2020
Benefits Information Guide

PFEnex

BEYOND BENEFITS

Health Benefits Solutions for Life Science Industry Employers

Hello!

Welcome to your 2020 Benefits Information Guide.

At Pfenex, we understand the importance of a well-rounded benefits program and are dedicated to providing you with unique benefits that meet the needs of you and your family. We are proud to offer a range of plans that help protect you in the case of illness or injury. This Benefits Information Guide is a comprehensive tool to help you become familiar with the plans and programs that you and your family can enroll in for the plan year.

Enclosed you will find:

- Step-by-step instructions for how to enroll
- Summary information about each medical, dental, and vision benefit option
- Information on additional benefits such as life insurance, employee assistance program (EAP) and many more
- Directory and contact information, in case you have questions

And much more!

We're here to help!

If you have any questions at all, please contact our benefits broker, Marsh & McLennan's Member Support team.

888.434.7703

Member.Support@MarshMMA.com

The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

Getting Started

Your Health

Life & Disability

Work/Life

Resources

Required Notices

Enrollment

Who can Enroll?

If you are an employee regularly working a minimum of 30 hours per week, you are eligible to participate in the benefits program. Eligible employees may also choose to enroll family members, including a legal spouse/registered domestic partner (as legally defined under state and local law) and unregistered domestic partner **(hereinafter referred to as "registered and unregistered domestic partner")** and/or eligible children.

Premiums for registered / unregistered domestic partners who do not meet the tax dependent definition of IRC section 152 for the employee, may be considered taxable income (unregistered domestic partners will not meet the relationship test under IRC section 152). Premiums for children / registered Domestic Partners' step-children under age 26 are not taxable. Premiums for children / stepchildren over age 26 are taxable if not an IRC section 152 tax dependent.

When Does Coverage Begin?

Your enrollment choices remain in effect from January 1, 2020 – December 31, 2020. Benefits for eligible new hires will commence as outlined below:

Eligibility Date	Benefit Plan
The first of the month following or coinciding with your date of hire. You must enroll within 30 days from your hire date.	• Medical • Dental • Vision • Flexible Spending Accounts • Basic Life/AD&D • Short and Long Term Disability • Unum Voluntary Life/AD&D, Voluntary Group Accident plan, and Voluntary Critical Illness with Cancer • WGA Cancer Guardian

You must enroll within 30 days from date of hire

For example, if you were hired on September 19, you will be eligible for benefits on October 1. You must make your benefit elections within the 30 days following September 19.

Action: Employees have an active open enrollment period; you **are required** to actively enroll in your benefits in order to continue coverage. Additionally, per IRS guidelines, you must re-elect contribution amounts to the Flexible Spending Account (FSA) and Health Savings Account (HSA).

How do I Enroll?

PLANSOURCE

PlanSource

To enroll, follow these steps:

- Log on at https://benefits.plansource.com
- Your username is your first name initial, up to six characters of your last name, and the last four digits of your SSN
- If you are initially logging in for the 2020 Open Enrollment or are a new hire, your password is your date of birth in numeric format without any slashes, YYYYMMDD
- You will be asked to create a password when you first log into the system. If you later forgot your password, simply click the **Forgot your password?** link
- Proceed with the remaining prompts to make your benefit selection. Be sure to update your cart each time you make a selection and finalize prior to submitting your elections

What if My Needs Change During the Year?

You are permitted to make changes to your benefits outside of the open enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within **30 days** of the qualified event. Change in status examples include:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Death of a dependent
- You or your spouse's/registered and unregistered domestic partner's loss or gain of coverage through our organization or another employer
- Change in residence affecting eligibility or access
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of qualified status changes, please refer to the "Legal Information Regarding Your Plans" contents.

Do I Have to Enroll?

Although the federal penalty has been reduced to $0, some states have their own state-specific individual mandates, requiring individuals to maintain health coverage or potentially pay a penalty.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as coverage from a State or Federal Health Insurance Exchange.

For information regarding Health Care Reform and the Individual Mandate, please visit www.cciio.cms.gov. You can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.

You may elect to "waive" medical coverage if you have access to coverage through another plan. To waive coverage, you must select the "Decline Coverage" option in PlanSource. It is important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be during open enrollment for the following plan year or if a qualifying status change occurs.

Medical

What are my options?

Use the chart below to help compare medical plan options and determine which would be the best for you and your family.

	HMO	HMO	PPO	HDHP
Network	Priority Select	CACare – Large Group	Prudent Buyer – Large Group	Prudent Buyer – Large Group
Primary Care Physician (PCP) Required	**Yes**	**Yes**	**No**	**No**
Seeing a Specialist	PCP referral required in most cases	PCP referral required in most cases	No referral required	No referral required
Deductible Required	No	No	Yes, in most cases	Yes
Claims Process	Typically handled by providers	Typically handled by providers	PPO network providers will submit claims. You submit claims for other services	PPO network providers will submit claims. You submit claims for other services
Compatible with Health Savings Account (HSA)	No	No	No	Yes
Other Important Tips	• This plan requires that you see a doctor in a specific network to receive coverage. The Priority Select network has fewer providers than the CACare HMO network • Out-of-Network services without proper PCP referral will not be covered • Emergencies covered worldwide	• This plan requires that you see a doctor in a specific network to receive coverage • Out-of-Network services without proper PCP referral will not be covered • Emergencies covered worldwide	• You may choose in or out of network care, however in-network care provides you a higher level of benefit • Emergencies covered worldwide • Out of Network providers will bill the balance to the member for amounts not covered by Anthem	• Although this plan has a higher deductible than most plans, it has lower payroll deductions • The HSA account provides a tax-favored vehicle to help you manage your out-of-pocket expenses • Emergencies covered worldwide • Out of Network providers will bill the balance to the member for amounts not covered by Anthem

Please note the above examples are used for general illustrative purposes only. Please consult with your Human Resources Department for more specific information as it relates to your specific plan. For a detailed view of your medical plan summaries, visit PlanSource.

How to Find a Provider

Before you go to the doctor or receive health care services, make sure your doctor, facility, or specialist is participating in your plan's network. This may ensure you receive the highest level of benefit and could reduce your health care costs. Check out the instructions below to find out how to perform a provider search for your plans. If you require assistance, call Anthem at (844) 909-0364 to speak with a representative.

- Visit www.anthem.com
- Click **Find a Doctor** from the top, right corner
- Scroll down along the page until you see the "Search as a Guest by Selecting a Plan" section and click **Continue**

For Anthem Medical:

1. From the first dropdown, "What type of care are your searching for?" select **Medical**
2. From the next dropdown, "What state do you want to search in?" select the state in which you reside
3. From the dropdown, "What type of plan do you want to search with?" select **Medical (Employer-Sponsored)**
4. From the last dropdown, "Select a plan/network" select from the following:
    - For Classic Priority Select HMO, select **Priority Select HMO** and click **Continue**
    - For Classic HMO, use plan name **Blue Cross HMO (CACare) – Large Group** and click **Continue**
    - For CA PPO and CA HDHP residents, use plan name **Blue Cross PPO (Prudent Buyer) – Large Group** and click **Continue**
    - For Non-CA PPO and Non-CA HDHP residents, use plan name **National PPO (BlueCard PPO)** and click **Continue**

For Anthem Dental:

1. From the first dropdown, "What type of care are your searching for?" select **Dental**
2. From the next dropdown, "What state do you want to search in?" select the state in which you reside
3. From the dropdown, "What type of plan do you want to search with?" select **Dental**
4. From the last dropdown, "Select a plan/network" use network name **Dental Complete**

For VSP Vision:

1. To find a VSP vision provider, visit www.vsp.com and click **Find a Doctor**
2. Expand **View Filters +**
3. From the dropdown, "Doctor Network" **Signature** and click **Apply Filters**
4. Enter parameters and click **Search**

Prescription Drug Coverage

Many FDA-approved prescription medications are covered through Anthem's four-tier prescriptions benefits program. Important information regarding your prescription drug coverage is outlined below:

- Tiered prescription drug plans require varying levels of payment depending on the drug's tier and your copayment or coinsurance will be higher with a higher tier number
- Tier 1 prescriptions offer the greatest value compared to other drugs that treat the same conditions and are often the lowest cost
- Tier 2 drugs are generally brand name with a moderate copayment. Some drugs may also be Tier 2 because they are "preferred" among other drugs that treat the same conditions
- Tier 3 drugs are a higher copayment compared to the lower tiers, as they are higher cost drugs. Some drugs on this list may have a generic counterpart in Tier 1 or Tier 2
- Many drugs on Tier 4 are "specialty" drugs used to treat complex, chronic conditions, and may require special storage or close monitoring

For a current version of the prescription drug lists, go to https://www11.anthem.com/ca/pharmacyinformation/ and select "National Drug List 4-Tier (Searchable)".

