Five9, Inc.

Health and Welfare Benefit Plan

Master Summary Plan Description

Restated Effective March 1, 2024

This document, together with the Benefit Descriptions, constitute the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102.

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

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1. Definitions

Capitalized terms used in this document have the following meanings:

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

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

“Benefit Description” means the insurance policies, certificates of coverage, information booklets supplied by insurance carriers, and other benefit summaries for the component benefit programs listed in Section 15.

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

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

"Company" means Five9, Inc. or any successor thereto.

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

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

"Employer" means the Company and any affiliated entity within the same controlled group, as that term is defined under section 414 of the Internal Revenue Code, that participates in the plan.

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

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

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

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

"Plan" means the Five9, Inc. Health and Welfare Benefit Plan and includes this document, written amendments and updates to this document, and the terms of all Benefit Descriptions for the component benefit programs listed in Section 15.

"Plan Administrator" means the Company.

"SPD" means the Summary Plan Description required by ERISA § 102 summarizing this Plan and includes this document and the Benefit Descriptions.

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

2. Introduction

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

Each of these benefit programs is summarized in a Benefit Description. A Benefit Description will be available from the insurer (if the benefit is fully-insured) or Plan Administrator (if the benefit is self-funded). Whether a benefit program is fully-insured or self-funded is noted in Section 15.

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

3. General Information about the Plan

Plan Name:	Five9, Inc. Health and Welfare Benefit Plan.
Type of Plan:	Welfare plan providing coverages listed in Section 15.
Plan Year:	June 1 to May 31.
Plan Number:	501
Effective Date:	June 1, 2011.
Funding Medium and Type of Plan Administration:	Benefits under the Plan are fully-insured. See Section 15 for a description of the benefit programs. For benefit programs which are fully-insured, benefits are insured under a group contract entered into between the Company and insurance companies or HMO. The insurance companies and/or HMO, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the insurance companies and/or HMO for administering these benefit programs, as described below.

	For benefit programs which are self-funded, the Company is responsible for processing and paying appropriate claims. The Company may hire a third party administrator (a "TPA") to process claims. Premiums for Employees and their eligible family members may be paid in part by the Employer out of its general assets and in part by Employees' pre-tax and/or post-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the benefit programs, as applicable. The Company provides Employees the opportunity to pay for benefits on a pre-tax basis through a cafeteria plan. Appendix C provides information with regard to such a plan.
Plan Sponsor:	The Company is the Plan Sponsor. Five9, Inc. 3001 Bishop Ranch, Suite 350 San Ramon, CA 94583 (925) 201-2000
Plan Sponsor's Employer Identification Number:	94-3394123
Insurance Companies/HMO:	See a complete list in Section 15 of this document.
Plan Administrator:	Attention: HR Department Five9, Inc. 3001 Bishop Ranch, Suite 350 San Ramon, CA 94583 (925) 201-2000
Named Fiduciary:	Five9, Inc. 3001 Bishop Ranch, Suite 350 San Ramon, CA 94583 (925) 201-2000
Agent for Service of Legal Process:	Five9, Inc. 3001 Bishop Ranch, Suite 350 San Ramon, CA 94583 (925) 201-2000 Service for legal process may also be made on the Plan Administrator.

Language assistance is available. If you have difficulty understanding any part of this Summary Plan Description contact the Plan Administrator, the HR Department at (925) 201-2000.

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

4. Eligibility and Participation Requirements

Eligibility and Participation

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

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

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

Eligible Dependent Status

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

In general, if a particular benefit program includes coverage for dependents, you can enroll the following family members on your plan. Refer to your Benefit Descriptions for the full list of eligible dependents.

- Your legal spouse
- Your civil union partner
- Your domestic partner
- Your dependent children – your own or those of your spouse, civil union partner or domestic partner
    - The children must be under 26 years of age, and they include:
        - Biological children
        - Stepchildren
        - Legally adopted children, including any children placed with you for adoption
        - Foster children
        - Children you are responsible for under a qualified medical support order or court-order
        - (whether or not the child resides with you and whether or not the child resides inside the
        - service area)
        - Grandchildren in your court-ordered custody
        - Any other child with whom you have a parent-child relationship

You may continue coverage for a disabled child past the age limit shown above. See the Appendix A: COBRA Continuation for more information.

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

Full Time Status and the ACA

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

Special Enrollment Provisions under HIPAA

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

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

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

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

Coverage during Certain Leaves of Absence

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

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

Human Resources must determine whether or not you are eligible for a statutory or other leave of absence. For many paid leaves of absence, your coverage will continue until the below dates, as referenced from any applicable Benefit Descriptions:

Benefit Program	When do benefits end?
Medical Insurance	Medical Insurance coverage may continue for leave due to illness, injury, sabbatical, or other authorized leave, but not beyond 30 months from the start of your absence. If your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave, coverage may continue until the date your employment ends. If you begin a military leave of absence, your coverage can continue but not beyond 24 months from the start of the absence. Coverage is terminated once employment ends. Refer to Section 15 for when your participation in the Plan ends.
Dental Insurance	Same as Medical Insurance.

Vision Insurance	Same as Medical Insurance.
Life Insurance	Life Insurance continues for 3 months following the date the leave of absence begins.
Short Term and Long Term Disability	Disability Insurance continues for 3 months following the date the leave of absence begins.
Flexible Spending Account	During a paid leave of absence Flexible Spending Account contributions should continue to be deducted and claims can continue to be incurred until the leave of absence becomes unpaid. During an unpaid leave of absence Flexible Spending Account claims cannot be submitted if incurred during the unpaid leave of absence, unless the participant continues to pay Flexible Spending Account contributions post-tax.

Terms of Participation

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

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

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

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

numbers, birth certificates, marriage certificates, or proof of dependent eligibility. Failure to cooperate and provide such information will lead to a loss of eligibility for benefits.

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

COBRA Rights

You may be eligible for COBRA continuation coverage or conversion policies when your coverage for a medical benefit program under this Plan terminates. Information about continuation coverage or conversion is contained in Appendix A. If you have questions about this law or these rights, please contact the Navia Benefits via the contact information listed in Appendix A (for benefit programs that are self-funded) or the insurance carrier (if the benefit is fully-insured). You can determine whether a benefit program is self-funded or fully-insured by consulting Section 15.

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

5. Summary of Plan Benefits

Benefits and Contribution

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

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

The Employer will make its contributions, if any, in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay Employer contributions and your contributions to any insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to, or on behalf

of, you or your eligible family members from the Company's general assets. Your contributions toward the cost of a particular benefit program will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit program.

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

Certain prescription drug benefits are considered “Creditable Coverage” under Medicare Part D. The Benefit Descriptions provide details regarding this coverage and an annual notice (attached and incorporated by reference in Appendix B) explains how this creditable coverage works for these prescription drug benefit programs.

6. Certain Federal Laws

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

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

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

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

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

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

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

Qualified Medical Child Support Orders

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

Lifetime and Annual Limits

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

Access to Primary Care Physicians

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

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

7. How the Plan Is Administered

Plan Administration

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

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

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

The Plan Administrator may delegate any of its duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

Power and Authority of Insurance Company

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

Questions

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

8. Circumstances Which May Affect Benefits

Denial or Loss of Benefits

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

Right to Recover Benefit Overpayments and Other Erroneous Payments

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

or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.

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

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

Additional information about subrogation and reimbursement is included in Section 14 and may be included in the Benefit Description for the applicable benefit program.

9. Amendment or Termination of the Plan

The Plan and any benefit program under the Plan may be amended or terminated at any time, in the sole discretion of the Company as Plan sponsor, by a written instrument signed by an authorized individual. Some benefit programs may also be amended or terminated by an insurance carrier, as more fully described in the Benefit Description. The insurance contracts and policies may also be amended or terminated at any time in accordance with their terms. No individual (including a retired employee) shall have a right to continuing benefits except to the extent required by law.

10. No Contract of Employment

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

11. No Assignment

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

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

12. Claims Procedure

Claims for Fully-Insured Benefits

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

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

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

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

To the extent not inconsistent with the provisions of the applicable Benefit Description, lawsuits must be brought no later than the earlier of (i) one year from the date of exhausting the claims procedures relating to the denial of such claim and (ii) three years from the date the claim was incurred; thereafter, any lawsuit is barred.

Claims for Self-Funded Benefits

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

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

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

See the appropriate Benefit Description for information about how to file a claim and for details regarding the claims procedures applicable to your claim. You must fully follow and exhaust these claims procedures before you can file a lawsuit in court. Lawsuits must be brought no later than the earlier of (i) one year from the date of exhausting the claims procedures relating to the denial of such claim and (ii) three years from the date the claim was incurred; thereafter, any lawsuit is barred.

The Role of Authorized Representatives

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

13. Statement of ERISA Rights

This Statement of ERISA Rights applies to those benefit programs that are subject to ERISA. The Cafeteria Plan, Health Savings Account, and DCAP are not subject to ERISA

Your Rights

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

- examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor (if any) and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies;
- receive a summary of the Plan's annual financial report, if any (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report);
- continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the

documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Fiduciary Obligations

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants.

No Discrimination

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

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

Questions

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

14. General Information

COBRA

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

Subrogation and Reimbursement

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

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

The Company, on behalf of this Plan, shall have a first priority right to recover from and a lien against any payment, whether designated as a payment for medical benefits or any other type of damages, from the proceeds of any recovery, including but not limited to any settlement, award or judgment which results from a claim or lawsuit by or on behalf of a covered person who received benefits under this Plan (even if such covered person is not made whole). The Plan is not required to contribute to any expenses or fees (including attorneys' fees or costs) incurred in obtaining the funds. The Plan's recovery will not be limited or reduced by doctrines (equitable or other) including but not limited to, the make-whole doctrine, contributory or comparative negligence, or the common fund doctrine. The Plan's right to full recovery is not reduced if settlement funds or other payments to you are spent or no longer in an individual's possession or control. Notice of the Plan's claim shall be sufficient to establish this Plan's lien against the third party or insurance carrier. The Company shall be entitled to deduct the amount of the lien from any future claims payable to or on behalf of the covered person or payee if the covered person or payee fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to this Plan's subrogation and reimbursement rights.

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

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

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

No Vesting of Benefits

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

Waiver and Estoppel

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

Effect on Other Benefit Plans

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

Severability

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

Contributions, Refunds, Rebates, and Plan Assets

Employee, participant, and beneficiary contributions will be treated as fixed premium obligations and such persons will not be entitled to any reduction or refund of their contributions (including, without limitation, applicable deductibles or co-payments) in the event that the claims experience of the Plan is more favorable than projected or the Plan receives any discount, refund, rebate, settlement or damages pursuant to an agreement with or settlement or judgment with or from any medical provider, claim fiduciary, or other organization.

In some situations, a rebate may be paid by an insurance company which provides coverage under the Plan. For example, a rebate may be provided under the Medical Loss Ratio ("MLR") rules, which are part of the Affordable Care Act. Except as specifically and unambiguously provided in a Benefit Description, or as otherwise required by applicable law, any rebate from any source will be an asset of the Plan in proportion to how much of the rebate relates to Employee, participant, or beneficiary contributions. The portion relating to Employer contributions shall not be considered a Plan asset. The Plan Administrator will have the ability to make certain assumptions or minor changes (such as rounding to the nearest $1 or $10) when determining the amount which is considered a plan asset. The Plan Administrator shall have discretion to determine how to use all amounts. Amounts which are plan assets will be used to benefit individuals selected by the Plan Administrator. This group of individuals may not be identical to the group which relates to the rebate. In addition, certain individuals can receive the rebate (or the benefit of the rebate) even if the rebate related to a different benefit, to the extent allowed by applicable law.

