frame allowance* • 20% savings on the amount over your allowance • $135 Costco® frame allowance	Included in Prescription (Rx) Glasses	Every other calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Rx Glasses	Every calendar year
Lens Enhancements	• Anti-glare coating • Tints/Light-reactive lenses • Scratch-resistant coating • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses	$0 $0 $0 $0 $95 - $105 $150 - $175	Every calendar year
Lightcare	• $250 allowance for ready-made non-Rx sunglasses, or ready-made non-Rx blue light filtering glasses, instead of Rx glasses or contacts	$25	Every other calendar year
Contacts (instead of glasses)	• $250 allowance for contacts • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
Extra Savings	**Glasses and Sunglasses** • Extra 20%-30% savings. See VSP summary for details.		
	Routine Retinal Screening No more than a $39 copay on routine retinal screening as an enhancement to a Well Vision Exam		
	Laser Vision Corrections Average 5%-15% off the price; discounts only available from contracted facilities		
Out-of-Network	If you are using a non-VSP provider, you may have benefits that can be reimbursed. Call 800.877.7195 for coverage details or vsp.com		

** Allowance from certain retailers may vary.*

Flexible Spending Account (FSA)

Overview

A FSA provides you with an important tax advantage that can help you pay for eligible health care and dependent day care expenses with tax-free dollars.

Your FSA account runs on the calendar year, beginning January 1st and continues until December 31st. If you decide to participate, you must re-enroll in the plan(s) each year.

How You Save

The amount you contribute to either or both FSAs is deducted from your paycheck before federal, state, local and social security taxes are withheld. When you have an eligible expense, you are reimbursed from your account and the money is not taxed.

Health Care Reimbursement Account

The Health Care portion of the FSA enables employees to pay for certain IRS-approved, out-of pocket health care and related expenses with pretax dollars. Qualifying expenses include:

- Medical copayments, deductibles, and prescription drugs costs
- Over-the-counter prescription drugs and feminine care products (added in 2020)
- Dental copayments and deductibles, including orthodontia
- Vision copayments and other services, including contact lenses, eye exams and eyeglasses

Dependent Day Care Reimbursement Account

The Dependent Day Care portion of the FSA lets employees use pretax dollars toward qualified dependent day care. Qualifying expenses include:

- The cost of all child care for children under age 13
- The cost for a licensed individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

HEALTHCARE FSA MAXIMUM CONTRIBUTION (per calendar year)	
	2023
Health Care FSA	$3,050
Amount you can carryover at the end of the plan year	$610
DEPENDENT CARE FSA MAXIMUM CONTRIBUTION (per calendar year)	
Married filing separately	$2,500
Individuals or married couples filing jointly	$5,000

Using Your Funds

To be reimbursed from your account, eligible expenses must be incurred – services actually received – during the plan year while you are/were an active participant. Your claims must be received within the grace period (generally 60-90 days after the plan year end).

Special Note

If you enroll in the Health Savings Account (HSA) plan, you may participate in a Limited Purpose FSA for dental and vision expenses ONLY. Use your HSA for all qualified medical expenses.

Lifestyle/Wellness Spending Account (LSA)

Overview

A Lifestyle Spending Account (LSA) is a ZOHO-funded, post-tax account that reimburses employees for eligible expenses related to your physical health and wellbeing. ZOHO funds the LSA up to a maximum benefit/ reimbursement of $500 annually.

This supplemental plan reimburses employees for Fitness related-eligible expenses including:

- Gym and health club memberships
- Group or individual exercise classes (e.g. yoga, Pilates, personal training, aerobics, etc.)
- Nutrition counseling with a certified Dietician
- Weight management program fees (e.g. Weight Watchers, Jenny Craig, etc.)
- Exercise apps, DVDs and videos
- Home fitness equipment (treadmills, bikes, elliptical or rowing machines, hand weights)

This benefit is for ZOHO-eligible employees only (spouse and dependent children are not included).