WHY PAY MORE?

There are a few ways you can save money when using the Prescription Drug Plan:

Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of a typical 30-day supply at a walk-in pharmacy.

Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. By calling ahead, you may determine which pharmacy provides the most competitive price.

Explore Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive option that serves the same purpose as prescription medications.

Benefits Information on the Go

iBenefits

Available for iOS and Android mobile devices, the iBenefits app makes checking your benefits information easier than ever!

With iBenefits, you can:

- View our company's benefit plans, 24/7, access group numbers and review detailed plan information
- Quickly contact an insurance company
- Store images of your ID cards directly in the app

Download it now from the App Store or Google Play and use our Company Code **pfenex2020** to login to the app.

Anthem's Mobile App, Sydney!

Anthem offers an array of services that can save you time and money, and help you feel your best. Here are a few resources to keep in mind:

- Sydney replaces Anthem's Anywhere app
- More intuitive user experience to view your benefits and access your claims information
- Provides a quick view of your care team and includes an interactive chat feature to give you answers right away
- Find what you need with text-based, real-time responses to questions to avoid having to call Member Services every time

Anthem LiveHealth Online!

With Anthem LiveHealth Online, you can:

- Access an online doctor/ registered physicians visit using two-way video and secure instant messaging 24/7
- Receive care for colds, the flu, allergies, and minor infections
- Avoid scheduling an appointment or sitting in waiting rooms
- Cost to utilize mirrors office visit copay of $15 for the HMO plans, $20 for PPO, and $49 for HDHP

Get started now at livehealthonline.com!

Anthem's Wellness Programs

Health and Wellness Advantage

The Health and Wellness Advantage offered by Anthem, is a collection of support and wellness programs that surrounds you with the tools you need to live healthier, feel better and save money.

Personalized information, 24/7 access to a nurse, and trained health management professionals are all available to help you navigate the health care system and use your benefits wisely. Plus, it's part of your plan at no extra cost. Start by taking a Well-Being Assessment at https://healthandwellness.anthem.com (click **Resources** and select **Health Kits**), which can analyze the choices you make and the steps you can take and include:

- **Tobacco Cessation:** Educational program and a personalized "quit" plan
- **Weight Management:** From dietary education to personal coaching, this program coaches members on how to reach and maintain a healthy weight
- **Stress Management:** Learn how to identify stress triggers and apply proven coping techniques every day
- **Physical Activity:** Set achievable goals and incentives to keep you motivated, healthier and happier
- **Diet & Nutrition:** Learn how to make meaningful changes in your diet, even if you don't need to lose weight
- **myStrength:** A free online and mobile program that supports emotional health and well-being

Diabetes Prevention Program

The Diabetes Prevention Program, administered by Solera Health, is a valuable lifestyle program that can help you and your covered spouses/domestic partners lose weight, adopt healthy habits and significantly decrease the risk of developing type 2 diabetes. Offered at no cost to Anthem CA members who qualify, you will be able to access a lifestyle health coach to help set goals, participate in individual or small group sessions, and use helpful tools along the way such as wireless scales and fitness trackers. To see if you qualify, start by taking a 1-minute quiz at www.solera4me.com/bbt.

Plan Highlights

Anthem Classic Priority Select HMO

	In-Network Only
Provider Network	Priority Select HMO [1]
Calendar Year Deductible	
Individual	None
Family	None
Calendar Year Out-of-pocket Maximum	
Individual	$2,000
Family	$4,000
Lifetime Maximum	
Individual	Unlimited
Professional Services	
Primary Care Physician (PCP)	$15 Copay
Specialist	$25 Copay
Preventive Care Exam	No Copay
Well-baby Care	No Copay
Diagnostic X-ray and Lab	No Copay
Complex Diagnostics (MRI/CT Scan)	$100 Copay / Test
Chiropractic	$15 Copay (Rehabilitation Therapy Only) [2]
Acupuncture	$15 Copay
Therapy, including Physical, Occupational and Speech	$15 Copay / Visit (Limited to 60-day Period of Care)
Hospital Services	
Inpatient	$250 Copay / Admit
Outpatient Surgery	$125 Copay / Admit
Emergency Room	$100 Copay / Visit (waived if admitted)
Urgent Care	$15 Copay / Visit
Maternity Care	
Physician Services (prenatal or postnatal)	$15 Copay / Visit
Hospital Services	$250 Copay / Admit
Mental Health & Substance Abuse	
Inpatient	$250 Copay / Admit
Outpatient	$15 Copay / Visit
Retail Prescription Drugs (30-day supply)	
Tier 1	$10 Copay
Tier 2	$25 Copay
Tier 3	$40 Copay
Tier 4	20% up to $150 per Rx
Mail Order Prescription Drugs (90-day supply)	
Tier 1	$10 Copay
Tier 2	$50 Copay
Tier 3	$80 Copay
Tier 4 (30-day supply only)	20% up to $150 per Rx

[1] **San Diego** –Network includes Greater Tri Cities, Mercy Physicians, Primary Care Associates, Rady Children's, Scripps Clinic, Scripps Coastal, Scripps Physicians, and SIMNSA

Orange County – Network includes Affiliated Doctors of OC Med, AMVI, Daehan Prospect, Family Choice, Fountain Valley IPA, HCP ARTA, Monarch, Noble AMA, and Prospect NWOC

[2] Limited to a 60-day period of care immediately following an illness or injury. PCP referral required.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Plan Highlights	Anthem Classic HMO
	In-Network Only
Provider Network	CACare HMO – Large Group
Calendar Year Deductible	
Individual	None
Family	None
Calendar Year Out-of-pocket Maximum	
Individual	$2,000
Family	$4,000
Lifetime Maximum	
Individual	Unlimited
Professional Services	
Primary Care Physician (PCP)	$15 Copay
Specialist	$25 Copay
Preventive Care Exam	No Copay
Well-baby Care	No Copay
Diagnostic X-ray and Lab	No Copay
Complex Diagnostics (MRI/CT Scan)	$100 Copay / Test
Chiropractic	$15 Copay (Rehabilitation Therapy Only) (1)
Acupuncture	$15 Copay
Therapy, including Physical, Occupational and Speech	$15 Copay / Visit (Limited to 60-day Period of Care)
Hospital Services	
Inpatient	$250 Copay / Admit
Outpatient Surgery	$125 Copay / Admit
Emergency Room	$100 Copay / Visit (waived if admitted)
Urgent Care	$15 Copay / Visit
Maternity Care	
Physician Services (prenatal or postnatal)	$15 Copay / Visit
Hospital Services	$250 Copay / Admit
Mental Health & Substance Abuse	
Inpatient	$250 Copay / Admit
Outpatient	$15 Copay / Visit
Retail Prescription Drugs (30-day supply)	
Tier 1	$10 Copay
Tier 2	$25 Copay
Tier 3	$40 Copay
Tier 4	20% up to $150 per Rx
Mail Order Prescription Drugs (90-day supply)	
Tier 1	$10 Copay
Tier 2	$50 Copay
Tier 3	$80 Copay
Tier 4 (30-day supply only)	20% up to $150 per Rx

(1) Limited to a 60-day period of care immediately following an illness or injury. PCP referral required.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Plan Highlights

