ANDERSEN®

myBenefits
2024

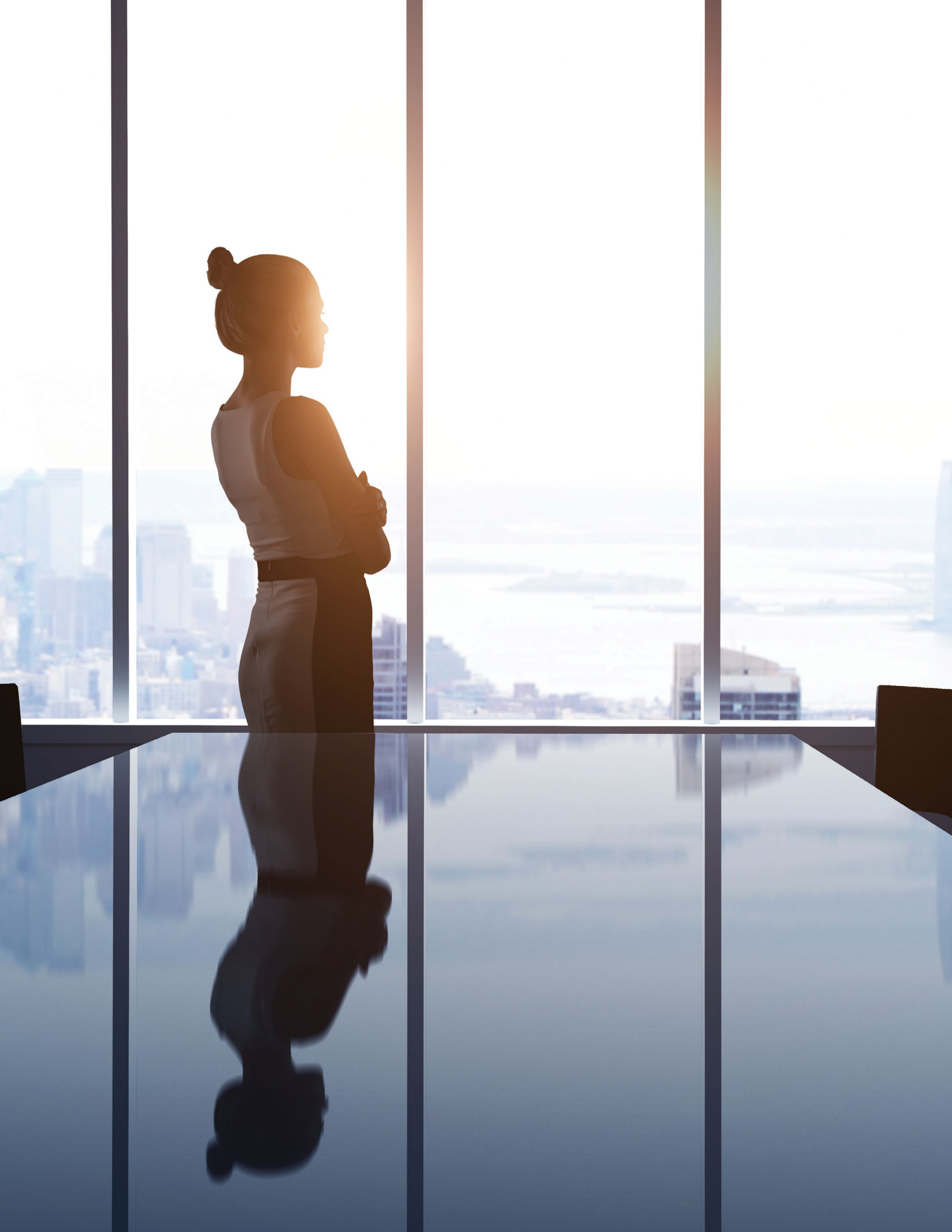


Table of Contents

This overview shows only the highlights of your employee benefits. This is not a complete detailed description, nor is it a contract of employment or a guarantee of benefits. More detailed information is contained in the relevant Summary Plan Description (SPD). Great care has been taken to ensure that this guide is accurate. However, oversights can occur, or condensed summaries can be misinterpreted. If there is a difference between this overview and the SPD or official plan documents governing the plan, the plan documents will be followed. The Firm reserves the right to amend or terminate the program in whole or in part at any time.

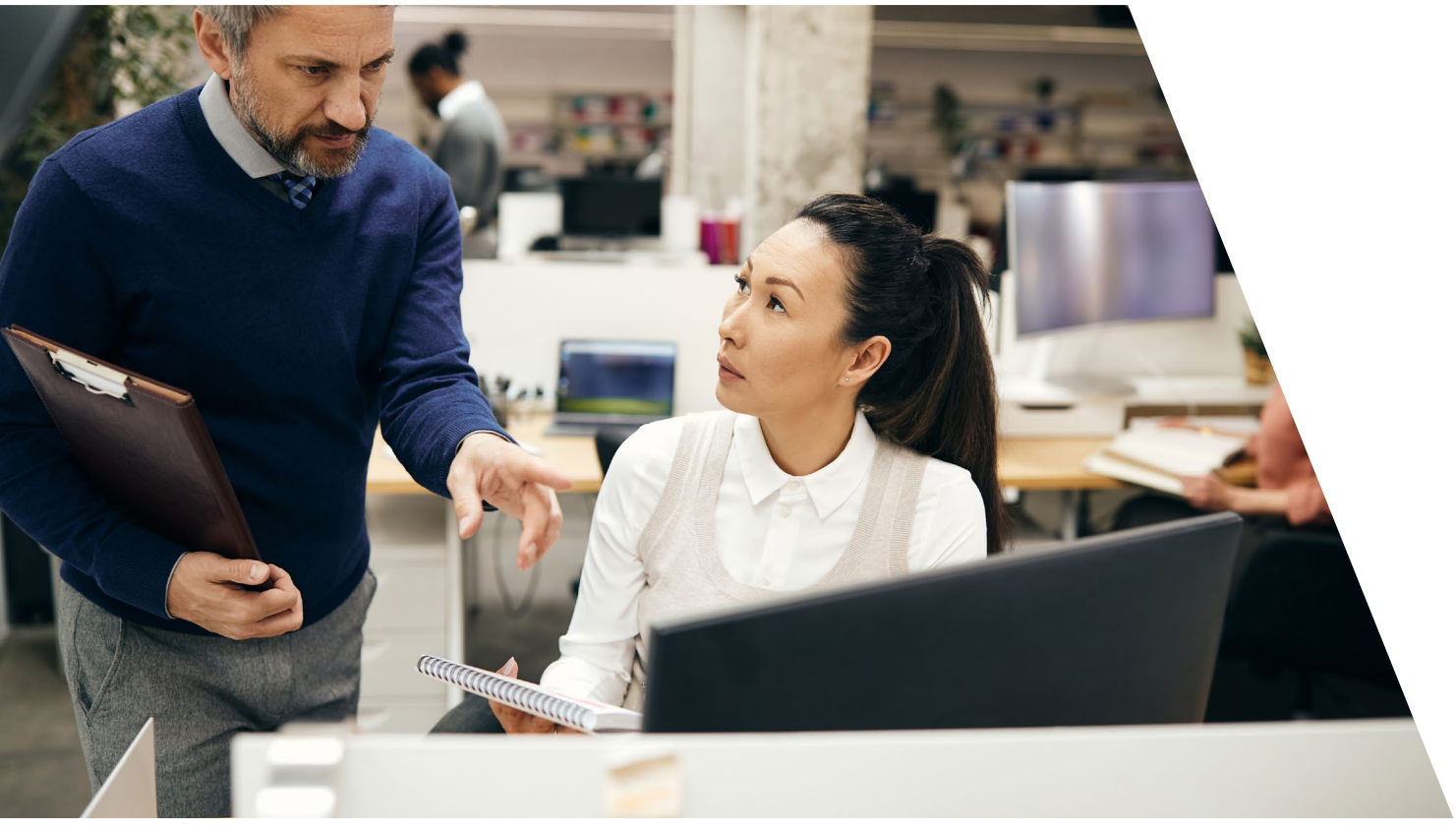
Welcome to the Andersen myBenefits Program

At Andersen, one of our highest priorities is addressing the health and welfare needs of our employees and their dependents. To help protect you and your dependents physically and financially, we are pleased to offer the Andersen myBenefits program. You have the flexibility to choose the types of plans and coverage levels that best meet your needs, and to benefit from the wide range of coverage that Andersen provides.

We have prepared this guide to help you understand and make informed decisions about your benefits coverage. Please review it carefully during the online enrollment process, and keep it handy for future reference. Contact information for the plan administrators is available on page 42, and the Human Resources team is always available to help if you have questions. You can also access this guide, your personalized benefits information and vendor login pages through the Andersen Insider app.

We appreciate your hard work and commitment to Andersen and hope you will take advantage of all that the Firm has to offer.

At Andersen, one of our highest priorities is addressing the health and welfare needs of our employees and their dependents.



Eligibility

You are eligible to participate in the Andersen myBenefits program if you are a regular, full or part-time employee scheduled to work 20 or more hours per week. If your hours are reduced under 20 per week, you may be eligible for medical coverage under the Affordable Care Act (ACA). Most benefits begin on the first (1st) of the month following your date of hire. If your date of hire falls on the first of the month, you are eligible for benefits on your date of hire. However, the TRIP 401(k) Plan has a 30-day service eligibility requirement.

Your dependents are also eligible for coverage under many of the plans in the program. You will be required to provide documents to verify your dependents before they can be enrolled in any coverage. Documents include marriage license or certificate for spouse and birth certificate or birth notification for children.

Eligible dependents include:

- Your spouse
- Your children up to age 26 (through the end of the month of their 26th birthday)
- Your unmarried children of any age who are not self-supporting because of a mental or physical handicap or disability that began before age 19

You and your eligible dependents will not be automatically enrolled in the voluntary plans in the Andersen myBenefits Program. You must complete the enrollment process within 30 days of your date of hire.

- To enroll in any of the benefits in the Andersen myBenefits Program, visit UKG Pro. Enrollment instructions can be found on page 31 of this guide.

2024 myBenefits at a Glance

The plans in the Andersen myBenefits program are summarized in the following table.