Your Lifestyle/Wellness Spending Account runs on the calendar year, beginning January 1st and continues until December 31st.

Income Protection Plans

Short Term Disability Insurance

In the event you become sick or disabled for more than 7 days, you may be eligible to receive disability benefits on a weekly basis up to 12 weeks through the Short Term Disability (STD) plan. This benefit is through the disability carrier and coordinates with CA SDI or disability benefits from other states to bring your weekly benefit up to 66 2/3% of your salary. The maximum weekly benefit under this plan is $2,000.

Your employer pays for the full cost of this coverage.

Long Term Disability Insurance

In the event you remain sick or disabled for more than 90 days, you are eligible to receive disability benefits on a monthly basis through the Long Term Disability (LTD) plan. You will continue to receive payments under the LTD plan as long as you are deemed "disabled" until you reach normal Social Security retirement age. This benefit coordinates with CA SDI to bring your monthly benefit up to 66 2/3% of your salary. The maximum benefit under this plan is $13,000. Your employer pays for the full cost of this coverage.

Term Life and AD&D Insurance

Life and Accidental Death and Dismemberment (AD&D) insurance can help provide financial resources for your family or loved ones in the event of your death or terminal illness.

Life insurance is paid to your beneficiaries after your death, while AD&D is paid in the event of an accidental death or for certain accidental injuries. If you leave the company, you may be able to convert to an individual plan.

IMPORTANT: *Make sure your beneficiaries are updated in Ease during the enrollment period.*

Insurance	Coverage	Maximum Benefit	Benefit Duration
Short Term Disability	66 2/3% of weekly earnings; coordinates with CA SDI (where applicable)	$2,000 per week	Begins on 8th day of disability up to 12 weeks
Long Term Disability	66 2/3% of monthly earnings coordinates with CA SDI (where applicable)	$13,000 per month	Begins on 91st day of disability until age 65 or normal Social Security retirement age
Term Life and AD&D	2 x your basic annual earnings	$600,000	Paid at time of death to designated beneficiary

Benefits listed above are a summary only; please refer to carrier plan summary and other documents for specific details and exclusions, available online via Ease.

Voluntary Term Life

MetLife

Overview

Employees who want to supplement their group Term Life insurance benefits may purchase additional coverage at discounted rates for themselves, their spouse/domestic partner, or children. You must elect coverage for yourself in order to elect coverage for your spouse/registered domestic partner and/or your child(ren).

When you enroll yourself and/or your dependents in this benefit, you pay the full cost through payroll deductions. If your employment with ZOHO ends, you may convert your coverage to an individual policy.

Guaranteed Issue

If you enroll as a new hire, you are guaranteed $100,000 of coverage without any medical questions or proof of good health. Any amount over the guaranteed issue amount requires proof of good health by completing a Statement of Health form. The Statement of Health form must be approved by MetLife before the higher amount of supplemental coverage is effective.

If enrolling after initial hire date or applying for more coverage at open enrollment you will be required to complete a Statement of Health form for approval.

Voluntary Term Life & AD&D	Coverage	Maximum Benefit	Guaranteed Issue
Employee	Increments of $10,000	The lesser of 5 times your Basic Annual Earnings or $500,000	$100,000 new employees only
Spouse	Increments of $5,000	$100,000 (not to exceed 50% of the employee amount)	$20,000
Child(ren) *Ages 6 months through 19 years of age (25 if full-time student)*	Flat Amounts: $1,000, $2,000, $4,000, $5,000, or $10,000	$10,000	$10,000