Anthem Classic PPO 400

	In-Network	Out-of-Network
Provider Network	CA: Prudent Buyer Large Group Non-CA: National PPO (BlueCard PPO)	Not Applicable
Calendar Year Deductible		
Individual	$400	
Family	$1,200	
Calendar Year Out-of-pocket Maximum [1]		
Individual	$3,500	$7,000
Family	$7,000	$14,000
Lifetime Maximum		
Individual	Unlimited	Unlimited
Professional Services		
Primary Care Physician (PCP)	$20 Copay / Visit	40% [2]
Specialist	$20 Copay / Visit	40% [2]
Preventive Care Exam	No Copay	40% [2]
Well-baby Care	No Copay	40% [2]
Diagnostic X-ray and Lab	20% [2]	40% [2]
Complex Diagnostics (MRI/CT Scan)	20% [2]	40% [2] (limited to $800 / test)
Chiropractic (30 visits / calendar year)	$20 Copay / Visit	40% [2]
Acupuncture (20 visits / calendar year)	$20 Copay / Visit	40% [2]
Therapy, including Physical, Occupational and Speech	20% [2]	40% [2]
Hospital Services		
Inpatient	20% [2]	40% [2] (benefit limited to $1,000 / day for non-emergency admission)
Outpatient Surgery	20% [2]	40% [2] (benefit limited to $350 / admit)
Emergency Room	$150 Copay + 20% (Copay waived if admitted)	
Urgent Care	$20 Copay / Visit	40% [2]
Maternity Care		
Physician Services (prenatal or postnatal)	$20 Copay / Visit	40% [2]
Hospital Services	20% [2]	40% [2] (benefit limited to $1,000 / day for non-emergency admission)
Mental Health & Substance Abuse		
Inpatient	20% [2]	40% [2] (benefit limited to $1,000 / day for non-emergency admission)
Outpatient	$20 Copay / Visit 20% [2] (Facility Care)	40% [2]
Retail Prescription Drugs (30-day supply)		
Tier 1	$10 Copay	Copay plus 50% of remaining maximum and costs in excess of allowed maximum up to $250 per prescription for Retail Pharmacy
Tier 2	$25 Copay	
Tier 3	$40 Copay	
Tier 4	20% up to $150 per Rx	
Mail Order Prescription Drugs (90-day supply)		
Tier 1	$10 Copay	Not Covered
Tier 2	$50 Copay	
Tier 3	$80 Copay	
Tier 4 (30-day supply only)	20% up to $150 per Rx	

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider

[2] After Annual Deductible has been satisfied

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Plan Highlights

Anthem HDHP 2800

	In-Network	Out-of-Network
Provider Network	CA: Prudent Buyer Large Group Non-CA: National PPO (BlueCard PPO)	Not Applicable
Calendar Year Deductible		
Individual	$2,800	$3,500
Family	$5,600	$7,000
Calendar Year Out-of-pocket Maximum [1]		
Individual	$3,000	$7,000
Family	$6,000	$14,000
Lifetime Maximum		
Individual	Unlimited	Unlimited
Professional Services		
Primary Care Physician (PCP)	20% after deductible	40% after deductible
Specialist	20% after deductible	40% after deductible
Preventive Care Exam	No Copay	40% after deductible
Well-baby Care	No Copay	40% after deductible
Diagnostic X-ray and Lab	20% after deductible	40% after deductible
Complex Diagnostics (MRI/CT Scan)	20% after deductible	40% after deductible
Chiropractic (30 visits / calendar year)	20% after deductible	40% after deductible
Acupuncture (20 visits / calendar year)	20% after deductible	40% after deductible
Therapy, including Physical, Occupational and Speech	20% after deductible	40% after deductible
Hospital Services		
Inpatient	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Emergency Room (waived if admitted)	20% after deductible	
Urgent Care	20% after deductible	40% after deductible
Maternity Care		
Physician Services (prenatal or postnatal)	20% after deductible	40% after deductible
Hospital Services	20% after deductible	40% after deductible
Mental Health & Substance Abuse		
Inpatient	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible
Retail Prescription Drugs (30-day supply)	**Medical Deductible Applies**	
Tier 1	$10 Copay	Copay plus 40% of remaining maximum and costs in excess of allowed maximum up to $250 per prescription for Retail Pharmacy
Tier 2	$30 Copay	
Tier 3	$50 Copay	
Tier 4	30% up to $150 per Rx	
Mail Order Prescription Drugs (90-day supply)	**Medical Deductible Applies**	
Tier 1	$10 Copay	Not Covered
Tier 2	$60 Copay	
Tier 3	$100 Copay	
Tier 4 (30 Day Supply)	30% up to $150 per Rx	

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Health Savings Account (HSA)

What is it?

By enrolling in the Anthem High Deductible Health Plan, you will have access to a Health Savings Account (HSA), which provides tax advantages and can be used to pay for qualified health care expenses, such as your deductible, copayments, and other out-of-pocket expenses.

What are the benefits?

Administered by HealthEquity, an HSA accumulates funds that can be used to pay current and future health care costs.

- You can contribute to your HSA on a pre-tax basis, for federal tax purposes, or you can contribute on a post-tax basis and take the deduction on your tax return
- HSA funds can grow on a tax-free basis, subject to state law [1]
- An HSA reduces your taxable income and may allow you to make tax-free withdrawals from the account when paying for qualified health care expenses (tax regulations vary by state [1])
- Because you own the HSA, there are no "Use it or Lose it" provisions, so unused HSA funds roll over from year-to-year, and can be used to reimburse future eligible out-of-pocket expenses
- You may enjoy lower monthly premium payments as compared to traditional PPO medical plans
- Because you own the HSA, the money in your account is yours to keep if you leave the company

How do I qualify for an HSA?

The IRS has guidelines regarding who qualifies for an HSA. You are considered eligible if:

- You are covered under a qualified medical plan
- You are not enrolled in non-qualified health insurance outside of Pfenex's HDHP (High Deductible Health Plan)
- You are not enrolled in Medicare
- You are not claimed as a dependent on someone else's tax return (excluding a spouse)
- You are not enrolled in a general Health Care Flexible Spending Account (Health FSA) or general Health Reimbursement Arrangement (HRA)

How do I get started?

If you're ready to activate your HSA, you can do so by:

- Go to www.healthequity.com and click on the **Register** button in the Member Login section
- From the Account Summary page, click **Activate Your HSA** and follow the prompts

Once the HSA is activated, you can manage and access your account at any time by visiting www.healthequity.com. If questions arise regarding account activation, contact HealthEquity or visit www.healthequity.com. Consult your tax advisor for taxation information or advice.

1. Please consult your tax advisor for applicable tax laws in your state.

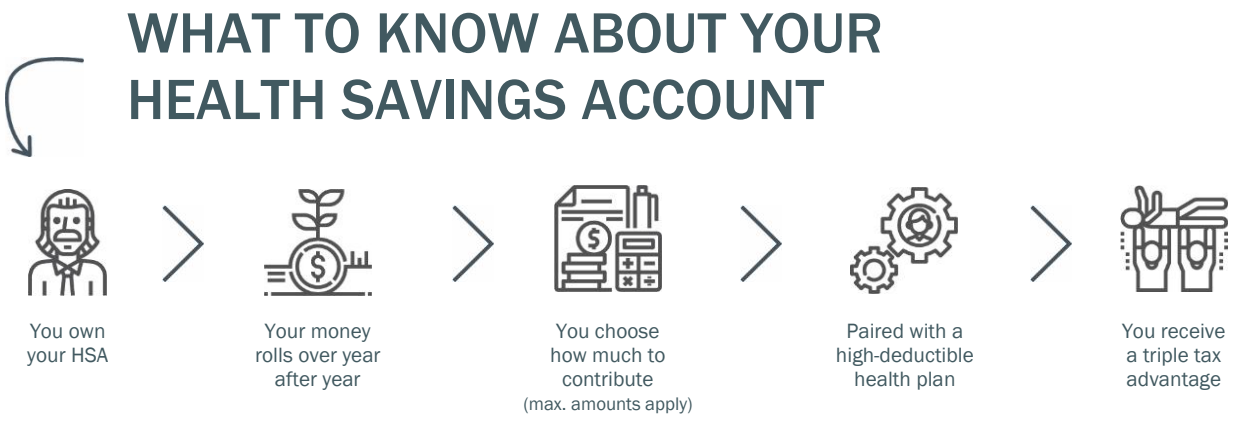
A few rules you need to know:

- For 2020, the maximum contribution limit for employee and employer contributions in an employee's HSA account is **$3,550** if you are enrolled in the HSA-HDHP for employee-only coverage, and **$7,100** for employees with dependent coverage
- It's important to monitor your contributions to avoid going over the IRS limit, as contributions in excess of the IRS limit are subject to standard income tax rates, plus a 6% excise tax
- There is a 20% penalty for using HSA funds on non-qualified health care expenses if you are under age 65. For more details about what are considered qualified health care expenses, visit www.healthequity.com
- You may not be able to contribute to your HSA if you are entitled to Medicare. However, funds accumulated before Medicare entitlement may be used to reimburse your qualified medical expenses
- You may not contribute to your HSA if you are covered under any medical benefits plan which is not an HSA-qualified high deductible medical plan (e.g., a spouse's non-HDHP medical plan, a general purpose Health Care FSA, or Medicare). However, you may be covered by a Limited Purpose Health Care FSA, or an FSA which can be used after your HDHP deductible is met
- Typically, the maximum amount an employee is eligible to contribute to an HSA per calendar year is based upon a **pro-rata** portion of the number of months an employee is eligible to contribute to an HSA. For example, an employee would normally be able to contribute 4/12 of the maximum annual limit in his/her first year of enrollment into the HSA plan, if the employee first joins the HSA plan on September 1. However, under the full contribution rule, an employee is allowed to contribute the maximum annual amount, regardless of the number of months he/she was eligible to contribute to an HSA in the first year, if he/she is eligible to contribute to an HSA on December 1 of the first year and continues to be eligible to contribute to an HSA until December 31 of the following year (i.e., for the entire subsequent year)

TIP

How do I manage my HSA?

