Affirm, Inc.

Welfare Benefits Plan

Master Summary Plan Description

Effective January 1, 2021

This document, together with the additional documents provided along with it, constitute the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the notice reproduced in Appendix B for more details.

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1. Definitions

Capitalized terms used in this document have the following meanings:

"AD&D" means accidental death and dismemberment insurance.

“Affordable Care Act” means the Patient Protection and Affordable Care Act, as amended.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Company" means Affirm, Inc. or any successor thereto, and any affiliated entity within the same controlled group, as that term is defined under section 414(b) of the Internal Revenue Code, that participates in the plan.

"DCAP" means a dependent care assistance program that may be established by the Company under a separate document. The DCAP is not a benefit program under the Plan. It may allow you to use pre-tax dollars to pay for the care of your eligible dependents while you are at work. It is not subject to ERISA.

"Employee" means any common-law employee of the Company who satisfies the eligibility provisions of in this document and is not excluded from participation by the terms of an applicable benefit program, except individuals classified or treated by the Company as independent contractors (regardless of any subsequent reclassification), or as an employee of an employment agency.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"Health FSA" means a health flexible spending account plan that may be established by the Company under a separate document. The health FSA is a benefit program under the Plan. It allows you to use before-tax dollars to pay for most medical and dental expenses not reimbursed under other programs.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

"Plan" means the Affirm, Inc. Welfare Benefits Plan and includes this document, written amendments and updates to this document, and the terms of all policies and component benefit programs listed in Section 15.

"Plan Administrator" means the Company.

"SPD" means the Summary Plan Description required by ERISA § 102 summarizing this Plan and includes this document, information booklets supplied by insurance carriers, and other benefits descriptions provided to participants with this document or at any other period as appropriate to provide updates to the document, such as during open enrollment.

"WHCRA" means the Women's Health and Cancer Rights Act of 1998, as amended.

2. Introduction

The Company maintains the Plan for the exclusive benefit of eligible Employees and eligible family members or “dependents.” It is important that you share this document and the materials referenced here in with your covered dependents. The Plan provides health and welfare benefits through the benefit programs listed in Section 15. See Section 15 for a listing of benefit programs and the entities that help administer the programs.

Each of these benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another document (a "Benefit Description"). A Benefit Description will be available from the insurer (if the benefit is fully-insured) or Plan Administrator (if the benefit is self-funded). Whether a benefit program is fully-insured or self-funded is noted in Section 15.

This document and its attachments constitute the plan document required by ERISA § 402. This document and its attachments, coupled with the information booklets and other descriptive materials provided for benefits as described in Section 15 constitutes the wrap Summary Plan Description as required by ERISA § 102.

3. General Information about the Plan

Plan Name:	Affirm, Inc. Welfare Benefits Plan.
Type of Plan:	Welfare plan providing coverages listed in Section 15. The Plan also includes funding through a cafeteria plan under Code § 125.
Plan Year:	January 1 to December 31.
Plan Number:	501
Effective Date:	January 1, 2021.
Funding Medium and Type of Plan Administration:	Some benefits under the Plan are self-funded, and some are fully-insured. See Section 15 for a description of the benefit programs and whether they are self-funded or fully-insured. For benefit programs which are fully-insured, benefits are insured under a group contract entered into between the Company and insurance companies or HMO. The insurance companies and/or HMO, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the insurance companies and/or HMO for administering these program benefits, as described below. For benefit programs which are self-funded, the Company is responsible for processing and paying appropriate claims. The Company may hire a third party administrator (a "TPA") to process claims.

	Premiums for Employees and their eligible family members may be paid in part by the Company out of its general assets and in part by Employees' pre-tax and/or post-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the benefit programs, as applicable. The Company provides Employees the opportunity to pay for benefits on a pre-tax basis through a cafeteria plan. Appendix C provides information with regard to such a plan.
Plan Sponsor:	The employer is the Plan Sponsor. Affirm, Inc. 650 California Street, 12th Floor San Francisco, CA 94108 benefits@affirm.com
Plan Sponsor's Employer Identification Number:	45-5413534
Insurance Companies/HMO:	See a complete list under the heading Plan Provider Information later in this document.
Plan Administrator:	Attention: Human Resources Affirm, Inc. 650 California Street, 12th Floor San Francisco, CA 94108 benefits@affirm.com
Named Fiduciary:	Affirm, Inc. 650 California Street, 12th Floor San Francisco, CA 94108 benefits@affirm.com
Agent for Service of Legal Process:	Affirm, Inc. 650 California Street, 12th Floor San Francisco, CA 94108 legal@affirm.com Service for legal process may also be made on the Plan Administrator.

Language assistance is available. If you have difficulty understanding any part of this Summary Plan Description contact the Plan Administrator at benefits@affirm.com.

Benefits hereunder may be provided pursuant to an insurance contract or pursuant to a governing document adopted by the Company. If so, these contracts are made a part of this Plan document, and the contracts and Plan document should be construed as consistent, if possible. If the terms of this Plan document conflict with the terms of such insurance contract or other governing document, then the terms of the insurance contract or governing document will control, with the exception of defining eligible employees and dependents, which is determined by the Company, unless otherwise required by law.

4. Eligibility and Participation Requirements

Eligibility and Participation

An eligible Employee with respect to the Plan will be an Employee who is eligible to participate in and receive benefits under one or more of the benefit programs. To determine whether you or your family members are eligible to participate in a benefit program, please see Section 15. Reclassification from non-employee to employee status by a court or any agency or by the Company will not create any retroactive right to coverage.

Certain benefit programs require that you make an annual election to enroll for coverage. ***Generally, you cannot enroll, drop coverage, or change your or your dependents coverage under the plan except during annual Open Enrollment.*** However you may be able to add or drop coverage for yourself or a dependent during the plan year if you experience an event that triggers a HIPAA Special Enrollment Right (see discussion below) or if you have a Status Change Event (see Appendix C for an explanation of Status Change Events). Please review the rules for changing your benefits elections described in Appendix C very carefully as the rules regarding making benefits changes mid-year must be strictly enforced.

Information about enrollment procedures is provided by the Company. Information about when your participation begins in various benefit programs is found under Section 15. You must follow any required enrollment procedures. ***Always make sure the Company has your current home address and other contact information for you and your covered dependent to correctly administer your benefits and to send you important benefits information.***

Eligible Dependent Status

Section 15 describes whether your spouse and or child can participate in a particular benefit program. Section 15 also describes any limits on such participation. For example, children covered under the Medical benefit program generally can be covered until the end of the month during which they reach age 26. However, coverage may end earlier for other benefits (or may not be available at all). For specifics on eligibility for each benefit offered refer to Section 15. Note that the definition of dependent may be different for the different benefits offered under the Plan.

You cannot be covered both as an employee and as a dependent under the plan.

Full Time Status and the ACA

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee who works on average 130 hours per month. Employers may also face penalties if they do not offer major medical coverage to substantially all full-time employees or if the coverage they offer is unaffordable or does not meet a minimum value standard. The Company determines full-time status using the Monthly method. ACA full-time status is not a guarantee of major medical benefits eligibility. Benefits eligibility is described in Section 15.