Voluntary Term Life with AD&D Example Costs Per Pay Period					
Age	**$50,000**	**$100,000**	**$150,000**	**$200,000**	**$250,000**
< 30	$2.20	$4.40	$6.60	$8.80	$11.00
30-34	$2.48	$4.95	$7.43	$9.90	$12.38
35-39	$2.75	$5.50	$8.25	$11.00	$13.75
40-44	$3.88	$7.75	$11.63	$15.50	$19.38
45-49	$5.88	$11.75	$17.63	$23.50	$29.38
50-54	$9.13	$18.25	$27.38	$36.50	$45.63
55-59	$14.08	$28.15	$42.23	$56.30	$70.38
60-64	$20.98	$41.95	$62.92	$83.90	$104.88
65-69	$33.45	$66.90	$100.35	$133.80	$167.25
70-99	$62.85	$125.70	$188.55	$251.40	$314.25

Employee Assistance Program

Overview

Provided by MetLife, administered by LifeWorks, the Employee Assistance Program (EAP) is available to all employees and your dependents, as well as any member of your household, including elderly parents who may be living with you.

The purpose of the program is to provide confidential assistance at no-cost for a wide range of personal topics.

Consultations are available for subjects such as:

- **Family**—going through a divorce, caring for a family member, returning to work after having a baby
- **Money**—budgeting, financial guidance, buying/selling a home
- **Legal Services**—civil, personal and family law, real estate and estate planning
- **ID Theft Recovery**—tips and help if you are victimized
- **Health**—coping with anxiety or depression, how to kick a bad habit like smoking
- **Everyday Life**—grieving over the loss of a loved one, military family matters

Using the Program

Help is always at your fingertips. The mobile app makes it easy for you to access and personalize educational content important to you. Search "LifeWorks" in the iTunes or Google App Store. The username and password is the same as noted below.

Your program also includes up to 5 in-person, phone or video consultations with licensed counselors for you and your eligible household members, per issue, per calendar year.

Call 888.319.7819 to speak with a counselor or to schedule an in-person, phone or video conference appointment. These services are available 24 hours a day, 7 days a week. When you call, just select "Employee Assistance Program" when prompted, and you'll immediately be connected to a counselor.

Or, you can **visit the LifeWorks website** at: metlifeeap.lifeworks.com.

Username: metlifeeap
Password: eap

Identity Theft Protection Services

Overview

ZOHO offers a voluntary benefit for protection against identity theft thru ID Watchdog.

ID Watchdog helps warn you when your personal information is stolen and helps you better protect yourself and your family from identity fraud—when stolen information is used for illicit gain. You'll have greater peace of mind knowing you don't have to face the complexities of identity theft alone.

ID Watchdog Platinum

ID Watchdog Platinum offers powerful features to help you:

Control and Manage

- Credit Report Lock | Multi-Bureau
- Blocked Inquiry Alerts | 1 Bureau
- Subprime Loan lock
- Financial Accounts Monitoring
- Social Account Monitoring & Takeover Alerts
- Registered Sex Offender Reporting
- Customized Alert Options
- and more

Monitor and Detect

- Dark Web Monitoring
- Data Breach Notifications
- High-Risk Transactions Monitoring
- Public Records Monitoring
- USPS Change of Address Monitoring
- Identity Profile Report
- VantageScore Credit Scores
- and more

Support and Restore

- Fully Managed Resolution Services
- Online Resolution Tracker
- Up to $1MM Identity Theft Insurance with 401K/ HSA Stolen Funds Reimbursement
- Lost Wallet Vault and Assistance
- Deceased Family Member Fraud Remediation
- Credit Freeze Assistance

ID Watchdog Platinum Plan Fees

ZOHO EMPLOYEE COST		
	Per month	**Per pay period**
Employee only	$6.48	$3.24
Employee + family	$11.48	$5.74

ZOHO pays 50% of the monthly premium for ID Watchdog Platinum Plan. (Monthly premium: $12.95 for employee only, $22.95 for employee + family).

On the Employee only plan, an individual under 18 can be added to the account with no additional cost.

Customer Support

Call 800.970.5182 or visit the ID Watchdog website at: idwatchdog.com.

401(k) Retirement Plan

Overview

Administered by Fidelity, the ZOHO 401(k) plan allows you to save and invest in your future by setting aside a portion of each paycheck into a tax-qualified retirement savings plan.