Plan	Administrator(s)	Funding Responsibility			Coverage Highlights
		Andersen	Employee	Andersen + Employee	
Medical	Cigna Kaiser Permanente			✓	All employees: 3 different Cigna Open Access Plus Plans CA, DC, MD, VA and WA employees: Cigna plans and Kaiser Permanente HMO Plan
Cigna One Guide	Cigna	✓			24/7 health management and insurance plan guidance
Dental	MetLife			✓	Two PPO options: Basic or Premium Plan Covers preventive care, basic and major services, and orthodontia
Vision	Ameritas	✓	✓	✓	Covers annual eye exams, lenses, and contacts Two plans available: EyeMed and VSP
Health Savings Account (HSA)	HSA Bank			✓	Allows participants in the High Deductible Plan to set aside pre-tax dollars to pay for qualified health care expenses
Flexible Spending Accounts	PlanSource		✓ (Health Care FSA)	✓ (Dependent Care FSA)	Allows participants to set aside pre-tax dollars to pay for qualified health and dependent care expenses
Basic Life and AD&D	NY Life	✓			Coverage equal to 2x annual earnings Life insurance maximum is $2 million
Voluntary Life and AD&D	NY Life		✓		Coverage available in increments of $10,000 up to 3x annual earnings Maximum is $1.5 million Available to spouse and children
Short-Term Disability	NY Life	✓			Replaces 60% to 100% of pre-disability income up to $5,000 per week for up to 25 weeks (percentage based on length of service)
Long-Term Disability	NY Life	✓ (Non-Managing Directors)	✓		Andersen-paid (for Non-Managing Directors): Replaces up to 60% of pre-disability income up to $12,500 per month Managing Director-paid: Replaces up to 50% of pre-disability income up to $17,500 per month

Plan	Administrator(s)	Funding Responsibility			Coverage Highlights
		Andersen	Employee	Andersen + Employee	
Long Term Disability	Unum		✓		Voluntary individual LTD covers 75% of your compensation (less Group LTD coverage) up to an additional $15,000 per month
Tax Reduction Investment Plan (TRIP)	Vanguard			✓	Contribute up to $23,000 per year on pre-tax basis to a 401(k) plan and/or Roth account Firm match of $0.25 per $1 on first 6% of your contributions 100% vested after one year of service
Employee Assistance Program (EAP)	Cigna	✓			Unlimited phone access to EAP counselors and five in-person sessions for many types of issues
One Medical Group	One Medical Group	✓			Modern, concierge medical service Primary care doctors with same day, in-office, appointments 24/7 access to virtual medical team
Commuter Benefits	PlanSource		✓		Contribute up to $315 for parking and mass transit per month on a pre-tax basis
Fertility Assistance	Andersen	✓			$12,000 lifetime maximum for fertility care
Adoption Assistance	Andersen	✓			$10,000 lifetime maximum for costs associated with adoption
Bright Horizons	Bright Horizons	✓			24/7/365 nationwide access to high-quality, credentialed, backup child, adult, elder care, tutoring and pet care
SNOO Baby Bassinet Rental	Happiest Baby	✓	✓		Rental of a SNOO Smart Sleeper Bassinet for 6 months
Pet Insurance	Nationwide Pet Insurance		✓		Discounted rates on Nationwide Pet insurance plans
Identity Protection	Aura		✓		Access to identity and personal privacy information theft protection
MetLaw Legal Plans	MetLaw Legal Plans		✓		Access to personal legal services
Long Term Care	Trustmark		✓		Up to $300,000 in LTC coverage and life insurance with a guarentee issue amount of $80,000

This matrix is intended to be used to help you compare benefits and is a summary only. The Evidence of Coverage, Disclosure Form and Plan Documents should be reviewed for a detailed description of coverage benefits and limitations.

Making Changes to Your Coverage under the Voluntary Plans

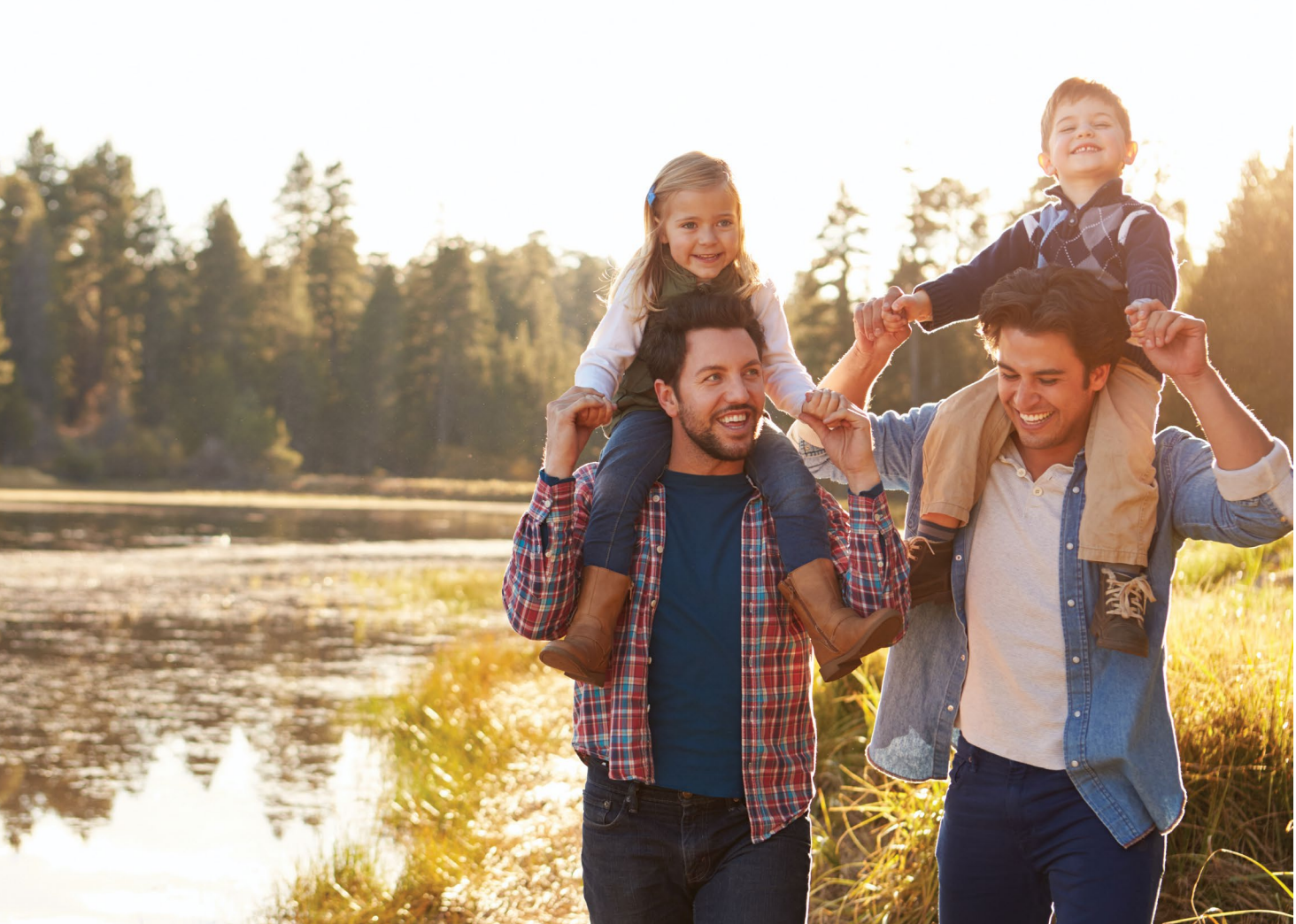
You may make changes to your coverage under the voluntary plans once a year during Open Enrollment. The choices you make will remain in effect for a full calendar year unless you have one of the following "qualifying life events":

- You add a dependent through marriage, birth or adoption
- You lose a dependent through a legal separation, divorce or death
- You gain or lose coverage under a spouse's or partner's plan due to a change in his or her employment
- Your dependent child no longer meets the age-based eligibility requirements
- You move outside the area served by your health care plan
- You take a Leave of Absence

You must log in to UKG Pro and complete the steps to change your current elections within 30 days of your qualifying life event.

The change to your benefits must be consistent with the qualifying life event. For example, if you have a new baby, you can enroll the child as a dependent under your medical plan, but you may not remove another dependent who is already covered. To make a life event change, log on to UKG Pro and follow the path below:
Menu > Myself > Manage My Benefits > Update My Benefits > Report Life Event

You can also use UKG Pro to update personal information such as your name, home address, phone number and emergency contacts. Log on to UKG Pro and follow the path below to make changes:
Menu > Myself > Personal > Employee Summary > Things I Can Do



Medical Plans

The health care plans in the Andersen myBenefits program are designed to provide you and your dependents with affordable, quality care. Depending on where you live, you have a choice of the medical plans listed below.

	All Employees	MO, OK and TX Employees	CA, DC, MD, VA and WA Employees
Cigna Low Deductible Plan	✔	✔	✔
Cigna Medium Deductible Plan	✔	✔	✔
Cigna High Deductible Plan	✔	✔	✔
Cigna Low Deductible Plan Non-Elective		✔	
Cigna Medium Deductible Plan Non-Elective		✔	
Cigna High Deductible Plan Non-Elective		✔	
Kaiser Permanente HMO			✔

Cigna Open Access Plus (OAP) Plans

- If you enroll in a Cigna OAP Plan, you may visit the provider of your choice whenever you need care.
- If you visit a provider in the OAP network, you may pay a deductible amount first and then a small fee — called a "copayment" — at the time you receive care. The plan then pays the balance of the eligible charges. In some cases, there is no copayment; you and the plan each pay a portion of eligible expenses. This is called "co-insurance".
- If you visit a non-network provider, you and the plan still share the cost of eligible expenses, but your portion will be higher.
- Cigna has contracted with network physicians and facilities to provide services to plan participants at discounted rates. These contracts do not exist for non-network providers.
  - If a non-network provider charges more than the negotiated rate for network providers, you will be responsible for your portion of the cost of services, plus any amount in excess of the negotiated rate.
- You have three OAP Plan options: Low Deductible, Medium Deductible and HSA-Compatible High Deductible plans.
  - The "deductible" is the amount you pay before Cigna begins paying benefits.
  - If you enroll in the Low or Medium Deductible plan, your fixed monthly costs — that is your contributions to the cost of coverage — will be higher than they would be if you enrolled in the HSA-Compatible High Deductible plan. However, your variable costs — that is, the amounts you pay whenever you receive care — will be lower.
  - Conversely, your fixed monthly costs will be lower if you enroll in the HSA-Compatible High Deductible plan, but your variable costs will be higher.
  - The HSA, or Health Savings Account, is explained in more detail on page 17.

- Additionally, all three Cigna plans offer Cigna Telehealth Connection that allows you to get the care you need — including most prescriptions — for a wide range of minor conditions. You can connect with a board-certified doctor via secure video chat or phone, without leaving your home or office. When, where and how it works best for you!

- Cigna is partnered with Express Scripts for RX coverage.
- Cigna One Guide is a free service included in your Cigna plan. Cigna One Guide can help you:
  - Understand the basics of health coverage
  - Choose the right plan
  - Find health professionals in your network
  - Get cost estimates
  - Understand your bills
  - Manage your health plan

  Call when selecting your benefits for the first time and during Open Enrollment each year to ensure that you are choosing the plan that is right for you.

Your Costs for Cigna Medical Plan Coverage

You may select from the below levels of coverage when selecting a medical plan. Your contributions to the cost of medical plan coverage are outlined in the table below. They will be deducted from your paycheck each pay period on a pre-tax basis.