Special Enrollment Provisions under HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a special enrollment period for the Medical benefit program (or similar benefit programs providing medical benefits) may be available, usually if you lose medical coverage under certain conditions or when you acquire a new dependent by marriage, birth, or adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you declined enrollment in the Plan for yourself or your dependents (including a spouse) because of coverage under Medicaid or a State Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

Finally, if you declined enrollment in the Plan for yourself or your dependents (including a spouse), and you or a dependent later becomes eligible for state “premium assistance” through Medicaid or a State Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance. ***Medicaid and State Children's Health Insurance Program premium assistance are not available with respect to coverage under a health FSA or a high-deductible health plan. Thus, this special enrollment event will not apply to such plans.***

Coverage during Certain Leaves of Absence

Certain Federal (and State) statutes like the Family and Medical Leave Act (FMLA) require that eligibility for medical benefits continue for employees on those protected leaves of absence under the same terms as active employees. When wages continue during such a leave, your contributions will be deducted from those wages on a pre-tax basis. When such a leave is unpaid, you are still required to pay your portion of the premium. Your portion of the premium may be paid as regular monthly intervals during the leave on a post-tax basis.

You may also generally discontinue coverage at the beginning of such an unpaid leave and when you return your benefits will either be reinstated or you may re-enroll for the remainder of the coverage period or plan year.

Human Resources must determine whether or not you are eligible for a statutory or other leave of absence.

Terms of Participation

Your participation and the participation of your spouse and dependents in a benefit program will terminate according to the terms of the specific benefit program. Generally, coverage for most benefit programs terminates on the last day of the month in which you terminate employment, but certain benefit programs may provide coverage only through the date your employment terminates. Please see Section 15 for further information on the date participation in a specific benefit program will terminate.

Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below the required hourly threshold for the particular benefit, if you engage in fraud or make an intentional misrepresentation of a material fact, or for any other reason as set forth in the attached documents. You should consult Section 15 for a general summary and the attached documents for specific termination events and information.

Coverage may be terminated retroactively in the normal course of business due to a participant's termination of employment, nonpayment of premiums, loss of dependent eligibility or other, similar factors. When you or a dependent lose eligibility for benefits, regardless of whether or not you timely report that loss of eligibility, a change to any existing salary reduction election will be made automatically. To the extent that the coverage at issue does not allow for retroactive termination of that coverage and election to the date of the loss of eligibility, such changes will be prospective. If coverage can be terminated retroactively to the date of the loss of eligibility, or sometime thereafter, excess salary reduction contributions will be refunded on a post-tax basis to the date the termination of coverage can be made effective.

Any person claiming benefits under the Plan shall furnish the Company, any insurance company or other entity working on behalf of the Plan or a benefit program with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan or a benefit program. This may include but is not limited to providing social security numbers, birth certificates, marriage certificates, or proof of dependent eligibility. Failure to cooperate and provide such information will lead to a loss of eligibility for benefits.

Knowingly enrolling an ineligible dependent in plan benefits constitutes fraud and is considered a material misrepresentation that will result in termination of coverage as well as other disciplinary action up to and including termination of employment. Eligibility for benefits is described in Section 15. If you have questions about whether a dependent is eligible you must contact Human Resources before enrolling that dependent.

COBRA Rights

You may be eligible for COBRA continuation coverage or conversion policies when your coverage for a medical benefit program under this Plan terminates. Information about continuation coverage or conversion is contained in Appendix A. If you have questions about this law or these rights, please contact the Plan Administrator (for benefit programs that are self-

funded) or the insurance carrier (if the benefit is fully-insured). You can determine whether a benefit program is self-funded or fully-insured by consulting Section 15.

For the Health FSA benefit program, COBRA continuation coverage is available if your account is underspent (if the COBRA premium for the account (the monthly salary reduction election + 2%) for the remainder of the coverage period is less than the account's balance) but generally cannot extend beyond the end of the Plan Year (including any 2½ month grace period). COBRA continuation coverage will not be offered with respect to the Health FSA benefit program if your Health FSA is overspent, unless otherwise required by applicable law.

5. Summary of Plan Benefits

Benefits and Contribution

The Plan provides you and your eligible spouse and dependents with the benefit programs listed in Section 15. A summary of each benefit program provided under the Plan may be provided in the attached documents (such as a certificate of insurance booklet, summary plan description for a specific benefit program or other governing document).Note that some of the attached documents may be labeled as a "summary plan description." If so, that document will only be a summary of the specific benefit program to which it relates. Notwithstanding any of the terms of such a document, that document is not the formal, single "Summary Plan Description" for this Plan. Rather, this document constitutes the formal, single "Summary Plan Description."

The cost of the benefits provided through the benefit programs may be funded in part by Company contributions and in part by pre-tax and/or post-tax employee contributions. The Company will determine and periodically communicate your share of the cost, if any, of the benefit programs. The Company reserves the right to change that determination.

The Company will make its contributions, if any, in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and your contributions to any insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to, or on behalf of, you or your eligible family members from the Company's general assets. Your contributions toward the cost of a particular benefit program will be used in their entirety prior to using Company contributions to pay for the cost of such benefit program.

Medical benefits under this Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, annual or lifetime limits, pre-authorization requirements or utilization review. There may also be limitations on the selection of primary care or network providers, limits on emergency medical care, or limited coverage for preventive services, drugs, medical tests, medical devices or medical procedures. These limitations are set forth in the attached documents.

Certain prescription drug benefits are considered “Creditable Coverage” under Medicare Part D. The attached documents provide details regarding this coverage and an annual

notice (attached and incorporated by reference in Appendix B) explains how this creditable coverage works for these prescription drug benefit programs.

The Plan will provide benefits in accordance with the requirements of all applicable Federal laws regulating group health plans, such as COBRA, HIPAA, NMHPA,WHCRA and the Affordable Care Act. A brief summary of some of these laws is below.

Newborns' and Mothers' Health Protection Act (NMHPA) of 1996

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

Women's Health and Cancer Rights Act (WHCRA) of 1998

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

Qualified Medical Child Support Orders

Group health plans and health insurance issuers generally must provide benefits as required by any qualified medical child support order, or "QMCSO." The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Michelle's Law: Mandate on Dependent Student Eligibility

Group health plans and health insurance issuers generally are prohibited from terminating a college student's health coverage on the basis of the child taking a medically necessary leave of absence from school or changing to a part-time status.

The leave of absence or reduction in hours must be medically necessary and must commence while the eligible student is suffering from a serious illness or injury and would otherwise lose coverage under the Plan because dependent age limitations (i.e.

non-student dependent eligibility ending at age 18). The student must have been enrolled in the group health plan before the first day of the leave. There must also be a written certification by the student's physician indicating that the student is indeed suffering from a serious illness or injury that necessitates the leave or change in enrollment status. The coverage under Michelle's Law must be extended for at least one year; however, coverage may end earlier for certain reasons, such as aging out of the Plan.

Lifetime and Annual Limits

Lifetime or annual limit on the dollar value of “essential health benefits” are no longer permitted under the major medical plans offered by the Plan. For more information on “essential health benefits” refer to the terms of policies and benefit program materials listed in Section 15. These documents are provided to you during enrollment and are available from Human Resources, the insurer (if the benefit is fully-insured), or Plan Administrator (if the benefit is self-funded).

6. Grandfathered Status under the Affordable Care Act

Non-Grandfathered Benefit Programs under the Affordable Care Act

The following benefit programs that provide health benefits are not “grandfathered health plans” under the Affordable Care Act:

- Blue Shield PPO
- Blue Shield EPO
- Kaiser HMO

These benefit programs must, under the Affordable Care Act, provide additional protections. The protections provided by the Affordable Care Act include the following:

Preventive Services covered at 100%

In-network preventive care services will be covered at 100% with no cost sharing (e.g., copayment, coinsurance percentage, deductible, etc.). Preventive services include those services outlined in the US Preventive Services Taskforce recommendations (services rated “A” or “B”). Please see the attached documents for the preventive services included at no cost share.