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

Controlling Law

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

HIPAA Privacy and Security Rules

This section contains the Plan's provisions required by the Standards for Privacy of Individually Identifiable Health Information contained in 45 CFR § 164.500 et seq. (the "Privacy Rules") and Security Standards for the Protection of Electronic Protected Health Information contained in 45 CFR § 164.302 et seq. (the "Security Rules"), each promulgated pursuant to Title II of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). The Privacy Rules relate to the permitted use and disclosure of protected health information ("PHI"), as that term is defined in the Privacy Rules, by the Plan, or by certain health maintenance organizations or health insurers with respect to the Plan, to the Company (or any successor in interest thereto). The Security Rules relate to the security of PHI that is transmitted by electronic media or is maintained in electronic media ("Electronic PHI"), that is created, received, maintained, or transmitted on behalf of the Plan. Notwithstanding anything in this Plan to the contrary, the Plan shall be operated in accordance with HIPAA. If there is any conflict between the provisions of this section and the remaining provisions of the Plan, the provisions of this section will control.

Disclosure of PHI to the Company

- The Plan may disclose to the Company "summary health information," as that term is defined in the Privacy Rules, for the purpose of allowing the Company to (i) obtain bids from insurers for providing health insurance coverage under the Plan; or (ii) amend or terminate the Plan.

- The Plan may disclose to the Company enrollment or disenrollment information regarding an individual.
- The Plan may disclose an individual's PHI to the Company if authorized by the individual to make such disclosure in accordance with the Privacy Rules.
- Except as provided above and subject to the other provisions of this section, the Plan may disclose the PHI of a participant of the Plan or his or her dependent-participant, if any, to the Company only as necessary to enable the Company to perform "Plan Administration Functions" on behalf of the Plan.
- The term "Plan Administration Functions" shall have the same meaning ascribed to it by the Privacy Rules and shall include those activities that meet the Privacy Rule's definition of "Payment" or "Health Care Operations," including, without limitation, activities related to claims processing, auditing, eligibility or coverage decisions, utilization review, quality assurance, case management, and benefit design. Notwithstanding the foregoing, the term "Plan Administration Functions" shall not include any activities related to (i) obtaining bids from health insurers for the purpose of providing health insurance coverage under the Plan; (ii) amending or terminating the Plan; or (iii) enrollment or disenrollment in the Plan.

Use and Disclosure of PHI by the Company

The Company may use and/or disclose the PHI that it receives from the Plan to perform Plan Administration Functions on behalf of the Plan to the extent necessary to perform those functions or as required by law. The following Employees assist with Plan Administration Functions, and in connection with those job responsibilities, may use and/or disclose PHI that is received from the Plan:

- The designated Privacy Official and Privacy Contact;
- The designated Security Official;
- Employees who work in the Company's human resources department and have the responsibility for the Plan;
- Employees who work in the Company's benefits department and have the responsibility for the Plan;
- Employees who work in the Company's legal department and have the responsibility for the Plan;
- Employees who work in the Company's finance department and have the responsibility for the Plan, including auditing and plan accounting functions; and
- Employees who work in the Company's payroll department and have the responsibility for payroll deductions relating to the Plan.

If any of the individuals identified above fails to comply with the provisions of this section, he or she will be subject to the Plan's HIPAA Privacy Policies and Procedures regarding sanctions for violating the Privacy Rule.

Plan Sponsor Certification

The Plan may disclose an individual's PHI to the Company for the Company to perform Plan Administration Functions on behalf of the Plan, provided the Company agrees and certifies as follows:

- The Company will not use or disclose such PHI other than as permitted by the Plan or as required by law.
- The Company will ensure that any agents to whom it provides such PHI agree to the same restrictions and conditions applicable to the Company with respect to such PHI.
- The Company will not use or disclose such PHI for employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Company.
- The Company will report to the Plan any known use or disclosure of such PHI which is inconsistent with the permitted uses or disclosures of the PHI.
- To the extent such PHI is part of a "Designated Record Set" ("DRS"), as that term is defined by the Privacy Rule, the Company will allow the individual that is the subject of the PHI to access and copy the PHI in accordance with the Privacy Rule.
- To the extent such PHI is part of a DRS, the Company will make such PHI available for amendment and incorporate any amendments to the PHI in accordance with the Privacy Rule.
- The Company will make available such information as is required to allow the Plan to provide an accounting of disclosures of PHI to an individual in accordance with the Privacy Rule.
- The Company will make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services as necessary for the Secretary to determine the Plan's compliance with the Privacy Rule.
- If feasible, the Company will return or destroy all PHI received from the Plan once it is no longer needed for the purpose for which the disclosure was made, and if the return or destruction of the PHI is not feasible, the Company will limit the future use and disclosure of such information to those purposes which make the return or destruction of the information infeasible.
- The Company will provide for adequate separation between the Plan and Company, in the manner described in the Privacy Rules and this Section.

Security of Electronic PHI

The Plan will disclose PHI to the Company only if the Company agrees with respect to any Electronic PHI, that the Company will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation as required by the HIPAA Privacy Rules and as set forth in 45 CFR § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- Ensure that any agent to whom the Company may provide this information agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan any security incident of which the Company becomes aware.

15. Benefit Program Information

Summary of Eligibility and Participation Provisions

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

Benefit Program	Fully-insured or self-funded?	Policy or Group #	Who is eligible[1]	When Participation begins[2]	When Participation Ends[3]	To File a Claim, Contact:
Medical HMO, POS, HDHP	Fully-Insured / Aetna	847235	Full time employees working 30+ hours per week. Spouses and children generally are covered.	Date of Hire	End of month in which you terminate employment	Aetna PO Box 14079 Lexington, KY 40512 (800) 445-5299 (HMO) (877) 204-9186 (PPO)
Medical HMO	Fully-Insured / Kaiser	651834	Full time employees working 30+ hours per week. Spouses and children generally are covered.	Date of Hire	End of month in which you terminate employment	Kaiser Member Services: (800) 464-4000
Medical HRA	Self-Insured / Fertility Reimbursement Program	FV9	Employees and spouses enrolled in on of Five9's U.S. medical plans	Date of Hire	End of month in which you terminate employment	Navia Benefits (800) 669-3539
Medical	Medical Benefits Abroad / Cigna	06274A	Full time employees working 30+ hours per week. Spouses and children generally are covered.	Date of Hire	End of month in which you terminate employment	Cigna Claims PO Box 15111 Wilmington, DE 19809 (800) 243-1348
Dental PPO	Fully-Insured/ Aetna	847235	Full time employees working 30+ hours per week. Spouses and children generally are covered.	Date of Hire	End of month in which you terminate employment	Aetna PO Box 14079 Lexington, KY 40512 (877) 238-6200

[1] References to spouse and/or children include eligible domestic partners and/or eligible children of domestic partners.
[2] Enrollments must be made within 30 days of date of hire to begin participation.
[2] Other Events (such as fraud or intentional misrepresentation of a material fact) can also terminate coverage -- see the Benefit Description details.

Benefit Program	Fully-insured or self-funded?	Policy or Group #	Who is eligible[1]	When Participation begins[2]	When Participation Ends[3]	To File a Claim, Contact:
Vision	Fully-Insured / VSP	30098659	Full time employees working 30+ hours per week. Spouses and children generally are covered.	Date of Hire	End of month in which you terminate employment	VSP Customer Care: (800) 877-7195
Life/AD&D, LTD, STD	Fully-Insured / Guardian	477224	Full time employees working 30+ hours per week.	Date of Hire	Date of termination of employment	Guardian Customer Response Unit (800) 525-4542
EAP	Fully-Insured / Spring Health	Work-life code: five9	Full time employees working 30+ hours per week, Spouses and children age 6 and over generally are covered.	Date of Hire	Date of termination of employment	Spring Health Support (855) 629-0554
EAP	Fully-Insured / Guardian	477224	Full time employees and their household members working 30+ hours per week.	Date of Hire	Date of termination of employment	Guardian Customer Response Unit (800) 525-4542
Health Care FSA	Self-Funded / Navia	FV9	Full time employees working 30+ hours per week.	Date of Hire	Date of termination of employment	Navia Benefits (800) 669-3539
Dependent Care FSA (Not subject to ERISA)	Self-Funded / Navia	FV9	Full time employees working 30+ hours per week.	Date of Hire	Date of termination of employment	Navia Benefits (800) 669-3539

Appendix A: COBRA Continuation

Five9
**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (Five9, Inc. Health and Welfare Benefit 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. What is COBRA continuation coverage?

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 must 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 60 days after the qualifying event occurs. You must provide this notice to:

Navia Benefits Solutions
PO Box 3961
Seattle, WA 98124
425-452-3490

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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

Navia Benefits Solutions
PO Box 3961
Seattle, WA 98124
425-452-3490

Cal-COBRA Continuation Coverage for Certain California Insured Plans

Insured medical plans with Contracts based in California are required to offer COBRA-qualified beneficiaries who are enrolled in their plans and exhaust their 18 or 29 months of federal COBRA an additional period of continuation coverage for a combined total of 36 months of continuation coverage from the date federal COBRA began. The premium charged for this additional coverage (after the maximum COBRA period has expired) will generally be 110% of the current premium rate. Contact your insurance carrier for further information on Cal-COBRA. Your insurance carrier will be able to supply you with further information regarding how to enroll, deadlines for enrollment, premium amounts, and deadlines for submitting premiums.

Appendix B: Medicare Part D Notice

Important Notice from Five9, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Five9, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. Five9, Inc. has determined that the prescription drug coverage offered by the Five9, Inc. Health and Welfare Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your Five9, Inc. coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Five9, Inc. Health and Welfare Benefit Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Five9, Inc. prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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

You should also know that if you drop or lose your current coverage with Five9, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information at HR.US@Five9.com. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Five9, Inc. changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	06/01/2023
Name of Entity/Sender:	Five9, Inc.
Contact-Position/Office:	HR Department
Address:	3001 Bishop Ranch, Suite 350 San Ramon, CA 94583
Phone Number:	(925) 201-2000

Appendix C: Cafeteria Plan and FSA Provisions

FIVE9, INC. FLEXIBLE BENEFITS PLAN

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FIVE9, INC. FLEXIBLE BENEFITS PLAN

INTRODUCTION

The Employer has amended this Plan effective January 1, 2017, to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to choose among different types of benefits based on their own particular goals, desires and needs. This Plan is a restatement of a Plan which was originally effective on June 1, 2012. The Plan shall be known as Five9, Inc. Flexible Benefits Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

ARTICLE I
DEFINITIONS

1.1 **"Administrator"** means the Employer unless another person or entity has been designated by the Employer pursuant to Section 9.1 to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

1.2 **"Affiliated Employer"** means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 **"Benefit"** or **"Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.4 **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefit Options as provided under Section 4.1. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.5 **"Code"** means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.6 **"Compensation"** means the amounts received by the Participant from the Employer during a Plan Year.

1.7 **"Dependent"** means any individual who qualifies as a dependent under an Insurance Contract for purposes of coverage under that Contract only or under Code Section 152 (as modified by Code Section 105(b)). Any child of a Plan Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Sec. 609 shall be considered a Dependent under this Plan.

"Dependent" shall include any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under the Health Care Flexible Spending Arrangement or as allowed by reason of the Affordable Care Act.

For purposes of the Health Care Flexible Spending Arrangement, a Participant's "Child" includes his/her natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

1.8 **"Effective Date"** means June 1, 2012.

1.9 **"Election Period"** means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.10 **"Eligible Employee"** means any Employee who has satisfied the provisions of Section 2.1.

An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

1.11 **"Employee"** means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

1.12 **"Employer"** means Five9, Inc. and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer shall include any Participating, Affiliated or Adopting Employer.

1.13 **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time to time.

1.14 **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit.

1.15 **"Insurance Premium Payment Plan"** means the plan of benefits contained in Section 4.1 of this Plan, which provides for the payment of Premiums.

1.16 **"Insurer"** means any insurance company that underwrites a Benefit under this Plan.

1.17 **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.18 **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.19 **"Plan"** means this instrument, including all amendments thereto.

