2022
BENEFITS SUMMARY

affirm

Fresh Look on Benefits

January 2022 – December 2022

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MEDICARE PART D NOTICE

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 Important Notices section for more details.

Welcome to your 2022 Benefits Guide

This guide is an overview

The benefits in this summary are effective **January 1, 2022** through **December 31, 2022**.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

This guide is about your benefits, but it's also about you and how to protect your health, your lifestyle, your future, and the people who are important to you.

You'll find details about your healthcare, life, disability and time off benefits and tips on how to use your benefits.

You will also discover the programs that Affirm, Inc. provides to help you save time and money, and balance your work and home life.

The Affirm Philosophy

Healthy and supported employees are foundational to building high performing and inclusive teams.

COMPETITIVE & RELEVANT offer competitive and patient-first benefits/perks that reflect our diverse employees

DYNAMIC & SUSTAINABLE continuously evaluate and update our programs to provide individual flexibility that are inclusive of the needs of our diverse population

SIMPLER IS BETTER reduce friction that prevents employees from effectively and proactively managing their health

Your Monthly Benefits Costs

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

You'll pay $0 in premiums across all Affirm medical, dental, and vision plans.

	Kaiser HMO	Cigna OAP	Cigna OAPIN
EMPLOYEE ONLY *(Affirm's average monthly contribution: $575.00)*	$0	$0	$0
EMPLOYEE + SPOUSE *(Affirm's average monthly contribution: $1,325.00)*	$0	$0	$0
EMPLOYEE + CHILDREN *(Affirm's average monthly contribution: $980.00)*	$0	$0	$0
EMPLOYEE + FAMILY *(Affirm's average monthly contribution: $1,670.00)*	$0	$0	$0

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax*. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify Affirm, Inc. if your domestic partner is your tax dependent.*

Your Monthly Benefits Costs

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

You'll pay $0 in premiums across all Affirm medical, dental, and vision plans.

	Dental (Delta Dental)	Vision (VSP)
EMPLOYEE ONLY *(Affirm's average monthly contribution: $60.00)*	$0	$0
EMPLOYEE + SPOUSE *(Affirm's average monthly contribution: $105.00)*	$0	$0
EMPLOYEE + CHILDREN *(Affirm's average monthly contribution: $135.00)*	$0	$0
EMPLOYEE + FAMILY *(Affirm's average monthly contribution: $225.00)*	$0	$0

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax*. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify Affirm, Inc. if your domestic partner is your tax dependent.*

Who's Eligible for Benefits?

Employees

You are eligible for our core benefits program if you are a regular full-time or part-time employee working 24 or more hours per week.

Refer to "Benefits Eligibility" later in this guide for details.

Eligible dependents

- Legally married spouse or same or opposite gender registered domestic partner
- Natural, adopted or step children up to age 26. Domestic partner's child(ren) are eligible.
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the benefit booklets for each benefit.

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the Date of Hire as long as you enroll within 30 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

Enrolling in Benefits

UltiPro is an online system that enables you to make all your benefit decisions in one place.

Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

Getting started

- **LOG IN** to : UKG

  Visit UltiPro > Menu > Myself > Life Events > I am a New Affirmer

- **ADD** your personal and dependent information.
- **SELECT** your benefit plans for the coming year.
- **REVIEW** your choices and costs before finalizing.

Changing Your Benefits

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 30 Days after the event.

Have questions about your benefits?

Contact your advocate!

Email
affirmbenefits@alliant.com

Phone
(925) 378-6823

Hours
Monday - Friday
8:00AM - 5:00PM PST

Get help from a Benefit Advocate

Are you getting married and not sure how and when to add your new spouse to your plan? Is your stepchild eligible for your healthcare plan? Do you need help understanding the nuances of an FSA? A Benefit Advocate can help answer these questions and more.

Benefit Advocates are trained benefits experts who can help you understand and use your healthcare and other coverage. Contact your Benefit Advocate for issues such as:

- General benefit questions
- Eligibility and coverage
- Finding a network provider
- Health care claim or billing issues, when warranted
- Coverage changes due to life events (marriage, new child, divorce, etc.).

Claims assistance

If you need claims assistance, you'll need to complete a HIPAA Authorization Form to grant your Benefit Advocate permission to work with your insurer and/or healthcare provider(s) to resolve your claims issues. Permission is granted on a limited time basis to only the individuals listed on the form. The form is revocable at any time. Your Benefit Advocate will provide the form to you when needed.

MEDICAL

OUR PLANS

Kaiser HMO

Cigna OAP

Cigna OAPIN

WHICH PLAN IS RIGHT FOR YOU?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

Do you prefer specific doctors or hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

Consider the bottom line

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

Kaiser HMO

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay.

	In-Network
Annual Deductible	None
Accumulation Period	Time period to incur eligible expenses toward the deductible: Calendar Year
Annual Out-of-Pocket Maximum	$1,500 per individual, up to $3,000 per family
Office Visit	$15 copay for primary care physician or specialist
Chiropractic	$15 copay (coverage limited to 20 visits per calendar year)
Lab and X-ray	No charge
Urgent Care	$15 copay
Emergency Room	$100 copay (copay waived if admitted)
Hospitalization	$250 copay per admission
Outpatient Surgery	$100 copay per procedure
PRESCRIPTION DRUGS	
Deductible	N/A
Out-of-Pocket Maximum	Combined with medical;
Generic	$10 copay
Brand Name	$20 copay
Specialty	20% coinsurance up to $150 per script
Mail Order	100 days supply
Generic	$20 copay
Brand Name	$40 copay

Cigna OAP

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay.