Non-Network Emergency Services covered as In-Network

Emergency services must be covered without the need for prior authorization, regardless of the participating status of the provider or facility, and at the in-network cost sharing level.

Access to Primary Care Physicians

The Affordable Care Act generally allows participants the right to designate any primary care provider who participates in the network and who is available to accept the participant and his or her family members. If the benefit program requires that a primary care provider be designated, but one is not designated, the benefit program or a health

insurance issuer will designate one until the participant or family member makes such a designation.

- For children, you may designate a pediatrician as the primary care provider.
- You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

7. How the Plan Is Administered

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The Plan Administrator is a named fiduciary within the meaning of ERISA § 402 and has full discretionary authority to administer the Plan, to interpret the Plan, and to determine eligibility for participation and for benefits under the terms of the Plan. However, insurers and parties that have entered into administrative service agreements (Third Party Service Providers or TPAs) assume sole responsibility for their performance under applicable policies or administrative services agreements and, under ERISA, may be fiduciaries with respect to their performance.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. (However, as noted below, one or more insurance companies may have these responsibilities with respect to fully-insured benefits.)

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Power and Authority of Insurance Company

As detailed in Section 15, certain benefits under the Plan may be fully insured. The insurance companies are responsible for: (1) determining eligibility for and the amount of any benefits payable under their respective benefit programs, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective benefit programs.

Questions

If you have any general questions regarding the Plan, or your eligibility for or the amount of any benefit payable under any benefit program, please contact the Plan Administrator or the appropriate insurance company as applicable.

8. Circumstances Which May Affect Benefits

Denial or Loss of Benefits

Your benefits (and the benefits of your eligible spouse and dependents) will cease when your participation in the Plan terminates. See Section 15. Your benefits will also cease on termination of the Plan.

Right to Recover Benefit Overpayments and Other Erroneous Payments

The Plan and its benefit programs (including any insurance company on behalf of a benefit program) have all necessary or helpful rights to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan, the recipient of such benefit (the "Recipient") shall be responsible for refunding the overpayment to the Plan or insurance company to the fullest extent permitted by law. In addition, if the Plan or insurance company makes any payment that, according to the terms of the Plan, policy or contract should not have been made, the insurance company, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurance company's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Plan Administrator or insurance company, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Any benefit payments or reimbursements made by check must be cashed or deposited within one year after the check is issued. If any check or other payment for a benefit is not cashed or deposited within one year of the date of issue, the Plan will have no liability for the benefit payment and the amount of the check will be deemed a forfeiture. No funds will escheat to any state.

9. Amendment or Termination of the Plan

Amendment or Termination

The Plan and any benefit program under the Plan may be amended or terminated at any time, in the sole discretion of the Company as Plan sponsor, by a written instrument signed by an

authorized individual. Some benefit programs may also be amended or terminated by an insurance carrier, as more fully described in any attached documents from an insurance carrier. The policies and agreements may also be amended or terminated at any time in accordance with their terms. No individual (including a retired employee) shall have a right to continuing benefits except to the extent required by law.

10. No Contract of Employment

The Plan is not intended to be, and may not be construed as, constituting a contract or other arrangement between you and the Company to the effect that you will be employed for any specific period of time.

11. No Assignment

Except as may otherwise be specifically provided in this Plan, the benefit programs, or applicable law, an individual's rights, interests or benefits under this Plan or the benefit programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the benefit programs, and any such attempt shall be void.

Specifically, participants and beneficiaries covered under this plan cannot assign their rights to medical providers to pursue direct payment of claims either as the participant or beneficiaries' agent or under power of attorney. Under the terms of this plan, medical providers cannot take action enforcing a patient's right to recover benefits under ERISA or assert any claims under ERISA on behalf of patients, even where the patient(s) have assigned their rights to their medical providers.

12. Claims Procedure

Claims for Fully-Insured Benefits

For purposes of determining of the amount of, and entitlement to, benefits of the benefit programs provided under insurance contracts or policies, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to benefits.

To obtain benefits from the insurer of a benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form.

The insurance company will decide your claim in accordance with its reasonable claims procedures as required by ERISA.

See the appropriate certificate of insurance or booklet for details regarding the insurance company's claims procedures. You must fully follow and exhaust these claims procedures before you can file a lawsuit in state or federal court. You may have a right to seek external review of your claims, if so noted in the applicable insurance contract or policy.

Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the benefit programs which are self-funded, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan.

To obtain benefits from a benefit program which is self-funded you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence, as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. You may have a right to seek external review of your claims, if so noted in the applicable attached document for the self-funded benefit program.

See the appropriate benefits description for information about how to file a claim and for details regarding the claims procedures applicable to your claim. You must fully follow and exhaust these claims procedures before you can file a lawsuit in court.

The Role of Authorized Representatives

Under ERISA and the ACA participants and beneficiaries have the right to designate an Authorized Representative for certain purposes. These purposes are generally limited to requesting documents or other information on behalf of a participant or beneficiary or acting on their behalf during claims and appeals procedures that can follow an adverse benefits determination. In any situation that does not constitute an urgent care claim, to designate any third party as an Authorized Representative a participant or beneficiary must use the signed statement included as an appendix of this document with the required witness signature. A medical provider will not become a participant or beneficiary’s Authorized Representative as a result of an attempt to secure an assignment of benefits. The Plan does not guarantee that any purported assignment will be valid under the terms of the Plan.

13. Statement of ERISA Rights

This Statement of ERISA Rights applies to those benefit programs which are subject to ERISA. Not all benefit programs which are part of this Plan will be subject to ERISA. The following benefit programs are not subject to ERISA: HSA, cafeteria plan and DCAP, Commuter Benefits, Twic Wallet, Rocket Lawyer, ARAG Legal, Norton LifeLock ID Theft, EAP

Your Rights

As a participant in an ERISA plan you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;
- obtain copies of the benefit program documents and other program information on written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies);
- receive a summary of the Plan's annual financial report, if any (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report);
- continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Fiduciary Obligations

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the benefit program. These people, called "fiduciaries" of the program, have a duty to operate the program prudently and in the interest of you and other program participants. Fiduciaries who violate ERISA may be removed and may be required to reimburse the Plan for any losses they have caused the program.

No Discrimination

No one, including the Company or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.

Right to Review

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan Administrator review and reconsider your claim.

Filing Suit

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a court.

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of the internal claims and appeals procedure is required prior to filing suit.

If it should happen that benefit program fiduciaries misuse the Program's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Questions

If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

14. General Information

COBRA

Benefit programs which provide health benefits generally are subject to the federal law known as COBRA. COBRA generally allows covered participants and beneficiaries to continue in the benefit program, even after a "qualifying event" occurs. For more information about COBRA please see Appendix A. You may also have state law continuation or conversion rights.