Plan Feature	Medical Plan					
	Low Deductible (Available to all employees)		Medium Deductible (Available to all employees)		High Deductible HSA (Available to all employees)	
	Elective	Non-Elective*	Elective	Non-Elective*	Elective	Non-Elective*
Employee Only	$90.67	$90.13	$88.15	$87.62	$81.36	$80.88
Employee + Spouse	$272.00	$270.37	$264.47	$262.88	$244.40	$242.94
Employee + Spouse With Other Coverage**	$318.15	$316.52	$310.62	$309.04	$290.56	$289.09
Employee + Child(ren)	$231.20	$229.81	$224.79	$223.44	$207.68	$206.44
Employee + Family	$448.80	$446.11	$436.37	$433.75	$403.49	$401.07
Employee + Family With Other Coverage**	$494.96	$492.26	$482.52	$479.90	$449.64	$447.23

** Plan option without abortion coverage for MO, OK and TX residents*

*** Spousal surcharge applied to this tier: $46.15 per pay period*

You may elect different coverage levels for the medical and dental plans. For example, you may elect "Employee Only" medical coverage and "Employee + Child(ren)" dental coverage. However, you cannot elect different medical or dental plans for each dependent; all covered dependents must be enrolled in the same medical and/or dental plan.

Cigna Medical Plan Features

The amounts you pay when you receive medical care are outlined in the table below. Please review the plan provisions carefully.

Plan Feature	Medical Plan					
	Low Deductible (Available to all employees)		Medium Deductible (Available to all employees)		High Deductible HSA (Available to all employees)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar-Year Deductible Individual Family	$250 $500	$500 $1,000	$750 $1,500	$750 $1,500	$1,600 $3,200	$1,600 $3,200
Out-of-Pocket Maximum Individual Family (Incudes Deductible)	$2,750 $5,500	$6,875 $13,750	$3,000 $6,000	$4,500 $9,000	$3,500 $6,550	$3,500 $6,550
Lifetime Benefit Maximum	Unlimited		Unlimited		Unlimited	
Coinsurance	10%	50%	20%	40%	20%	40%
Office Visit	$30 copay	50% after deductible	$25 copay	40% after deductible	20% after deductible	40% after deductible
Specialist Visit	$50 copay	50% after deductible	$35 copay	40% after deductible	20% after deductible	40% after deductible
Preventive Care	No charge	50% after deductible	No charge	40% after deductible	No charge	40% after deductible
Hospital Inpatient	$250 per admission	50% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Surgery	$150 per procedure	50% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Urgent Care	$50 copay		$50 copay		20% after deductible	
Emergency Room	$100 copay (waived if admitted)		$100 copay (waived if admitted)		20% after deductible	
Chiropractic (20 visits/year)	$50 copay	50% after deductible	$35 copay	40% after deductible	20% after deductible	40% after deductible
Prescription Drugs Mail Order Generic Brand Formulary Brand Non-Formulary Specialty Drugs	2x retail copay $15 copay $30 copay $60 copay 30% not to exceed $200	Not Covered Not Covered Not Covered Not Covered	2x retail copay $15 copay $30 copay $60 copay 30% not to exceed $200	Not Covered Not Covered Not Covered Not Covered	Subject to Deductible 2x retail copay $15 copay $30 copay $60 copay 30% not to exceed $250	Subject to Deductible Not Covered Not Covered Not Covered Not Covered

This matrix is intended to be used to help you compare benefits and is a summary only. The Evidence of Coverage, Disclosure Form and Plan Document should be reviewed for a detailed description of coverage benefits and limitations.

Kaiser Permanente Health Maintenance Organization (HMO) — CA, DC, MD, VA, WA

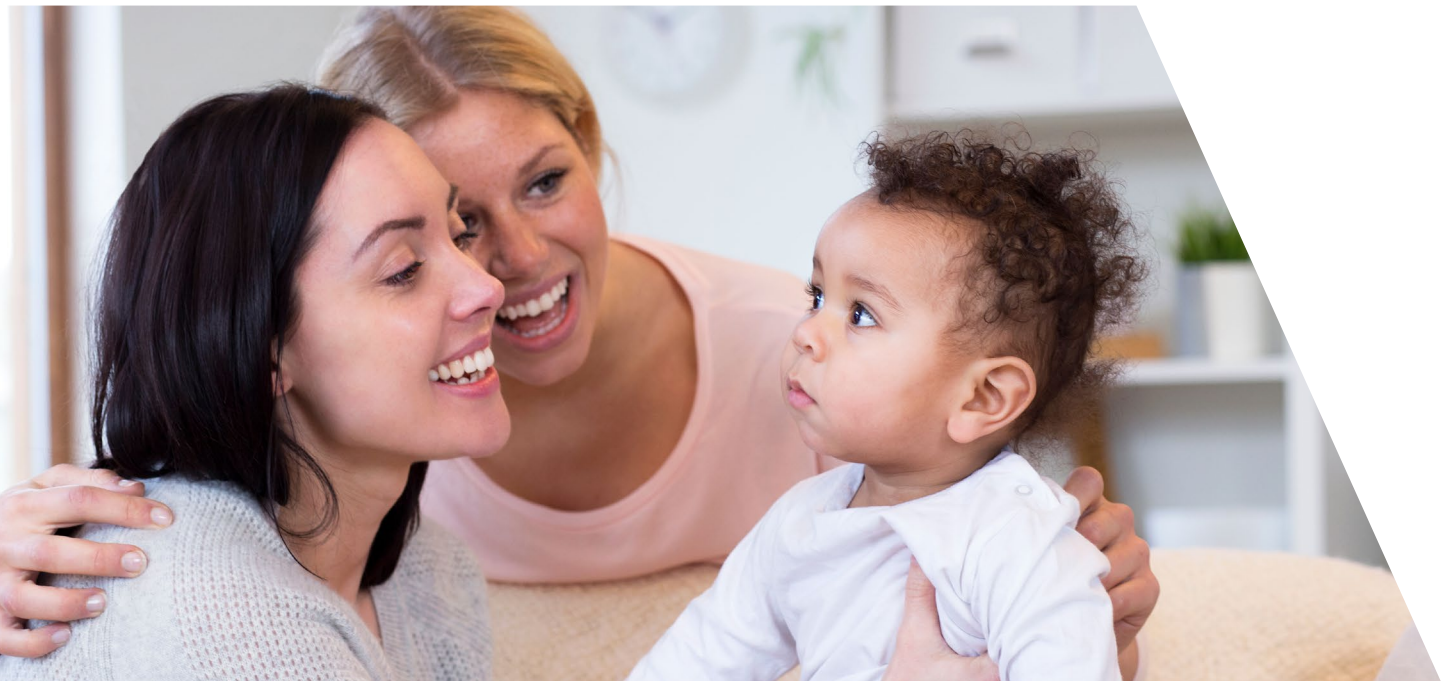
- If you enroll in the Kaiser Permanente HMO you must receive all care from physicians and facilities within Kaiser Permanente's network and fill prescriptions at Kaiser Permanente pharmacies.
- For most services, you pay a small fee — called a "copayment" — at the time you receive care. The plan then pays the balance of the charges.
- The plan will not pay for services you receive from a non-Kaiser Permanente provider (unless services were provided in a medical emergency).
- You can get urgent and emergency care anywhere in the world. When you are outside of a Kaiser Permanente state, you can visit any Cigna PPO Network provider without paying upfront or filing a claim for reimbursement. Contact Kaiser for detailed plan information.

Your Costs for Kaiser Medical Plan Coverage

You may select from the below levels of coverage when selecting a medical plan. Your contributions to the cost of medical plan coverage are outlined in the table below. They will be deducted from your paycheck each pay period on a pre-tax basis.

Plan Level	Coverage Area		
	CA	WA	DC, MD and VA
Employee Only	$60.96	$52.86	$51.61
Employee + Spouse	$201.17	$174.17	$170.03
Employee + Spouse With Other Coverage*	$247.32	$220.32	$216.18
Employee + Child(ren)	$182.89	$158.34	$154.57
Employee + Family	$274.34	$237.52	$231.87
Employee + Family With Other Coverage*	$320.50	$283.68	$278.02

** Spousal surcharge applied to this tier: $46.15 per pay period*



Kaiser Medical Plan Features

The amounts you pay when you receive medical care are outlined in the table below. Please review the plan provisions carefully.

Plan Feature	Medical Plan		
	Kaiser Permanente (CA Only) HMO Network	Kaiser Permanente (WA Only) HMO Network	Kaiser Permanente (DC, MD, VA Only) HMO Network
Calendar-Year Deductible Individual Family	None None	None None	None None
Out-of-Pocket Maximum Individual Family (Incudes Deductible)	$1,500 $3,000	$1,500 $3,000	$1,300 $2,600
Lifetime Benefit Maximum	Unlimited	Unlimited	Unlimited
Coinsurance	0%	0%	0%
Office Visit	$25 copay	$25 copay	$25 copay
Specialist Visit	$25 copay	$25 copay	$25 copay
Preventive Care	No charge	No charge	No charge
Hospital Inpatient	$250 per admission	$250 per admission	$250 per admission
Outpatient Surgery	$25/procedure	$25/procedure	$25/procedure
Urgent Care	$25 copay	$25 copay	$25 copay
Emergency Room (copay waived if admitted)	$100 copay	$100 copay	$100 copay
Chiropractic	$15 copay	$25 copay	$25 copay
Prescription Drugs Mail Order Generic Brand Formulary Brand Non-Formulary Specialty	2x copay for 100 day supply $10 copay $30 copay $30 copay 20% not to exceed $150	2x copay for 90 day supply $10 copay $20 copay $30 copay 20% not to exceed $150	2x copay for 90 day supply $10 copay $30 copay $50 copay 50% not to exceed $150

This matrix is intended to be used to help you compare benefits and is a summary only. The Evidence of Coverage, Disclosure Form and Plan Document should be reviewed for a detailed description of coverage benefits and limitations.

You may elect different coverage levels for the medical and dental plans. For example, you may elect "Employee Only" medical coverage and "Employee + Child(ren)" dental coverage. However, you cannot elect different medical or dental plans for each dependent; all covered dependents must be enrolled in the same medical and/or dental plan.

Dental Plans

There are two dental plans in the Andersen myBenefits program: the Basic Plan and the Premium Plan. Both are Preferred Provider Organization (PPO) plans administered by MetLife.

- Both plans allow you to visit the dentist of your choice whenever you need care.
- If you visit a dentist in the PPO network, the plan pays all or a portion of eligible expenses.
- If you visit a non-network dentist, the plan still pays a portion of eligible expenses, but you will pay more out-of-pocket. MetLife has contracted with network dentists to provide services to plan participants at discounted rates. These contracts do not exist for non-network dentists.
    - If you enroll in the Basic or Premium Plan and receive care from a non-network dentist, the plan will pay the “Reasonable and Customary” (R&C) rate for similar services in your geographical region. If a non-network dentist charges more than the R&C rate, you will be responsible for your portion of the cost of services, plus any amount in excess of the R&C rate.