1.20 **"Plan Year"** means the 12-month period beginning January 1 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.21 **"Premiums"** mean the Participant's cost for the Benefits described in Section 4.1.

1.22 **"Premium Conversion Benefit"** means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant shall be paid or reimbursed. If more than one type of insured Benefit is elected, sub-accounts shall be established for each type of insured Benefit.

1.23 **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.24 **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

1.25 **"Spouse"** means spouse as determined under Federal law.

ARTICLE II
PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder as of the date he satisfies the eligibility conditions for the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference. However, any Eligible Employee who was a Participant in the Plan on the effective date of this amendment shall continue to be eligible to participate in the Plan.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the entry date under the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured Benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

(a) **Termination of employment.** The Participant's termination of employment, subject to the provisions of Section 2.5;

(b) **Death.** The Participant's death, subject to the provisions of Section 2.6; or

(c) **Termination of the plan.** The termination of this Plan, subject to the provisions of Section 10.2.

2.5 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Benefit Options provided under Section 4.1 shall be governed in accordance with the following:

(a) **Insurance Benefit.** With regard to Benefits which are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid.

(b) **Day Care FSA.** With regard to the Day Care Flexible Spending Arrangement, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Day Care Expense reimbursements for claims incurred through the remainder of the Plan Year in which such termination occurs and submitted within 90 days after the end of the Plan Year, based on the level of the Participant's Day Care Flexible Spending Arrangement as of the date of termination.

(c) **COBRA applicability.** With regard to the Health Care Flexible Spending Arrangement, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year before the end of the period for which payments to the Health Care Flexible Spending Arrangement have already been made. Thereafter, the health benefits under this Plan including the Health Care Flexible Spending Arrangement shall be applied and administered consistent with such further rights a Participant and his Dependents may be entitled to pursuant to Code Section 4980B and Section 11.14 of the Plan.

2.6 DEATH

If a Participant dies, his participation in the Plan shall cease. However, such Participant's spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Care Flexible Spending Arrangement.

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION

Benefits under the Plan shall be financed by Salary Redirections sufficient to support Benefits that a Participant has elected hereunder and to pay the Participant's Premiums. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article IV.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.2 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Care Flexible Spending Arrangement or Day Care Flexible Spending Arrangement shall be credited to such fund or account. Amounts designated for the Participant's Premium Conversion Benefit shall likewise be credited to such account for the purpose of paying Premiums.

3.3 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the

Health Care Flexible Spending Arrangement, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS

Each Participant may elect any one or more of the following optional Benefits:

(1) Health Care Flexible Spending Arrangement

(2) Day Care Flexible Spending Arrangement

(3) Health Savings Account Benefit

In addition, except for the Health Savings Account Benefit, each Participant shall have a sufficient portion of his Salary Redirections applied to the following Benefits unless the Participant elects not to receive such Benefits:

(4) Health Insurance Benefit

(5) Dental Insurance Benefit

(6) Disability Insurance Benefit

(7) Vision Insurance Benefit

4.2 HEALTH CARE FLEXIBLE SPENDING ARRANGEMENT BENEFIT

Each Participant may elect to participate in the Health Care Flexible Spending Arrangement option, in which case Article VI shall apply.

4.3 DAY CARE FLEXIBLE SPENDING ARRANGEMENT BENEFIT

Each Participant may elect to participate in the Day Care Flexible Spending Arrangement option, in which case Article VII shall apply.

4.4 HEALTH INSURANCE BENEFIT

(a) **Coverage for Participant and Dependents.** Each Participant may elect to be covered under a health Insurance Contract for the Participant, his or her Spouse, and his or her Dependents.

(b) **Employer selects contracts.** The Employer may select suitable health Insurance Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

4.5 DENTAL INSURANCE BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.

(b) **Employer selects contracts.** The Employer may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.

4.6 DISABILITY INSURANCE BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's disability Insurance Contract.

(b) **Long term and/or short term coverage selected by Employer.** The Employer may select suitable disability Insurance Contracts for use in providing this disability Benefit. The disability Insurance Contracts may provide for long-term or short-term coverage.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the Benefits payable from such disability Insurance Contract shall be determined therefrom, and such disability Insurance Contract shall be incorporated herein by reference.

4.7 VISION INSURANCE BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's vision Insurance Contract. In addition, the Participant may elect either individual or family coverage.

(b) **Employer selects contracts.** The Employer may select suitable vision Insurance Contracts for use in providing this vision insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such vision Insurance Contract shall be determined therefrom, and such vision Insurance Contract shall be incorporated herein by reference.

4.8 HEALTH SAVINGS ACCOUNT BENEFIT

Each Participant may elect to have a portion of his Salary Redirections contributed to a Health Savings Account, as defined in Code Section 223. The amounts contributed shall be subject to the terms of the Health Savings Account as established.

4.9 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reduce contributions or non-taxable Benefits in order to assure compliance with the Code and regulations. Any act taken by the Administrator shall be carried out in a uniform and nondiscriminatory manner. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Care Flexible Spending Arrangement Benefits and Day Care Flexible Spending Arrangement Benefits, and once all these Benefits are expended, proportionately among insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his effective date of participation pursuant to Section 2.2.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, which spending account Benefit options he wishes to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.4.

5.3 FAILURE TO ELECT

With regard to Benefits available under the Plan for which no Premiums apply, any Participant who fails to complete a new benefit election form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized or made for the subsequent Plan Year for such Benefits.

With regard to Benefits available under the Plan for which Premiums apply, any Participant who fails to complete a new benefit election form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have made the same Benefit elections as are then in effect for the current Plan Year. The Participant shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit options.

5.4 CHANGE IN STATUS

(a) **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Regardless of the consistency requirement, if the individual, the individual's Spouse, or Dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code

Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

(1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;

(2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

(3) Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Day Care Flexible Spending Arrangement, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and guidance thereunder, shall qualify as a change in status.

(b) **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for group health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(c) **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(d) **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the

Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

(e) **Cost increase or decrease.** If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

(f) **Loss of coverage.** If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

(g) **Addition of a new benefit.** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

(h) **Loss of coverage under certain other plans.** A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

(i) **Change of coverage due to change under certain other plans.** A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

(j) **Change in Day Care provider.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the Day Care provider. The availability of Day Care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Day Care Flexible Spending Arrangement only if the cost change is imposed by a Day Care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

(k) **Health FSA cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Health Care Flexible Spending Arrangement as a result of a cost or coverage change under any health insurance benefits.

(l) **Health Savings Account changes.** With regard to the Health Savings Account Benefit specified in Section 4.8, a Participant who has elected to make elective contributions under such arrangement may modify or revoke the election prospectively, provided such change is consistent with Code Section 223 and the Treasury regulations thereunder.

(m) **Changes due to reduction in hours or enrollment in an Exchange Plan.** A Participant may prospectively revoke coverage under the group health plan (that is not a Health Care Flexible Spending Arrangement) which provides minimum essential coverage (as defined in Code §5000A(f)(1)) provided the following conditions are met:

Conditions for revocation due to reduction in hours of service:

(1) The Participant has been reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and

(2) The revocation of coverage under the group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

The Administrator may rely on the reasonable representation of the Participant who is reasonably expected to have an average of less than 30 hours of service per week for future periods that the Participant and related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Conditions for revocation due to enrollment in a Qualified Health Plan:

(1) The Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace (federal or state exchange) pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

(2) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

The Administrator may rely on the reasonable representation of a Participant who has an enrollment opportunity for a Qualified Health Plan through a Marketplace that the Participant and related individuals have enrolled or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

ARTICLE VI
HEALTH CARE FLEXIBLE SPENDING ARRANGEMENT

6.1 ESTABLISHMENT OF PLAN

This Health Care Flexible Spending Arrangement is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Care Flexible Spending Arrangement may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Care Flexible Spending Arrangement. Periodic payments reimbursing Participants from the Health Care Flexible Spending Arrangement shall in no event occur less frequently than monthly. There is an additional "limited FSA" designed to coordinate with a Health Savings Account and high deductible health plan.

6.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan, the terms below have the following meaning:

(a) **"Health Care Flexible Spending Arrangement"** means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed.

(b) **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) one of the 5 highest paid officers;

(2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

(3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(c) **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant who contributes to a Health Savings Account may only be reimbursed for medical expenses that are considered to be for dental, vision or preventive care expenses as allowed under Code Section 223.

A Participant may not be reimbursed for the cost of any medicine or drug that is not "prescribed" within the meaning of Code Section 106(f) or is not insulin.

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(d) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Care Flexible Spending Arrangement.

6.3 FORFEITURES

The amount in the Health Care Flexible Spending Arrangement as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof, excluding any carryover) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 8.2.

6.4 LIMITATION ON ALLOCATIONS

(a) Notwithstanding any provision contained in this Health Care Flexible Spending Arrangement to the contrary, the maximum amount of salary reductions that may be allocated to the Health Care Flexible Spending Arrangement by a Participant in or on account of any Plan Year is $2,500, as adjusted for increases in the cost of living in accordance with Code Section 125(i)(2). The cost of living adjustment in effect for a calendar year applies to any Plan Year beginning with or within such calendar year. The dollar increase in effect on January 1 of any calendar year shall be effective for the Plan Year beginning with or within such calendar year. For any short Plan Year, the limit shall be an amount equal to the limit for the calendar year in which the Plan Year begins multiplied by the ratio obtained by dividing the number of full months in the short Plan Year by twelve (12).

(b) **Participation in Other Plans.** All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the statutory limit. If a Participant participates in multiple cafeteria plans offering Health Care Flexible Spending Arrangements maintained by members of a controlled group or affiliated service group, the Participant's total Health Care Flexible Spending Arrangement contributions under all of the cafeteria plans are limited to the statutory limit (as adjusted). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to the statutory limit (as adjusted) under each Employer's Health Care Flexible Spending Arrangement.

(c) **Carryover.** A Participant in the Health Care Flexible Spending Arrangement may roll over up to $500 of unused amounts in the Health Care Flexible Spending Arrangement remaining at the end of one Plan Year to the immediately following Plan Year. These amounts can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirection contributions for the Plan Year to which they are carried over. Unused amounts are those remaining after expenses have been reimbursed during the runout period. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Amounts in excess of $500 will be forfeited. The Plan is allowed, but not required, to treat claims as being paid first from the current year amounts, then from the carryover amounts.

6.5 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Health Care Flexible Spending Arrangement not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Care Flexible Spending Arrangement, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Care Flexible Spending Arrangement by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Care Flexible Spending Arrangement for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

6.6 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Care Flexible Spending Arrangement. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health Care Flexible Spending Arrangement. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

6.7 HEALTH CARE FLEXIBLE SPENDING ARRANGEMENT CLAIMS

(a) **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year shall be reimbursed during the Plan Year subject to Section 2.5, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(b) **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Care Flexible Spending Arrangement for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore,

a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Care Flexible Spending Arrangement, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

(d) **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator.

6.8 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

(a) **Card only for medical expenses.** Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reloaded for each Plan Year the Participant remains a Participant in the Health Care Flexible Spending Arrangement. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Care Flexible Spending Arrangement.

(c) **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 6.4.

(d) **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator following IRS guidelines.

(e) **Card use.** The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:

(1) Co-payments for doctor and other medical care;

(2) Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;

(3) Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(g) **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to

ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) if subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

ARTICLE VII
DAY CARE FLEXIBLE SPENDING ARRANGEMENT

7.1 ESTABLISHMENT OF ACCOUNT

This Day Care Flexible Spending Arrangement is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Day Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Day Care Flexible Spending Arrangement.

7.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan the terms below shall have the following meaning:

(a) **"Day Care Flexible Spending Arrangement"** means the account established for a Participant pursuant to this Article to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Day Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

(b) **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for Day Care assistance to the Participant.