An employee is eligible to participate in the plan on the first day of the month following 30 days from date of hire.

The amount you choose to invest gets deducted directly from your paycheck, making the savings automatic and convenient!

Make sure to contribute at least 5% of your salary after-tax to take full advantage of ZOHO's company-match!

Enrollment and Account Access

To enroll in the 401(k) plan, make contribution changes, and elect your investment choices, please visit: Fidelity.com or call Customer Service at 800.835.5097.

Contribution Limits

You can contribute between 0% and 100% of eligible compensation up to the contribution limits:

IRS Annual Contribution Limits for 2023	
CONTRIBUTION TYPE	LIMIT
401(k) Elective Deferrals (up to 50)	$22,500
Catch-Up Contribution (50+)	$ 7,500

Rollover Contributions

The plan allows an employee to rollover a distribution from a previous employer's 401(k), 403(b), or other tax qualified plan at any time during the plan year. **Contact Fidelity customer service for more details.**

Why Invest in a 401(k)?

For most Americans, Social Security provides less than half of the income needed in retirement! Contributing to your company's 401(k) Retirement Plan provides you with 3 distinct advantages in saving for retirement:

1. **Tax Advantages**

- Your contributions are taken out before taxes are calculated, and your money grows tax-deferred, which means your savings will grow faster!
- Or you can elect Roth deferrals, which means your contributions are taken after-tax, and your investments grow tax-free, with no tax on distributions in retirement.

2. **Maximize Your Money**

- ZOHO offers a generous match on your salary deferrals: 100% of the first 3% and 50% of the next 2%.

ZOHO Contributions (Based on an annual salary of $80,000)			
Deferral %	**Employee Deferral**	**Employer Contribution**	**Total**
1%	$800	$800	$1,600
2%	$1,600	$1,600	$3,200
3%	$2,400	$2,400	$4,800
4%	$3,200	$2,800	$6,000
5%	**$4,000**	**$3,200**	**$7,200**

3. **Long Term Growth**

Your contributions, and any matching contributions you receive, are invested in top-notch, market-based stock, bond or fixed-income investment funds. There may be short term fluctuations in value, but over time the power of staying invested and continuing to automatically invest will result in a substantial nest egg for your future!

Medicare

Overview

Medicare is a federal health insurance program primarily for retirees age **65+**. However, there are other circumstances where it can apply, including certain disabled people under age 65, anyone with kidney failure, and occasionally individuals who are still working but chose to transition to Medicare before retirement.

What Happens When I Turn 65?

During the months leading up to your 65th birthday, you will begin to receive various marketing communications regarding enrollment in Medicare, Medicare Advantage, and Medicare Supplemental coverage. The relevance of this information depends on your situation:

- **If you are continuing to work and remain eligible for employer-based benefits, you can defer Medicare enrollment until retirement without restrictions or penalties.** Generally this option is best, due to the substantial employer funding of health insurance premiums, and the strength of prescription drug coverage under most employer plans. The employer group prescription benefits must meet the "creditable coverage requirement" on the month you turn 65. Anyone on HDHP employer group plans may have to change plans.
- If you are retiring, this information is pertinent, but can be overwhelming. Six months prior to turning 65 is an ideal time to discuss your needs and coverage options with a qualified Medicare advisor who can guide you in the process of evaluating plan options and enrolling in coverage.

For More Information

For information regarding Medicare and Supplemental Medicare insurance plans, visit: medicare.mindsharegroup.com. If you wish to speak to a Medicare Advisor regarding Medicare, Medicare Advantage and Medicare Supplemental plans and costs, including Prescription Drug coverage with Medicare Part D, please contact Paul at Mindshare Group:

Paul Unpingco - Medicare Advisor/Insurance Agent
paul@mindsharegroup.com
925.227.9900 x116

When Should I Sign Up for Medicare Part A and B?