Subrogation and Reimbursement

If an individual has a claim for benefits under this Plan or any benefit program, and that individual acquires any right or action against a third party for the person's injury, sickness or other illness which is so covered, then: (a) the Plan shall be entitled to reimbursement for such benefits from such third party up to 100% of the benefits paid by the Plan; and (b) the Plan is automatically subrogated to all such rights or claims of the covered person. The covered person shall cooperate fully with the Plan in the enforcement of the Plan’s subrogation and reimbursement rights. In addition, the person shall permit suit to be brought in the person's name under the direction of and at the expense of the Company if the Company so chooses. The Plan shall not be liable for such a person’s attorney’s fees absent prior written approval from the Plan. The Plan Administrator may require the receipt of a signed and dated subrogation and reimbursement agreement from the person before advancing any monies.

The failure or refusal of a covered person to fully cooperate with the Plan in the enforcement of the Plan’s subrogation and reimbursement rights shall result in a forfeiture of all benefits payable to that person, even if such benefits have already been paid, in which event the Company shall retain a right to recover paid benefits which are forfeited in such a manner.

The Company, on behalf of this Plan, shall have a first priority right to recover from and a lien against any payment, whether designated as a payment for medical benefits or any other type of damages, from the proceeds of any recovery, including but not limited to any settlement, award or judgment which results from a claim or lawsuit by or on behalf of a covered person who received benefits under this Plan (even if such covered person is not made whole). The

plan is not required to contribute to any expenses or fees (including attorney's fees or costs) incurred in obtaining the funds. The plan's recovery will not be limited or reduced by doctrines (equitable or other) including but not limited to, the make-whole doctrine, contributory or comparative negligence, or the common fund doctrine. The plan's right to full recovery is not reduced if settlement funds or other payments to you are spent or no longer in an individual's possession or control. Notice of the Plan's claim shall be sufficient to establish this Plan's lien against the third party or insurance carrier. The Company shall be entitled to deduct the amount of the lien from any future claims payable to or on behalf of the covered person or payee if the covered person or payee fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to this Plan's subrogation and reimbursement rights.

In the event that the Plan obtains a recovery against a third party in excess of payments made to or on behalf of the covered person and reasonable out of pocket expenses of the recovery, then the Plan shall pay to the covered person that excess amount recovered by the Plan.

In the event of any direct conflict between this Section 13 and the subrogation and reimbursement provisions in any benefit program, the subrogation and reimbursement provisions in the benefit program shall control. Otherwise, the provisions of this Section 13 shall apply and may supplement those contained in any benefit program.

The above provisions of this "Subrogation and Reimbursement" section apply with respect to a benefit program that is self-funded and does not, in its governing documents (but excluding this Plan document) have a subrogation and reimbursement section. If the benefit program does have such a section that section shall control. With respect to a fully-insured benefit program, the contract or policy from the insurer shall control with respect to subrogation and reimbursement matters.

No Vesting of Benefits

Nothing in the Plan, nor anything in any benefit program, shall be construed as creating any vested rights to benefits in favor of any employee, former employee or covered person.

Waiver and Estoppel

No term, condition, or provision of this Plan or any benefit program shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan or benefit program, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No covered person other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purposes.

Effect on Other Benefit Plans

Amounts credited or paid under this Plan or any benefit program shall not be considered to be compensation for purposes of any benefit program hereunder or any qualified or nonqualified pension plan maintained by the Company unless expressly provided in such benefit program or qualified or nonqualified pension plan, as applicable, or if required by applicable law. The treatment of amounts paid under this Plan or any benefit program for purposes of any other

employee benefit plan maintained by the Company shall be determined under the provisions of the applicable employee benefit plan.

Severability

If any provision of this Plan or any benefit program is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

Rebates

In some situations, a rebate may be paid by an insurance company which provides coverage under the Plan. For example, a rebate may be provided under the Medical Loss Ratio ("MLR") rules, which are part of the Affordable Care Act. Except as specifically and unambiguously provided in a Benefit Description, or as otherwise required by applicable law, any rebate from any source will be:

☒ An asset of the Plan in proportion to how much of the rebate relates to Employee, participant, or beneficiary contributions. The portion relating to Company contributions shall not be considered a Plan asset. The Company will have the ability to make certain assumptions or minor changes (such as rounding to the nearest $1 or $10) when determining the amount which is considered a plan asset. The Company shall have discretion to determine how to use all amounts. Amounts which are plan assets will be used to benefit individuals selected by the Company. This group of individuals may not be identical to the group which relates to the rebate. In addition, certain individuals can receive the rebate (or the benefit of the rebate) even if the rebate related to a different benefit, to the extent allowed by applicable law.

In all situations where ERISA applies the use of any ERISA-covered plan assets will be governed by applicable law, including but not limited to U.S. Department of Labor Technical Release 2011-04.

Controlling Law

This Plan shall be administered, construed, and enforced according to the federal law and the laws of the State of California, to the extent not preempted by federal law. However, with respect to a fully-insured benefit program, the applicable insurance policy or contract will control with respect to which state's laws apply.

15. Benefit Program Information

Summary of Eligibility and Participation Provisions

Note: If you have any questions about eligibility or participation, contact the Plan Administrator

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends[1]	To File a Claim, Contact:
Medical PPO, EPO	Fully-Insured / Blue Shield of CA	W0041834	Full time exempt and non-exempt working 40+ hours per week, Part time employees working between 24-32 hours per week. Spouses/Domestic Partners and children generally are covered	Immediately on date of hire and proper election within 30 days	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Customer Service Call Centers (855) 599-2650 www.blueshieldca.com
Medical HMO	Fully-Insured / Kaiser	707505	Full time exempt and non-exempt working 40+ hours per week, Part time employees working between 24-32 hours per week. Spouses/Domestic Partners and children generally are covered	Immediately on date of hire and proper election within 30 days	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Member Services (800) 464-4000 kp.org
Dental Base PPO	Self-funded / Guardian	514939	Full time exempt and non-exempt working 40+ hours per week, Part time employees working between 24-32 hours per week. Spouses/Domestic Partners and children generally are covered	Immediately on date of hire and proper election within 30 days	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Member Services (888) 715-0760 www.guardianlife.com
Dental Buy Up PPO	Self-funded / Guardian	514939	Full time exempt and non-exempt working 40+ hours per week. Spouses/Domestic	Immediately on date of hire and proper election within 30 days	At the end of the month in which coverage is dropped or employment is terminated.	Member Services (888) 715-0760 www.guardianlife.com

[1] Other Events (such as fraud or intentional misrepresentation of a material fact) can also terminate coverage -- see the benefit program details.

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends[1]	To File a Claim, Contact:
			Partners and children generally are covered		Continuation coverage usually is available.	
Vision	Fully-Insured / Guardian	514939	Full time exempt and non-exempt working 40+ hours per week, Part time employees working between 24-32 hours per week. Spouses/Domestic Partners and children generally are covered	Immediately on date of hire and proper election within 30 days	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Member Services (888) 715-0760 www.guardianlife.com
Basic & Vol Life/AD&D Disability (STD & LTD), EAP	Fully-Insured / Guardian	514939	Full time exempt and non-exempt working 40+ hours per week, Part time employees working between 24-32 hours per week. Spouses and children generally are covered ***(Vol Life/AD&D, EAP – Full time only)***	Immediately on date of hire and proper election within 30 days	Immediately upon termination of employment. Some conversion/portability options may be available	Member Services (888) 715-0760 www.guardianlife.com
Health Care FSA	Self-Funded / Twic	N/A	Full time exempt and non-exempt working 40+ hours per week, Part time employees working between 24-32 hours per week. Spouses/Domestic Partners and children generally are covered	Immediately on date of hire and proper election within 30 days	Immediately upon termination of employment. Continuation coverage usually is available unless Health FSA is "overspent"	Member Experience Team support@twic.ai
Medical Concierge	One Medical	N/A	Full time exempt and non-exempt working 40+ hours per week, Part time employees working between 24-32 hours per week and enrolled in a Blue Shield Affirm offered medical plan. Spouses/Domestic Partners	Immediately on date of hire and proper election within 30 days	Immediately upon termination of employment.	onemedical.com/mybenefit