(c) **"Employment-Related Day Care Expenses"** means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Day Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the Day Care that gives rise to the Employment-Related Day Care Expenses, not when the Participant is formally billed or charged for, or pays for the Day Care. The determination of whether an amount qualifies as an Employment-Related Day Care Expense shall be made subject to the following rules:

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Day Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(d)(1) (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or for a Qualifying Dependent as defined in Section 7.2(d)(2) (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least 8 hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(3) Employment-Related Day Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

(d) **"Qualifying Dependent"** means, for Day Care Flexible Spending Arrangement purposes,

(1) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;

(2) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

(3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Day Care Flexible Spending Arrangement.

7.3 DAY CARE FLEXIBLE SPENDING ARRANGEMENTS

The Administrator shall establish a Day Care Flexible Spending Arrangement for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Day Care Flexible Spending Arrangement benefits.

7.4 INCREASES IN DAY CARE FLEXIBLE SPENDING ARRANGEMENTS

A Participant's Day Care Flexible Spending Arrangement shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that he has elected to apply toward his Day Care Flexible Spending Arrangement pursuant to elections made under Article V hereof.

7.5 DECREASES IN DAY CARE FLEXIBLE SPENDING ARRANGEMENTS

A Participant's Day Care Flexible Spending Arrangement shall be reduced by the amount of any Employment-Related Day Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DAY CARE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Day Care Flexible Spending Arrangement, a Participant who incurs Employment-Related Day Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

7.8 FORFEITURES

The amount in a Participant's Day Care Flexible Spending Arrangement as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.12 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

7.9 LIMITATION ON PAYMENTS

(a) **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Day Care Flexible Spending Arrangement in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

7.10 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Day Care Flexible Spending Arrangement that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(b) **25% test for shareholders.** It is the intent of this Day Care Flexible Spending Arrangement that not more than 25 percent of the amounts paid by the Employer for Day Care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Day Care Flexible Spending Arrangement by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Day Care Flexible Spending Arrangement for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.11 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Day Care Flexible Spending Arrangement. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Day Care Flexible Spending Arrangement. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

7.12 DAY CARE FLEXIBLE SPENDING ARRANGEMENT CLAIMS

The Administrator shall direct the payment of all such Day Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Day Care Expenses submit a statement which may contain some or all of the following information:

(a) The Dependent or Dependents for whom the services were performed;

(b) The nature of the services performed for the Participant, the cost of which he wishes reimbursement;

(c) The relationship, if any, of the person performing the services to the Participant;

(d) If the services are being performed by a child of the Participant, the age of the child;

(e) A statement as to where the services were performed;

(f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

(g) If the services were being performed in a day care center, a statement:

(1) that the day care center complies with all applicable laws and regulations of the state of residence,

(2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(3) of the amount of fee paid to the provider.

(h) If the Participant is married, a statement containing the following:

(1) the Spouse's salary or wages if he or she is employed, or

(2) if the Participant's Spouse is not employed, that

(i) he or she is incapacitated, or

(ii) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

(i) **Claims for reimbursement.** If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

ARTICLE VIII
BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS

(a) **Insurance claims.** Any claim for Benefits underwritten by Insurance Contract(s) shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure.

(b) **Health and Day Care Flexible Spending Arrangement Claims.** The Participant must submit all claims no later than 90 days after the end of the Plan Year. Any claims submitted after that time will not be considered. If a claim under the Plan is denied in whole or in part, the Participant will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure.

A level one appeal must be submitted within 180 days of receipt of the denial. Any such request should be accompanied by documents or records in support of the appeal. The Participant may review pertinent documents and submit issues and comments in writing. The claims administrator will review the claim and provide, within 30 days, a written response to the appeal (extended by reasonable time if necessary). In this response, the claims administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. If the Participant disagrees with the level one appeal decision, the Participant may submit a request for a level two appeal to be determined by the Employer. The Participant must submit the request for a level two appeal within 60 days of receipt of the level one notice. The Participant will be notified within 30 days after the Employer received the appeal (extended by reasonable time if necessary). The Employer has the exclusive right to interpret the appropriate Plan provisions. Decisions of the Employer are conclusive and binding.

The following timetable for claims applies:

Notification of whether claim is accepted or denied: 30 days

Extension due to matters beyond the control of the Plan: 15 days

Denial or insufficient information on the claim:

Notification of: 15 days

Response by Participant: 45 days

Review of claim denial: 30 days

The Participant must file the appeal by submitting a written request by email, fax, or mail to Navia and indicate either level one or two on the email, fax, or letter.

Email:claims@naviabenefits.com

Fax: 425-451-7002 or 866-535-9227

Mail: Navia Benefit Solutions, Inc. PO Box 53250 Bellevue, Washington 98015

The response will provide written or electronic notification of any claim denial. The notice will state:

(1) The specific reason or reasons for the denial;

(2) Reference to the specific Plan provisions on which the denial was based;

(3) A description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary;

(4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under section 502 of ERISA following a denial on review;

(5) A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and

(6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the Participant upon request.

When the Participant receives a denial, the Participant will have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the claim. If the Participant requests, the Participant will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

(1) was relied upon in making the claim determination;

(2) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all Participants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

(c) **Forfeitures.** Any balance remaining in the Participant's Health Care Flexible Spending Arrangement (excluding any carryover) or Day Care Flexible Spending Arrangement as of the end of the time for claims reimbursement for each Plan Year and Grace Period (if applicable) shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3 or Section 7.8, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

8.2 APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan (excepting any carryover); nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan. No amounts attributable to the Health Savings Account shall be subject to the benefit plan surplus.

8.3 NAMED FIDUCIARY

The Administrator shall be the named fiduciary pursuant to ERISA Section 402 and shall be responsible for the management and control of the operation and administration of the Plan.

8.4 GENERAL FIDUCIARY RESPONSIBILITIES

The Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and

(a) for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;

(b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

(c) in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

8.5 NONASSIGNABILITY OF RIGHTS

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be required by law.

ARTICLE IX
ADMINISTRATION

9.1 PLAN ADMINISTRATION

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator.

Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

If the Employer elects, the Employer shall appoint one or more Administrators. Any person, including, but not limited to, the Employees of the Employer, shall be eligible to serve as an Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. An Administrator may resign by delivering a resignation in writing (or such other form as acceptable to both parties) to the Employer or be removed by the Employer by delivery of notice of removal (in writing or such other form as acceptable to both parties), to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of the Act, the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconciles any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

(a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

(f) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

(g) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

(h) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609; and

(i) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

9.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

9.3 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

9.4 INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

9.5 INDEMNIFICATION OF ADMINISTRATOR

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

ARTICLE X
AMENDMENT OR TERMINATION OF PLAN

10.1 AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

10.2 TERMINATION

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

No further additions shall be made to the Health Care Flexible Spending Arrangement or Day Care Flexible Spending Arrangement, but all payments from such fund shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

ARTICLE XI
MISCELLANEOUS

11.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 11.12.

11.2 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

11.3 WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

11.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

11.5 PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

11.6 ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

11.7 EMPLOYER'S PROTECTIVE CLAUSES

(a) **Insurance purchase.** Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's Benefits shall be limited to the insurance premium(s), if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim.

(b) **Validity of insurance contract.** The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance Contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

11.8 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

11.9 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant

as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

11.10 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

11.11 GOVERNING LAW

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of California.

11.12 SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

11.13 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

11.14 CONTINUATION OF COVERAGE (COBRA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

11.15 FAMILY AND MEDICAL LEAVE ACT (FMLA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

11.16 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

11.17 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.

11.18 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

(a) **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

(b) **Disclosure of PHI.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(c) **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(d) **PHI disclosed to certain workforce members.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy official. The privacy official shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(e) **Certification.** The Employer must provide certification to the Plan that it agrees to:

(1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

(5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(9) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(10) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

11.19 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

(a) **Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(b) **Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(c) **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 11.18.

11.20 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712.

11.21 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

11.22 WOMEN'S HEALTH AND CANCER RIGHTS ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

11.23 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

Appendix D: Notice of HIPAA Privacy Practices

Five9, Inc. Health and Welfare Benefit Plan
PRIVACY PRACTICES NOTICE

Effective Date: June 1, 2023

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Our Privacy Practices

We may use and disclose your protected health information ("medical information"), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We may disclose to your employer whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose summary health information to your employer for certain limited purposes. We may disclose your medical information to your employer to administer your group health plan if your employer explains the limitations on its use and disclosure of your medical information in the plan document for your group health plan.

Except for certain legally-approved uses and disclosures, we will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

Contact Information

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Contact Office.

Contact Office: HR Department

Telephone: (925) 201-2000

E-mail: HR.US@Five9.com

Address: 3001 Bishop Ranch, Suite 350 San Ramon, CA 94583

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information ("medical information"). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **June 1, 2023**, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

Uses and Disclosures of Your Medical Information

Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities,

competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We generally may use or disclose any psychotherapy notes we hold only with your authorization.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing medical information related to your care or payment is in your best interest under the circumstances.

Your medical information remains protected by us for at least 50 years after you die. After you die, we may disclose to a family member, or other person involved in your health care prior to your death, the medical information that is relevant to that person's involvement, unless doing so is inconsistent with your preference and you have told us so.

Your Employer: We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan (this is sometimes called "underwriting"). Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the summary health information as yours. We are expressly prohibited from using or disclosing any health information containing your genetic information for underwriting purposes.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;

- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Your Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You should submit your request in writing to our Contact Office.

We may charge you reasonable, cost-based fees (including labor costs) for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Contact Office for information about our fees.

Your medical information may be maintained electronically. If so, you can request an electronic copy of your medical information. If you do, we will provide you with your medical information in the electronic form and format you requested, if it is readily producible in such form and format. If not, we will produce it in a readable electronic form and format as we mutually agree upon.

You may request that we transmit your medical information directly to another person you designate. If so, we will provide the copy to the designated person. Your request must be in writing, signed by you and must clearly identify the designated person and where we should send the copy of your medical information.

Disclosure Accounting: You have the right to a list of instances from the prior six years in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the Contact Office. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before the plan's effective date (if the plan was created less than six years ago).

Amendment. You have the right to request that we amend your medical information. You should submit your request in writing to the Contact Office.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request, except for certain required restrictions, described below. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the Contact Office. We will agree to (and not terminate) a restriction request if:

1. the disclosure is to a health plan for purposes of carrying out payment or health care

operations and is not otherwise required by law; and

2. the medical information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. You should submit your request in writing to the Contact Office.

We will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Notification may be delayed or not provided if so required by a law enforcement official. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Contact Office to obtain this notice in written form.

Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may complain to our Contact Office.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Appendix E: Authorized Representatives

Appointment of Authorized Representative

I, _____

[name of claimant]

hereby appoint_____ to act on my behalf

[name of Authorized Representative]

or on behalf of_____

[name of patient: plan participant or beneficiary]

in connection with any claim for coverage or benefits, including receipt of any approvals or authorizations that are required before medical services are provided under the plan named above ("Plan"). I authorize my representative to receive any and all information that is provided to me, and to act for me and for my covered spouse or dependent, if named above as the patient, in providing any information to the Plan that relates to any claim for coverage or benefits under the Plan.

This form does not constitute an assignment of rights for direct payment.

□ Distribute to me and to my Authorized Representative: All information and notifications should be distributed to me and to my Authorized Representative.