	In-Network Benefits	Out-of-Network Benefits
Annual Deductible	$250 per individual, up to $750 per family	$750 per individual, up to $2,250 per family
Accumulation Period	Time period to incur eligible expenses toward the deductible: Calendar Year	
Annual Out-of-Pocket Maximum	$2,250 per individual, up to $4,500 per family (combined with out-of-network)	$3,500 per individual, up to $7,000 per family
Office Visit	$10 copay for primary care physician or specialist	30% after deductible for primary care physician or specialist
Chiropractic	$25 copay (coverage limited to 20 visits per calendar year combined with out-of-network)	30% after deductible (coverage limited to 20 visits per calendar year combined with in-network)
Lab and X-ray	Lab & x-ray: $10 copay after deductible in center; $35 copay after deductible in outpatient hospital; advance imaging: 10% after deductible in radiology	30% after deductible (coverage limited to $350/day at outpatient hospital)
Urgent Care	$10 copay	30% after deductible
Emergency Room	$150 copay then 10% (copay waived if admitted)	$150 copay then 10% (copay waived if admitted)
Hospitalization	10% after deductible	30% after deductible (coverage limited to $600/day)
Outpatient Surgery	5% after deductible at center; 15% after deductible at outpatient hospital	30% after deductible (coverage limited to $350/day)
Outpatient Mental Health	No charge	No charge
Transgender Health Services	After deductible, copays/coinsurance apply. Patients should work with a Cigna Case Manager to navigate care, find specialized providers, and ensure authorizations are in place for treatment along your journey. Covered services include but are not limited to: • Gender reassignment procedures including prosthetics; hair removal; top, bottom, and facial surgeries; and voice therapy • Hormone therapy and related lab testing • Behavioral counseling and routine medical care	
PRESCRIPTION DRUGS		
Deductible	None	None
Out-of-Pocket Maximum	Combined with medical	Combined with medical
Generic	$10 copay	25% coinsurance up to $250 per script
Brand Name	**Preferred**: $30 copay; **Non-Preferred:** $50 copay	25% coinsurance up to $250 per script
Specialty	30% coinsurance up to $250 per script	25% coinsurance up to $250 per script
Mail Order	90 days supply	N/A
Generic	$20 copay	Not covered
Brand Name	**Preferred**: $60 copay; **Non-Preferred:** $100 copay	Not covered
Specialty	30% coinsurance up to $500 per script	N/A

Cigna OAPIN

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay.

	In-Network
Annual Deductible	None
Accumulation Period	Time period to incur eligible expenses toward the deductible: Calendar Year
Annual Out-of-Pocket Maximum	$1,500 per individual, up to $3,000 per family
Office Visit	$15 copay for primary care physician or specialist
Chiropractic	$25 copay (coverage limited to 20 visits per calendar year)
Lab and X-ray	No charge
Urgent Care	$15 copay
Emergency Room	$100 copay (copay waived if admitted)
Hospitalization	$250 copay per admission
Outpatient Surgery	$100 copay in center; $125 copay in outpatient hospital
Outpatient Mental Health	0% coinsurance both In and OON
Transgender Health Services	After deductible, copays/coinsurance apply. Patients should work with a Cigna Case Manager to navigate care, find specialized providers, and ensure authorizations are in place for treatment along your journey. Covered services include but are not limited to: • Gender reassignment procedures including prosthetics; hair removal; top, bottom, and facial surgeries; and voice therapy • Hormone therapy and related lab testing • Behavioral counseling and routine medical care
PRESCRIPTION DRUGS	
Deductible	N/A
Out-of-Pocket Maximum	Combined with medical;
Generic	$10 copay
Brand Name	**Preferred**: $25 copay; **Non-Preferred:** $40 copay
Specialty	30% coinsurance up to $250 per script
Mail Order	90 days supply
Generic	$20 copay
Brand Name	**Preferred**: $50 copay; **Non-Preferred:** $80 copay
Specialty	30% coinsurance up to $500 per script

Transition Of Care

What is Transition of Care?

With **Transition of Care**, you may be able to continue to receive services for specified medical and behavioral conditions with health care providers who are not in the Cigna network at in-network coverage levels.

This care is for a defined period of time until the safe transfer of care to an in-network provider or facility can be arranged. You must apply for Transition of Care at enrollment, or when there is a change in your medical plan. You must apply no later than 30 days after the effective date of your coverage.

What is Continuity of Care?

With **Continuity of Care**, you may be able to receive services at in-network coverage levels for specified medical and behavioral conditions when your health care provider leaves your plan's network and the immediate transfer of your care to another health care provider would be inappropriate and/or unsafe.

This care is for a defined period of time. You must apply for Continuity of Care within 30 days of your health care provider's termination date. This is the date that they are leaving your plan's network.

How do I apply for Transition of Care/Continuity of Care coverage?

Requests must be submitted in writing, using the Transition of Care/Continuity of Care request form.

This form must be submitted at the time of enrollment, change in medical plan, or when your healthcare provider leaves the Cigna network. It cannot be submitted more than 30 days after the effective date of your plan or your health care provider's termination. After receiving your request, Cigna will review and evaluate the information provided. Then, we will send you a letter informing you whether your request was approved or denied. A denial will include information about how to appeal the determination.

Examples of acute medical conditions that may qualify for Transition of Care / Continuity of Care include, but are not limited to:

1. Pregnancy in the second or third trimester at the **time of the plan effective date** or of the health care provider termination.