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends[1]	To File a Claim, Contact:
			and children generally are covered			
Mental Health	Spring Health	N/A	Full time exempt and non-exempt working 40+ hours per week. Spouses/Domestic Partners and children generally are covered	Immediately on date of hire and proper election within 30 days	Immediately upon termination of employment.	CareTeam (240) 558-5796 careteam@springhealth.com
Fertility	Maven	N/A	Full time exempt and non-exempt working 40+ hours per week. Spouses/Domestic Partners and children generally are covered	Immediately on date of hire and proper election within 30 days	Immediately upon termination of employment.	Member Services support@mavenclinic.com
Accident and Critical Illness	Voya	N/A	Full time exempt and non-exempt working 40+ hours per week. Spouses and children generally are covered	Immediately on date of hire and proper election within 30 days	Immediately upon termination of employment. Some conversion/portability options may be available	Customer Service Team (877) 236-7564

Appendix A: COBRA Continuation

Discovery Benefits, LLC TEST
PO Box 2079
Omaha, NE 68103-2079

9/29/2020

Jane Doe & Family
123 1st street
Fargo, ND 58102

Dear Jane Doe & Family:

GENERAL NOTICE OF YOUR RIGHTS
GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

THIS LETTER IS FOR YOUR INFORMATION ONLY. PLEASE RETAIN FOR FUTURE REFERENCE.
THERE HAS NOT BEEN A CHANGE IN YOUR STATUS WITH YOUR COMPANY.

This letter contains important information about your employee benefits plan(s). Please read the entire letter.

On April 7, 1986, a federal law called COBRA was enacted (Public Law 99-272, Title X), requiring that most employers sponsoring group health plans offer employees and their families (qualified beneficiary/ies) the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights as a qualified beneficiary and obligations under COBRA. Both you and your spouse, if applicable, should take the time to read this notice carefully. This notice does not fully describe COBRA or other rights under the Discovery Studios group health plan ("Group Health Plan"). For additional information you should review the Group Health Plan's Summary Plan Description or contact the Discovery Studios Plan Administrator at (701) 555-5555. Also, you may visit the Department of Labor website (www.dol.gov) for more information on COBRA.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

QUALIFYING EVENTS
If you are an employee of Discovery Studios covered by the Group Health Plan, you have a right to choose COBRA if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the Group Health Plan, you have the right to choose COBRA for yourself if you lose group health coverage under the Group Health Plan for any of the following reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with Discovery Studios;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by the Group Health Plan, he or she has the right to choose COBRA if the Group Health Plan is lost for any of the following reasons:

1. The death of the parent-employee;
2. A termination of the parent-employee's employment (for reasons other than gross misconduct) or reduction in the parent-employee's hours of employment with Discovery Studios;
3. The parent-employee's divorce or legal separation;

4. The parent-employee became entitled to Medicare prior to his/her qualifying event; or
5. The dependent child ceases to be a dependent child under the Group Health Plan.

Children born to or adopted by a covered employee during the continuation coverage period may also elect continuation coverage, provided that the covered employee has elected COBRA coverage for himself or herself. The coverage period will be determined according to the date of the qualifying event that resulted in the covered employee's COBRA coverage.

Sometimes, filing a bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Discovery Studios and that bankruptcy results in the loss of coverage of any retired employee under the Group Health Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Group Health Plan.

COVERAGE PROVIDED
Under COBRA, the employee or a family member has the responsibility to inform the Discovery Studios Plan Administrator at (701) 555-5555 of a divorce, legal separation, or a child losing dependent status under the Group Health Plan within 60 days of the later of (1) the date of the qualifying event or (2) the date on which coverage would be lost as a result of the qualifying event.

If notification is not made within 60 days after the applicable qualifying event occurs or if you do not timely provide any additional documentation or information (if requested) in a timely manner, your notification will be rejected and COBRA coverage will not be offered.

Discovery Studios has the responsibility to notify the COBRA administrator of the employee's death, termination, and reduction in hours of employment or Medicare entitlement. Once the plan receives notice that a qualifying event has occurred, COBRA coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA coverage for 60 days from the later of the date coverage is lost under the plan or the date of notification to elect COBRA coverage. Covered employees may elect COBRA coverage on behalf of their spouse, and parents may elect COBRA coverage on behalf of their eligible dependent children. If a qualified beneficiary does not elect COBRA/continuation coverage within this period, the right to COBRA/continuation coverage will terminate.

If you elect COBRA, Discovery Studios is required to give you and your covered dependents, if any, coverage that is identical to the coverage provided under the plan to similarly situated employees or family members. Under COBRA, you may have to pay all or part of the premium for your continuation coverage.

PERIOD OF COVERAGE
COBRA requires that you be afforded the opportunity to maintain coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required COBRA period is 18 months.

The 18-month period may be extended to 29 months if an individual is determined by the Social Security Administration (SSA) to be disabled (for Social Security purposes) at any time during the first 60 days of COBRA coverage or before COBRA coverage began and you are still disabled at the end of the original maximum continuation period of coverage (generally 18 months). To benefit from this extension, a qualified beneficiary must notify Discovery Benefits, LLC TEST at (866) 451-3399 of that determination within 60 days of the later of (1) the date the qualified beneficiary is determined to be disabled by the Social Security Administration; (2) the date of the qualifying event; and (3) the date on which the qualified beneficiary would lose coverage because of the qualifying event, and before the end of the original 18-month period.

If the above notification is not made within 60 days of the date of the disability determination made by the Social Security Administration and before the end of the 18-month period of COBRA/continuation coverage, or if you do not provide the additional documentation or information (if requested) in a timely manner, your notification will be rejected and any additional COBRA/continuation coverage beyond the original 18-month period will not be offered.

The affected individual must also notify the Discovery Benefits, LLC TEST within 30 days of any final determination that the individual is no longer disabled.

SECOND QUALIFYING EVENT EXTENSION

If the original event causing the loss of coverage was a termination (other than for gross misconduct) or a reduction in hours, another extension of the 18-month continuation period may occur, if during the 18 months of COBRA coverage, a qualified beneficiary experiences certain secondary qualifying events:

1. Divorce or legal separation
2. Death
3. Medicare entitlement
4. Dependent child ceasing to be a dependent

You will be required to have certain information available about your qualifying event, including: the type of qualifying event (divorce, legal separation, losing dependent coverage); the date of the divorce, legal separation or dependent losing coverage; the name and Social Security number of the covered employee; and the name, address and Social Security number of the covered spouse or dependent who is losing coverage.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage for his spouse and eligible dependents can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA coverage can be extended.

If a second qualifying event does take place, COBRA provides that the qualified beneficiary may be eligible to extend COBRA up to 36 months from the date of the original qualifying event. If a second qualifying event occurs, it is the qualified beneficiary's responsibility to inform the Discovery Studios Plan Administrator within 60 days of the event. In no event, however, will COBRA last beyond three years from the date of the event that originally made the qualified beneficiary eligible for COBRA. If COBRA coverage is elected, the coverage previously in effect will generally be continued. From time to time, some changes in coverage are possible. For example, benefits and cost will be modified as regular changes are made to the plan. Once you make your election, you will have up to 45 days to pay your first COBRA coverage premium, which will include any make-up premiums you missed. COBRA coverage will be effective the day after the qualifying event or the last day of active coverage, whichever is later. Premiums will be equal to the entire cost of the coverage, with an additional two percent to cover administrative expenses.