To request an estimate of the amounts that the plan will pay for basic or major services, contact MetLife and request a “pre-determination of benefits.”

Your Costs for Dental Plan Coverage

You may select from the following levels of coverage when you enroll in a dental plan. Your contributions to the cost of dental plan coverage are outlined in the table below. They will be deducted from your paycheck each pay period on a pre-tax basis.

Plan Level	Dental Plan	
	Basic Option	Premium Option
Employee Only	$3.33	$12.10
Employee + Spouse	$8.74	$22.62
Employee + Child(ren)	$10.36	$25.23
Employee + Family	$16.04	$39.60

Note: Non-Network services on the Basic and the Premium Plan will be reimbursed on a Fee Schedule according to the geographic reasonable and customary fees (R&C). Going out of network, you may incur out-of-pocket costs.

Dental Plan Features

The amounts that the plan pays for dental care are outlined in the table below. Please review the plan provisions carefully before completing the online enrollment process.

Plan Feature	Basic Option		Premium Option	
	Network	Non-Network*	Network	Non-Network*
Annual Deductible Individual Family	$50 $150	$50 $150	$25 $75	$25 $75
Annual Maximum Benefit	$1,000 per person		$2,000 per person	
Preventive Care	100%	100% of R&C	100%	100% of R&C
Basic Services	60% after deductible	50% of R&C after deductible	80% after deductible	70% of R&C after deductible
Major Services	50% after deductible	50% of R&C after deductible	60% after deductible	50% of R&C after deductible
Orthodontia	50% after deductible		60% after deductible	
Lifetime maximum	$1,000 per person		$1,500 per person	

This matrix is intended to help you compare benefits and is a summary only. Please review the Evidence of Coverage, Disclosure Form and Plan Document for detailed descriptions of benefits coverage and limitations.

** Employees residing in the state of Texas have the same plan provisions for non-network care as they do for in-network care.*

Vision Plan

If you enroll in one of the medical plans through Andersen, you will automatically be enrolled in the Vision Plan at no additional cost. The plan, which is administered by Ameritas, allows you to choose between EyeMed and VSP when you need eye care.

If you visit an in-network provider, the plan pays a portion of eligible expenses. If you visit a non-network provider, the plan still pays a portion of eligible expenses, but you will pay more out-of-pocket.

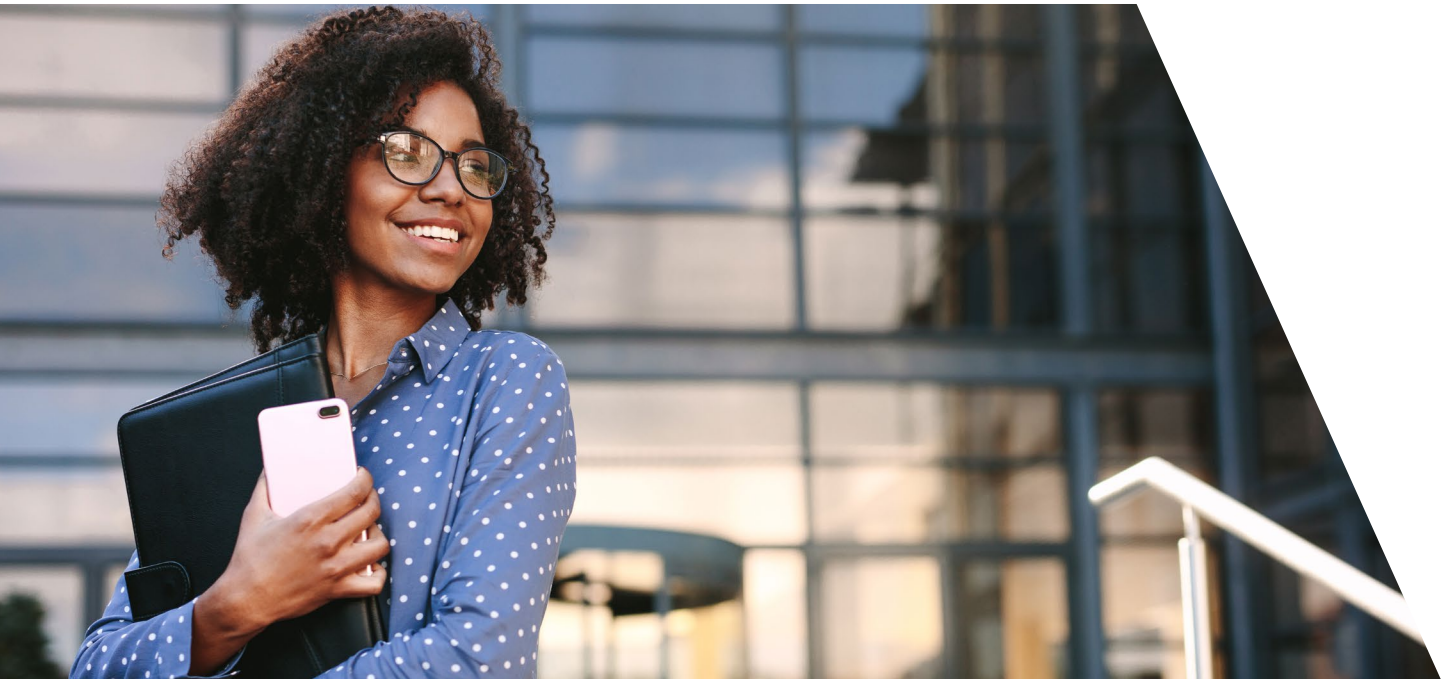
In addition to the standard vision benefits, EyeMed and VSP offer member discounts on many services, including Lasik, frames and hearing aids.

Your Costs for Vision Plan Coverage

Your contributions to the cost of vision plan coverage are outlined in the table below. They will be deducted from your paycheck each pay period on a pre-tax basis.

Plan Level	Vision Cost	
	With Medical Coverage*	Without Medical Coverage**
Employee Only	$0.00	$1.26
Employee + Spouse	$0.00	$2.40
Employee + Child(ren)	$0.00	$2.53
Employee + Family	$0.00	$3.71

** Must be enrolled in an Andersen medical plan for fully paid vision coverage*
*** For employees who enroll in Vision coverage who are not enrolled in a medical plan*
Family = Employee, Spouse and Child(ren)



Vision Plan Features

The amounts that the plan pays for vision services are outlined in the following table. Each plan feature is available once every 12 months.

Plan Feature	Provider and Benefit Level			
	EyeMed (Available to all employees)		VSP (Available to all employees)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Eye Exam	Plan pays 100% after $10 deductible	Plan pays up to $35	Plan pays 100% after $10 deductible	Plan pays up to $10
Eyeglass Lenses				
Single	Plan pays 100% after $25 deductible	Plan pays up to $25	Plan pays 100% after $25 deductible*	Plan pays up to $30 after $25 deductible
Bifocal	Plan pays 100% after $25 deductible	Plan pays up to $40	Plan pays 100% after $25 deductible*	Plan pays up to $50 after $25 deductible
Trifocal	Plan pays 100% after $25 deductible	Plan pays up to $55	Plan pays 100% after $25 deductible*	Plan pays up to $65 after $25 deductible
Lenticular	Plan provides 20% discount	Not covered	Plan pays 100% after $25 deductible*	Plan pays up to $100 after $25 deductible
Special Features (anti-reflective coating, tinting)	Plan provides discounts on materials	Not covered	Plan provides discounts on materials	Not covered
Contact Lenses				
Fit & Follow Up Exams			Member cost up to $60	Not covered
Standard	Member cost up to $40	Not covered		
Premium (Allowance)	10% off retail cost	Not covered		
Elective	Plan pays up to $180	Plan pays up to $144	Plan pays up to $180	Plan pays up to $145
Medically Necessary	Plan pays 100%	Plan pays up to $200	Plan pays 100%	Plan pays up to $210
Eyeglass Frames	Plan pays up to $180	Plan pays up to $90	Plan pays up to $180**	Plan pays up to $70
Available Retailers	LensCrafters, Pearle Vision, Target Optical	N/A	Costco Optical, Walmart, Sam's Club, Visionworks	N/A

This matrix is intended to help you compare benefits and is a summary only. Please review the Evidence of Coverage, Disclosure Form and Plan Document for detailed descriptions of benefits coverage and limitations.

** Deductible applies to a complete pair of glasses or to frames, whichever is selected | ** The Costco and Walmart allowance will be the wholesale equivalent*

EyeMed Network

EyeMed's network includes some of the most recognized names, including:

- LensCrafters
- Pearle Vision
- Taget Optical

VSP Network

VSP offers the nation's largest network of independent doctors, retail locations include:

- Costco
- Walmart
- Sam's Club
- Visionworks

Health Savings Account

If you enroll in the Cigna HSA-Compatible High Deductible Plan, you may open a Health Savings Account, or HSA. An HSA allows you to set aside pre-tax contributions to pay for current or future health care expenses, long-term care insurance and even COBRA premiums.

To be eligible for an HSA, an individual:

- Must be covered under an HSA-Compatible High Deductible Health Plan (HDHP) like the Cigna Plan offered by Andersen
- Must not be covered by any other health plan that is not an HDHP
- Must not be enrolled in Medicare or TRICARE (the Armed Services Health Care Plan)
- Cannot be claimed as a dependent on another person's tax return
- Cannot simultaneously be enrolled in a Health Care Flexible Spending Account

If you open an HSA, you decide how much you want to contribute to your account each pay period. Andersen will also make contributions: $23.08 per pay period if you elect medical coverage for yourself, or $39.24 per pay period if you elect coverage for yourself and one or more dependents. The maximum combined contribution amount for 2024 is $4,150 for individual coverage and $8,300 for dependent coverage. Participants age 55 or older can contribute an additional $1,000 per year.

Unused contributions roll over from one year to the next and are yours to keep even if you leave Andersen. There is a $1.85 monthly account fee for HSAs at HSA Bank, our preferred provider.

Important Note: You must stop all HSA contributions six months prior to enrolling in Medicare and/or collecting Social Security. Medicare Part A will be retroactive up to six months (but not prior to Medicare eligibility), and any HSA contributions made during those months are subject to a tax penalty.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) allow you to use pre-tax dollars to pay for eligible health and dependent care expenses. If you open a Health or Dependent Care FSA, you set an annual contribution amount for each account. Your annual contribution will be divided into equal amounts and deducted from your paycheck each pay period before federal and, in most cases, state and local income taxes are withheld. As you incur eligible expenses throughout the year, you submit a claim for reimbursement from the appropriate FSA. Please note that your FSA benefits will start on the first of the month following the date you enroll on PlanSource.

Health Care FSA

You may contribute a maximum of $3,200 in 2024 to your Health Care FSA. You may use your contributions to pay for certain medical, dental and vision expenses that aren't covered by any health care plan.