- **The most convenient way to pay for qualified expenses is to utilize the debit card**
- **You can also use your own cash or a personal credit card and reimburse yourself through your online HSA account**
- **It is recommended that you keep receipts of HSA purchases, should you ever be audited by the IRS**
- **View the status of your claims and check your HSA balance at www.healthequity.com**



Dental Plan

Your Dental PPO Plan

You and your eligible dependents have the opportunity to enroll in a Dental Preferred Provider Organization (PPO) plan offered by Anthem.

Using the Plan

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists.

To locate an in-network provider or view a complete plan summary, visit www.anthem.com and log into your Anthem member portal.

Plan Highlights	Anthem Dental PPO 4A	
	In-Network	**Out-of-Network**
Provider Network	Dental Complete	Not Applicable
Calendar Year Deductible		
Individual	$50	$50
Family	$150	$150
Calendar Year Maximum (per insured member)	$2,500	$2,500
Preventive (deductible waived) (1)	100%	100%
Basic Services	90%	80%
Major Services	60%	50%
Orthodontia Services		
Adult	50%	50%
Child(ren) up to age 19	50%	50%
Lifetime Maximum (per insured member)	$2,500	$2,500

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

TIP

Choose a Contracted Dentist

When using a Dental PPO plan, you can receive services from dental providers both in and out of your insurance network. However, you'll receive better coverage when you use an in-network dentist. To determine whether your dentist is in or out of your insurance network, go to www.anthem.com and search the Dental Complete Network, or call 877.567.1804.

How to find a dental provider

To find an Anthem dental provider, visit https://www.anthem.com, select **Dental** as the type of service you're searching for and use **Dental Complete** as the network name**.** Modify your parameters by entering additional details.

Vision Plan

Your Vision Plan

Vision coverage is offered by VSP as a Preferred Provider Organization (PPO) plan.

Using the Plan

As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount.

To locate an in-network provider or to view a complete plan summary, visit www.vsp.com.

Plan Highlights	VSP Vision Plan C 12/12/12 $10/$25 PPO	
	In-Network	**Out-of-Network**
Provider Network	VSP Signature	Not Applicable
Exam – Every calendar year	$10 Copay	Up to $50 Allowance
Lenses – Every calendar year		
Single	$25 Material Copay	Up to $50 Allowance
Bifocal	$25 Material Copay	Up to $75 Allowance
Trifocal	$25 Material Copay	Up to $100 Allowance
Frames – Every calendar year	$150 Allowance + 20%	Up to $70 Allowance
Contacts – Every calendar year, in lieu of lenses & frames		
Contact Lens Fitting	$60	Included in Contact Lens Allowance
Medically Necessary	Covered in Full	Up to $210 Allowance
Cosmetic	$150 Allowance	Up to $105 Allowance
Additional Pairs of Glasses	30% off	Not Covered
LASIK	Average 15% off the regular price or 5% off the promotional price	Not Covered

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

TIP

Five Tips for Superior Vision

Don't take your eyes for granted! The following pointers can help you keep your vision strong:

- **Eat lots of leafy greens and dark berries; get regular eye exams**
- **Give your eyes a rest from staring into the computer screen; wear sunglasses to protect your eyes from bright light; wear safety eyewear whenever necessary**

How to find a vision provider

To find a VSP vision provider, visit www.vsp.com, click **Find a Doctor**; expand **View Filters +**, from the dropdown, "Doctor Network" select **Signature**; click **Apply Filters**; enter parameters and click **Search**.

Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible health care and dependent care expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
Health Care FSA	• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance • Maximum contribution for 2020 is **$2,750**
Limited Purpose FSA	• Option for employees enrolled in a Health Savings Account (HSA) eligible plan • Use this FSA to reimburse for eligible preventive care, dental and vision expenses • Maximum contribution for 2020 is **$2,750**
Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) child care expenses and/or care for a disabled family member in the household, who is unable to care for themselves • Maximum contribution for 2020 is **$5,000**

What are the benefits?

- Your taxable income is reduced and your spendable income increases!
- Save money while keeping you and your family healthy.

How do I use it?

You must enroll in the FSA program within 30 days of your hire date or during annual open enrollment. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status, and more. Visit www.goigoe.com to access Igoe's online portal.

A few rules you need to know:

- Pfenex's FSA plan runs on a calendar year basis, from January 1, 2020 through December 31, 2020
- Our FSA plan allows a grace period where you may carry over up to $500 from your 2020 Health FSA into to the 2021 plan year
- Pfenex's FSA plan allows an annual run-out period of 90 days, or March 31, 2021, where you may request reimbursement for any expenses that were incurred during the prior plan year (January 1, 2020 to December 31, 2020)

Basic Life and AD&D

Protect your loved ones

In the event of your death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Your coverage

Paid for in full by Pfenex, the benefits outlined below are provided by Anthem:

- Basic Life Insurance of 1x annual earnings up to $500,000
- AD&D Insurance of 1x annual earnings up to $500,000

Please Note: Benefits will reduce by 35% when you reach age 70 and will reduce to 50% when you reach age 75

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the "economic value" of the coverage provided to you.

TIP

Required! Are Your Beneficiaries Up to Date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- **You can change your beneficiary designation at any time**
- **You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated**
- **To select or change your beneficiary, visit https://benefits.plansource.com**

Voluntary Life/AD&D

If you would like to supplement your employer paid insurance, additional Life and AD&D coverage through Unum is available for you to purchase via payroll deduction for either you and/or your dependents.

- **For employees:** Increments of $10,000, up to the lesser of either 5x your salary or $500,000. If you enroll in the plan within 30 days of becoming eligible, you are guaranteed the full election amount and, if applicable, you are eligible to increase coverage at future enrollment periods
- **For your spouse:** Increments of $5,000 up to a $50,000 maximum. If you enroll in the plan within 30 days of becoming eligible, you are guaranteed the full election amount and, if applicable, you are eligible to increase coverage at future enrollment periods
- **For your child(ren):** 0 days old up to 6 months of age, $2,000; 6 months old up to age 26 with a guarantee issue benefit of $10,000

If you enroll for any amount of Life/AD&D when you are initially eligible, you can increase your coverage by $10,000 for yourself and $5,000 for your spouse during an annual open enrollment period.

If you **do not** enroll in the plan within the initial enrollment period, you will not be able to increase or elect coverage at a future open enrollment date.

Please note: Benefits coverage may reduce when you reach age 70. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

Cost of Voluntary Life/AD&D Coverage

Age of Insured	Employee Life/AD&D Monthly Rate per $10,000	Spouse Life/AD&D Monthly Rate per $5,000
Less than 20	$0.620	$0.310
21-24	$0.620	$0.310
25–29	$0.640	$0.320
30–34	$0.740	$0.370
35–39	$0.960	$0.480
40–44	$1.290	$0.645
45–49	$1.790	$0.895
50–54	$2.580	$1.290
55–59	$3.580	$1.790
60–64	$4.540	$2.270
65–69	$6.300	$3.150
70–74	$11.660	$5.830
75+	$20.800	$10.400

Benefit	Monthly Rate per $2,000
Child(ren) Life / AD&D	$0.800

Term Life Calculation

To calculate your cost, complete the following by selecting your coverage amount and rate (based on your insurance age).

Coverage Amount		Increment	Rate [1]		Monthly Cost
Employee	$	÷ $10,000	x $	=	$
Spouse [2]	$	÷ $5,000	x $	=	$
Child(ren) [3]	$	÷ $2,000	x $	=	$
			Total Monthly Cost	=	$

1. Rate will change based on new age band at time of Plan's anniversary, January 1.
2. Spouse rate is based on spouse age.
3. Child benefit is per family.