If the above notification is not made within 60 days after the second qualifying event occurs or if you do not provide any additional documentation or information (if requested) in a timely manner, your notification will be rejected and any additional COBRA coverage beyond the original 18- (or 29-) month period will not be offered.

SPECIAL RULE FOR HEALTH FSAs

COBRA coverage under the Discovery Studios Health FSA will be offered only to qualified beneficiaries losing coverage that have under-spent accounts. A qualified beneficiary has an under-spent account if the annual limit elected by the covered employee, reduced by reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for the Discovery Studios Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Discovery Studios Health FSA coverage in force at the time of the qualifying event. The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and the COBRA coverage for the FSA plan will terminate at the end of the plan year.

Unless otherwise elected, all qualified beneficiaries who were covered under the Discovery Studios Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact Discovery Benefits, LLC TEST at (866) 451-3399 during business hours for more information.

SPECIAL RULE FOR EMPLOYEES IN THE UNIFORMED SERVICES

If you are an employee and your coverage under the plan terminates due to your service in the uniformed services, you may elect special continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) for yourself and your covered spouse and covered dependents. This special continuation of coverage may extend for up to 24 months beginning from the date your plan coverage would otherwise terminate due to your service in the uniformed services. Service in the uniformed services includes your performance of duty on a voluntary or involuntary basis in the Armed Forces (including the Coast Guard and the Reserves), the Army National Guard, the Air National Guard, and the commissioned corps of the Public Health Service. If you believe this special continuation of coverage rule applies to you, please contact your human resources contact at your employer.

ALTERNATE RECIPIENTS UNDER QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by Discovery Studios during the covered employee's period of employment with Discovery Studios is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

PLAN CONTACT INFORMATION

To ensure that all covered individuals receive information properly and timely, it is important that you notify our Customer Service Department at (866) 451-3399 of any change in dependent status or any address change of any family member as soon as possible. Certain changes must be submitted to us in writing. You should keep a copy, for your records, of any notices you send. Failure on your part to notify us of any changes may result in delayed notification or loss of continuation of coverage options.

OTHER COVERAGE OPTIONS

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

ENROLLMENT IN MEDICARE

In general, if you don’t enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of the month after your employment ends or the month after group health plan coverage based on current employment ends. For more information visit https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you don’t enroll in Medicare Part B and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

If you have any questions about COBRA, please contact our Customer Service Department at (866) 451-3399 during business hours.

Sincerely,

Appendix B: Medicare Part D

Medicare Part D Notice

Important Notice from Affirm, Inc. About
Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Affirm, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Affirm, Inc. has determined that the prescription drug coverage offered by the Affirm, Inc.Welfare Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your Affirm, Inc. coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Affirm, Inc. Welfare Benefits Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Affirm, Inc. prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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

You should also know that if you drop or lose your current coverage with Affirm, Inc. Welfare Benefits Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Affirm, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	1/1/2021
Name of Entity/Sender:	Affirm, Inc.
Contact-Position/Office:	Human Resources
Address:	650 California Street, 12th Floor San Francisco, CA 94108
Contact email:	benefits@affirm.com

Appendix C: Cafeteria Plan and FSA Provisions

Affirm Program Policy

J Written by Jenn Kim
Updated over a week ago

Last Updated 4/21/2021
Program policy is effective starting 1/1/21

What is Twic?

Affirm's goal in 2021 is to meet employees where they are, which is why we're partnering with Twic!

Twic is a platform that gives employees the freedom to choose health and wellness options that are right for them. We have personalized our Twic experience to meet Affirmers' needs and asks.

There are five wallet categories:

1. **Technology Wallet**
2. **Food Wallet**
3. **Lifestyle Wallet**
4. **S.A.F.E. Journey Wallet (Surrogacy, Adoption, Fertility and Egg Freezing)**
5. **ERG Wallet** (only applicable for ERG Leads)**

Within the platform, you will have a bird's eye view of your wallet accounts. If you click into a specific account, you can review current balance, expiration date, and past transactions for quick tracking.

You do not need to be insured through Affirm to be able to use the Twic Digital Wallets. Your Twic account will be activated on January 1, 2021, or on the date of hire. To access your Twic account, you can either use OneLogin SSO, or additionally, there is an app for Apple and Android devices. You can find the app on the App Store or on Google Play by searching "Twic."

Affirm's Product Testing Stipend still exists separately from the Wallet program. You may use a Wallet to make up the difference for an acceptable expense.

Frequently Asked Questions can be found at the bottom of this document.

Eligible Expenses

Please review this list of acceptable expenses for the wallets. This list is dynamic and what is considered an acceptable expense can change. The list will be updated accordingly as changes occur. Affirm reserves the right to change any and all eligible expenses. If there is abuse of the policy, Twic will lock the account. If the account is locked, you will have to reach out to Twic support for assistance.

Note: under the list of acceptable expenses for wallets, there are examples listed to demonstrate different products/services eligible under the subcategory. The examples listed aren't meant to be conclusive. If you have any questions about a product or service's eligibility, please reach out to Twic support via live chat or support@twic.ai.

Ineligible Expenses

The purchase of weapons of any kind, gift cards, or contributions to charities or political donations are all ineligible expenses. Affirm reserves the right to change any and all ineligible expenses. Please note that this is a company sponsored benefit, and if there is abuse of the policy, Twic will lock the account. If the account is locked, you will have to reach out to Twic support for assistance.

Who is Eligible?

Full-time, part-time**, and interning** Affirm employees are eligible to participate in the programs. You must be employed by Affirm when eligible expenses are incurred (paid for).

USA (USD)

	Tech Wallet	Lifestyle Wallet	Food Wallet	S.A.F.E. Wallet
Full-Time Employee 33 - 40 hours/week	$200/month *$600 cap*	$250/month *$2,500 cap*	$220/month *Renews monthly*	$20,000 *Lifetime amount*
Part-Time Employee 24-32 hours/week	$100/month *$300 cap*	$125/month *$1,250 cap*	$110/month *Renews monthly*	*Not Eligible*
Intern	$200/month *$600 cap*	*Not Eligible*	$220/month *Renews monthly*	*Not Eligible*

Canada (CAD)

	Tech Wallet	Lifestyle Wallet	Food Wallet	S.A.F.E. Wallet
Full-Time Employee 33 - 40 hours/week	$190/month *$570 cap*	$240/month *$2,400 cap*	$210/month *Renews monthly*	$19,000 *Lifetime amount*
Part-Time Employee 24-32 hours/week	$95/month *$285 cap*	$120/month *$1,200 cap*	$105/month *Renews monthly*	*Not Eligible*
Intern	$190/month *$570 cap*	*Not Eligible*	$210/month *Renews monthly*	*Not Eligible*

You can use your discretion in who you share your Twic card information with as long as it's within your household and on eligible dependents (e.g: yourself and/or your partner and/or family that lives with you).

Twic will accept claims from your account with receipts that include your family member's or roommate's name on it, in good faith that the purchase still supports and benefits you in some way.