_____ _____

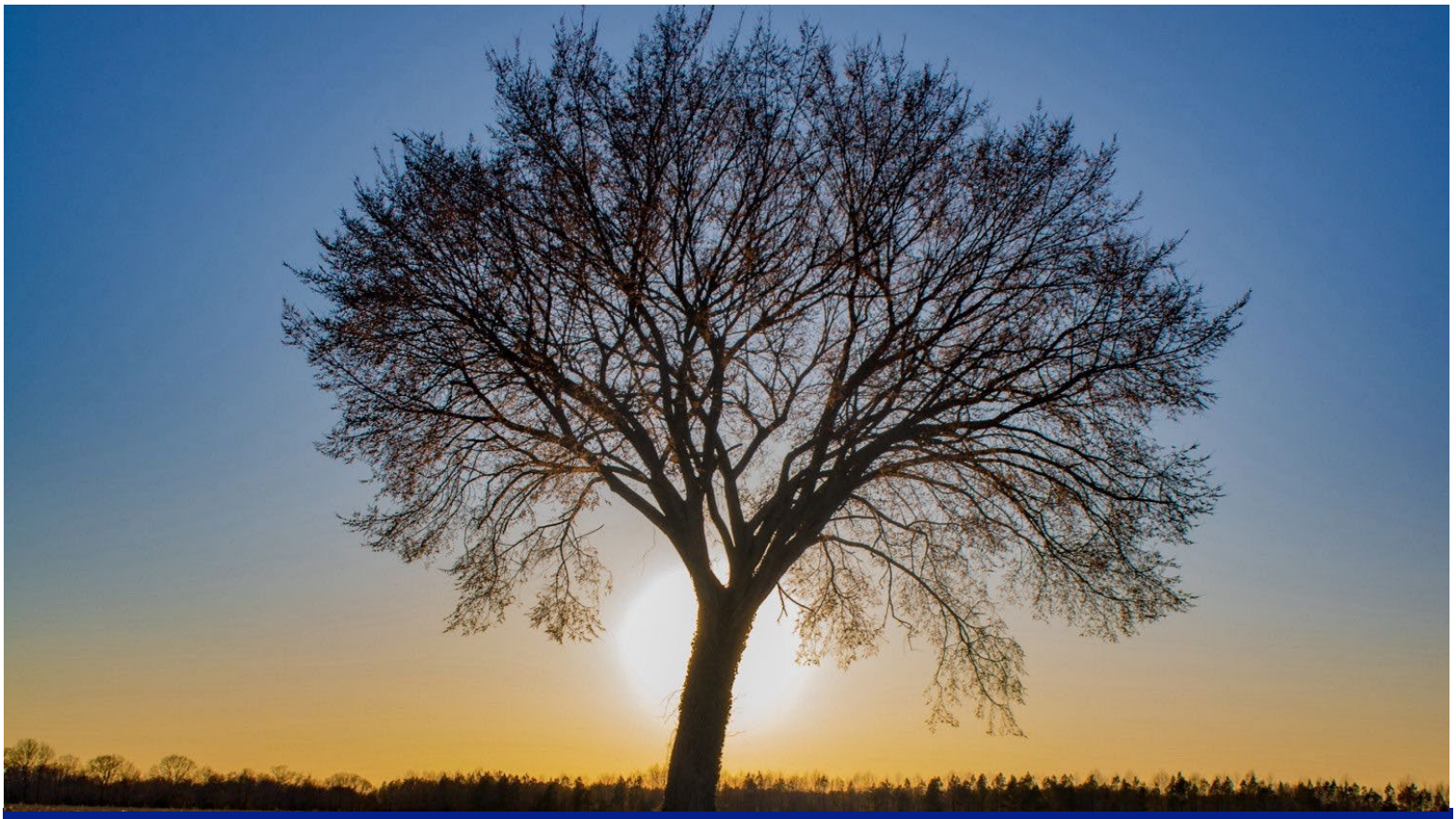
Claimant's signature Date

Accepted:_____ _____

Authorized Representative's signature Date

Witness:_____ _____

Witness signature Date



Five9 2024 Benefits

FUELING GROWTH, FOSTERING #JOY

Five9 The Intelligent CX Platform

06/01/2024 - 12/31/2024

Updated 05/28/2024

Here's some important information you should know.

Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices for more details.

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

A list of plan contacts is included at the back of this guide.

The benefits in this summary are effective 06/01/2024 through 12/31/2024

Welcome to your 2024 benefits. Our benefits program provides you with the best in coverage that is simple and easy to use. We offer programs that protect your health, your money, your family, and help you find balance between your concerns at work and at home. We also know the value of understanding your coverage, so you know how to get care, when you need it, at the lowest cost. With the information and tools in this guide and related resources, we hope to help you be well today and work toward a healthy and secure future.

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Are you eligible for benefits?

You're eligible for benefits if you are a regular, full-time employee working 30 hours per week, unless otherwise specified by your employer.

Your eligible dependents

- Legally married spouse or qualified domestic partner (including same- or opposite-sex)
- Natural, adopted, stepchildren, and children of your qualified domestic partner up to age 26
  - Coverage ends at the end of the month in which the child reaches age 26
- Tax dependent children of any age who are disabled and dependent on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law

Family members such as parents, grandparents, grandchildren, siblings, or anyone who is not your tax dependents as described above are not eligible for coverage. In some situations, eligible domestic partners (and their children) may be covered under many of our plans. However, covering non-tax dependent domestic partners (and/or their children) will result in an additional tax liability for you. To enroll a domestic partner (and/or their children) you will be required to submit a completed Affidavit to our Benefits Advocate at five9@alliant.com.

When you can enroll

You can enroll in benefits as a new hire, during the annual open enrollment period, or with a qualified life event. New hire coverage for full-time employees begins on your date of hire as long as you enroll **within 30 days** of becoming eligible. If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason). If you are an intern working 30 hours per week, you become eligible for coverage 90 days after your date of hire.

Changing your benefits

Outside of open enrollment, you may be able to enroll, add or remove dependents or change benefit options if you have a significant change in your life. All Life event change need to be submitted **within 30 days** from the date of the Qualifying Event. Eligible events include:

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

Changes to your benefits must be consistent with the Life Event and documentation is required, as applicable. Send your documentation to five9@alliant.com at the time you submit your Life Event. If you do not have the required documentation, i.e. Marriage Certificate, Birth Certificate, Evidence of Other Coverage, etc. within the 30 days, you MUST still submit your Life Event change through UltiPro within the 30-day time requirement.

Following successful completion of your mid-year change in UltiPro and submission of any required documentation, the effective date of coverage will be the date of your Life Event. Send an e-mail to five9@alliant.com indicating your Life Event submission and documentation will follow. Coverage will not be in place until the required documentation is received. Documentation must be received no later than 60 days following the date of your event. If you fail to notify or submit the required documentation within the necessary timeframes, your coverage will not be processed and you will be responsible for the entire cost of any services you receive.

Enrolling in your benefits & making changes

When you have made your benefits decisions and are ready to enroll or make a benefits change, go to UltiPro through Okta, Five9's employee single sign on. Go to Menu (3 horizontal lines in the upper left) > Myself > New Hire Enrollment/Life Event Changes, select the appropriate Life Event.

Your Elections

- Five9's Medical, Dental and Vision Short Plan Year will be June 1 – Dec 31
- As of 1/1/2025, Five9's Medical, Dental, and Vision Plan Year will align for Jan 1 – Dec 31
- Annual deductibles and Out-of-pocket expenses run on a calendar year basis
- The Flexible Spending Accounts (FSA) are on a calendar year basis (FSA Open Enrollment is generally held in the October/November timeframe)
- Short-Term and Long-Term Disability Tax Choice – Changes are allowed during the Annual Benefits Open Enrollment period.
- Voluntary/Supplemental Life Insurance – Until 1/1/2025, changes are allowed at any time based on a Family Status Change (see page 19 for qualifying events). As of 1/1/2025, changes will only be allowed during the Open Enrollment Period.
- Benefit elections can be changed during the applicable Open Enrollment Period and within 30 days of a Qualifying Life Event

When does your coverage end

- Your health benefits (medical, dental, vision) end at the end of the month in which you are considered ineligible, or you have a Qualified Life Event and request coverage termination. You are considered ineligible if you are no longer a regular, full-time employee working 30 hours per week.
- Your contributions will continue until the end of the month if you are still employed. If you are no longer employed, the full amount of your deductions for the month will be taken on your final paycheck.
- Your income replacement benefits (life, AD&D, short-term disability and long-term disability) end on the date in which your employment ends with Five9.
- Your Healthcare and Limited Purpose Flexible Spending Account (FSA) coverage ends on the date of your termination. You will have 90 days from your date of termination to submit any claims, otherwise, your funds will be forfeited.
- Your Dependent Care Flexible Spending Account (FSA) coverage ends on the date of your termination. While you will no longer be able to fund your account after this date, you will be able to incur eligible expenses until the end of the calendar year and submit claims until 90 days following the end of the calendar year.
- Your Health Savings Account (HSA) will remain yours, even if you leave Five9. HSA Bank will continue to administer the account and begin charging a monthly fee.

Need help?

Get help with your benefits however you feel most comfortable. You have many different ways to get answers to your questions and assistance with coverage and claims issues. Use the resources on the following pages freely!

Say hello to your Benefit Advocate

Reach out to your Benefit Advocate for personal and confidential assistance with

- General benefit questions
- Eligibility and coverage
- Finding a network provider
- Coverage changes due to life events such as marriage, a new child, or divorce
- Health care claim or billing issues

Vanessa Ortiz

Five9@alliant.com
(925) 658-1569
8:00 am – 5:00 pm Mon-Thu
8:00 am – 4:30 pm Fri (Pacific Time)

Make friends with mobile apps

Stay informed while you're on the go! Many of your benefit plans offer apps that provide personalized information about your benefits coverage and individual usage.

Visit the plan's website for app information or search on the Apple Store or Google Play.

Employee Benefits Portal

Many of our plan specifics and documents can be found on our online benefits portal, MyBenefits.Life. Plan information, contacts, legal documents, and carrier resources are available for you and your family members. To access the site, go to Five9.MyBenefits.Life and use the Employer Key: Five9.

There is also a MyBenefits.Life app available to you through the App Store and Google Play!

Retirement Questions

For questions about the 401(k) plan, please contact Fidelity at www.401k.com or (800) 835-5097

Cost of coverage

The total amount that you pay for your benefits coverage depends on the plans you choose and the dependents you cover.

Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes. As required by the IRS, employees covering domestic partners (and/or children of domestic partners) will be taxed on the value of coverage each pay period. To enroll a domestic partner (and/or their children), you will be required to submit a completed Affidavit to our Benefits Advocate at five9@alliant.com.

Five9 covers the cost of your coverage and shares in the cost of your eligible dependents.

Costs shown are semi-monthly (24/year) and are effective from June 1, 2024 – Dec 31, 2024.

Medical	Employee Only	Employee + Spouse/Domestic Partner	Employee + Child(ren)/Child(ren) of Domestic Partner	Employee + Family/Domestic Partner Family
Cigna HDHP	$0	$160.84	$107.23	$281.47
Cigna PPO OAP	$0	$248.60	$165.73	$435.04
***Cigna OAPIN (CA only)**	$0	$242.10	$161.40	$423.67
***Kaiser HMO (CA only)**	$0	$161.68	$134.73	$269.47

Dental	Employee Only	Employee + Spouse/Domestic Partner	Employee + Child(ren)/Child(ren) of Domestic Partner	Employee + Family/Domestic Partner Family
Cigna Dental PPO	$0.00	$5.00	$5.00	$10.00

Vision	Employee Only	Employee + 1 (EE + 1 Child or EE + Spouse/DP)	Employee + Family	Employee + Domestic Partner Family
VSP Vision (Direct)	$0.00	$2.50	$5.00	$5.00

***Kaiser HMO (CA ONLY), limited to Kaiser service areas. Some California residents may not have access to the Kaiser HMO service areas based on zip code.

*Cigna OAPIN (CA ONLY) is only available to California residents.

Please Note: Cigna Medical, Cigna Dental and VSP Vision contributions will not change until January 1, 2026.

Your contributions will begin on the next possible paycheck following your enrollment. Based on the timing in which you complete your enrollment, you may have multiple contributions on one paycheck. To avoid multiple contributions on one paycheck, be sure to complete your enrollment as soon as possible.