Disability

Added protection

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings.

Your Plans	Coverage Details
Short Term Disability (STD)	• Administered by Anthem, STD coverage provides a benefit equal to **60% of your weekly earnings, up to $2,769 per week** for a period up to 12 weeks • The plan begins paying these benefits after you have been absent from work for 7 consecutive days due to an accident or an illness
Long Term Disability Coverage (LTD)	• If your disability extends beyond 90 days, the LTD coverage through Anthem can replace **60% of your monthly earnings, up to maximum of $12,000 per month** • Your benefits may continue to be paid until you reach social security normal retirement age (SSNRA) as long as you meet the definition of disability
State Disability Insurance	• The state you reside in may provide a partial wage-replacement disability insurance plan • Pfenex's STD plan coordinates with State Disability Insurance and state benefits are taxable to you • For more information regarding statutory disability programs, contact Human Resources

Disability Facts and Figures

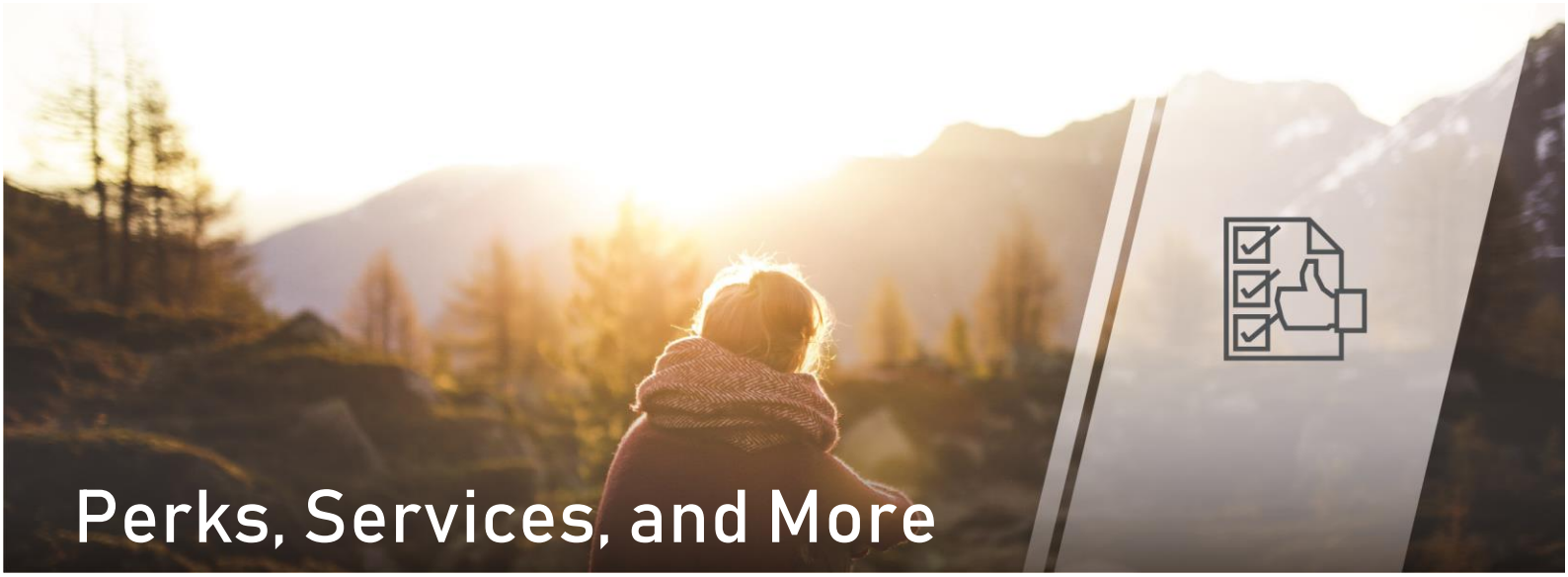
- **One in every 7 people will become disabled for five years or more in their lifetime.**
- **30% of people use disability coverage.**
- **Nearly half (46%) of all foreclosures are caused by financial hardship due to a disability.**

Source: www.affordableinsuranceprotection.com/disability_facts

Tax considerations

Because disability coverage is an employer-paid benefit and is available for employees at no cost, any disability payments made to you will be taxable.

Please note: Consult your tax advisor for additional taxation information or advice.



Perks, Services, and More

Perks from Work

To round out your benefits package, we offer these additional perks to support both your personal and professional needs.

2020 Holidays

The following paid holidays will be observed:

- New Year's Day — Wednesday, January 1
- President's Day — Monday, February 17
- Memorial Day — Monday, May 25
- Independence Day — Friday, July 3
- Labor Day — Monday, September 7
- Thanksgiving Day — Thursday, November 26
- Day after Thanksgiving — Friday, November 27
- Winter Break — Thursday, December 24 through Thursday, December 31
- New Year's Day — Friday, January 1, 2021

Vacation Time

Vacation time is available for employees starting from the employee's hire date through the end of the calendar year

Years of Service	Vacation Days for Exempt Employees
0 – 5	15
6 – 10	20
11 – 15	23
16 – 20	25
21 – 25	27
26 +	30

Flexible Sick Leave

Leave of Absence

Time off is also available for family, medical, and personal leaves of absence.

Perks from Work (Continued)

Supplemental Services

Unum Voluntary Critical Illness Coverage (100% Employee Paid)

This policy, provided to you by Unum, will pay you cash to help families with the expenses associated with life-threatening diseases, debilitating illness, and injuries. Benefits may be paid for initial diagnosis, hospital stays, doctor visits, physical therapy, home health care, nursing home care, and possibly more. Some of the covered medical conditions include:

- Heart attack
- Stroke
- Coma, or paralysis
- Kidney failure
- Organ transplant
- Severe burns

Unum Voluntary Accident Plan (100% Employee Paid)

Accidents happen when you least expect them and can include motor vehicle accidents, sports injuries, slips, falls or just every day mishaps! Unum's policy may pay you cash to help families offset the expenses associated with accidents or injuries. Benefits may be paid for:

- Emergency room and doctor visits
- Follow up and physical therapy visits
- Hospital admission and confinement
- Ambulance
- Medical Equipment (crutches, leg braces, etc.)

If you're considering enrolling in any of the Unum products, you must enroll when you first become eligible or during the annual open enrollment period. Coverage details and cost are located in PlanSource.

Wamberg Genomic Advisors (WGA) Cancer Guardian

A cancer diagnosis for you or your family members can be devastating, lonely and confusing. Cancer patients who have access to personalized support, information, guidance, and advanced genetic testing have better outcomes.

In addition to the benefits below, if you or any of your enrolled dependents are diagnosed with cancer, this plan covers certain genomic tests.

- Hereditary Genetic Screening
- Cancer Guardian Support Line
- Cancer Support Specialists
- Expert Second Opinion Pathology Review
- Digital Medical Records Platform
- Advanced DNA Testing

Pfenex provides this benefit to you and your children up to age 26 at no cost! You have the option to purchase this benefit for your spouse/domestic partner. The cost to cover your spouse/domestic partner is located in PlanSource.

Workplace Wellness

Why Wellness?