1. Pregnancy is considered high risk if mother's age is 35 years or older, or patient has/had:
    - Early delivery (three weeks) in previous pregnancy.
    - Gestational diabetes.
    - Pregnancy induced hypertension.
    - Multiple inpatient admissions during this pregnancy.

3. Newly diagnosed or relapsed cancer in the midst of chemotherapy, radiation therapy or reconstruction.

3. Trauma.

3. Transplant candidates, unstable recipients or recipients in need of ongoing care due to complications associated with a transplant.

3. Recent major surgeries still in the follow-up period, that is generally six to eight weeks.

3. Acute conditions in **active treatment*** such as heart attacks, strokes or unstable chronic conditions.

3. Hospital confinement on the plan effective date (only for those plans that do not have extension of coverage provisions).

3. Behavioral health conditions during active treatment.

***Active treatment** is defined as a provider visit or hospital stay with documented changes in a therapeutic regimen. This is within 21 days prior to your plan effective date or your health care provider's termination date.

Balance Billing Overview

What is Balance Billing?

Balance Billing is when a provider charges you for the difference between the provider's charge and the carrier's allowed amount.

When will you see balance billing apply?

Out-of-network mental health coverage is subject to balance billing.

There's always a possibility that there's a remaining balance because of the allowed amount.

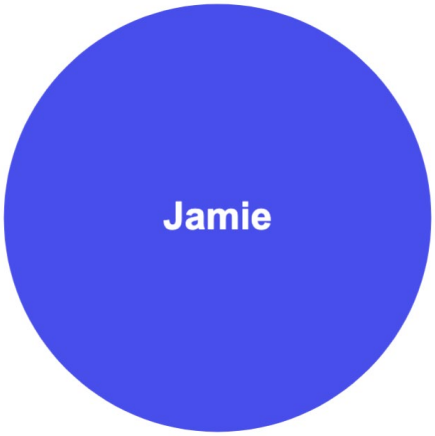
Carriers don't share what the limits are, so it's always good to discuss this possibility with your provider ahead of service.

Scenario A

Jamie has **not reached** their $750 Out-of-Network deductible, so their plan does not pay any of the costs.

Jamie pays 100%. Their plan pays 0%.
Office visit cost: $250

Jamie Pays: $250
Insurance Pays: $0



Scenario B

Jamie **reached** their $750 Out-of-Network deductible, so their plan now pays 100% of the allowable amount.

Jamie pays 0%. Their plan pays 100% of the allowable amount.
Office visit cost: $250
Allowable Amount: $150
Insurance pays 100% of Allowable Amount: $150
Balance Billing: $100 *(difference)*

Jamie Pays: $100
Insurance Pays: $150

Balance Billing

In-Network vs. Out-of-Network

Applied Behavioral Analysis (ABA) Therapy Services Example

In-Network

ABA therapy charges are $800/week but the contracted rate as an in-network provider with Cigna is $550. The provider is obligated to submit claim to Cigna on your behalf and Cigna pays 100% of the $550 rate. You have $0 responsibility since the provider is contracted with Cigna.

Out-of-Network

ABA therapy charges $800/week. There is no Cigna contracted rate since provider is out of network and the provider is not obligated to submit a claim to Cigna on your behalf so you may need to submit an itemized bill to Cigna. Cigna pays 100% of the allowed amount (Maximum Reimbursable Amount). If the Maximum Reimbursable Amount is $550 for the codes billed, the therapist may bill you the balance of $250.

Therapy Appointment Example

In-Network

Your therapist charges $200. The contracted rate as an in-network provider with Cigna is $150. The provider is obligated to submit a claim to Cigna on your behalf and Cigna pays 100% of the $150 rate. You have $0 responsibility since the provider is contracted with Cigna.

Out-of-Network

Your therapist charges $200. There is no Cigna contracted rate since provider is out of network. The provider is not obligated to submit a claim to Cigna, so you may need to submit an itemized bill to Cigna. Cigna pays 100% of the allowed amount (Maximum Reimbursable Amount). If the allowed amount is $150 for the specific procedure being billed, the therapist may bill you the balance of $50.

Healthcare Flexible Spending Account

FSA with Forma

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year.

How the Forma FSA works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to $2,850, the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Estimate carefully!

If you don't spend all the money in your account, you can **roll over up to $570** in 2023.

Due to the COVID-19 stimulus bill there was more flexibility within this program for 2021.

Are you eligible?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Find out more

- Here – now includes more over-the-counter items!
- Ineligible Expenses

Do you pay for dependent care?

Look in the **Financial Wellness** section for information on tax savings through the **Dependent Care FSA**.

FSA TAX SAVINGS EXAMPLE

$60,000 Annual Pay, with $1,500 FSA Contribution

$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings

$120,000 Annual Pay, with $2,750 FSA Contribution

$660 24% Federal income tax	**$210** 7.65% FICA tax	**$870** Annual FSA tax savings

Your tax savings may vary depending on tax filing status and other variables

Know where to go

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	· Identifying symptoms · Decide if immediate care is needed · Home treatment options and advice	24/7	**$0**
Online visit 	Many non-emergency health conditions	· Cold, flu, allergies · Headache, migraine · Skin conditions, rashes · Minor injuries · Mental health concerns	24/7	**$0 - $15 copay**
Office visit 	Routine medical care and overall health management	· Preventive care · Illnesses, injuries · Managing existing conditions	Office Hours	**$10 - $15 copay**
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	· Stitches · Sprains · Animal bites · Ear-nose-throat infections	Office Hours, or up to 24/7	**$10 - $15 copay**
Emergency room 	Life-threatening conditions requiring immediate medical expertise	· Suspected heart attack or · stroke · Major bone breaks · Excessive bleeding · Severe pain · Difficulty breathing	24/7	**$100 - $150 copay per visit (+10% coinsurance for Cigna OAP)**