BENEFIT WAIVER

If you decline Medical, Dental and Vision coverage, you will receive $50.00 per paycheck (taxable income). The Benefit Waiver payment begins on the paycheck following your submitted and approved election to decline benefits, which you make during Open Enrollment, New Hire Enrollment, or with the Qualified Life Event process in UKG. After declining coverage, please be

sure to review your next two paychecks (it may take a full pay cycle to take effect) to ensure you are receiving your waiver payment. If you find you are not receiving the payment, email our Benefits Advocate at five9@alliant.com. Back payments can only be processed for two paychecks, and in no event can they be processed for the prior year.

If you do not complete the enrollment process to decline coverage at the time of your eligibility or in conjunction with a Qualified Life Event, your next opportunity to receive the Benefit Waiver payment will be during the next Open Enrollment period. You must complete Open Enrollment and decline Medical, Dental and Vision coverage.

VOLUNTARY LIFE AND AD&D

The cost for Voluntary Life & AD&D for you and your spouse is dependent upon your age and the benefit amount you elect. Costs increase with the employee's age and the elected benefit amount. The cost of child coverage is based on the benefit amount and covers all of the employee's dependent children. Rates will be calculated for you when you complete your enrollment in UKG.

Compare medical plans

Five9 offers different medical plans for different needs and budgets. Here's an overview of how each type of plan works.

HDHP

High Deductible Health Plan

- Cigna HDHP

An HDHP may have a higher deductible than a traditional plan, but it is the only plan with a Health Savings Account (HSA). Five9 contributes $150 per month ($1,800 annually) to the HSA for an employee enrolling only themselves and $240 per month ($2,880 annually) to the HSA for those enrolling one or more dependents if you are enrolled in the Five9 HDHP. Optionally, you can contribute your own tax-free dollars (Refer to HSA & FSA (HSA Features) section of this booklet for details regarding taxation). The HSA helps you pay your deductible and other healthcare expenses. You can visit any provider, and if you stay in-network, you'll be able to save more of your HSA dollars for future healthcare needs.

Cigna Network: Open Access Plus/OAP **without** Carelink*

PPO

Preferred Provider Organization

- Cigna PPO OAP
- Cigna OAPIN (CA Only)

The PPO OAP gives you flexibility and choice, for a price. You can go to any doctor without a referral, but you will pay a larger share of the cost if they are not in the plan's network. You'll need to meet an annual deductible for most medical services before the plan starts to pay.

The OAPIN functions like a PPO since no PCP or referrals are needed, but services function like an HMO since services are covered in-network only.

Cigna Network: Open Access Plus/OAP **without** Carelink*

HMO

Health Maintenance Organization

- Kaiser HMO (CA Only)

An HMO gives you more predictable costs but less flexibility. You pay a copay for most services, but all care must be received within the HMO network. Out-of-network care is not covered except in an emergency. Kaiser plans are unique in that you must receive all care at Kaiser facilities.

*Open Access Plus is the national network name. There may be a slight variation in the plan names shown. In all cases, be sure to select the "Open Access Plus/OAP" option **without** Carelink.

Medical

CIGNA HDHP

	In-network	Out-of-network
Annual deductible (calendar year)	$3,200 per individual; $6,000 per family	$3,200 per individual; $6,000 per family
Annual out-of-pocket maximum	$3,500 per individual; $7,000 per family	$7,000 per individual; $14,000 per family
Primary provider office visit	No charge after deductible	30% after deductible
Specialist office visit	No charge after deductible	30% after deductible
Acupuncture	No charge after deductible	30% after deductible
Preventive care	No charge	30% after deductible
Diagnostic lab and X-ray	No charge after deductible	30% after deductible
Urgent care	No charge after deductible	30% after deductible
Emergency room	No charge after deductible	No charge after deductible
Hospitalization	No charge after deductible	30% after deductible
Outpatient surgery	No charge after deductible	30% after deductible

Prescription Drugs

Annual deductible	Subject to Medical deductible	
Annual out-of-pocket maximum	Subject to Medical out-of-pocket maximum	
Generic	**Pharmacy:** $5 copay after deductible **Mail order:** $10 copay after deductible	**Pharmacy:** Not Covered **Mail order:** N/A
Preferred brand	**Pharmacy:** $30 copay after deductible **Mail order:** $60 copay after deductible	**Pharmacy:** Not Covered **Mail order:** N/A
Non-preferred brand	**Pharmacy:** $50 copay after deductible **Mail order:** $100 copay after deductible	**Pharmacy:** Not Covered **Mail order:** N/A
Specialty Drugs	20% after deductible up to $250	**Not Covered**
Number of days' supply	**Pharmacy:** Up to 30 days **Mail order:** Up to 90 days	Not applicable

Five9 HSA Funding: Five9 contributes $150 monthly ($1,800 annually) to the HSA for employees enrolling only themselves in the Five9 Cigna HDHP or $240 monthly ($2,880 annually) to the HSA for those enrolling themselves and one or more dependents in the Five9 Cigna HDHP.

Out of network coverage: If you receive coverage from an out of network doctor, professional, hospital, or facility, Cigna will cover your costs based on their "recognized" amount. The amount is based on what Medicare pays for the service which is set by the government. Your non-network provider may charge a rate higher than the "recognized" amount and you will be responsible for any balance in excess of the "recognized" amount.

Medical

CIGNA PPO OAP

	In-network	Out-of-network
Annual deductible (calendar year)	$250 per individual; $750 family limit	$250 per individual; $750 family limit
Annual out-of-pocket maximum	$2,500 per individual; $5,000 family limit	$6,500 per individual; $13,000 family limit
Primary provider office visit	$20 copay	30% after deductible
Specialist office visit	$20 copay	30% after deductible
Acupuncture	10% after deductible	30% after deductible
Preventive care	No charge	30% after deductible
Diagnostic lab and X-ray	10% after deductible	30% after deductible
Urgent care	$35 copay	30% after deductible
Emergency room	$150 copay + 10%	$150 copay + 10%
Hospitalization	10% after deductible	30% after $500 copay after deductible
Outpatient surgery	10% after deductible	30% after deductible
Prescription Drugs		
Annual deductible	Not subject to deductible	
Annual out-of-pocket maximum	Subject to Medical out-of-pocket maximum	
Generic	**Pharmacy:** $5 copay **Mail order:** $10 copay	**Pharmacy:** Not Covered **Mail order:** N/A
Preferred brand	**Pharmacy:** $30 copay **Mail order:** $60 copay	**Pharmacy:** Not Covered **Mail order:** N/A
Non-preferred brand	**Pharmacy:** $50 copay **Mail order:** $100 copay	**Pharmacy:** Not Covered **Mail order:** N/A
Specialty Drugs	**20% up to $150**	**Not Covered**
Number of days' supply	**Pharmacy:** Up to 30 days **Mail order:** Up to 90 days	Not applicable

Out of network coverage: If you receive coverage from an out of network doctor, professional, hospital, or facility Cigna will cover your costs based on their "recognized" amount. The amount is based on what Medicare pays for the service which is set by the government. Your non-network provider may charge a rate higher than the "recognized" amount and you will be responsible for any balance in excess of the "recognized" amount.

Medical

	*KAISER HMO (CA ONLY) In-network only	*CIGNA OAPIN (CA ONLY) In-network only
Annual deductible (calendar year)	None	None
Annual out-of-pocket maximum	$1,500 per individual; $3,000 per family	$2,000 per individual; $4,000 per family
Primary provider office visit	$20 copay	$20 copay
Specialist office visit	$20 copay	$40 copay
Acupuncture	$20 copay	$15 copay
Preventive care	No charge	No charge
Diagnostic lab and X-ray	$10 copay	No charge
Urgent care	$20 copay	$35 copay
Emergency room	$50 copay	$100 copay
Hospitalization	$250 copay	$250 copay
Outpatient surgery	$100 copay	$125 copay
Prescription Drugs		
Annual deductible	Not subject to deductible	Not subject to deductible
Annual out-of-pocket maximum	Subject to Medical out-of-pocket maximum	Subject to Medical out-of-pocket maximum
Generic	**Pharmacy:** $10 copay **Mail order:** $20 copay	**Pharmacy:** $5 copay **Mail order:** $10 copay
Preferred brand	**Pharmacy:** $30 copay **Mail order:** $60 copay	**Pharmacy:** $30 copay **Mail order:** $60 copay
Non-preferred brand	**Pharmacy:** $30 copay **Mail order:** $60 copay	**Pharmacy:** $50 copay **Mail order:** $100 copay
Specialty Drugs	**20% up to $150**	**Covered at copay**
Number of days' supply	**Pharmacy:** Up to 30 days **Mail order:** Up to 100 days	**Pharmacy:** Up to 90 days **Mail order:** Up to 90 days

*Kaiser HMO (CA ONLY), limited to Kaiser service areas. Some California residents may not have access to the Kaiser HMO service areas based on zip code.

*Cigna OAPIN (CA ONLY) is only available to California residents.

Finding a Cigna provider for 2024:

With our change to Cigna for Medical and Dental, be sure to check whether your doctor and dentist is in-network. Cigna's network of providers can be reviewed through their provider lookup tool and selecting the Open Access Plus/OAP Option **without** Carelink. If you wish to have a Medical ID card, these can be accessed through Cigna's website or accessed through their IOS or Android mobile apps.

Prescription drug savings

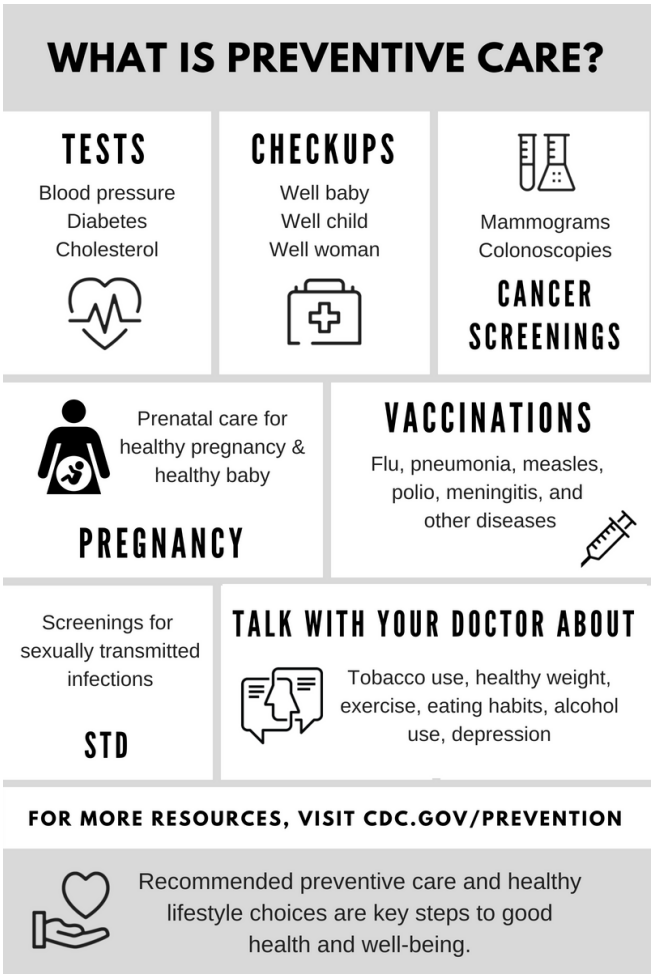
Are prescription drug costs breaking your budget?

A little research before you go to the pharmacy could result in huge savings. This is especially important in a high deductible health plan because you pay the full cost of prescription drugs until you meet your deductible.