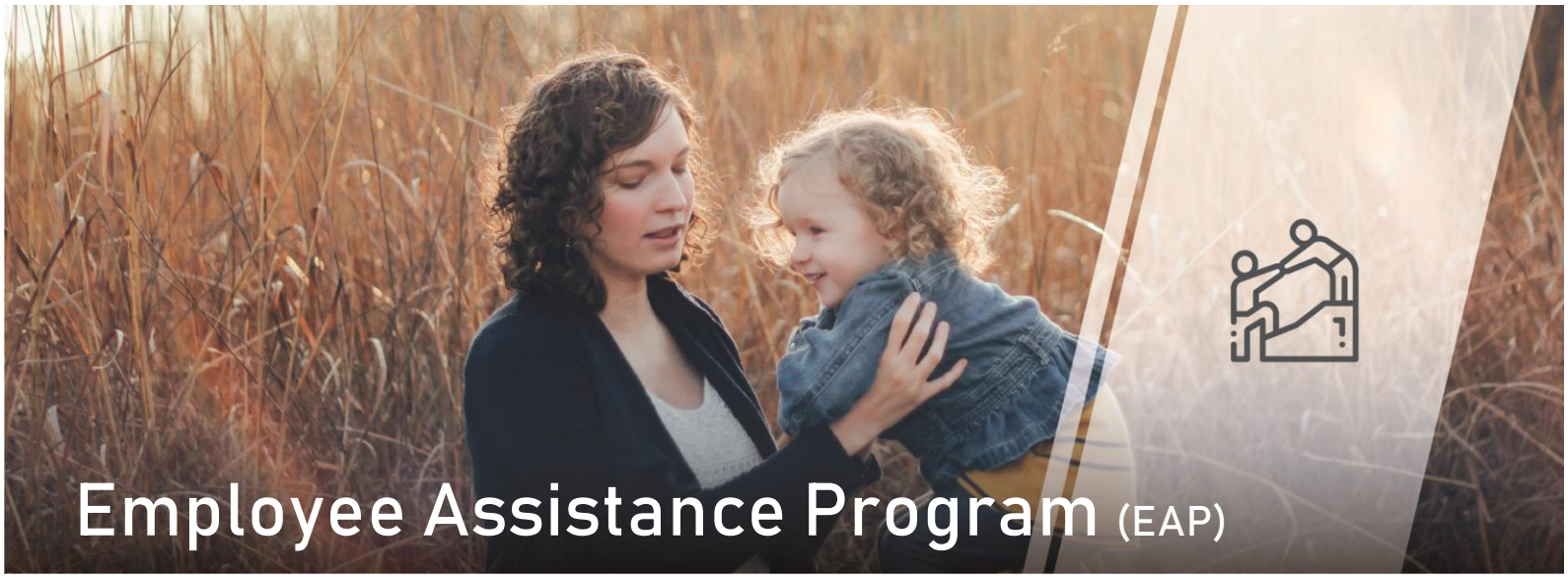
Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual health care costs. We care about your total well-being and encourage all employees to engage in our Wellness Program at no-cost.

Altitude Newsletters & Monthly Challenges

Sponsored by MMA, the monthly Altitude Newsletters and Monthly Challenges are intended to raise awareness, provide educational activities, and offer tools and resources you can apply immediately to improve your health and well-being. These resources cover a wide range of topics to help you reach your total health potential including:

- Fitness
- Stress management
- Nutrition
- Goal setting
- Self-care
- Weight maintenance
- Living green
- Family
- Financial wellness
- Giving back

By voluntarily participating and successfully completing monthly Well-Being Challenges, you become eligible to win great prizes sponsored by MMA that total over $1,000 per month in value.



Employee Assistance Program (EAP)

Pfenex understands that you and your family members might experience a variety of personal or work-related challenges. Through the EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

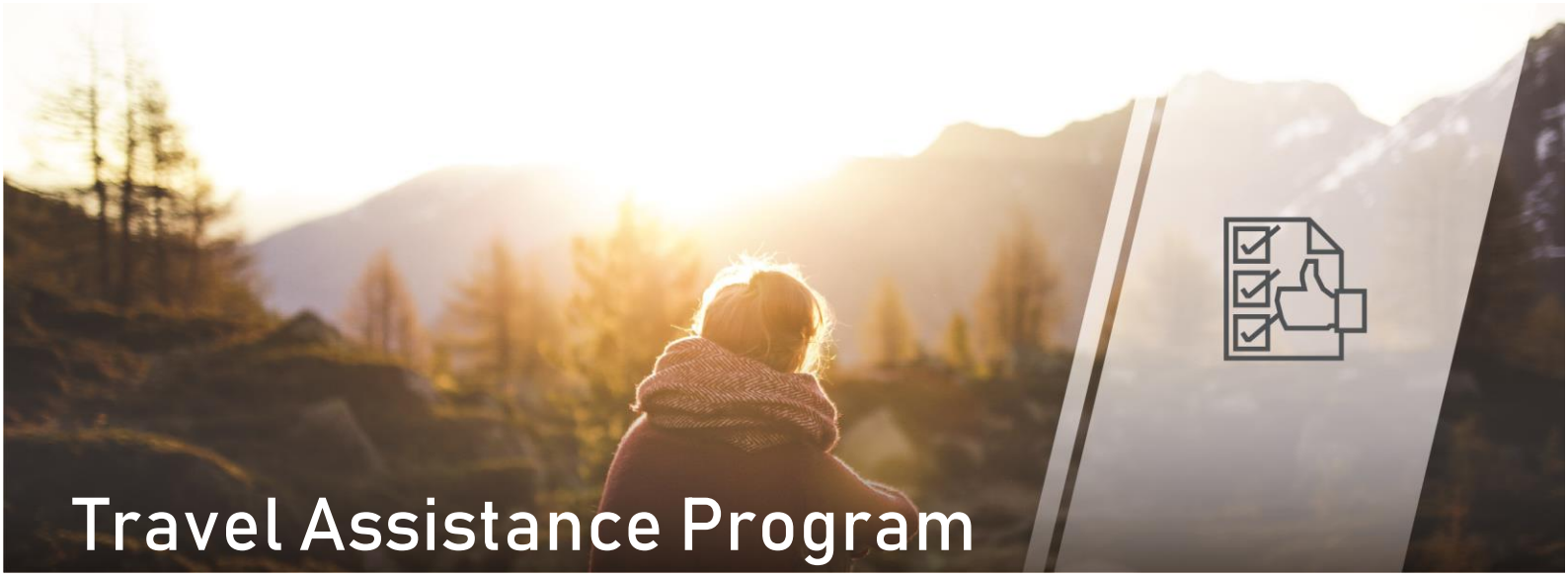
Be sure to identify yourself as a participant of the Beyond Benefits Life Science Association Trust program (Beyond Benefits).

Program Component	Coverage Details
Who Can Utilize	All employees, dependents of employees, and members of your household
Topics May Include	• Childcare • Eldercare • Legal services • Identity theft • Marital, relationship or family problems • Bereavement or grief counseling • Substance abuse and recovery • Financial support • Educational materials
Number of Sessions	3 face-to-face sessions per incident, per year, per member

TIP

How to Access:

- **By Phone: 888.209.7840**
- **Online: www.resourceadvisorca.anthem.com**
- **Program Name: ResourceAdvisor**
- **Be sure to identify yourself as a participant of the Beyond Benefits Life Science Association Trust or "Beyond Benefits"**



Travel Assistance Program

Anthem's Generali Global Assistance program provides emergency medical and travel services and pre-trip planning assistance when traveling more than 100 miles from home on company business or vacation.

Be sure to identify yourself as a participant of the Beyond Benefits Life Science Association Trust program (Beyond Benefits).

Services include:

- Emergency medical evacuation assistance
- 24-hour multilingual assistance
- Translation and interpretation services
- Medical referrals
- Assistance with lost or stolen items
- Pre-trip planning services
- Prescription refill services

TIP

How to Access:

Customer Service is available 24 hours a day, 365 days a year.
U.S. & Canada (toll-free): 866.295.4890
International (call collect): 202.296.7482

Retirement Plan

Your 401(k) Plan Option

Administered by John Hancock, the 401 (k) plan allows you to plan for your future by investing a portion of each paycheck. Employees can begin investing immediately and elect to have a percentage of their paycheck withheld and invested in the 401 (k) account, subject to federal law and plan guidelines. Pfenex will provide a 100% match up the first 4% of your contributions.

Enrollment & Account Access

For enrollment, investment tools, and more, visit mylife.jhrps.com or call 800.294.3575.

Additional 401(k) Information

Contribution Limits: For 2020, the IRS annual contribution limits are $19,500 for everyone under age 50. For everyone over age 50 prior to December 31, 2020, the IRS annual contribution limit is $26,000. If you have multiple employers during the year, these limits are combined for all plans that you contribute to during the year. Restrictions may apply to these limits based on plan documents and annual testing requirements.

Contribution Changes: Check with Human Resources for frequency and process for changing your contributions. You may also stop your contribution entirely at any time. Requests to change or stop your contributions must be made through the provider website or in writing to Human Resources.

Employer Contributions: Check with Human Resources for current status of any employer contributions to the plan.

Loans & Hardship Withdrawals: If allowed by the plan document, please see Human Resources for information and requirements for either option.

Rollover Contributions: If you have an outside qualified retirement plan or account such as a 401(k), 403(b), 457(b) or IRA, you may be able to transfer that account into your new plan. Please contact John Hancock or Human Resources for additional information.

Termination of Employment: Upon termination of employment from our organization, regardless of reason, you will be entitled to request a full distribution of your vested account balance. This may be done as a rollover to another plan or IRA. You may also request a lump-sum cash payment to yourself. Please be aware of possible taxes and penalties which may apply to any payment other than a rollover.