Program Administration

Twic is the administrator for the Technology, Lifestyle, Food, and S.A.F.E. Journey programs. For general FAQs, please refer to the help center. You can reach Twic's Member Experience Team by emailing support@twic.ai or through the live-chat feature directly in your Twic account.

How do the wallets work?

Eligible employees will receive stipends for each wallet in their Twic accounts (see below for the details of each wallet). You may spend the stipend through any of the three following ways:

1. Twic Store
2. Twic Card (U.S.-only)
3. Reimbursement Claims

For purchases that are more expensive than the amounts in your wallet, Twic will prioritize using wallet funds, followed by using your personal card to cover the remainder of the expense.

For purchases that require two wallets, this is easiest explained through an example: Let's say you have your eye on a particular keyboard, but you don't have enough

funds in your Technology Wallet. This purchase is an acceptable expense on your Technology Wallet and Lifestyle Wallet, so you want to use funds from both accounts.

You have a few options:

1. **Pay with your own card**, followed by submitting a claim within Twic. Please save your receipt for the purchase(s), and upload to your Twic profile. The Twic team will reimburse you by pulling the available funds from your Technology Wallet, followed by your Lifestyle Wallet.
2. **Use your Twic card**, which is intelligent enough to use the funds from your Technology Wallet and Lifestyle Wallet.

Lastly, you can use a combination of your Twic card and personal card if you are shopping at the Twic Store to take advantage of discounts. If you don't have enough funds in your wallet, you can put the rest on your personal card.

Twic Store

On your dashboard, you will see a collection of vendors, products, and services that are available to you. Twic negotiates competitive rates with these vendors to bring better rates to you. You'll save on average 20-30% off of retail price, from gym memberships to wearable technology. Everything you see is already an eligible expense – submitting a reimbursement receipt is not required!

Twic Card (U.S.-only)

This is a pre-programmed debit card that Twic can issue to you upon request. All of your wallets are linked to one physical card. You can use the card as you normally would at the register, and it is intelligent enough to draw funds from the appropriate wallet.

Reimbursement Claims

You may love your credit card rewards! Or potentially you would just like to use your own payment method. If you prefer to use your own card, you can pay out of pocket followed by submitting a new claim within Twic. Retain your receipt, fill out details about the transaction, and submit the claim. The Twic team will review the transaction and reimburse you based on funds in your account.

If your request for reimbursement is approved, the amount of your reimbursement will be paid to you via payroll.

The date of purchase OR date of service OR date of payment installment must be on or after 1/1/2021 in order to be eligible for reimbursement.

- For the Tech, Lifestyle wallets, you must submit reimbursement claims within 30 days of purchase, service or 30 days of installment payment.
- For the S.A.F.E. Journey wallet, you must submit reimbursement claims within 120 days of purchase, payment, or service.
- For the Food wallet, you must submit reimbursement claims within the month of purchase. Remember, the Food wallet refreshes each month, so make sure you use it and submit your claim before the 1st of the next month!

Once approved, the reimbursements will arrive in your paycheck once each month based on the timeline below:

Example Claim Submission Date	**Expected Payout**
Jan 1 to Jan 10	Jan 31
Jan 11 to Jan 25	Feb 15
Jan 26 to Feb 10	Feb 28
Feb 11 to Feb 25	Mar 15
Feb 26 to Mar 10	Mar 31
Mar 11 to Mar 25	Apr 15
Mar 26 to Apr 10	Apr 30
Apr 11 to Apr 25	May 15
Apr 26 to May 10	May 30

In general, if your claim is approved between the 11th and 25th of the current month, you will be reimbursed in the first paycheck of the following month. If your claim is approved between the 26th and 10th, you will be reimbursed in the second paycheck of the following month. As an example, if your claim is approved on March 3rd, you should expect to see the reimbursement in your March 31st paycheck. If your claim is approved on March 23rd, you should expect to see the reimbursement in your April 15th paycheck.

You may also set up a Recurring Reimbursement Claim for big ticket items or services that exceed the amount in your wallets, such as a large exercise equipment purchase. Once you set up a recurring reimbursement, you will be auto-reimbursed every 30 days from the claim approval date. Please refer to this article for additional information and details.

Tax Treatment

As required by IRS regulations (see IRS Publication 15-B), Affirm treats this program as a taxable fringe benefit. You will only be taxed on the amount you receive under the program, and the amount will be included in your income for tax reporting and withholding purposes. Accordingly, there are some tax costs to you associated with your participation in this program. The Technology Wallet is not taxed. The Food Wallet, Lifestyle Wallet, and S.A.F.E. Journey Wallets are taxed according to IRS regulations. You'll see it as an Earnings on your paycheck and that amount will be taxed, similar to the way our current reimbursements operate (e.g., fitness).

Acknowledgment

Participation in these programs is voluntary. By participating, you acknowledge that you are opting into this Program. Further, you acknowledge that Affirm will not endorse or verify the credentials, health and safety, and price of any services you receive using the program. If you elect to participate in this program, you are responsible for ensuring a safe, healthy, and affordable program.

Termination Policy

If you have an active membership or subscription (ie: a monthly Classpass membership via Twic) at the time you terminate employment, the membership or subscription will stay active until the current billing cycle ends. You may find information on the billing cycle in the Settings section under Subscriptions or reach out to Twic's Member Experience Team for this information. Your eligibility to participate in the programs end on the day of your termination and you will no longer be eligible to participate or submit reimbursement claims.

Technology Wallet

The Technology Wallet can be used for cell phone bills, internet bills, and work from home equipment.

Benefit Amount

Full-time and interning Affirm employees will receive a stipend of $200 USD ($190 CAD) per month starting 1/1/21, or date of hire, for any eligible technology-related expenses. Any unused amounts will roll over onto the next month but will cap at $600 USD ($570 CAD), at which point employees must spend down their balance to accrue. New hires who start after 1/1/21 will receive $200 USD ($190 CAD) for immediate funding in their Twic accounts.

Part-time Affirm employees (part time employees at Affirm are defined as employees who work between 24-32 hours a week) will receive a stipend of $100 USD ($95 CAD) per month starting 1/1/21, or date of hire, for any eligible technology-related expenses described below. Any unused amounts will roll over onto the next month but will cap at $300 USD ($285 CAD), at which point employees must spend down their balance to accrue. New hires who start after 1/1/21 will receive $100 USD ($95 CAD) for immediate funding in their Twic accounts.

Claim Deadline

You must submit reimbursement claims within 30 days of purchase, 30 days of service, or 30 days of installment payment (if using Affirm). As an example, if you purchased an item or service on January 15th, you would need to submit your reimbursement claim by the last day of February.

Technology Wallet Eligible Expenses

Please find the full list of eligible expenses for the Technology wallet here.

Affirm Company Phone Policy

The policy allows for employees to be able to request additional funds if extraordinary circumstances arise that a tech expenditure is incurred that surpasses the amount provided (e.g., international cell plan to access work emails while traveling abroad).

Affimers will have access to company-provided cell phones in conjunction with the Technology Wallet. Affirmers will be allowed both, and can request a company-provided cell phone through Affirm's IT department if needed.

Termination Policy

If you have an active membership or subscription (ie: a monthly Classpass membership via Twic) at the time you terminate employment, the membership or subscription will stay active until the current billing cycle ends. You may find information on the billing cycle in the Settings section under Subscriptions or reach out to Twic's Member Experience Team for this information. Your eligibility to participate in the programs end on the day of your termination and you will no longer be eligible to participate or submit reimbursement claims.