Alternative facilities

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Need	Alternative	Features	Savings
Surgery 	Ambulatory Surgery Center (ASC)	· Specializes in same-day surgeries · Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more · Held to same safety standards as hospitals	Up to 50% over hospital stay*
Physical therapy 	Free-standing physical therapy center	· Important part of the recovery process after an injury or surgery	40 to 60% over a hospital setting*
Sleep study 	Home testing	· Diagnoses sleep apnea and other conditions · Cost is often covered by insurance if considered medically necessary	Approx. $4,500*
Infusion therapy 	Home or outpatient infusion therapy	· For drugs that must be delivered by intravenous injections, or epidurals · Delivered by licensed infusion therapy provider · Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% over hospital stay* **in-network*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on your plan's website; or call member services for assistance.

Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings. Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

Preventive care screening benefits

Typical Screenings for adults

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit **cdc.gov/prevention** for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

Are prescription drugs breaking your budget?

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Formulary drug tiers determine your cost

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

DENTAL

OUR PLAN

Delta Dental PPO

Why sign up for Dental coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers three types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

Delta Dental PPO

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay.

	In-Network	Out-of-Network
Annual Deductible	$0	$0
Annual Plan Maximum	$2,500	$2,500
Diagnostic & Preventive	No charge	No charge
Basic Services	No charge	No charge
Major Services	40% coinsurance	40% coinsurance
Orthodontia	40% coinsurance Children: Covered Adults: Covered	40% coinsurance Children: Covered Adults: Covered
Ortho Lifetime Max	$3,000	$3,000

Additionally, the 2022 plan...

- Removes the missing tooth clause
- Adds mouth guards
- Adds composite fillings for all teeth
- Adds numbing reversal

VISION

OUR PLAN

VSP Vision

Why sign up for Vision coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK, rebates on contact lenses, and money off on other related services. Visit the plan's website to check out these extra savings.

VSP Vision

Your vision checkup is fully covered in-network. The plan covers frames, lenses, and contacts as described below.

	In-Network	Out-of-Network
Copay	**Exam:** $0 copay **Materials:** $0 copay	**Exam:** Reimbursed up to $50 **Materials:** Reimbursed up to plan allowance
Frames	Coverage limited to $200 per pair (see Second Pair Rider details below), then 80% of remaining balance	Reimbursed up to $70
Lenses	**Single Vision:** No charge **Bifocal:** No charge **Trifocal:** No charge **Progressives**: No charge **Anti-Reflective Coating**: No charge **Anti-Scratch Coating**: No charge **Gradient Lenses**: No charge **High Index**: No charge **Photochromic**: No charge	**Single Vision:** Reimbursed up to $50 **Bifocal:** Reimbursed up to $75 **Trifocal**: Reimbursed up to $100
Contacts (Elective)	Coverage limited to $200 (see Second Pair Rider details below)	Reimbursed up to $105
Frequency	**Exam:** Once every calendar year **Frames:** Once every calendar year **Lenses**: Once every calendar year **Contacts (Elective):** Once every calendar year (in lieu of lenses and frames)	**Exam:** Once every calendar year **Frames:** Once every calendar year **Lenses**: Once every calendar year **Contacts (Elective):** Once every calendar year (in lieu of lenses and frames)

Computer VisionCare Plan

Eye Exam

• An annual, fully covered (less any applicable copay) comprehensive WellVision exam
• Exam specifically designed to detect eye health and vision issues caused by regular computer and digital device use

Eyewear

• Frames and lenses fully covered up to your retail allowance (less any applicable copay)
• Up to 20% savings on your retail frame allowance (less any applicable copay)
• Savings on additional pairs of prescription glasses

Second Pair Rider – Take your pick!

• 1 pair of glasses (up to $200) and 1 set of elective contacts (up to $200) **OR**
• 2 pairs of glasses (up to $200 per pair) **OR**
• 2 sets of elective contact lenses (up to $400)

WELFARE

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, debt, etc.) after the death of a spouse.

We provide short and long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

Life and AD&D Insurance

Prudential

Affirm Provided Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. The cost of coverage is paid in full by the company.

Prudential Basic Life/AD&D

2 x covered annual earnings up to $650,000. Guaranteed issue of $650,000.

The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for details.

Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself.

Prudential Voluntary Life/AD&D

Employee	Increments of $10,000 up to $500,000. Guaranteed issue of Age 15-64: $250,000; age 65-69: $50,000; age 70 and up: $10,000.
Spouse	Increments of $5,000 up to $250,000. Guaranteed issue of Age 15-64: $50,000; age 65-69: $10,000; age 70 and up: $0.
Child(ren)	Increments of $1,000 up to $10,000. Guaranteed issue of $10,000.

WHAT'S GUARANTEED ISSUE?

If you select coverage above a certain limit (the "guaranteed issue") or after your initial eligibility, you will need to provide additional information about your health status in order to qualify for the requested amount of coverage.

A NOTE ABOUT TAXES

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

Short-Term Disability Insurance (STD)

Prudential

EXPECT THE UNEXPECTED

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

STD Benefits

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. Affirm pays the cost of this coverage.