Vesting: Pfenex plan's safe harbor matching contributions are immediately 100% vested.

TIP

Your Target Retirement

Are you wondering how much you should save for retirement? Learn more by accessing a free retirement planning calculator at http://www.mmaretirement.com/calculators.cfm

Marsh & McLennan Insurance Agency LLC does not serve as advisor, broker-dealer or registered investment advisor for this plan. All of the terms and conditions of your plan are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

Member Support

Understanding your employee benefits options can be confusing and complicated. Member Support through Marsh & McLennan Agency provides answers and information at your fingertips.

You're Not Alone

Plan options, copays and deductibles...

Planning for you and your family's health and welfare needs can be an overwhelming task. Member Support is your resource for guidance when navigating your benefits plan, from open enrollment to handling life's many changes.

Just a Call or Click Away

Bilingual Member Support is available Monday through Friday, 8:00 a.m. – 5:00 p.m. Pacific Time.

- **Toll-free:** 888.434.7703
- **Email:** Member.Support@MarshMMA.com

Dedicated Benefits Resource

As a company-sponsored benefit, Member Support gives you unlimited direct access to insurance professionals who are dedicated to knowing our plan options inside and out. Whether you're a new employee, looking for information on how to continue your coverage or your insurance needs are changing, you're bound to have questions on your plan options and programs.

TIP

General Benefits Support

- **How to enroll**
- **Finding a service provider**
- **General benefit questions**

Life Changing Events

- **Add coverage for your newborn or adopted child**
- **Add/remove coverage due to change in marital or employment status**

COBRA Support

- **Information regarding continuation coverage**
- **Navigate through your individual options**

Cost Breakdown

PFEnex

The rates below are effective January 1, 2020 – December 31, 2020.

Coverage Level	Total Monthly Cost	Pfenex Monthly Contribution	Employee Monthly Cost	Employee Payroll Deduction [1]
Anthem Medical Classic Priority Select HMO				
Employee Only	$660.98	$528.78	$132.20	$61.02
Employee and Spouse/ Registered and Unregistered Domestic Partner [2]	$1,454.17	$1,163.33	$290.84	$134.23
Employee and Child(ren)	$1,189.73	$951.77	$237.96	$109.83
Employee and Family	$2,049.01	$1,639.21	$409.80	$189.14
Anthem Medical Classic HMO				
Employee Only	$734.99	$587.99	$147.00	$67.85
Employee and Spouse/ Registered and Unregistered Domestic Partner [2]	$1,616.99	$1,293.59	$323.40	$149.26
Employee and Child(ren)	$1,322.89	$1,058.31	$264.58	$122.11
Employee and Family	$2,278.44	$1,822.76	$455.68	$210.31
Anthem Medical Classic PPO 400				
Employee Only	$796.60	$637.29	$159.31	$73.53
Employee and Spouse/ Registered and Unregistered Domestic Partner [2]	$1,752.57	$1,402.06	$350.51	$161.77
Employee and Child(ren)	$1,433.90	$1,147.13	$286.77	$132.36
Employee and Family	$2,469.54	$1,975.63	$493.91	$227.96
Anthem Medical HDHP 2800/HSA				
Employee Only	$609.91	$548.92	$60.99	$28.15
Employee and Spouse/ Registered and Unregistered Domestic Partner [2]	$1,341.79	$1,207.60	$134.19	$61.93
Employee and Child(ren)	$1,097.86	$988.07	$109.79	$50.67
Employee and Family	$1,890.73	$1,701.65	$189.08	$87.27
Anthem Dental PPO				
Employee Only	$51.23	$38.43	$12.80	$5.91
Employee and Spouse/ Registered and Unregistered Domestic Partner [2]	$104.64	$78.49	$26.15	$12.07
Employee and Child(ren)	$122.65	$92.00	$30.65	$14.15
Employee and Family	$179.61	$134.71	$44.90	$20.72
VSP Vision PPO				
Employee Only	$11.34	$11.34	$0.00	$0.00
Employee and Spouse/ Registered and Unregistered Domestic Partner [2]	$19.43	$19.43	$0.00	$0.00
Employee and Child(ren)	$19.84	$19.84	$0.00	$0.00
Employee and Family	$31.98	$31.98	$0.00	$0.00

1. Based on 26 pay periods per year

2. Premiums for registered / unregistered domestic partners who do not meet the tax dependent definition of IRC section 152 for the employee, may be considered taxable income (unregistered domestic partners will not meet the relationship test under IRC section 152). Premiums for children / registered Domestic Partners' step-children under age 26 are not taxable. Premiums for children / stepchildren over age 26 are taxable if not an IRC section 152 tax dependent.

Directory & Resources

Below, please find important contact information and resources for Pfenex.

Information Regarding	Group Number	Phone Number	Website
Enrollment & Eligibility			
• Human Resources: • Online Enrollment Vendor:	David Pollak Lali Cespedes PlanSource	858.352.4315 858.352.4325	DPollak@Pfenex.com CCespedes@Pfenex.com http://benefits.plansource.com
Medical Coverage			
Anthem • CA Only HMO (Priority Select Network) • CA Only HMO (Full-Network) • CA PPO • BC "BlueCard" PPO (Non-CA) • CA HDHP • BC "BlueCard" HDHP (Non-CA)	 276923H031 276923 276923M031 276923M094 276923M052 276923M115	844.909.0364	www.anthem.com **If calling Anthem, indicate that you are a member of the Beyond Benefits Life Science Trust**
Dental Coverage			
Anthem PPO • Dental Complete Network	276923	877.567.1804	www.anthem.com **If calling Anthem, indicate that you are a member of the Beyond Benefits Life Science Trust**
Vision Coverage			
VSP PPO • Signature Network	30029652-0174	800.877.7195	www.vsp.com **If calling Anthem, indicate that you are a member of the Beyond Benefits Life Science Trust**
Life/AD&D and Disability			
Anthem • Basic Life/AD&D • Short-Term Disability (STD) • Long-Term Disability (LTD)	 2769230341 / 2769230342 276923 276923	 800.552.2137 800.232.0113	www.anthem.com
Unum Voluntary Benefits			
• Voluntary Life/AD&D • Accident / Critical Illness	417910-001 R0575787	800.445.0402 800.635.5597	www.unum.com **If calling Unum, indicate that you are a member of the Beyond Benefits Life Science Trust**
Flexible Spending Accounts (FSA)			
Igoe • Health Care / Limited Purpose • Dependent Care	Member Services	800.633.8818	www.goigoe.com
Health Savings Account (HSA)			
HealthEquity	Member Services	866.346.5800	www.healthequity.com
401(k) Retirement Plan Adviser			
John Hancock	Member Services	800.294.3575	www.mylife.jhrps.com
Employee Assistance Plan (EAP)			
Anthem's ResourceAdvisor	ResourceAdvisor	888.209.7840	www.resourceadvisorca.anthem.com Program Name: ResourceAdvisor
Travel Assistance			
Anthem	Generali Global	866.295.4890	https://us.generaliglobalassistance.com/
Benefits Questions			
MMA's Member Support	Beyond Benefits	888.434.7703	Member.Support@MarshMMA.com
Benefits Broker			
Marsh & McLennan Insurance Agency LLC 9171 Towne Centre Dr., Ste. 100 San Diego, CA 92122	 Seara Allen, Benefit Analyst Allison Bingham, Client Manager Laurie Shock, Client Executive Nicole Mehrara, Principal	800.321.4696 858.875.3073 858.587.7509 858.587.7575 858.875.6583	www.MarshMMA.com Seara.Allen@MarshMMA.com Allison.Bingham@MarshMMA.com Laurie.Shock@MarshMMA.com Nicole.Mehrara@MarshMMA.com

Guidelines/Evidence of Coverage

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

Medicare Part D notice

Important Notice about Your Prescription Drug Coverage and Medicare

Model Individual CREDITABLE Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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 prescription 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. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, 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 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact Human Resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your medical benefits brochure contains a description of your current prescription drug benefits.

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 your employer and don't join a Medicare prescription 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 your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer 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 www.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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

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

Remember: **Keep this Creditable Coverage notice. If you decide to join one of the Medicare prescription 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).**

Medicare Part D Notice

Important Notice about Your Prescription Drug Coverage and Medicare

Model Individual NON-CREDITABLE Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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. For information about where you can get help to make decisions about your prescription drug coverage, contact your Human Resources Department.