Most people turning 65 have contributed to Medicare via payroll taxes for many years. If you have been paying Medicare taxes for more than 10 years, there is no premium for Medicare Part A. In general, with one exception, enrolling in Part A is fine, even if you remain on employer-based coverage. **The ONE EXCEPTION is for those on a High-Deductible plan who are contributing to a Health Savings Account (HSA). Due to more recent IRS rules, you are NOT eligible to contribute to a HSA if you are enrolled in Medicare Part A. In these circumstances, signing up for Part A is NOT recommended.**

Anyone enrolling in Medicare Part B pays a premium for coverage. If you are continuing coverage under your employer plan (recommended), then it is best to defer Part B until retiring and moving to full Medicare coverage. There are no restrictions or penalties to defer Part B as long as you maintain employer sponsored group coverage from the month you turn 65.

Other factors to consider are the income related adjustment for highly compensated individuals, those with high cost prescription medications, if your spouse has not turned 65, and if you work for an employer with fewer than 20 employees.

Once you determine that you are enrolling in Medicare coverage, you must make the transition within 63 days of losing employer group coverage (COBRA does not qualify as employer group coverage).

Frequently Used Terms

Affordable Care Act (ACA) The comprehensive health care reform law enacted in March 2010.

AD&D (Accidental Death and Dismemberment) A Plan that provides benefits in the event of an accidental death or dismemberment (generally, an accident that results in death, loss of a part of the body, or the loss of use of part of the body).

Balance Billing A provider's billing of a patient for the difference between the provider's charge and the patient's insurance plan's allowed amount. For example, if the provider's charge is $100 and the patient's insurance plan's allowed amount is $70, the provider might bill the patient for the remaining $30.

Brand-Name Drug A drug sold by a drug company under a specific name or trademark, protected by a patent. Brand-name drugs may be available by prescription or over the counter.

Beneficiary A person or entity designated by a participant that may become entitled to receive a benefit under the plan. In the health insurance world, a beneficiary refers to someone eligible to receive distributions from a life insurance policy.

Claim A request for payment of a benefit by a plan participant or his or her health care provider to the insurer for items or services the participant believes are covered by the plan.

Coinsurance The percentage of costs of a covered health care service the participant pays after having paid his or her deductible.

Copayment (Copay) A fixed amount paid for a covered health care service, usually when a person receives the service.

Deductible The amount a plan participant pays for covered health care services before his or her insurance plan starts to pay.

Dependent Individuals, such as a spouse, domestic partner or dependent child, who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent.

Domestic Partner Defined as couples of any gender who are registered with any state or local government domestic partner registry, and couples not registered with an agency who meet all of the following criteria: not related to each other; live together; not currently in a domestic partnership, civil union or marriage with a different person; share mutual fiscal responsibility for each other; in an intimate, committed relationship of at least six months' duration.

Eligibility Period The time frame following the eligibility date, usually 31 days, during which potential members of a group may enroll in a benefits program.

Evidence of Insurability (EOI) Proof of good health required by an insurance company before the company will cover a participant. Proof of good health is generally only required for life and disability benefits.

Explanation of Benefits (EOB) A statement from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.

Formulary A list of prescription drugs covered by a prescription drug plan or other insurance plan offering prescription drug benefits. A formulary is often also called a drug list.

Generic Drug A drug that has the same active-ingredient formula as a brand-name drug. Generally generic drugs are only a fraction of the cost of brand name drugs.

Guaranteed Issue Does not require you to answer health questions, undergo a medical exam, or allow an insurance company to review your medical and prescription records.

Health Care Provider An individual or facility that provides health care services including doctors, clinics, hospitals, and pharmacies.

Health Flexible Spending Account (Health FSA) An account an individual establishes through his or her employer to pay for out-of-pocket medical expenses with tax- free dollars. These expenses include insurance copays and deductibles, and qualified prescription drugs, insulin, and medical devices.

Health Maintenance Organization (HMO) A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. There are two main types of HMOs: traditional HMOs and open-access HMOs.