Prudential STD	
Weekly benefit amount	60% up to a maximum of $2,800
Guarantee Issue	$2,800/week
Benefits begin	After 7 days of disability due to accident or 7 days due to sickness
Maximum payment period	12 (based on first day you are disabled, not when benefits begin)

Long-Term Disability Insurance (LTD)

Prudential

3 things to know about LTD insurance

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. Affirm pays the cost of this coverage.

Prudential LTD	
Monthly benefit amount	60% up to a maximum of $15,000.
Guarantee Issue	100% guarantee issue, up to $15,000/month
Benefits begin	After 90 days of disability
Maximum payment period	Social Security normal retirement age; the ADEA I table applies for individuals becoming disabled at age 60+

Accident Insurance (Optional)

Prudential

ACCIDENT INSURANCE

Accident Insurance pays you benefits for specific injuries and events resulting from a covered accident that occurs while you are not at work, on or after your coverage effective date. The benefit amount depends on the type of injury and care received. Accident Insurance is a limited benefit policy. It is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

PRUDENTIAL ACCIDENT INSURANCE	
Hospital Confinement (up to 365 days)	$300 /Day
Hospital Admission	$1,000 /Trip
Transportation	$1,000
Ambulance (Ground/Air)	$200 | $500
Physical Therapy (6 Treatments)	$25

For a complete summary of benefits, reference your Accident Benefit Summary.

	Monthly Rates
EMPLOYEE ONLY	$7.68
EMPLOYEE + SPOUSE	$11.03
EMPLOYEE + CHILDREN	$11.66
EMPLOYEE + FAMILY	$17.88

Critical Illness Insurance (Optional)

Prudential

CRITICAL ILLNESS INSURANCE

Critical Illness Insurance pays a lump-sum benefit if you are diagnosed with a covered illness or condition on or after your coverage effective date. Critical Illness Insurance is a limited benefit policy. It is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

PRUDENTIAL CRITICAL ILLNESS INSURANCE	
Base Module: Heart Attack, Stroke, Major Organ Failure, Coma, Paralysis	100%
Module A: Deafness, Blindness, Benign Brain Tumor	100%
Cancer	Cancer: 100% Carcinoma in SITU: 25% Skin Cancer: $250, payable once per covered person per calendar year

For a complete summary of benefits, reference your Critical Illness Benefit Summary.

Paying for childcare expenses? Make it tax free!

DCFSA with Forma

EVERY OPPORTUNITY TO SAVE
The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up to $5,000 per year tax-free

A dependent care Flexible Spending Account (DCFSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by .

Here's how the Forma FSA works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only child care, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Estimate carefully! *You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.*

Make commuting expenses tax-free, too!

WageWorks

Transportation Savings Account, up to $540 per month tax-free (WageWorks)

Do you have out-of-pocket commuting expenses for public transportation, van pooling, or for worksite parking? If so, you can save on taxes by enrolling in our transportation savings account, administered by WageWorks.

The account lets you set aside money—before it's taxed—through payroll deduction. You may enroll in or stop this program at any time. Money in the account can be used in future months or plan years.

Set aside up to $280 per month for work-related parking expenses and up to $280 per month for work-related commute expenses.

WELLBEING & BALANCE

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, chemical dependency, mental health, fertility, legal, identity theft, and family issues
- Maximize your physical well-being
- Take time to spend with family and friends, take care of personal business, or just have a little extra "me time".

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

Medical Concierge
One Medical

Go to www.onemedical.com/mybenefit and use the company code: AFFXOM to get started with onsite care.

Go to www.onemedical.com/mynow and use the company code: AFFXOM to get started with virtual care.

How Does It Work With My Insurance?

Your standard copay, coinsurance, and deductible apply for in-person visits. However, 24/7 virtual care is completely free — no copay, coinsurance, or additional fees. You do not need to be on the company health plan to be a member.

We're excited to offer free membership to One Medical to all Affirm employees including their dependents who are enrolled in Cigna plans.

Preventive services
Receive focused, tailored attention to reach your health goals, prevent disease, review family medical history and understand what vaccines you may need. Most plans cover 100%.

Primary care
Manage acute and chronic conditions including, anxiety & stress management, cold/flu, digestive disorders, sports injuries, allergies & asthma, diabetes & hypertension, exercise, nutrition, and weight management, women's health, men's health, and travel health.

24/7 virtual care
After your first in-person visit you can use the free mobile app to access a doctor 24/7, anywhere in the world - no claim, copay, coinsurance, or additional fee. Contact a provider anytime by phone, email, or the mobile app.

On-site lab services
After a provider orders you a lab service, trained phlebotomists can draw blood and collect diagnostic samples. No appointment needed. Test results and analysis are emailed to you.

100% dedicated support team
This group of patient service professionals acts as your 'health care hub' to provide you with easy explanations and guidance for insurance, paperwork and billing coordination, and cost-saving solutions to better manage health expenses. Contact them anytime via phone, email, or the mobile app.

Mental Health Resources

Spring Health

Sign up and begin your confidential assessment at affirm.springhealth.com.

You'll need your employee ID handy, which you can find on UltiPro in the employee summary section.

Spring Health is a mental health platform that assists with screening, care navigation and virtual visits with licensed therapists or physicians.

Affirm employees receive up to 6 free virtual visits* with a Spring Health provider after which you'll have the opportunity to purchase more sessions.

Spring Health can help you find the treatment that works best for you. Even if you are feeling great, clinical guidelines recommend an annual wellness screening to make sure all is well. We understand that without help, navigating mental health care benefits can be incredibly confusing. We kicked off this benefit to make sure you have wellness resources that are convenient, user-friendly, and confidential (your individual information is secure and not shared with Affirm).