Lifestyle Wallet

The Lifestyle Wallet can be used for fitness, mental health, L&D, wellness, financial wellness, legal fees, pet insurance, and more. We purposely made this wallet very flexible to allow us to meet Affirmers where they are.

Benefit Amount

Full-time Affirm employees will receive a stipend of $250 USD ($240 CAD) per month starting 1/1/21, or date of hire, for any eligible lifestyle-related expenses. Any unused amounts will roll over onto the next month but will cap at $2,500 USD ($2,400 CAD), at which point employees must spend down their balance to accrue.

Part-time Affirm employees will receive a stipend of $125 USD ($120 CAD) per month starting 1/1/21, or date of hire, for any eligible lifestyle-related expenses described below. Any unused amounts will roll over onto the next month but will cap at $1,250 USD ($1,200 CAD), at which point employees must spend down their balance to accrue.

Claim Deadline

You must submit reimbursement claims within 30 days of purchase, 30 days of service, or 30 days of installment payment (if using Affirm). As an example, if you purchased an item or service on January 1st, you would need to submit your reimbursement claim by January 30th.

Lifestyle Wallet Eligible Expenses

Please find the full list of eligible expenses for the Lifestyle wallet here.

Termination Policy

If you have an active membership or subscription (ie: a monthly Classpass membership via Twic) at the time you terminate employment, the membership or subscription will stay active until the current billing cycle ends. You may find information on the billing cycle in the Settings section under Subscriptions or reach out to Twic's Member Experience Team for this information. Your eligibility to participate in the programs end on the day of your termination and you will no longer be eligible to participate or submit reimbursement claims.

Programs not used with Twic

The following programs are available to Affirmers at no additional cost and should not be expensed under the Lifestyle program:

- OneMedical: All Affirmers and eligible dependents enrolled in **Blue Shield plans** receive free membership
- Spring Health: Affirmers and dependents aged 13+ are eligible for either: **6** free virtual therapist visits, or **4** free virtual therapist visits & **2** virtual physician visits
- RocketLawyer: Affirmers are eligible for RocketLawyer access at no-cost
- Maven Clinic: Affirmers and their partners have free, unlimited access to Maven.
- Homeroom: Affirm offers interactive learning experiences with remote, certified teachers through Homeroom. Classes for Affirmer's families are available at no cost to Affirmers.
- CrisisTextLine: This is a free resource available to Affirmers who are in need of immediate assistance with a mental health crisis

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Food Wallet

The Food Wallet can be used for delivery services (DoorDash, Grubhub, Instacart etc.), meal services (Blue Apron, Home Chef, etc.), as well as the grocery store.

Benefit Amount

Full-time and interning Affirm employees will receive a stipend of $220 USD ($210 CAD) per month starting 1/1/21, or date of hire, for any eligible food-related expenses. Your balance will renew every month and any unused funds will not roll over.

Part-time Affirm employees will receive a stipend of $110 USD ($105 CAD) per month starting 1/1/21, or date of hire, for any eligible food-related expenses described below.

Your balance will renew every month and any unused funds will not roll over.

The approach we take on this wallet will be dynamic and contingent on the state of Affirm as a remote-first business. Eligibility and/or amount of the wallet may shift as employees return to offices.

Claim Deadline

You must submit reimbursement claims by the last day of each month.

Food Wallet Eligible Expenses

Please find the full list of eligible expenses for the Food wallet here.

Termination Policy

If you have an active membership or subscription (ie: monthly Classpass membership via Twic) at the time you terminate employment, the membership or subscription will stay active until the current billing cycle ends. You may find information on the billing cycle in the Settings section under Subscriptions or reach out to Twic's Member Experience Team for this information. Your eligibility to participate in the programs end on the day of your termination and you will no longer be eligible to participate or submit reimbursement claims.

S.A.F.E. (Surrogacy, Adoption, Fertility, Egg Freezing) Journey Wallet

The S.A.F.E Journey Wallet can be used on eligible expenses such as adoption, surrogacy, egg freezing and/or fertility programs.

This wallet can be used with or without Maven. Affirm has partnered with Maven to provide you and your partners with free, unlimited access to Maven, which offers on-demand virtual support for women's and family health.

Benefit Amount

Full-time Affirm employees are granted a lifetime stipend of $20,000 USD ($19,000 CAD) total for expenses related to surrogacy, adoption, fertility, and egg freezing starting 1/1/21, or date of hire, for any eligible family planning support-related expenses.

Claim Deadline

You must submit reimbursement claims within 120 days of purchase, or 120 days of service. As an example, if you purchased an item or service on January 1st, you would need to submit your reimbursement claim by April 30th.

Expense Verification & Approval Process

To ensure that your treatment, service, or product is eligible under Affirm's S.A.F.E. Journey program, please follow the below steps:

1. Receive a quote for a service eligible under the S.A.F.E. Journey program
2. Submit the quote to Twic (via support@twic.ai or live chat in your account) to see if it's a qualified expense
3. Twic will validate the quote
4. When using Twic Card to make eligible purchases, Twic will ask the Affirmer to upload the receipt for the treatment, service, or product
5. If the receipt is verified and it is used for a qualified expense, the transaction will be approved
6. If the receipt is not for a qualified expense, Twic will lock the account
7. If the account is locked, please reach out to Twic support for assistance

S.A.F.E. Journey Eligible Expenses

Please find the full list of eligible expenses for the S.A.F.E. Journey wallet here.
Your eligibility to participate in the programs end on the day of your termination and you will no longer be eligible to participate or submit reimbursement claims.

Termination Policy

If you have an active membership or subscription (ie: a monthly Classpass membership via Twic) at the time you terminate employment, the membership or subscription will stay active until the current billing cycle ends. You may find information on the billing cycle in the Settings section under Subscriptions or reach out to Twic's Member Experience Team for this information. Your eligibility to participate in the programs end on the day of your termination and you will no longer be eligible to participate or submit reimbursement claims.

ERG Wallet

The ERG Wallet can be used for DEI related learnings that improve role performance as an ERG lead or for future growth. This wallet is only applicable and available for ERG leads. You must get approval from your manager before utilizing the ERG wallet.

Benefit Amount

Affirm employees that are ERG Leads are granted a yearly stipend of $1,500 USD ($1,400 CAD) total annually for expenses related to DEI related learnings that improve role performance as an ERG lead or for future growth. This wallet is only applicable and available for ERG leads, starting 1/1/21, or date of hire, for any eligible DEI Learning and Development expenses.

Claim Deadline

You must submit reimbursement claims within 30 days of purchase, 30 days of service, or 30 days of installment payment (if using Affirm). As an example, if you purchased an item or service on January 1st, you would need to submit your reimbursement claim by January 30th.

ERG Wallet Eligible Expenses

Please find the full list of eligible expenses for the ERG wallet here.

Termination Policy

If you have an active membership or subscription (ie: a monthly Classpass membership via Twic) at the time you terminate employment, the membership or subscription will stay active until the current billing cycle ends. You may find information on the billing cycle in the Settings section under Subscriptions or reach out to Twic's Member Experience Team for this information. Your eligibility to participate in the programs end on the day of your termination and you will no longer be eligible to participate or submit reimbursement claims.

Frequently Asked Questions

What is Twic?

Twic is a platform that gives employees the freedom to choose health and wellness options that are right for them. We have personalized our Twic experience to meet Affirmers' needs and asks.