Health Savings Account (HSA) A type of savings account that allows an individual to set aside money on a pre-tax basis to pay for qualified medical expenses, if he or she has a high deductible health insurance plan. HSA contributions are subject to an annual limit that is adjusted for inflation each year.

High Deductible Health Plan (HDHP) A plan with a higher deductible than a traditional insurance plan. To be considered a HDHP, the plan must meet minimum deductible and maximum out-of-pocket limit requirements, which are annually adjusted for inflation.

Individual Health Insurance Policy Insurance policy for an individual who is not covered under an employer-sponsored plan.

In-Network The facilities, providers, and suppliers a health insurer or plan has contracted with to provide health care services. The insured person typically pays a lower price for using services within the network.

Frequently Used Terms

Mail-Order Drugs Drugs that can be ordered through the mail. Generally, mail-order drugs offer cost savings.

Medicare A federal health insurance program for people aged 65 and older, certain younger people with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). Medicare consists of four parts: Medicare Part A, Medicare Part B, Medicare Part C, and Medicare Part D. Please see the Medicare page of this booklet for more information.

Open Enrollment Period Open enrollment is a short period of time each year in which benefit changes are allowed without restrictions. These adjustments may include changing carriers, modifying your coverage levels, or adding/dropping a spouse and/or dependent(s) from coverage.

Out of Network Services received outside an insurer's network. These services typically carry a higher cost to the insured person because the facilities, providers, and suppliers providing the health care services are not contracted with the health insurer or plan.

Out-of-Pocket Costs Expenses for medical care that are not reimbursed by insurance including deductibles, coinsurance, and copays for covered services plus all costs for services that are not covered.

Out-of-Pocket Limit The most a plan participant can be required to pay for covered services in a plan year. The out-of-pocket limit does not include monthly premium amounts or spending for services the plan does not cover. An out-of-pocket limit is also called an "out-of-pocket maximum.

Out-of-Pocket Maximum (OOPM) The maximum amount a participant can be required to pay for health care during one year, excluding the monthly premium. Expenses such as deductibles, co-insurance and co-pays accrue towards this maximum. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.

Prior Authorization A decision by a health plan that a health care service or product is medically necessary. A health plan may require prior authorization for certain services before they are provided (except in an emergency).

Pre-Existing Condition A health problem an individual had before the date that his or her new health coverage started.

Preferred Provider Organization (PPO) A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Under a PPO, a plan participant pays less in out-of-pocket costs if he or she uses providers that belong to the PPO's network.

Premium The amount charged every month by the health insurance for health plan coverage.

Preventive Services Routine health care that includes screenings, check-ups, and patient counseling to prevent health problems.

Primary Care Physician (PCP) A health care professional who practices general medicine. PCPs are generally the first stop for medical care and continue to coordinate /arrange other primary care services and/or specialty care. Most PCPs are doctors, but nurse practitioners and physician assistants can also be PCPs.

Qualifying Life Event A life event that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.

Referral A written order from a primary care physician directing a patient to see a specialist or receive certain health care services. Under many health plans, especially HMOs, a plan participant must obtain a referral before he or she can receive health care services from anyone except his or her primary care provider.

Specialist A health care provider focusing on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Summary of Benefits and Coverage (SBC) An easy-to-read summary that allows for apples-to-apples comparisons of costs and coverage between health plans.

Urgent Care Medical care provided for illnesses or injuries which require prompt attention but are typically not of such seriousness as to require the services of an emergency room. Obtaining care at an urgent care facility can result in significant cost savings versus a trip to the emergency room.

Usual, Customary, and Reasonable Charge (UCR) The amount paid for a medical or dental service in a geographic area based on what providers in the area usually charge for the same or similar medical or dental service. The UCR amount is sometimes used to determine the allowed amount.

Waiting Period The time that must pass before coverage can become effective for an employee or dependent who is otherwise eligible for coverage under an employer- sponsored health plan.