6 virtual visits with a Spring Health Therapist

OR

4 virtual visits with a Spring Health Therapist & 2 virtual visits with a Spring Health Physician

Fertility Treatment & Parenthood

Maven

Visit mavenclinic.com/join/affirm to learn more

Support at every stage of the journey

Planning, Fertility, Egg Freezing
- Nutritionist plans
- Fertility specialists
- Treatment discounts
- Emotional support

Pregnancy, Post-Partum
- Midwives, OB-GYNs, Doulas
- Birth Planning
- Surrogacy & Adoption Support
- Mental Health Specialist
- Loss Support

Parenting, Pediatrics
- Pediatricians
- Childcare Navigation
- Infant Sleep Coaching
- Back to Work Support
- Behavioral Health Resources

Maven is modern, holistic healthcare through a virtual clinic, including dedicated care advocates and on-demand access to a custom network of providers.

Affirm is partnered with Maven to provide around-the-clock support at every stage of your journey. Maven provides on-demand virtual care, clinically informed content, and a supportive community for planning, starting, and raising a family. Membership is free for Affirm employees and their partners.

Unlimited access to over 20 specialties of women's and family health providers through video chat and messaging

Dedicated Care Advocate who can help you find care, navigate your benefits, and understand your health bills

Personal referrals to high-quality fertility clinics, plus preferred pricing on select treatments

All-in-one pediatrics and behavioral health platform for parents of children up to 10

Financial Wellness
Origin

Visit https://app.useorigin.com to sign up

Questions? Please reach out to hereforyou@useorigin.com

Origin is our new financial wellness partner designed to alleviate the biggest source of stress for employees: Money.

Employees and their partners will have access to Origin's services!

Origin pairs you with your own Certified Financial Planner to develop a customized financial plan that helps you reach your goals.

• You can schedule meetings and message your advisor at **any time**.
• Advisers will be knowledgeable with Affirm's benefits and will be able to advise you on how to take advantage of them based on your personal situation.
• All planners are **fiduciaries**, who are required to give you advice in your best interest.

All-in-One Platform

Employees have access to Origin's **money management tools**, **net worth calculator**, **investment account**, and even manage all of your **equity** in one place.

Assistance with Equity

Origin is able to review and understand your rewards, and develop a strategy that fits your personal financial plan, including:

• Assistance with complete financial plan
• Cash flow & budgeting
• Retirement planning
• Real estate planning
• Tax planning*
• Insurance planning

***Please note**: Employees will not be charged a fee for tax planning, including one state and one federal tax filing. Employees may incur a fee if they have a complex tax circumstance (filing in multiple states, owning an LLC, etc).*

Affirm Sponsored Wallets

Forma

Go to https://www.joinforma.com/ and click on Member Sign In button. You'll be directed to provide login credentials.

Alternatively, go to OneLogin and select the Twic/Forma tile.

Employer-sponsored wallets with Forma give you the freedom to choose health and wellness options that are right for you.

Technology Wallet

- $200 per month will be added to your account
- A max of $600 can be accumulated
- The program policy is available in the portal
- Technology Wallet is not taxed

Food Wallet

- $220 per month will be added to your account
- Amount expires at the end of each month
- Food Wallet is taxed

Lifestyle Wallet

- $250 per month will be added to your account
- A max of $2,500 can be accumulated
- The program policy is available in the portal
- Lifestyle Wallet is taxed

S.A.F.E. Journey Wallet

- S.A.F.E stands for Surrogacy, Adoption, Fertility, Egg Freezing
- $20,000 will be added to your account one-time
- S.A.F.E. Journey Wallet is taxed

Forma Store - From navigation bar, click on Store

- Enjoy up to 30% off of retail
- Automatically verified eligibility
- No reimbursement required

Forma Card - From your profile at the top, click on Settings, then click on Cards

- When you use the Forma Card, no reimbursement is required
- You can request a physical card within the Formaportal
- If you use the Forma Card for a taxable wallets (Food, Wallet, or S.A.F.E.), you will be taxed via payroll.

Claims - From navigation bar, click on Claims

- Always keep the receipts of eligible expenses!
- The Forma team will review the claims within 1-2 days, and you'll get a noticed once the results are in
- You will get reimbursed automatically via payroll reimbursements

Employee Assistance Program (EAP)

Prudential

Contact the EAP phone at (800) 311-4327. You can also visit their website at Guidanceresources.com. Your company WEB ID: GEN311

AVAILABLE AROUND THE CLOCK

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 3
- Unlimited web access to helpful articles, resources, and self-assessment tools.

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Prudential can help you handle a wide variety of personal issue such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; will prep services; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

EDUCATION
- Admissions Testing & Procedures
- Audit Re-entry Programs
- College Planning
- Financial Aid Resources
- Finding a Pre-school

DEPENDENT CARE
- Adoption Assistance
- Before/after school programs
- Day Care/Elder Care
- Elder Care
- In-home Services

WORKING SMARTER
- Career Development
- Effective Managing
- Relocation

LEGAL CONSULTATION
- Basic Tax Planning
- Credit | Collections
- Debt Counseling
- Home Buying
- Immigration

Legal Protection

Rocket Lawyer

Visit go.rocketlawyer.com/affirm Enter your work email address. You will receive an email from Rocket Lawyer. Fill out the form and you are all set!