There are three 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. Your employer has determined that the prescription drug coverage offered is NOT expected to pay, on average, as much as standard Medicare prescription drug coverage pays and is therefore considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from your employer. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from your employer. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

When can you join a Medicare drug plan?

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

If Your Plan is an Employer/Union Sponsored Group Plan: However, if you decide to drop your current coverage with Pfenex, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however, you also may pay a higher premium (a penalty) because you did not have creditable coverage under employer/union sponsored group plan.

If Previous Coverage Provided was Creditable Coverage: Since you are losing creditable prescription drug coverage, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

Since the coverage provided by your employer, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that is creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What happens to your current coverage if you decide to join a Medicare prescription drug plan?

If you decide to join a Medicare drug plan, your current coverage will be affected.

For individuals who elect Part D coverage, coverage under the employer plan will end for the individual and all covered dependents.

See pages 9–11 of the CMS Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

For More Information about this Notice or Your Current Prescription Drug Coverage…

Contact your Human Resources Department for further information NOTE: You'll receive this notice annually, before the next period you can join a Medicare drug plan, and if this coverage through your employer 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 www.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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

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

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Legal Information Regarding Your Plans

REQUIRED NOTICES

Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

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

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

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage [1]
- Acquisition of a new spouse or dependent through marriage [1], adoption [1], placement for adoption [1] or birth [1]
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) [1]
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

"Change in Status" Permitted Midyear Election Changes

- Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved "change in status" as defined by the IRS.
- Examples of permitted "change in status" events include:
- Change in legal marital status (e.g., marriage [2], divorce or legal separation)
- Change in number of dependents (e.g., birth [2], adoption [2] or death)
- Change in eligibility of a child
- Change in your / your spouse's / your registered and unregistered domestic partner's employment status (e.g., reduction in hours affecting eligibility or change in employment)
- A substantial change in your / your spouse's / your registered and unregistered domestic partner's benefits coverage
- A relocation that impacts network access
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment
- Qualified Medical Child Support Order or other judicial decree
- A dependent's eligibility ceases resulting in a loss of coverage [3]
- Loss of other coverage [2]
- Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

You must notify Human Resources within 30 days of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

IMPORTANT INFORMATION ON HOW HEALTH CARE REFORM AFFECTS YOUR PLAN

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources office

For plans and issuers that require or allow for the designation of a primary care provider for a child:

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

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

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

Grandfathered Plans

If your group health plan is grandfathered, then the following will apply. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator.

Prohibition on Excess Waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. State law may require shorter waiting periods for insured group health plans. California law requires fully-insured plans to comply with the more restrictive waiting period limitation of no more than 60-days.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about **your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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.

[1] Indicates that this event is also a qualified "Change in Status"
[2] Indicates this event is also a HIPAA Special Enrollment Right
[3] Indicates that this event is also a COBRA Qualifying Event

CONTINUATION COVERAGE RIGHTS UNDER COBRA (CONTINUED)

What is COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan.

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or aren't required to pay] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to anyone covered under the Plan who are spouses, dependent children, or anyone else eligible for COBRA continuation coverage under the Plan.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. 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.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (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.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

IGOE Administrative Services
PO Box 2291
Omaha, NE 68103-2291
(800) 633-8818 (Press 2 for Option #2)

For More Information

This notice doesn't fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact your Human Resources Representative.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.healthcare.gov.

EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER THE FAMILY MEDICAL LEAVE ACT

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness [1]; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. [1]

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months [2], and if at least 50 employees are employed by the employer within 75 miles.

[1] The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition"

[2] Special hours of service eligibility requirements apply to airline flight crew employees

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TYY: (877) 889-5627
www.wagehour.dol.gov

UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT NOTICE OF 1994, NOTICE OF RIGHT TO CONTINUED COVERAGE UNDER USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You do not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work / Applying for Reemployment

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definitions

For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

HIPAA PRIVACY NOTICE

Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice is EFFECTIVE: January 1, 2020

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to provide information about the legal protections that apply to your health information. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your Protected Health Information (PHI). PHI is health information that contains identifiers (such as your name, address, social security number, or other information that identifies you) and information related to your past, present or future health condition and treatments.

This notice is for participants in the Company Health & Welfare Plan (referred to as the "Plan"), including its component plans.

Required by Law

- The Plan must make sure that health information that identifies you is kept private.
- The Plan must give you this notice of our legal duties and privacy practices with respect to health information about you.
- The Plan must obtain written authorization from you for the use and disclosure of your PHI related to psychotherapy notes; when for purposes of marketing; and/or for disclosures constituting a sale of PHI.
- The Plan must follow the terms of the notice that are currently in effect.

Permitted Plan use of Your Health Information

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact the Plan Privacy Officer.

You have both the right and choice to tell us to: share information with your family, close friends, or others involved in payment for your care; share information in a disaster relief situation; and contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious, the Plan may go ahead and share your information if it believes it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety.

The Plan will never share your information unless you give us written permission for: marketing purposes and the sale of your information.

Treatment: The Plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the Plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees. We may also use and disclose your information to run our organization and contact you when necessary. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. The Plan is also not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Payment for Health Services and Administration of the Plan: The Plan can use and disclose your health information when paying for your health services. For example, the Plan may share information about you with your dental plan to coordinate payment for your dental work. The Plan may disclose your health information to your health plan sponsor for plan administration. For example, where your company contracts with an insurer to provide a health plan, and the Plan provides your company with certain statistics to explain the premiums charged.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy rules and HIPAA security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law (this includes the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law).

To Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director: We may share health information about you with organ procurement organizations; and may share health information with a coroner, medical examiner, or funeral director when an individual dies.

Workers' Compensation: We may release health information about you for workers' compensation programs or claims or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement and other Government Requests: We may disclose your health information for law enforcement purposes or with a law enforcement official, in response to a valid subpoena or other judicial or administrative request/order, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services.

Public Health and Research: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation). Additionally, we may share health information about you when: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety or for purposes of health research.

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information where concerning a service already paid for.
- Obtain a paper copy of the notice of health information practices promptly (even if you have agreed to receive the notice electronically) by requesting it from the Plan Privacy Officer.
- Ask to see or get a copy of your health and claims records and other health information we have about you. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Inspect and obtain a copy of your PHI contained in a "designated record set." A designated records set includes medical and billing records; enrollment, payment, billing, claims adjudication and case or medical management record systems; or other information used in whole or in part by or for the covered entity to make decisions about individuals. A written request to access your PHI must be submitted to your company Privacy Officer. Requested information will be provided within 30 days if maintained on site or 60 days if maintained off site.
- Request an amendment/correction to your health information: you can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- Obtain an accounting of disclosures of your PHI during the preceding six years, who we shared it with, and why, with the exception of disclosures made for purposes of treatment, payment or health care operations, and certain other disclosures (such as any you asked us to make); made to individuals about their own PHI; or, made through use of an authorization form. A reasonable fee may be charged for more than one request per year.
- Request confidential communications of your health information be sent in a different way (for example, home, office or phone) or to a different place than usual (for example, you could request that the envelope be marked "confidential" or that we send it to your work address rather than your home address). We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.
- Receive notification within 60 days (5 days for California residents) for any breaches of your unsecured PHI.
- Assign someone as your medical power of attorney or your legal guardian, who can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Plan Responsibilities

The Plan is required to maintain the privacy of PHI and to comply with the terms of this notice. The Plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you within 60 days of the effective date of any material change to the rights and duties listed in this notice. The Plan is required to:

- Maintain the privacy and security of your health information.
- Make reasonable efforts not to use, share, disclose or request more than the minimum necessary amount of PHI needed to accomplish the intended purpose, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- Follow the duties and privacy practices described in this notice with respect to information we collect and maintain about you and provide you a copy of the notice.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction, amendment or other request.
- Notify you of any breaches of your protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).
- Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA. The plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.

For more information, see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Your Right to File a Complaint

If you believe your privacy rights have been violated, you can file a formal complaint with the Plan Privacy Officer; or with the U.S. Department of Health and Human Services (by mail or email). We will not retaliate against you and you will not be penalized for filing a complaint.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Contact Person

If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the Plan Privacy Officer. All requests must be submitted in writing to the address shown below.

Pfenex
Attention: Human Resources
10790 Roselle Street
San Diego, CA 92121
(858) 352-4400

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH CAROLINA – Medicaid	**WASHINGTON – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA - Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
TEXAS – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
UTAH – Medicaid and CHIP	**WYOMING – Medicaid**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531
VERMONT– Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2020)

Notes

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