Frequently Used Retirement Plan Terms

Automatic Enrollment In some plans employees are automatically enrolled in the 401(k) plan without an active election.

Automatic Escalation If applicable, automatically increases an employee's contribution amount based on a predetermined formula.

Bond Fund A mutual fund that invests primarily in bonds and other debt instruments.

Contribution Limits Limits defined by the IRS on employee contributions.

Diversification A risk management strategy that mixes a wide variety of investments within a portfolio.

Elective Deferrals A portion of an employee's salary that is withheld and invested into a retirement plan. Elective deferrals can be made on a pre-tax or after-tax basis.

Employer Match The employer contributions to your retirement plan, often based on your level of contribution**.**

Fixed Income Fund A low-risk mutual fund that pays out a set level of cash flows to investors, typically in the form of fixed interest or dividends.

Hardship Distributions A withdrawal from a participant's account because of an immediate and heavy financial need.

International Fund A mutual fund that invests primarily in companies located outside of the U.S.

Large Cap Fund A mutual fund that invests primarily in companies with market capitalization over $10 billion.

Mid Cap Fund A mutual fund that invests primarily in companies with market capitalization ranging from $2 billion to $10 billion.

Mutual Fund A pooled investment vehicle managed by a professional money manager with the goal of producing capital gains or income for the fund's investors via investment in securities such as stocks, bonds, money market instruments, and other assets.

Qualified Default Investment Alternative (QDIA) The plan's diversified default investment fund if no active fund election is made.

Qualified Distribution A penalty-free withdrawal allowed from the retirement plan if you are at least 59 ½ years of age.

Required Minimum Distribution (RMD) The minimum amount you must withdraw from your retirement account each year once you reach age 72 and are fully retired.

Risk Profile A measure of an individual's willingness to take risks within their investment portfolio.

Rollover The transfer of holdings from one qualified retirement plan to another, without creating a taxable event.

Roth 401(k) After-tax contributions to your retirement account.

Safe Harbor 401(k) Plan Ensures all employees have some level of fully vested minimum contributions made to their retirement accounts, regardless of title, compensation, or length of service.

Small Cap Fund A mutual fund that invests primarily in companies with market capitalization ranging from $300 million to $2 billion.

Target-Date Fund Automatically re-balances your investments from higher-risk, higher-return to lower-risk, lower-return options as you near retirement.

Target-Risk Fund Targets a certain risk exposure, ranging from conservative to aggressive, and keeps the risk level constant over time.

Vesting Defines your ownership percentage of Employer-provided contributions over time.

Annual Notices

Medicare Part D Creditable Coverage Notice

If you or any of your eligible dependents are eligible for Medicare, or will soon become eligible for Medicare, please read this notice. If not, you can disregard this notice.

This notice has information about your current prescription drug coverage under the health plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The prescription drug coverage offered under your employer PPO or HMO health plans, on average for all plan participants, is expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (or penalty) if you later decide to join a Medicare drug plan. **NOTE**: If you are covered under a High-Deductible Health Plan (HDHP) with no prescription drug coverage until meeting your annual plan deductible, your health plan may not be considered Creditable Coverage. If this applies, please contact Mindshare Group for clarification and to avoid potential penalties under Medicare Part D.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current Creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage may be affected. Contact your plan administrator for an explanation of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current Employer coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

If you drop or lose your current Employer coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (or penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium will be subject to the Part D late enrollment penalty. For example, if you go 19 months without creditable coverage, you will pay 19% of the national average Part D premium. This penalty will be added to your monthly premium for life. In addition you may have to wait until October to enroll in a Part D plan where coverage would begin on January 1st.

For More Information About This Notice or Your Current Prescription Drug Coverage, Please Contact Your Employer or Administrator.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

Annual Notices

The Health Insurance and Portability and Accountability Act (HIPAA), the Affordable Care Act (ACA), the Centers for Medicare and Medicaid Services, and the Department of Labor require that we provide various notices to eligible employees. Many of these notices are included on the following pages, and other notices are available online or upon request.