ARAG Legal

Call 800-247-4184 when you have a legal matter. Customer Care will walk you through your options and help you get connected to network attorneys.

See the complete list of what your plan covers at ARAGlegal.com/myinfo. Access Code: 18723af

ID Theft Protection

Norton Lifelock

Call 800-607-9174 if you ever need assistance or have an identity related question.

A legal benefit from Rocket Lawyer covers a wide range of legal needs like the examples below — and more – to help you address life's legal situations.

Benefits-at-a-Glance
Service: Entitlement
Legal Documents: Unlimited
Ask a Lawyer questions: Unlimited
Attorney Discounts: 40% of hourly rate or as low as $125/hr
Attorney Consultations: Free 30 minute per new legal matter
Document Reviews: 2 per month, up to 10 pages

ARAG provides robust legal benefits, including coverage attorney fees, for you and your family.

Most of us aren't prepared for the unexpected. Legal insurance provides a benefit you can use to plan for it all — the expected and unexpected times in your life.

Legal Protection:	(semi monthly cost)
RocketLawyer	$0.00
ARAG Legal Ultimate Advisor (without divorce)	$8.63
ARAG Ultimate Advisor Plus (with divorce)	$11.63

LifeLock with Norton helps provide peace of mind with comprehensive all-in-one protection for your identity, personal information and connected devices.

Some of the services include: Home Title Monitoring, LifeLock Skill for Amazon Alexa, Credit, Bank & Utility Account Freezes, LifeLock Identity Alert™ System, LifeLock for Norton360 mobile app (Android™ & iOS), Dark Web Monitoring, USPS Address Change Verification, and much more!

ID Theft Protection:	(semi monthly cost)
Employee Only:	$0.00
Employee + Family:	$3.25

Away Days

Review the **Away Days Guide** for a full overview of this benefit!

- Affirm offices will be closed throughout the year on allocated Away Days to observe holidays and provide a companywide break.
- Non-exempt employees regularly scheduled to work on Away Days will be entitled to holiday pay.
- Away Days are subject to change year over year.

Away Day	January. 3, 2022
Away Day	January 17, 2022
Away Day	February 21, 2022
Away Day	February 25, 2022
Away Day	March 21, 2022
Away Break	April 15, 2022 April 18, 2022
Away Day	May 23, 2022
Away Day	May 30, 2022
Away Break	June 16, 2022 June 17, 2022
Away Break	July 1, 2022 July 4, 2022
Away Day	Aug. 1, 2022
Away Break	Sept. 2, 2022 Sept. 5, 2022
Away Break	Oct. 10, 2022 Oct. 11, 2022 Oct. 12, 2022
Away Day	Nov. 24, 2022
Away Break	Dec. 22, 2022 Dec. 23, 2022 Dec. 26, 2022 Dec. 27, 2022
Away Day	Dec. 30, 2022

2022

Away Day No Meeting Day

JANUARY

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FEBRUARY

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MARCH

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APRIL

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MAY

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JUNE

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JULY

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AUGUST

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SEPTEMBER

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OCTOBER

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30	31					

NOVEMBER

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DECEMBER

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*November 8 = Log up to 4 hours of Voting Time Off in US

IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your benefits eligibility
- Your medical, dental and vision benefit contributions for 2022
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

Benefits Eligibility

	Full-Time Exempt & Non-Exempt	Part-Time Benefits Eligible Exempt & Non-Exempt: *Works 24-32 Hours/Week*	Part-Time Exempt & Non-Exempt: *Works less than 24 Hours/Week*	Temporary Employee: Temporary FTE, Intern & Apprentice
Medical Plans	Yes	Yes	No	Yes
Health Waiver Stipend	Yes	No	No	No
Dental Buy-Up	Yes	No	No	No
Vision	Yes	Yes	No	Yes
Affirm paid Welfare	Yes	Yes	No	No
Vol. Life and AD&D, Accident, and Critical Illness	Yes	No	No	No
EAP/Will Prep/Perks	Yes	No	No	No
FSA and DCAP	Yes	Yes	No	No
401k	Yes	Yes	No	No
Commuter Pre Tax Account	Yes	Yes	No	Yes
Commuter Stipend	Office Only	Office Only	No	Office Only
Product Stipend	Yes	Yes	No	Yes
Spring Health	Yes	No	No	No
Office food and drinks, Equipment & IT, and ergonomic assessments	Yes	Yes	Yes	Yes
Forma: Lifestyle	Yes	Yes - at 50% of monthly Contribution	No	No
Forma: Technology & Food	Yes	Yes - at 50% of monthly Contribution	No	Yes
Forma: SAFE	Yes	No	No	No
Forma: Employee Resource Group Lead/Co-Lead $1500 L&D Stipend	ERG Leads/Co-Leads only	No	No	No
Identity Theft (LifeLock)	Yes	No	No	No
Legal Assistance (Rocket Lawyer/ARAG)	Yes	No	No	No