	Insider tip	Rx expert!
	Your medical plan includes prescription drug coverage. You pay a different amount depending on the "tier" or class of drug.	GENERIC drugs are almost always the least expensive. Get in the habit of asking your doctor or pharmacist if there's a generic alternative.
	A FORMULARY is a list of drugs that are preferred by the plan. Plans use formularies to encourage the most cost-effective drugs.	If a generic drug is not available, ask your doctor whether there is an effective brand name medication that is on the plan's preferred drug list.
	A PARTICIPATING PHARMACY (one that contracts with your medical plan) will usually offer the best price. You can find a participating (in-network) pharmacy on your plan's website or by calling member services.	SHOP AROUND! Even within the same drugstore chain, you may find a better price at a different location. Your medical plan may have an online tool or app to compare prices. Or try websites like goodrx.com or lowestmed.com. Note, using these websites may disallow use of your insurance plan.
	SPECIAL HANDLING REQUIRED? Your prescription may require preauthorization (plan approval) or step therapy (trying certain drugs before others). Specialty drugs such as injectables may need to be purchased from a certain provider.	Talk with your doctor about your course of treatment and confirm whether your plan requires any special procedures. Before filling your prescription, verify that the pharmacy is in-network.
	You can get medicines that you take routinely by MAIL ORDER. Your doctor will need to authorize an extended supply. You can submit refills through a website or app, or by phone.	Compare your plan's mail-order copay and shipping costs against your local pharmacy price and/or other discount programs.

Preventive care & you

Your body doesn't come with an owner's manual, but you have to take care of it to make sure it will keep running for a long time. An important part of self-care is getting preventive medical exams to check that you're staying healthy or to identify and treat diseases before they become serious. Standard preventive services are covered in full by your insurance if you see an in-network provider.



Prevention is a habit

- Make healthy lifestyle choices —food, exercise, sleep, safety.
- Schedule an annual physical with your primary care doctor and follow your doctor's recommendations.
- Set health and wellness goals and work towards them daily.

Know your numbers

Keep a record of your health screening dates and results so you can talk to your doctor about any changes.

- Date of last checkup
- Height and weight
- Blood pressure
- Cholesterol
- Immunizations and vaccines
- Other test results

What preventive care do you need?

Visit **healthfinder.gov** and enter your age and sex in the app to get a list of recommended preventive screenings for your stage in life. Talk to your doctor about which are appropriate for you.

Know where to go

ER or urgent care?

The emergency room shouldn't be your first choice unless there's a true emergency.

Consider urgent care for...

Symptoms, pain or conditions that require quick medical attention but do not require hospital care, such as:

- Earache
- Sore throat
- Rashes
- Sprains
- Broken fingers or toes
- Flu
- Fever up to 104 degrees

Go to the emergency room for...

Serious or life-threatening conditions that require immediate treatment that you can get only at a hospital, such as:

- Chest pain or severe abdominal pain
- Trouble breathing
- Loss of consciousness
- Severe bleeding that can't be stopped
- Large broken bones
- Major injuries from a car crash, fall or other accident
- Fever above 104 degrees

Can't get to the doctor's office? Have your visit online!

Have you ever needed to see a doctor but couldn't because of scheduling, holidays, weekends, travel or even bad weather? Cigna and Kaiser save you time and money by connecting you to a doctor via video chat from any location, 24/7, no appointment needed. You'll be connected to a board-certified doctor who can diagnose and treat many common medical problems such as colds and flu, ear infections, skin problems, allergies, sinus problems, and more. General telemedicine visits are charged the same as general in office physician visits, consult your plan documents for further information on coverage levels.

Carrier	Website	Cost	Phone Number/App
Cigna	Access MDLIVE through myCigna.com	Covered the same as in person visits	(888) 726-3171
Kaiser	kp.org/mydoctor/videovisits	Covered at no cost	KP Preventive Care App (Apple and Android)

Other non-emergency care options

Our medical plans offer options when you need care or advice, but it's not an emergency:

Plan	Call a nurse 24/7	Find doctor/urgent care
Cigna HDHP	(800) 244-6224	https://hcpdirectory.cigna.com/web/public/consumer/directory/search
Cigna PPO OAP		Click "Health Facilities and Group Practices", then "Urgent Care Facility"
Cigna OAPIN		Network – select the "Open Access Plus/OAP" option **without** Carelink
Kaiser HMO	(800) 464-4000	https://healthy.kaiserpermanente.org/doctors-locations

Health Savings Account (HSA) & Flexible Spending Accounts (FSA)

Would you like to save up to 30% on medical, dental and vision costs? Using these accounts saves you money because you can pay your healthcare bills with tax-free dollars! There are different accounts for different situations and needs. Each type of account has its own eligibility requirements and rules.

HSA

Health Savings Account - for Five9 Cigna HDHP members only

An HSA is what makes high deductible health plans (HDHP) so popular. It helps with your current healthcare expenses and helps you build a safety net for the future. Unused money rolls over year after year, earns interest, and can even be invested. Deposits, withdrawals for eligible healthcare expenses, and earnings are federally tax-free. After 65, you can even use the money for non-healthcare expenses (subject to your regular tax rate). You own the account, even if you change jobs.

To open an HSA, you must be enrolled in Five9's Cigna HDHP, and you may not have non-HDHP medical coverage, including Medicare, Medicaid, or Tricare. You may not be a tax dependent. You (or your spouse) may not have a healthcare Flexible Spending Account, unless it's a limited purpose FSA for dental and vision expenses only.

FSA

Healthcare Flexible Spending Account

You can set aside money from your pay, pre-tax, and use it for medical, dental, and vision expenses any time during the plan year. You can use the account for yourself, your spouse, your children under age 26 as of the end of the tax year, and your legal tax dependents. You don't have to enroll in one of our medical plans to participate in the healthcare FSA. The catch is that you need to estimate carefully. If you set aside more than you need and don't spend it by the deadline, you may forfeit some or all of your remaining account balance. See the table on the next page for more details.

The FSA plan year runs from January 1st to December 31st and you have until March 31st to submit claims for expenses paid for in the prior year.

If you or your spouse participate in an HSA-compatible plan, you are eligible for the Limited Purpose FSA which you can use for dental and vision expenses only (not medical).

You can use a tax-free health account for a wide variety of expenses

- Deductibles, copays, coinsurance
- Medically necessary expenses not covered by your health plan
- Prescription drugs
- Over-the-counter (OTC) drugs
- Feminine hygiene products
- Some drugstore items such as diabetic supplies and first aid
- Dental and vision care services
- Certain types of medical equipment

* Information on the **Dependent Care FSA** can be found on page 21.

Flexible Spending Account (FSA) features

	Healthcare FSA	Limited FSA
Medical plan enrollment	Any plan other than the Cigna HDHP.	For HDHP member dental and vision expenses only.
Eligible dependents	Spouse, children under age 26, and tax dependents. Domestic partner must be tax dependent.	Spouse, children under age 26, and tax dependents. Domestic partner must be tax dependent.
Contribution from Five9	$0	$0
Annual contribution limit	$3,200	$3,200
Federal and state tax	None	None
Funds are available	Day 1 of plan year	Day 1 of plan year
Account balance earns interest	No	No
Allows rollover to next plan year	Yes, up to $640 can rollover from 2024 to 2025. FSA must be elected for 2025 to receive a rollover from 2024. If FSA is not elected for 2025, any unused 2024 balance will be forfeited.	Yes, up to $640 can rollover from 2024 to 2025. FSA must be elected for 2025 to receive a rollover from 2024. If FSA is not elected for 2025, any unused 2024 balance will be forfeited.
Deadline to submit expenses	Reimbursements for eligible expenses in a calendar year must be submitted by 3/31 of the following year.	Reimbursements for eligible expenses in a calendar year must be submitted by 3/31 of the following year.
If you leave Five9	You may be eligible to elect COBRA continuation of coverage for the FSA.	You may be eligible to elect COBRA continuation of coverage for the FSA.
Administered by	Navia Benefit Solutions	Navia Benefit Solutions

Flexible Spending Account and Health Savings Account Compatibility

If you elected the Healthcare FSA for the current calendar year, no contributions (employee or employer) can be made to an HSA until the next calendar year. HSA contributions, to include your contributions and Five9's contributions, can only begin in the next calendar year if your Healthcare FSA has a $0 balance.

NEW HIRES & LIFE EVENTS

If you participated in the Health Care FSA through Five9, another employer or through your spouse during the current calendar year, you are ineligible to contribute to the HSA for the remainder of this year. For those who are eligible, your HSA contribution limits will be prorated based on the number of months you were covered under a qualified High Deductible Health Plan (HDHP) and whether you covered dependents (count each month in which you were enrolled on the 1st). For example, if you cover yourself and a dependent child under the Five9 HDHP beginning July 1st, your contribution limit for the year would be $4,150.

OPEN ENROLLMENT

If you plan to enroll in the HDHP during the Open Enrollment Period, you will need to spend any remaining balance in your Health Care FSA before the end of the prior calendar year to be eligible for HSA contributions through Five9's Cigna HDHP during the year in which you enroll in the HDHP.

Health Savings Account (HSA) features

	HSA
Medical plan enrollment	Five9's Cigna HDHP. You may not have other non-HDHP coverage.
Eligible dependents	Spouse and tax dependents. Adult children must be tax dependents. Domestic partner may open a separate HSA outside of Five9's offering.
Contribution from Five9	**$150 per month ($1,800 annually) to the HSA for an employee enrolling only themselves in Five9's Cigna HDHP and $240 per month ($2,880 annually) to the HSA for those enrolling one or more dependents in Five9's Cigna HDHP.** If you enroll in the HDHP for the first time during Open Enrollment, company contributions will begin to your account beginning on the 6/15 pay-period. If you are a new hire, company contributions will begin on the next month after your elections become effective.
Five9 contribution timing	If you open your HSA on or before the 25th day of the month, Five9 will contribute to your HSA beginning in the following month. If you open your HSA after the 25th day of the month, Five9 will contribute to your HSA one month after the end of the month in which you open your HSA. Once Five9 contributions begin, Five9 will retroactively fund your HSA for the contributions missed during the prior month. *For example, if you open your HSA on October 26th, Five9 will begin HSA contributions in December and retroactively fund your HSA with November contributions.*
Annual contribution limit	$4,150 employee only or $8,300 employee plus one or more total, includes the company funds above. Due to Five9's contributions, the employee individual limit is $2,350, or $5,420 for employees who have enrolled at least one dependent. Employees who are 55+ during the tax year are eligible to contribute an additional $1,000. If you begin HSA eligibility or enroll/drop dependents mid-year, your annual contribution limits will be prorated for the calendar year.
Changing your annual goal or per-paycheck deductions	You can change your annual goal or per paycheck contributions to the HSA throughout the year. To do so, please reach out to our Benefit Advocate at Five9@alliant.com. If you update your elections, changes will be made as soon as administratively possible.
Second year note	If you began contributing to an HSA in the middle of the prior year, your per paycheck deduction will be based on your annual contribution goal. In your second year, your prior year per-paycheck deduction amount will continue. For example, someone who begins contributing to the HSA in October with an annual goal of $2,400 will be deducted $600 per paycheck for the remainder of the year. In the next year, the system will continue to deduct $600 per-paycheck until you reach your annual goal. Please reach out to our Benefit Advocate at Five9@alliant.com to update your per paycheck deduction or annual goal.
Federal and state tax	No federal tax. CA and NJ do not exclude HSA contributions from income.
Funds are available	After deposit
Account balance earns interest	Yes
Allows rollover to next plan year	Yes, unlimited
Deadline to submit expenses	N/A
If you leave Five9	Your account goes with you for future eligible healthcare expenses, tax-free. Banking fees may apply.
Administered by	HSA Bank

Dental

Dental coverage provides periodic preventive care, and if there's a problem, helps with the cost of dental work. To submit services through insurance, the dental office can verify enrollment with your Cigna group number (3346257) and your SSN. To find a Cigna Dental provider for 2024, check out Cigna's provider search tool. If you wish to have a dental ID card, these can be accessed through Cigna's website or accessed through their IOS or Android mobile apps.