Eligible expenses include, but are not limited to, those for:

- Deductibles and copays
- Hearing exams and hearing aids
- Orthodontia

Ineligible expenses include, but are not limited to, those for:

- Vitamins
- Cosmetic surgery
- Teeth whitening
- Your contributions to the cost of health care coverage

Dependent Care FSA

You may contribute a maximum of $3,333.33 each year to your Dependent Care FSA. Andersen will contribute $0.50 for every $1 you contribute up to $1,666.67 per year. Total combined employer and employee contributions cannot exceed $5,000 per year.

If you are paying for dependent care so that you and your spouse* can work, you may use your contributions to cover the cost of services provided to:

- Children under age 13
- Children or adults of any age who are physically or mentally unable to care for themselves

These individuals must also qualify as dependents on your federal tax return.

Eligible expenses include, but aren't limited to, those for:

- Childcare for children under age 13
- Nursery school or preschool for children under age 5
- Before or after school care
- Care for adult dependents who are physically or mentally unable to care for themselves
- Day camp

*You may also be eligible to contribute to a Dependent Care FSA if your spouse is attending school full time or actively seeking employment.

Ineligible expenses include, but are not limited to, those for:

- Services provided by an individual who does not report your payments as income
- Child support payments
- Private school tuition
- Activity registration fees
- Overnight camp

To see an exhaustive list of FSA expenses, please visit fsastore.com/fsa-eligibility-list.

Estimating Your Contributions

Estimate your FSA contribution amounts carefully. Due to their tax advantages, FSAs are strictly regulated by the IRS and are subject to the following restrictions:

- You may not change your elections unless you have a qualifying life event.
- For both FSA accounts, there is a 3 month run-out period to submit claims from the prior year.
- You forfeit any money remaining in your Dependent Care FSA at the end of the year. Unused FSA healthcare funds will be rolled over up to the IRS limit.
- You may not transfer money from one account to another; money in your Health Care FSA may not be used for dependent care expenses, and money in your Dependent Care FSA may not be used for health care expenses.
- You may not claim expenses reimbursed from your FSAs as deductions or credits on your year-end tax returns.

FSAs usually offer more tax advantages than federal income tax credits. However, since tax situations vary from person to person, you may want to review your options with your accountant or financial advisor before opening an FSA.

Life and Accidental Death & Dismemberment (AD&D) Plans

To help you provide a secure financial future for your family, the Andersen myBenefits plan includes Basic and Voluntary Life and Accidental Death and Dismemberment (AD&D) Plans.

Basic Life

Andersen provides Basic Life coverage at no cost to you. The amount of Life Insurance coverage is equal to two (2) times your base annual earnings.

If the amount of your benefit is less than $750,000 ($1.15 million for Managing Directors), your coverage will be effective on the date you become eligible for benefits through Andersen. If the amount of your benefit is $750,000 ($1.15 million for Managing Directors) or more, you must answer a short survey about your health history before coverage for any amount over $750,000 ($1.15 million for Managing Directors) will be effective.

The Basic Life Plan includes an accelerated benefit that allows you to request a prepayment of benefits if you become terminally ill. You may request up to 80% of your benefit amount, up to a maximum of $500,000, to help you pay for expenses while you are living. Any remaining benefit amount will be paid to your beneficiary upon your death. In the event of your death, your beneficiary will receive a benefit equal to two times your annual salary, up to a maximum of $1 million for Non-Managing Directors and $2 million for Managing Directors.

Voluntary Life

Employee Coverage

While the Andersen firm-paid life insurance program provides a foundation of financial security for you and your family, you may want to purchase additional coverage through the Voluntary Life Insurance Plan.

Coverage is available in $10,000 increments, up to five (5) times your annual salary. If the amount you elect is more than $250,000, you must answer a short survey about your health history before your coverage over $250,000 will be effective. Please note the Guaranteed Issue amount applies only to new hire elections. If you increase your coverage in subsequent enrollment periods, Eligibility of Insurance will be required for all increased amounts requested.

Voluntary Life Insurance Plan coverage cannot exceed $1.25 million.

Your Cost for Voluntary Life Insurance: Employee and Spouse Coverage

Employee Age	Rate Per Pay Period for Each $10,000 of Coverage	
	Employee Coverage	Spouse Coverage
20 to 24	$0.25	$0.25
25 to 29	$0.28	$0.28
30 to 34	$0.28	$0.28
35 to 39	$0.42	$0.42
40 to 44	$0.69	$0.69
45 to 49	$1.15	$1.15
50 to 54	$1.98	$1.98
55 to 59	$3.23	$3.23
60 to 64	$4.29	$4.29
65 to 69	$6.78	$6.78
70 to 74	$12.00	$12.00
75 +	$20.12	$20.12

**Note: According to the Internal Revenue Service, employers are required to tax the value of Group Term Life (GTL) insurance benefits that exceed $50,000. This taxable amount will be treated as imputed income. This tax obligation will appear on each paycheck as "Bas EmpLife Imp" in the "earnings and deductions" sections.*

Spouse and Children Coverage

If you elect voluntary coverage for yourself, you may also purchase life insurance for your spouse or children.

Coverage for your spouse is available in $5,000 increments, up to a maximum of 50% of your Voluntary Life Insurance benefit, or $100,000, whichever is less. The premium rate for spouse coverage is based on the employee's age. If the amount of coverage you elect for your spouse is more than $30,000, your spouse must answer a short survey about his or her health history before coverage over $30,000 will be effective. The spousal guarantee issue amount is availabe as a new hire if you are married prior to working at Andersen or during a marriage life event.

Your Cost for Voluntary Life Insurance: Children Coverage

Coverage Level	Rate Per Pay Period
$10,000 (fixed coverage amount)	$1.25

You may purchase $10,000 of coverage for your children under the age of 26.

Basic AD&D

Andersen also provides Basic AD&D coverage at no cost to you. The amount of AD&D coverage is equal to two (2) times your base annual earnings. If your death is the result of an accident, your beneficiary will receive a benefit equal to two times your annual salary, up to a maximum of $1 million for Non-Managing Directors and $2 million for Managing Directors

If you lose a limb or your eyesight or hearing in an accident, you will receive a percentage of your benefit amount.

Voluntary AD&D

You may purchase Voluntary AD&D Insurance to provide additional peace of mind for yourself and your family.

Coverage is available in $10,000 increments, up to five (5) times your annual salary and a maximum of $1.25 million. In the event of your accidental death, your beneficiary will receive the benefit. If you lose a limb or your eyesight or hearing in an accident, you will receive a percentage of your benefit amount.

If you elect to purchase family coverage, your spouse's coverage amount will be equal to 75% of the coverage amount you elect for yourself, and your children's coverage amount will be equal to 25% of the coverage amount you elect for yourself.

Your Cost for Voluntary AD&D Insurance

Coverage Level	Rate Per Pay Period for Each $10,000 of Coverage
Employee	$0.09
Family	$0.18

**Note: The life insurance benefits offered have age reduction scales starting at age 65. Please refer to the plan document for further details.*

Disability Plans

To help protect your standard of living if you become disabled, the Andersen myBenefits package provides Short and Long-Term Disability Plans. The plans, which are administered by NY Life, replace a portion of your salary if you are unable to work because of a non–work-related illness or injury.

Short-Term Disability Benefits

- Andersen provides Short-Term Disability (STD) Plan coverage at no cost to you.
- The STD Plan replaces 60% to 100% of your pre-disability income up to $5,000 per week, for up to 25 weeks. Benefits are based on your length of service, as illustrated in the table below, and begin after a seven-day waiting period.

Length of Service	Weeks at 100% base pay	Weeks at 60% base pay	Total weeks of benefit
More than 3 months, but less than 1 year of service	3	22	25
At least 1 year, but less than 4 years of service	6	19	25
4 years	8	17	25
5 years	10	15	25
6 years	12	13	25
7 years	14	11	25
8 years	16	9	25
9 years	18	7	25
10 or more years	25	0	25

Long-Term Disability Benefits

- If you are disabled for more than 180 days, you may be eligible to receive Long-Term Disability (LTD) Plan benefits.
- The LTD Plan replaces up to 60% of your pre-disability earnings (50% for Managing Directors), up to a maximum monthly benefit of $12,500 (or $17,500 for Managing Directors). Benefits are coordinated with Social Security, Workers' Compensation, and other disability benefits that you may be entitled to receive.
- You may receive LTD Plan benefits until you recover or reach retirement age.

Your Cost for LTD Coverage — NY Life

- For Non-Managing Directors, Andersen provides LTD Plan coverage at no cost to you. In the event of a disability, any benefits you receive are considered taxable income.
- For Managing Directors, LTD Plan coverage is not provided automatically; you must enroll in the plan.
    - Your cost for LTD Plan coverage is deducted from your pay on an after-tax basis each pay period. In the event of your disability, any benefits you receive are not considered taxable income.

Calculating Your Cost of Coverage

1. Calculate your monthly gross salary (your annual gross salary divided by 12)
2. Divide your monthly gross salary by 100
3. Multiply this number by the monthly rate for your age group listed in the table below to calculate your monthly cost of coverage
4. Multiply your monthly cost of coverage by 12 to calculate your annual cost of coverage
5. Divide this number by 26 to calculate your per-pay-period cost of coverage

Age	Rate Per Month for Each $100 of Monthly Covered Payroll
Under 25	$0.04
25 to 29	$0.05
30 to 34	$0.10
35 to 39	$0.16
40 to 44	$0.24
45 to 49	$0.42
50 to 54	$0.55
55 to 59	$0.68
60 to 64	$0.65
65 to 69	$0.62
70 to 74	$0.64
75 +	$0.64

Sample Calculation:

The calculation below assumes you are 39 years old and your gross annual salary is $240,000.

1. $240,000 ÷ 12 = $20,000
2. $20,000 ÷ 100 = $200
3. $200 X $0.16 = $32.00 = your monthly cost of coverage
4. $32 X 12 = $384 = your annual cost of coverage
5. $384 ÷ 26 = $14.77 = your per-pay-period cost of coverage

Voluntary Individual LTD Coverage

At Andersen, we recognize the importance of having adequate financial protection should the need arise. As such, Voluntary Individual Disability Coverage is available to all Managers and above earning more than $75,000 per year. The voluntary LTD covers up to 75% of your compensation (less Group LTD coverage) up to an additional $15,000 per month. Additionally, the Voluntary Individual Disability Coverage is portable, meaning if you leave Andersen, you can still maintain your policy. This benefit is insured by Unum.

If your annual base salary is greater than $75,000 per year and you are a Manager, you may purchase Voluntary LTD Plan coverage through Unum. Policies are individually customized based on factors such as age, earnings and tobacco usage.

Individuals who are hired at the Manager and above level are eligible to enroll in this benefit during the first open enrollment period following their hire date. Employees who are promoted to Manager are eligible to enroll in the open enrollment period following their promotion date. Please contact the Andersen Benefits team at BenefitsAdministration@Andersen.com for more information.