Continuation Coverage Rights Under COBRA

Consolidated Omnibus Budget Reconciliation Act

If you are enrolled in an employer sponsored health plan(s), you and your enrolled spouse and/or dependents may be eligible for COBRA continuation coverage due to employment termination or reduction of work hours. COBRA is a temporary extension of health plan coverage that generally lasts for 18 months. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

A spouse and dependent children also qualify for COBRA coverage due to any of the following qualifying events:

- Divorce or legal separation from primary subscriber (employee), or
- Primary subscriber (employee) enrolls in Medicare benefits, or
- Death of primary subscriber (employee)

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Under COBRA, monthly health plan premiums are paid directly by the subscriber to a third party administrator or directly to insurance carrier(s). Additional fees for administration of COBRA may apply.

For all qualifying events, if you elect to continue your coverage under COBRA, you must notify the Plan Administrator within 60 days after the qualifying event occurs.

Questions concerning your COBRA continuation coverage should be directed to your employer. The Health Insurance and Portability and Accountability Act (HIPAA), the Affordable Care Act (ACA), the Centers for Medicare and Medicaid Services, and the Department of Labor require that we provide various notices to eligible employees.

HIPAA Notice Of Privacy Practices

HIPAA establishes a set of national standards to address the use and disclosure of individual's health information – called Protected Health Information (PHI). To obtain a copy of the Notice of Privacy Practices (NOPP), or for more information regarding the Plan's privacy policies or your rights under HIPAA, please contact HR.

HIPAA Special Enrollment Rules

You have the right to later enroll yourself and eligible dependents for coverage in the health plan(s) under "special enrollment provisions", described:

- Loss of Coverage. If you decline coverage for yourself or your dependents (including your spouse) because of group health plan coverage or other health insurance, you may be able to enroll yourself or your dependents if you or your dependents lose eligibility for that other coverage; or if the other employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 30 days after your or your dependents' other coverage ends, or after the employer stops contributing toward the other coverage.
- Marriage, Birth or Adoption. If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your dependents. You must request enrollment within 30 days after the marriage, birth, or placement for adoption.
- Medicaid Event. If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Additional information regarding your rights to enroll in group coverage can be found in the applicable group health plan Explanation of Coverage (EOC) or insurance contract.

Notice Of Patient Protections

HMO plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in your HMO network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, your carrier will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carrier.

You do not need prior authorization from your carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your insurance carrier.

Women's Health And Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. See the health insurance plan summaries for details. If you would like more information on WHCRA benefits, you may contact your insurance carrier.

Annual Notices

Newborns' And Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Premium Assistance Under Medicaid And The Children's Health Insurance Program

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

If you or your dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available. To request contact information for your states Medicaid or CHIP office, please call Mindshare Group at 925-227-9900.

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

Health Insurance Exchange Notice

This notice provides some basic information about the Health Insurance Marketplace, an alternative place to purchase health insurance coverage. **IMPORTANT NOTE**: Health Insurance coverage purchased through an Exchange, such as Covered CA, is individual coverage, not employer sponsored group coverage, and may have lower levels of benefits and smaller provider and facility networks

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

The 2023 open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1, 2022, through Dec. 15, 2022. Individuals must enroll or change plans prior to Dec. 15, 2022, for coverage starting Jan. 1, 2023. After Jan. 1, 2023, you can get coverage through the Marketplace for 2023 only if you qualify for a special enrollment period or are applying for Medicaid.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.8 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. Your employer sponsored health plans meet the "minimum value standard" and provide "minimum essential benefits" to all employees and dependents, so employees will not qualify for any premium subsidy.

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

Please visit HealthCare.gov or CoveredCA.com for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Uniformed Services Employment And Reemployment Rights Act

Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

For further information on USERRA, contact VETS at 866.4.USA.DOL or visit its website at dol.gov/vets.

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