Time Off & Leave of Absence

	Full-Time Exempt	Full-Time Non-Exempt	Part-Time Benefits Eligible Exempt: *Works 24-32 Hours/Week*	Part-Time Benefits Eligible Non-Exempt: *Works 24-32 Hours/Week*	Part-Time Exempt & Non-Exempt: *Works less than 24 Hours/Week*	Temporary Employee: Temporary FTE, Intern & Apprentice
Away Days	Yes	Yes	Y - Paid if it falls on a scheduled work day	Yes - Paid if it falls on a scheduled work day	Yes - unpaid	Yes - unpaid
Flexible Time Off	Yes	No	Yes	No	No	No
Accrued Vacation	No	Yes	No	Yes - Prorated by hours worked/week	No	No
Health Days	Yes	Yes	Yes	Yes	Yes	Yes
Volunteer Time	Yes	Yes	Yes	Yes	No	No
Floating Away Day	No	Yes	No	No	No	Yes - 2 days per internship/ apprenticeship
Bereavement	Yes	Yes	Yes	Yes	Yes	Yes
Life Happens Leave	Yes	Yes	Yes	Yes	Yes	Yes
Jury Duty	Yes	Yes	Yes	Yes	Yes	Yes
Voting Time Off	Yes	Yes	Yes	Yes	Yes	Yes
Parental Leave	Yes	Yes	Yes	Yes	No	No
Medical/Mental Leave	Yes	Yes	Yes	Yes	No	No
Military Leave	Yes	Yes	Yes	Yes	No	No
Work-related Injury Leave	Yes	Yes	Yes	Yes	Yes	Yes
Volunteer Firefighter, Reserve Peace Officer, and Emergency Rescue Personnel	Yes	Yes	Yes	Yes	Yes	Yes
Leave for Victims of Domestic Violence, Sexual Assault, or Stalking	Yes	Yes	Yes	Yes	Yes	Yes
Crime Victim's Leave	Yes	Yes	Yes	Yes	Yes	Yes
Organ and Marrow Donor Leave	Yes	Yes	Yes	Yes	No	No

Plan Contacts

MEDICAL	**Kaiser Medical HMO** Policy #707505 www.kp.org Member Services (800) 464-4000	**Cigna Medical OAPIN/OAP** Policy #3344694 www.cigna.com Member Services 1 (800) 244-6224	**One Medical** Policy #Affixom www.onemedical.com/myhealth Member Services (415) 523-6317
DENTAL	**Delta Dental** Policy #21525 www.deltadental.com Member Services (800) 632-8555		
VISION	**VSP Vision** Policy #0030107186 vsp.com Member Services (800) 877-7195		
WELFARE	**Prudential** Policy #70892 www.prudential.com Member Services, Life, STD, LTD, Critical Illness, Accident 973-548-5277	**SpringHealth** benefits.springhealth.com/affirm	**Maven Clinic** support@mavenclinic.com get.mavenclinic.com/2021
LEGAL / ID THEFT	**ARAG Legal** ARAGlegal.com/myinfo access code: 18723af Member Services (800) 247-4148	**Rocket Lawyer** go.rocketlawyer.com/affirm Member Services (877) 881-0947	**Norton LifeLock** my.norton.com Member Services (800) 607-9174

Glossary

A	**AD&D Insurance** An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.
	Allowed Amount The maximum amount your plan will pay for a covered healthcare service.
	Ambulatory Surgery Center (ASC) A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.
	Annual Limit A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.
B	**Balance Billing** In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference.
	Beneficiary The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.
	Brand Name Drug A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.
C	**COBRA** A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.
	Claim A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.
	Coinsurance Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.
	Copayment A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

D	**Deductible** The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services. Family coverage may have an aggregate or embedded deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.
	Dental Basic Services Services such as fillings, routine extractions and some oral surgery procedures.
	Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.
	Dental Major Services Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.
	Dependent Care Flexible Spending Account (FSA) An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.
E	**Eligible Expense** A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.
	Excluded Service A service that your health plan doesn't pay for or cover.
F	**Formulary** A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.
G	**Generic Drug** A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.
	Grandfathered A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).
H	**Health Reimbursement Account (HRA)** An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.
	Healthcare Flexible Spending Account (FSA) A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

H	**High Deductible Health Plan (HDHP)** A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.
I	**In-Network** In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more, or may not be covered.
L	**Life Insurance** An insurance plan that pays your beneficiary a lump sum if you die.
	Long Term Disability Insurance Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.
M	**Mail Order** A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply
O	**Open Enrollment** The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.
	Out-of-Network Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and OAPINs, do not cover out-of- network services at all.
	Out-of-Pocket Cost A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.
	Out-of-Pocket Maximum Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year. Family coverage may have an aggregate or embedded maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
	Outpatient Care Care from a hospital that doesn't require you to stay overnight.
P	**Participating Pharmacy** A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Glossary (continued)

P	**Plan Year** A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.
	Preferred Drug Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non- preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.
	Preventive Care Services Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.
	Primary Care Provider (PCP) The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.
S	**Short Term Disability Insurance** Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.
T	**Telehealth / Telemedicine / Teledoc** A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.
U	**UCR (Usual, Customary, and Reasonable)** The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.
	Urgent Care Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.
V	**Vaccinations** Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.
	Voluntary Benefit An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

Required Plan Notices

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located on affirm.mybenefits.life:

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

Plan Documents

Important documents for our health plan and retirement plan are available on affirm.mybenefits.life. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- Affirm, Inc. Group Health Plan

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available on affirm.mybenefits.life.

- Kaiser HMO
- Cigna OAP
- Cigna OAPIN

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Affirm, Inc. Group Health Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Determining Eligibility

MONTHLY MEASUREMENT METHOD

The information below explains how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

You and your dependents are eligible for the plan if you are a full-time employee. A full-time employee is generally an employee who works on average 130 hours per month, as defined by the ACA. Hours that count toward full-time status include each hour for which an employee is paid or entitled to payment for the performance of duties for the employer, and each hour for which an employee is paid or entitled to payment for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.

ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. Affirm, Inc. uses the monthly measurement method to determine whether an employee meets this eligibility threshold.