Tax Reduction Investment Plan (TRIP)

The Andersen Tax Reduction Investment Plan (TRIP) is a 401(k) plan designed to help you save and invest for retirement. There are many advantages to participating in the plan:

Automatic Payroll Deductions

- After you have completed 30 days of service, Andersen will automatically contribute 1% of your pre-tax pay to your TRIP account. You may increase this amount or waive participation in the plan at any time by contacting Vanguard, the plan recordkeeper.
- You may contribute up to 40% of your eligible compensation to the plan from each paycheck, up to the annual maximums established by the IRS. In 2024, the maximum is $23,000 for employees age 49 and under and $30,500 for employees age 50 and over.

Tax-Deferred Contributions and Investment Earnings

- You don't pay taxes on the money you contribute to your TRIP account until you withdraw the money. By contributing to the plan on a pre-tax basis — that is, before federal and most state taxes are deducted — you lower the amount of your taxable income.
- Taxes on account earnings are also deferred until you withdraw money from your account.

Roth 401(k) Contributions

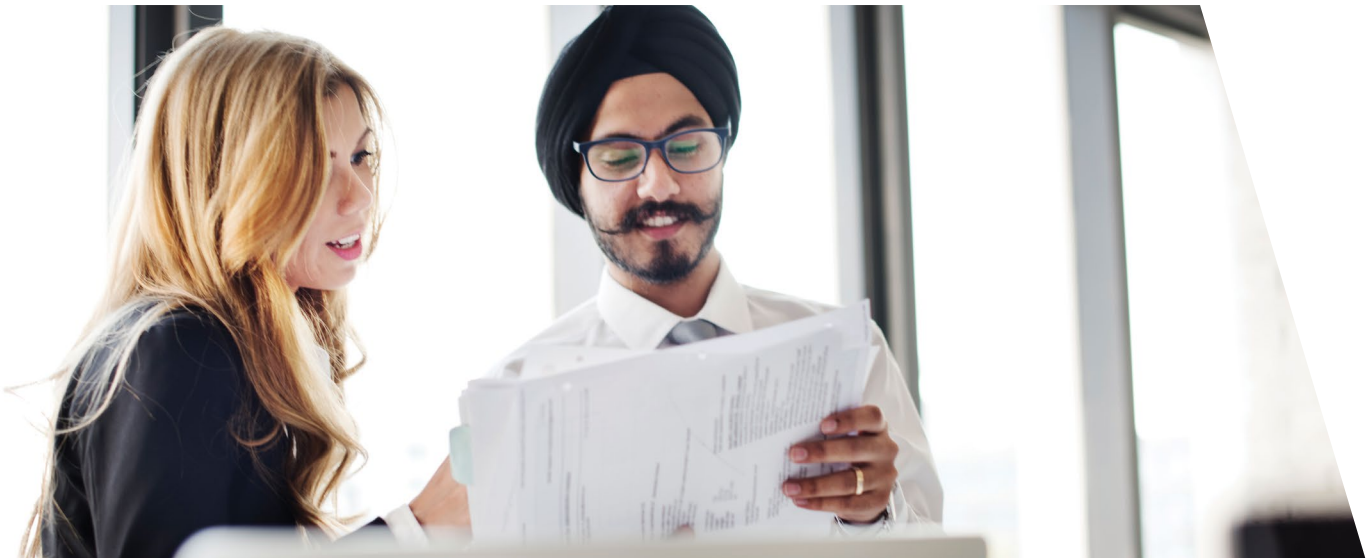
- Contributions are after taxes and allow qualified tax-and penalty-free withdrawals of both Roth 401(k) contributions and earnings with certain conditions.

Matching Contributions from Andersen

- For every $1 from each paycheck that you contribute to your TRIP account, Andersen will contribute an additional $0.25. This applies to the first 6% that you contribute.
- You will be eligible for the matching contribution immediately and you will be 100% vested after completing one year of service.

Access to a Broad Variety of Investment Options

- Vanguard will mail an enrollment packet to your home address when you become eligible to participate in the plan. Review the packet to learn about the investment options available to TRIP participants.
- Please register for a Vanguard account through their website to access educational tools and calculators to help you plan your investments. Access to your online account will be available approximately one week after your date of hire. You can enroll online prior to receiving your enrollment packet in the mail.



2024 Holidays

Andersen Holidays

Andersen offices will be closed in celebration of the following holidays in 2024.

Holiday	Observed Day & Date
New Year's Day	Monday, January 1
Martin Luther King, Jr. Day	Monday, January 15
Memorial Day	Monday, May 27
Juneteenth	Wednesday, June 19
Day Before Independence Day	Wednesday, July 3
Independence Day	Thursday, July 4
Day After Independence Day	Friday, July 5
Labor Day	Monday, September 2
Thanksgiving Day	Thursday, November 28
Day After Thanksgiving	Friday, November 29
Christmas Eve	Tuesday, December 24
Christmas Day	Wednesday, December 25

At Andersen, we recognize that people choose to celebrate different holidays throughout the year and we respect each individual's preference and choice to do so. In observance of some of the major holidays, as communicated at the start of each calendar year, our Firm will officially close. Due to the nature of our business and the needs of our clients, individuals will sometimes be required to work on a designated firm holiday; in such cases, individuals will be allowed to take a floating holiday in the quarter immediately following. PTO can and should be used for all other days an individual wishes to take off, whether in observance of a specific holiday or otherwise.

Employee Assistance Program (EAP)

Andersen's Employee Assistance Program (EAP) is available to all benefits eligible employees, even those not enrolled in a medical plan. You and your household members can address a wide range of topics with your counselor:

- Marriage, family and relationships
- Alcohol and drug use
- Emotional, personal and stress-related topics
- Legal matters
- Financial and credit assistance
- Child care or elder care assistance
- Pre-retirement planning
- Taxpayer assistance

EAP counselors are available 24 hours a day, every day of the year. You have unlimited phone access to them, and five face-to-face sessions with a therapist, financial planner, or legal advisor. You may visit the same counselor each time, or spend one session with each of the three types of counselors. Any information you share with an EAP counselor is completely confidential, and Andersen has no way of knowing who uses this benefit.

One Medical Group Membership

Andersen offers Cigna members and eligible dependents access to an innovative, in-network primary care doctor at One Medical Group. As a member, you'll receive care tailored to a busy lifestyle with benefits such as:

- Same and next-day appointments
- Direct email access to your provider
- Online/mobile appointment booking, virtual care, Rx renewals
- 24/7 access to the Virtual Medical Team
- Onsite lab services
- Conveniently located near most of our offices
- Emergency medical assistance and personal services
- Pre-trip information

To register for One Medical Group, use code ANDXOM. Employees enrolled in a Kaiser medical plan are not eligible for this benefit.

Commuter Benefits

You may make monthly pre-tax contributions of up to $315 per month for parking and mass transit commuter expenses. Your elections can be changed during the enrollment period. Please note that your commuter FSA benefit will start on the first of the month following the date you enroll in UKG Pro. You do not need a qualified life event to update your monthly contribution.

Gradifi Student Loan Paydown Program

Andersen provides a Student Loan Paydown Program, administered by Gradifi, to help you pay off your loans faster. The benefit provides a $100 contribution per month for 60 months, and a lump-sum of $6,000 at 60 months, toward your outstanding loan, provided you are making monthly contributions as well. As a new hire, you can expect to receive an email with further enrollment information. Additionally, please note you will not receive a contribution until you register your student loan with Gradifi.

Important Note: please ensure that you keep your loan details current with Gradifi in order to receive contributions (i.e., loan servicer changes, loan paid off, etc.).

Fertility Assistance

If you incur out-of-pocket costs associated with the diagnosis and treatment of infertility, including inducement of fertilization, Andersen will provide a reimbursement of up to a lifetime maximum of $12,000 to help cover the services. For more information, please contact the Benefits team at BenefitsAdministration@Andersen.com.

Adoption Assistance

If you choose to adopt a child, Andersen provides up to a lifetime maximum of $10,000 to help you pay for court fees, legal fees, placement fees, private or public agency fees, temporary foster care and uninsured maternity expenses for the biological mother. For more information, please contact the Benefits team at BenefitsAdministration@Andersen.com.

Milk Stork

Breastfeeding employees have access to Milk Stork in support of their child's needs during business travel. Milk Stork is the first-ever breast milk shipping company for business traveling, breastfeeding moms. If you are traveling for work, have a cooler sent to your hotel room ahead of your arrival, pump your milk and then send it home to your child's caregiver. To access this benefit, simply create your account with Milkstork, place your order and pay, and submit your expense for reimbursement in ChromeRiver. For more information, please contact the Benefits team at BenefitsAdministration@Andersen.com.

Bright Horizons - Dependent Care Program

Benefits-eligible Andersen employees have access to two programs through Bright Horizons Family Solutions, a leading provider of early education and preschool, employer-sponsored care, educational advisory services and other work/life solutions.

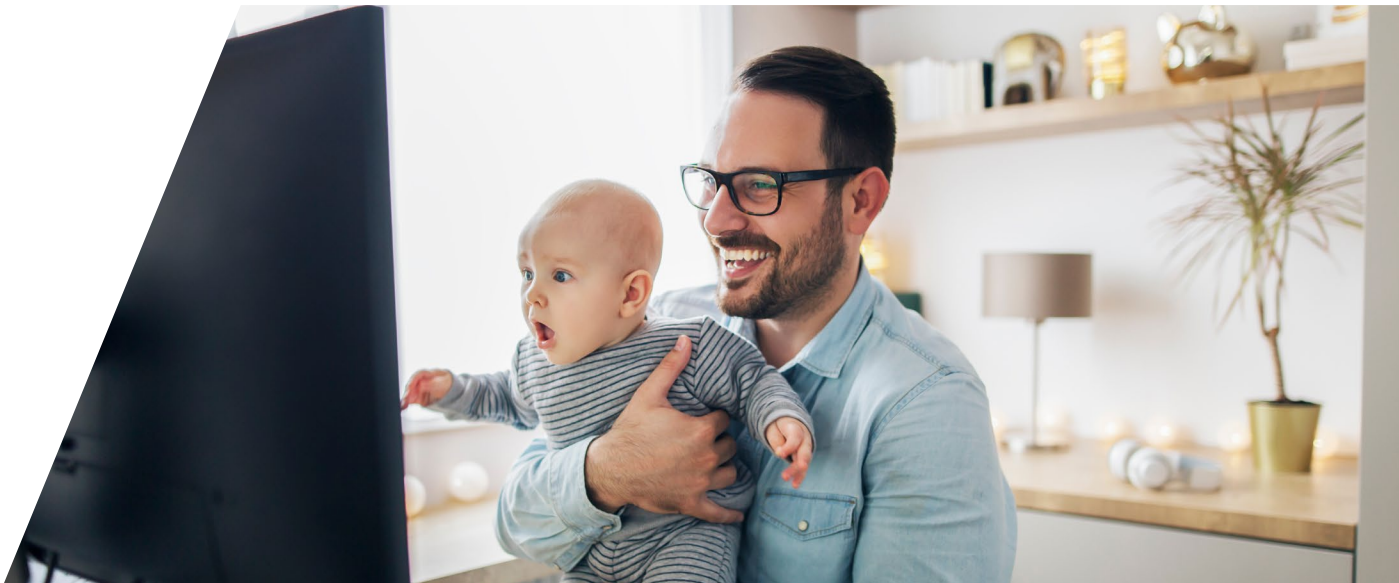
- Back-up Care Advantage Program – offers employees access to high-quality, credentialed child, adult, elder and pet care that can be reserved in advance or accessed last minute.
- Bright Horizons Care Direct – allows employees to self-select the appropriate match for their dependent care and personal challenges.
- Bright Horizons Tutoring – select virtual tutoring through Varsity Tutoring or Sylvan Learning. Four hours of tutoring equals one day of use.
- Andersen provides each employee ten subsidized uses per year. Two uses can be used towards Rover Pet Care.

How to enroll in Bright Horizons: Visit clients.brighthorizons.com/andersen. You will need your Andersen ID, which you can find in UKG Pro or on your paystub.

SNOO Smart Sleeper Bassinet Rentals

The SNOO Smart Sleeper Bassinet mimics the sounds, movements, and feeling of the womb, helping calm babies and getting them to sleep for another 1-2+ hours each night. Andersen covers 100% of the rental fee of a SNOO Smart Sleeper Bassinet for six months, and employees who rent a SNOO will need to pay a $99 refundable security deposit. You can also rent a SNOO on behalf of a friend or family member at a reduced rate.

To rent a SNOO for yourself or someone else, email the Benefits team at BenefitsAdministration@Andersen.com.



Pet Insurance

Andersen offers pet insurance through Nationwide Pet Insurance. Costs for trips to the vet can really add up, especially in the event of an emergency. Pet insurance helps reduce costs for accidents, chronic illnesses, medication and much more.

New policy holders can choose My Pet Protection or My Pet Protection Wellness. Existing My Pet Protection policy holders can add the My Pet Protection Wellness coverage during the annual open enrollment period.

Feature	My Pet Protection	My Pet Protection with Wellness
Accidents, including poisonings and allergic reactions	✔	✔
Injuries, including cuts, sprains and broken bones	✔	✔
Common illnesses, including ear infections, vomiting and diarrhea	✔	✔
Serious/chronic illnesses, including cancer and diabetes	✔	✔
Hereditary and congenital conditions	✔	✔
Surgeries and hospitalization	✔	✔
X-rays, MRIs and CT scans	✔	✔
Prescription medications and therapeutic diets	✔	✔
Wellness exams		✔
Vaccinations		✔
Spay/neuter		✔
Flea and tick prevention		✔
Heartworm testing and prevention		✔
Routine blood tests		✔

To enroll in the Nationwide Pet Insurance plan, visit benefits.petinsurance.com/andersen. If you need to insure an avian or exotic pet, please call 877-738-7874.

Travel Assistance

If you travel for work or pleasure and are more than 100 miles from home, you have access to our travel assistance program. Services provided through NY Life include:

- Emergency medical assistance
- Emergency personal services
- Pre-trip information

MetLife Legal Plans

Andersen offers employees access to group legal services at the cost of $9.90 per pay period. Services include extensive legal advice and/or representation on a wide range of matters including will and estate planning and unlimited notary services. Telephone and in-person office consultations are available to the employee, spouse and eligible dependents. Please note, if you enroll in this plan, you are locked in for one year.

Aura Identity Theft Protection

Andersen provides identity theft protection with Aura. Identity theft is a real threat, and we want to offer up options to help protect you as necessary. Identity Guard uses real-time data to protect your identity and Personal Privacy Information at all times.

Coverage Level	Rate Per Month		
	Total	Premier	Ultimate
Employee Only	$5.00	$11.00	$15.00
Employee + Family	$9.00	$20.00	$27.00

Feature	Total	Premier	Ultimate
Dark Web Personal Information Monitoring	✔	✔	✔
Digital Vault	✔	✔	✔
SSN & Identity Authentication Alerts	✔	✔	✔
Credit Monitoring & Alerts	✔	✔	✔
Annual Credit Report	✔	✔	✔
Credit Score Simulator			✔
Credit, Bank & Account Freeze Assistance	✔	✔	✔
Investment & Loan Account Monitoring	✔	✔	✔
Tax Fraud Prevention Assistance	✔	✔	✔
Password Manager	✔	✔	✔
Social Media Monitoring		✔	✔
Parental Controls		✔	✔
Child Cyberullying Protection	✔	✔	✔
Sex Offender Geo Alerts	✔	✔	✔

Note: The above chart is not an exhaustive list of covered services. Please refer to the plan benefit document for more information.

beFIT - Wellness Program

Andersen takes wellness seriously. We have partnered with Walkingspree to help kick start – or continue – an active lifestyle. In addition to firmwide challenges, every participant who reaches 7,500 average steps a day (through walking or other physical activity) in any given month will receive $50. The Firm provides a $100 stipend toward the device of your choice purchased through the Walkingspree app.

Long-Term Care (LTC)

New hires are able to enroll in our Long-Term Care plan during the first Open Enrollment following their hire date. This benefit provides up to $300,000 in LTC coverage and life insurance with a guaranteed issue amount of $80,000 during your first open enrollment period.

myRecognition Program

myRecognition is a rewards and recognition program designed just for you. You will receive recognition for demonstrating actions and attitudes that exemplify our Firm's core values, as well as for the everyday things that you do. As a member of this program, you will be able to recognize your peers and direct reports as well as accumulate points from others to purchase exciting merchandise, gift cards, experiences, and tickets through an online Rewards Catalog.

- Living Our Values - Managers and above are able to award points-based recognitions to anyone in the Firm
- Everyday Recognition - All regular employees are able to give recognitions that do not have points

Completing the Online Enrollment Process

Benefits Administration

Benefits Administration is Andersen's online benefits administration system. Follow the steps below to elect coverage under the Health Care, Life, and AD&D Insurance Plans as well as FSA and Commuter account benefits.

1. Go to UKG Pro and sign in via SSO
2. Click "Menu"
3. Click "Manage My Benefits"
4. Review your profile and shop the benefits for which you are eligible
5. Click on each plan and select or decline coverage
    - If you do not want to enroll in the coverage, you must decline coverage
    - You cannot complete the enrollment process until you have enrolled or declined each benefit option
    - If you leave the enrollment page, click the continue button to pick up where you left off
6. Click "Review and Checkout" when you have completed the enrollment process to submit your elections

Note: Have your dependent documents ready when you enroll in your benefits.

Disclosures

The information on the next several pages summarizes many of the rights of Andersen employees and participants in the Andersen myBenefits program.

ACA: Summary or Summaries of Benefits and Coverage (SBCs)

Andersen Tax LLC is required by applicable law to provide you with certain notices each year that inform you of your rights and our responsibilities with respect to the Andersen Tax LLC.

Employee Benefit Plan (the "Plan"). Please carefully review the information contained below and share it with your covered dependents. We suggest you keep this information with your Summary Plan Description ("SPD") for future reference.

In the event of a conflict between the official Plan Document and these legal notices, the SPD, or any other communication related to the Plan, the official Plan Document will govern. If you have any questions, please contact Andersen Benefits Department 213-593-2300.

Important Notice About Your Prescription Drug Coverage and Medicare

If you (and/or your dependents) have Medicare or will become eligible for Medicare within the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please read the notice on Page 5 for more details.

HIPAA Notice of Availability of Notice of Privacy Practices

This Plan is required by law to provide notice of the Plan's duties and privacy practices with respect to covered individuals' protected health information by providing a Notice of Privacy Practices (NOPP) to participants. The Plan's NOPP is available upon request. To obtain a copy of the NOPP, or for more information regarding the Plan's privacy policies or your rights under HIPAA, contact Andersen Benefits Department 213-593-2300.

General Special Enrollment Rules

HIPAA requires we notify you about your right to later enroll yourself and eligible dependents for coverage in Andersen Tax LLC health plan under "special enrollment provisions" briefly described below.

- ***Loss of Other Coverage.*** If you decline enrollment for yourself or for an eligible dependent because you have other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents under Andersen Tax LLC health plan 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" or any longer period that applies under the plan after you or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage.
- ***New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.*** If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents under Andersen Tax LLC health plan. You must request enrollment within "30 days" or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse, if your spouse was not previously covered.
- ***Enrollment Due to Medicaid/CHIP Events.*** If you or your eligible dependents are not already enrolled Andersen Tax LLC health plan, you may be able to enroll yourself and your eligible dependents if: (i) you

or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. The CHIP Model Notice containing additional information about this right as well as contact information for state assistance is included below. You may also request a copy from the Plan Administrator.

Please contact the Plan Administrator at 213-593-2300 for details, including the effective dates of coverage applicable to each of these special enrollment provisions. Additional information regarding your rights to enroll in group health coverage is found in the applicable group health plan summary plan description(s) or insurance contract(s).

Women's Health & Cancer Rights Act of 1998

In the case of an employee or dependent who receives benefits under the plan in connection with a mastectomy and who elects breast reconstruction (in a manner determined in consultation with the attending physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which mastectomy has been performed, including nipple and areola reconstruction and re-pigmentation to restore the physical appearance of the breast;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under the Plan.

If you would like more information on WHCRA benefits, call your Plan Administrator at 213-593-2300.

Newborns' and Mothers' Health Protection Act of 1996

Under federal law (Newborns' Act), group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with child birth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan, or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification.

A number of states adopted requirements for benefits covering maternity stays prior to the enactment of the Newborns' Act. The federal law does not preempt state law if the state law meets certain criteria. For information on pre-certification, contact your Plan Administrator at 213-593-2300.

Affordable Care Act

Patient Protection Disclosure

Kaiser Foundation Health Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you and/or your family members: Until you make this designation, Kaiser designates one for you. For information on how to select a primary care provider, and for a list of participating primary care providers, contact Kaiser California 800-464-4000 or Kaiser Mid-Atlantic 800-777-7902.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Kaiser 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 or 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 the Plan Administrator at 213-593-2300.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Beginning July 1, 2017, California law protects consumers from surprise medical bills when they get non-emergency services, go to an in-network health facility and receive care from an out-of-network provider without their consent. In this case, the law states that consumers only have to pay their in-network cost sharing. Medical providers are prohibited from sending consumers out-of-network bills when the consumer followed their health insurer's requirements and received non-emergency services in an in-network facility. Facilities include hospitals, ambulatory surgery centers or other outpatient settings, laboratories, and radiology and imaging centers.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Department's Help Center online or call us at 1-800-927-4357 for more information about your rights under California laws.

Important Notice About Your Prescription Drug Coverage and Medicare: Creditable Coverage

If you (and/or your dependents) have Medicare, or will become eligible for Medicare within the next 12 months, federal law gives you more choices about your prescription drug coverage. Please read the following notice for more details.

Please read this notice carefully. It has information about your prescription drug coverage under Andersen Tax LLC health plan (Employer Plan) and the coverage options available to Medicare Part-D eligible individuals. This Notice also provides information on additional resources that may help you decide which prescription drug coverage to choose.

You should keep this notice with your important records. If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Notice of Creditable Coverage

The purpose of this notice is to advise you that the Employer Plan prescription drug coverage listed below is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay. This is known as "creditable coverage."

- Kaiser HMO Plans (California, DC, Maryland, Virginia, and Washington)
- Cigna Low, Medium and High Deductible Plans (including Non-Elective)

Why this is important: Coverage under one of these plans may help you avoid a Medicare Part D late enrollment penalty. If you or your covered dependent(s) are enrolled in the Employer Plan and are currently or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty—as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment.

Late Enrollment Penalty (Higher Premium Charge)

You should know that if you waive or drop coverage under the Employer Plan

and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Medicare Part D premium may go up by at least 1% per month for every month that you do not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium may consistently be at least 19% higher than what most other people pay. You may have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Medicare Part D.

Medicare Prescription Drug Coverage

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

Individuals can enroll in a Medicare prescription drug plan when they first become Part D eligible, and each year thereafter during Medicare open enrollment (October 15 through December 7). Individuals who decide to drop their creditable employer/union coverage may be eligible for a two month Medicare Special Enrollment Period.

Interaction Between Coverages

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or a family member of an active employee, your current Employer Plan coverage will not be affected.

In addition, if you waive or drop your current Employer Plan coverage to enroll in a Medicare Part D plan, you and your dependents will be able to re-enroll in the Employer Plan coverage at open enrollment or when you have a special enrollment event.

Additional Information

Contact the person listed at the end of this Notice for further information about your current prescription drug coverage. NOTE: You may receive this notice at other times in the future—such as before the next period you can enroll in Medicare prescription drug coverage, if the Employer Plan coverage changes, or upon your request.

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. Medicare participants will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. For information about this extra help, contact the Social Security Administration (SSA) online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan, you may be required to provide a copy of this notice when you join a Part D plan to show that you have maintained creditable coverage and, therefore, may not be required to pay a higher Part D premium.

For more information about this notice or your employer-sponsored prescription drug coverage, contact:

Andersen Benefits Department
Andersen Tax LLC
350 S. Grand Ave., Suite 2000
Los Angeles, CA 90071
213-593-2300

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility.

ALABAMA - Medicaid	ALASKA - Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS - Medicaid	**CALIFORNIA - Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO - Medicaid and CHIP+	**FLORIDA - Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA - Medicaid	INDIANA - Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003/TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740/TTY: Maine relay 711	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.ACCESSNebraska.ne.gov Phone: 855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free for HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-410	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/PagesMedical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Websites: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To See if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Resources

Plan	Administrator	Group Number	Customer Service
Medical	Cigna Express Scripts	3338289 BIN - 017010 PCN - 0215COMM	www.myCigna.com 800-244-6224
	Kaiser Permanente	SoCal: 229108 NorCal: 602676 WA: 2166500 DC, MD, VA: 25555	www.kp.org CA: 800-464-4000 WA: 888-901-4636 DC, MD, VA: 800-777-7902
Cigna One Guide	Cigna	N/A	www.myCigna.com 800-244-6224
Dental	MetLife	237868	www.metlife.com/dental 800-942-0854
Vision	Ameritas		EyeMed www.eyemed.com 866-289-0614 VSP www.vsp.com 800-877-7195
Health Savings Account (HSA)	HSA Bank	N/A	www.myCigna.com 800-357-6246
Flexible Spending Accounts (FSAs)	PlanSource	N/A	plansource.wealthcareportal.com 888-266-1732, Select Option #2
Life and AD&D	NY Life	OK9648888	800-238-2125
Disability	NY Life	LK750764	myNYLGBS.com 888-842-4462
TRIP (401(k) Plan)	Vanguard	095882	www.vanguard.com/retirementplans 800-523-1188
Employee Assistance Program (EAP)	Cigna	LK962329	www.myCigna.com 877-622-4327
One Medical Group	One Medical Group	N/A	www.onemedical.com Activation Code: ANDXOM 1-888-663-6331
Student Loan Paydown Plan	Gradifi	N/A	www.gradifi.com 844-472-3434
Commuter Benefits	PlanSource	N/A	plansource.wealthcareportal.com 888-266-1732, Select Option #2
Travel Assistance	NY Life	OK964888	From the U.S. and Canada: 888-226-4567 Outside U.S. and Canada, call collect: 202-331-7635

MilkStork	MilkStork	N/A	www.milkstork.com 510-356-0221
Legal Services	MetLife Legal Plans	N/A	info.legalplans.com 800-821-6400
Bright Horizons	Bright Horizons	N/A	clients.brighthorizons.com/andersen 866-854-1958
SNOO	Happiest Baby	N/A	snoo.rentals/pages/andersen Access Code: ANDERSENEMPLOYEE 855-424-6323
Pet Insurance	Nationwide Pet Insurance	N/A	benefits.petinsurance.com/andersen 800-540-2016
Long-Term Care (LTC)	Trustmark	N/A	myvb.trustmarkbenefits.com 800-918-8877
Identity Theft Protection	Aura	N/A	www.my.aura.com 855-443-7748
Voluntary Long Term Disability	Unum	N/A	800-633-7490

Glossary of Terms

These definitions of common health insurance terms will help you navigate your benefits options.

Coinsurance – The amount or percentage you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met and can vary based on the plan design.

Copayment – The flat fee you pay towards the cost of covered medical expenses.

Covered Expenses – Health care expenses that are considered eligible expenses under your health plan.

Deductible – Before benefits are available through a health plan, you must pay a specific dollar amount out-of-pocket. Under some plans, the deductible is waived for certain services.

Deductible (Aggregate) – For family coverage, the entire family annual deductible must be met before Co-pay or coinsurance is applied for any individual family member.

Deductible (Embedded) – Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.

Dependent – Individuals who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent. Dependents are typically the covered employee's spouse and/or children.

Exclusive Provider Organization (EPO) – As a member of an EPO, you can use the doctors and hospitals that are within the EPO network. There are no out-of-network benefits, so you cannot go outside the EPO network for care and services.

Flexible Spending Account (FSA) – An account that allows you to save tax-free dollars for qualified health and/or dependent care expenses that are not reimbursed through the health plans. During open enrollment, you determine the annual amount you want to contribute to the FSA during the calendar year. If funds are left in the account at the end of the calendar year, the money is forfeited back to your employer to help cover the administrative expenses incurred to provide the FSA plans.

Health Savings Account (HSA) – This is a special savings account set-up and used to pay for eligible health expenses. Your HSA contribution is taken on a pre-tax (or post-tax) basis and directly deposited into your account. Account balances carry over from year to the next. Withdrawals for non-health related expenses are subject to income taxes (and additional penalty if age 65 or under). You must be enrolled in a qualified high deductible health plan (HDHP) to make contributions to a health savings account. Once established, the account belongs to you; even if you're no longer participating in an HDHP or your employment ends.

High Deductible Health Plan (HDHP) – A qualified health plan that gives you more control over your health care spending by offering lower monthly premiums in exchange for higher deductibles and out-of-pocket limits. These plans are often coupled with an HSA.

Health Maintenance Organization (HMO) – HMO plans offer a wide range of health care services through a network of providers who agree to supply services to members. HMO members are required to choose a Primary Care Physician (PCP) who will take care of most of their health care needs. Before you can see a specialist, you will need to obtain a referral from your PCP.

In-Network – Care you receive from your primary care physician or from a specialist within a specified list of health care practitioners, as determined by the health plan.

Inpatient – A person who is treated as a registered patient in a hospital or other health care facility. This person accrues room and board charges.

Medically Necessary – Services or supplies provided by a hospital, other health care facility or physician that meet the following criteria: (1) are appropriate for the symptoms and diagnosis and/or treatment of the condition, illness, disease or injury; (2) serve to provide diagnosis or direct care and/or treatment of the condition, illness, disease or injury ; (3) are in accordance with standards of good medical practice; (4) are not primarily serving as convenience; and (5) are considered the most appropriate care available.

Medicare – An insurance program administered by the U.S. Government to provide health coverage to individuals typically age 65 and older.

Member – Individuals become members when enrolled in a health plan. Members include eligible employees, their dependents, COBRA beneficiaries and surviving spouses.

Open Access Plans (OAP) – OAP's combines the benefits of HMO's and traditional health coverage. Members do not need to select a Primary Care Physician (PCP), and will allow them to choose care from any provider (in or out of network). If you need to see a specialist, you do not need a referral to see a doctor who participates in the OAP plan's network.

Out-of-Network – Care you receive without a physician referral or services received by a non-network service provider. Out-of-network health care and plan payments are typically subject to higher deductibles, copayments and coinsurance. Out-of-network care and services may be excluded from being covered by the health plan.

Out-of-Pocket Expenses – Amount you must pay towards the cost health care services. This includes deductibles, copayments and coinsurance.

Out-of-Pocket Maximum (OPM) – The top amount paid for covered services during a benefit period. Both the deductible and the coinsurance apply towards meeting the OPM, but copayments may not apply. Under some plans, the deductible and OPM may have the same dollar limit.

Preferred Provider Organization (PPO) – A health plan that offers both in-network and out-of-network benefits. Members must choose one of the in-network providers or facilities to receive the highest level of benefits.

Premium – The amount you pay for a health plan in exchange for coverage. Health plans with higher deductibles, higher copayments and/or higher coinsurance typically have lower premiums.

Preventive Care – Routine health care determined by the Department of Health and Human Services that includes annual check-ups, patient counseling and screenings to prevent illness, disease and other health-related problems.

Primary Care Physician (PCP) – The doctor that you select to coordinate your care under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

Reasonable and Customary (R&C) Rate – The fee paid for covered services that is: (1) a similar amount to the fee charged from a health care provider to the majority of patients for the same procedure; (2) the customary fee paid to providers with similar training and expertise in a similar geographic area, and (3) reasonable in light of any unusual clinical circumstances, etc.

Andersen has made every effort to ensure the accuracy of this guide. However, it is possible that your benefits may differ from the amounts or policies outlined herein. Andersen reserves the right to make any changes or corrections to this brochure. The applicable benefit plan documents govern the benefit plans. Those plan documents cannot be modified by the contents of this guide or by any oral or written statements to you, direct or indirect, from benefit administrators or other personnel. Copies of benefit plan documents are available for your review upon request. Andersen reserves the right, in accordance with applicable law, to amend or terminate any or all plans described in this guide at any time. Participation in these benefit plans does not guarantee, directly or indirectly, employment with Andersen. Please contact your local HR/Operations representative with any questions.