	CIGNA DENTAL PPO PLAN*	
	In-network	Out-of-network
Annual deductible (calendar year)	$50 per individual; $150 per family	$50 per individual; $150 per family
Annual plan maximum	$2,000 (combined in and out of network)	$2,000 (combined in and out of network)
Diagnostic and preventive	No charge	No charge
Basic services		
Fillings	10% after deductible	20% after deductible
Root canals	10% after deductible	20% after deductible
Periodontics	10% after deductible	20% after deductible
Major services	40% after deductible	50% after deductible
Orthodontia services		
Orthodontia	50%	50%
Dependent children	Covered	Covered
Adults	Covered	Covered
Lifetime orthodontia maximum	$1,500 (combined with in and out of network)	$1,500 (combined with in and out of network)

Plan	Phone	Find dentist
Cigna Dental PPO	(800) 244-6224	https://hcpdirectory.cigna.com/web/public/consumer/directory/ Click "Doctor by Type", then "General Dentist" Network – Total Cigna DPPO (Cigna DPPO Advantage and Cigna DPPO)

Out of network coverage: If you receive coverage from an out of network provider Cigna will cover your costs based on the usual and customary amount for the service. Your non-network provider may charge a rate higher than the usual and customary amount and you will be responsible for any balance in excess of this amount.
Preventive Exams: You are allowed 1 office visit every 6-month period.
Restorative Services: Amalgam restoration covered for all teeth; composite restoration limited to anterior teeth only.

***TX, LA, MS:** in-network benefits apply to out-of-network services.

Vision

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease. Our provider (VSP) does not provide ID cards as you or your covered dependents only need to identify yourself as a VSP member at the time of service. If you wish to have a personalized ID card, you can print one through the VSP member portal.

	VSP VISION (DIRECT)	
	In-network	Out-of-network
Frequency		
Examination	Once per calendar year	Once per calendar year
Frames	One per every 2 calendar years	One per every 2 calendar years
Eyeglass lenses	Once per calendar year	Once per calendar year
Contacts (elective)	Once per calendar year	Once per calendar year
Benefit		
Examination	$25 copay (combined for exam and materials)	Up to $50 allowance
Materials	$25 copay (combined for exam and materials)	Reimbursed according to schedule
Frames	Up to $130 allowance; 20% discount on amount over $130 Up to $130 allowance when purchasing at Walmart/Sam's Club Up to $70 allowance when purchasing at Costco	Up to $70 allowance
Single vision lenses	No charge after copay	Up to $50 allowance
Bifocal lenses	No charge after copay	Up to $75 allowance
Trifocal lenses	No charge after copay	Up to $100 allowance
Standard progressives	No charge after copay	Not covered
Contacts (elective)	Up to $130 allowance (in lieu of lenses and frames)	Up to $105 allowance (in lieu of lenses and frames)

Plan	Phone	Find provider
VSP Vision Direct	(800) 877-7195	https://www.vsp.com/eye-doctor Network – VSP Signature

Basic Life/Group Term Insurance

Life insurance can fill a number of financial gaps for a family recovering from the death of a loved one. Without enough life insurance, many families have to reduce their standard of living after the loss of an income. Consider your current and future financial needs when evaluating how much coverage you need. The most common short and long-term financial needs include:

- Medical bills and funeral expenses
- Living expenses for the surviving family (housing, food, clothing, utilities, etc.)
- Large expenses, e.g., college education, or home mortgage
- Taxes and debts that need to be settled

Make sure that you have named a beneficiary for your life insurance benefit and update it in UltiPro if your family or marital status changes.

Company-provided coverage

Basic Life and AD&D

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

GUARDIAN LIFE AND AD&D

Basic Life	2x annual salary up to $1,000,000. Guaranteed issue is $1,000,000
Basic AD&D	2x annual salary up to $1,000,000. Guaranteed issue is $1,000,000

A note about taxes: A life insurance benefit over $50,000 is considered a taxable benefit. You will see the value of the benefit over $50,000 included in your taxable income on your paycheck and W-2.

Age Reduction: Your benefit will reduce by 33% at age 70 and 50% at age 75.

Voluntary (Supplemental) coverage

Voluntary Life and AD&D

Voluntary Life and AD&D Insurance allows you to purchase additional life and accidental death and dismemberment insurance to protect your family's financial security in case you suffer from loss of life, a limb, speech, sight or hearing or if you have a fatal accident. Coverage is available for your spouse/domestic partner and/or child(ren)/child(ren) of domestic partner if you purchase coverage for yourself. *Note: Any reference to Spouse also applies to Domestic Partners.*

GUARDIAN VOLUNTARY LIFE AND AD&D

	Employee	Spouse/Domestic Partner	Child(ren)/Child(ren) of Domestic Partner
Minimum coverage amount	$10,000	$5,000	$1,000
Maximum coverage amount	Lesser of five times covered annual earnings or $500,000.	Lesser of 50% of employee approved amount or $250,000.	Lesser of 10% of employee approved amount or $10,000.
Guaranteed Issue	$200,000 for employees between 15-64 years of age, $10,000 for those between 65-69. Evidence of insurability is required for those 70 or over.	$50,000 for spouses/Domestic Partners between 15-64 years of age, and $5,000 for those 65 and older. Coverage for your Spouse/Domestic Partner ends when he/she turns age 70.	Guaranteed issue is $10,000 Coverage for your Child(ren) ends when he/she turns 26.
Coverage increments	$10,000	$5,000	$1,000

If you select coverage above the "guaranteed issue" amount or make an election after your initial eligibility period without experiencing a Family Status Change, you will need to submit an Evidence of Insurability form with additional information about your health for the insurance company to approve this higher amount of coverage. Your coverage amount will remain at the guaranteed issue amount until approval from Guardian is received. It is your responsibility to follow up with Guardian to complete your Evidence of Insurability and confirm your coverage amount is updated in UKG after receiving approval. Family Status Changes include your marriage or divorce, death of a spouse or child, birth or adoption of a child, or a change in your spouse's employment that results in the loss of group coverage. Additionally, please note that effective 1/1/2025, changes to your Life election will only be allowed during Open Enrollment or a Family Status Change.

VOLUNTARY LIFE AND AD&D PREMIUM

The premium you pay for voluntary life is based on the amount of coverage you elect and your age. Effective 1/1/2025, your age will be calculated based on the 1st of the plan year rather than your birthday. Premium for your spouse is based on the amount of spousal coverage and your age and terminates when your spouse reaches age 70. Below is the table of rates (including voluntary life and AD&D) with an example calculation. The child rate is fixed based on amount at $0.323 per $1,000 of child coverage.

Employee's Age	Rate per $1,000 of coverage
Less than 35	$0.074
35 – 39	$0.080
40 – 44	$0.090
45 – 49	$0.116
50 – 54	$0.149
55 – 59	$0.221
60 - 64	$0.323
65 – 69	$0.510
70 – 74	$0.800
Greater than 74	$2.088

Example: A 45-year-old employee elects $100,000 of voluntary life and AD&D insurance for themselves, $50,000 of voluntary life and AD&D insurance for their spouse, and $10,000 of voluntary life and AD&D for their children.

Employee - $100,000 / $1,000 x $0.116 = $11.60 per month
Spouse - $50,000 / $1,000 x $0.116 = $5.80 per month
Child(ren) - $10,000 / $1,000 x $0.323 = $3.23 per month

Total for the family = **$20.63 per month**

Disability insurance

Disability benefits help protect you by providing a portion of your income during times when you are unable to work due to a qualifying disability. Five9's Short-Term Disability (STD) and Long-Term Disability (LTD) plans provide for income replacement in the event you become disabled, at no cost to you. Most people underestimate their likelihood of being disabled at some point in their life. Because Five9 pays the premiums, if you become disabled, any approved benefits payable to you are considered Taxable Income.

To change the taxable nature of your STD and/or LTD benefit, you have the option to make an election to pay taxes on the STD/LTD premium (instead of the paid disability benefits) that is paid on your behalf by Five9. **Five9 offers a 'Tax Choice' for disability benefits:**

> **Elect Tax Choice:** The premium Five9 pays is included in your taxable income, you pay tax on this taxable income. If you become disabled, there would be no taxes payable on the paid benefits you receive.
>
> **Decline Tax Choice:** The premium Five9 pays on your behalf will be non-taxable. However, if you become disabled, the paid benefits you receive are taxable.

Elections are made independently; you do not have to have the same Tax Choice for both STD and LTD.

When can you make an election?

- You will have the opportunity to elect your tax choice during New Hire Enrollment and during an Open Enrollment period.
    - Your Tax Choice election is irrevocable until the next Open Enrollment period.

Short-term disability

*Used for **limited duration issues** such as pregnancy issues, childbirth recovery, prolonged illness or injury, and recovery from surgery.*

Short-term disability (STD) coverage through Guardian pays a benefit if you temporarily can't work because of an injury, illness, or pregnancy. Payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. The cost of coverage is paid in full by the company.

Weekly benefit amount	60% of covered weekly earnings up to a maximum weekly benefit of $2,500
Benefits begin	After 7 calendar days of disability due to accident or sickness
Maximum payment period	12 weeks

Long-term disability

*Used for **longer term issues** such as debilitating illness, serious injuries, heart attack, or stroke.*

If you can't work for an extended period, long-term disability (LTD) coverage through Guardian replaces part of your monthly income. If you qualify, LTD benefits begin after STD benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. The cost of coverage is paid in full by the company.

Monthly benefit amount	60% of covered monthly earnings up to a maximum monthly benefit of $10,000
Benefits begin	After 90 calendar days
Maximum payment period	Social Security normal retirement age (The age at which disability begins may affect duration of benefits, review plan materials for certain limitations.)

Dependent Care FSA

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while participating in these programs which you pay for with pre-tax dollars?

Dependent Care FSA

A dependent care flexible spending account (FSA) can help families save potentially hundreds of dollars per year on childcare. A dependent care FSA allows you to set aside pre-tax dollars to pay for eligible day care expenses that allow for you and your spouse to work or attend school. These expenses include not only day care, but also before- and after-school care programs, and preschool and summer day camps for children under age 13. The account can also be used for care for a spouse or other dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year, tax-free. **Estimate carefully!** Money contributed to a dependent care FSA must be used for expenses incurred during that plan year. Any remaining account balance will be forfeited. You have until March 31st to submit claims for the prior calendar year.

Dependent care FSA elections are irrevocable unless you have a change in your care situation. Be sure to inform five9@alliant.com within 30 days of your change in care situation. Any changes to your dependent care FSA will be prospective, meaning prior contributions cannot be reversed.

You are only eligible to contribute to a dependent care FSA when you and your spouse are "gainfully employed" which includes actively working, actively searching for work, or physically or mentally disabled. You are eligible to contribute if you meet these qualifications and your spouse is a full-time student. You can continue your contributions during a temporary leave of absence for up to 2 weeks.

If you use the Dependent Care FSA, the IRS will not allow you to claim a dependent care tax credit. Consult your tax advisor if you have questions about the federal tax credit.

Transportation – Commuter & Parking

Do you have out-of-pocket commuting expenses for public transportation, van pooling, or for worksite (or transit) parking? If so, you can save on taxes by enrolling in our transportation savings account, administered by Navia Benefit Solutions. A transportation savings account lets you set aside money—before it's taxed—through payroll deduction. You may set up automatic monthly elections, elect for individual months, or select specific months to enroll within the Navia system. Your choice can be adjusted each month. Money in the account can be used in future months or plan years but is forfeited should you ever leave Five9. The company code when enrolling online is FV9.

Here are the maximum amounts of money you can set aside (these amounts are evaluated annually by the IRS and subject to change):

	Commuter	Parking
Maximum contribution amount	Up to $315 per month	Up to $315 per month
Which expenses are allowed?	• Mass transit fares • Monthly bus passes • Vanpooling fees • Uber Pool and Lyft Line	• Parking at or near your work • Parking at a location from which you participate in a carpool or board mass transit
Which expenses are not allowed?	• Taxi fares • Bridge tolls • Cost of auto maintenance	• Parking costs at home • Parking when not commuting to or from work location

How does this benefit work?

- Funds are deducted from your paycheck on a pre-tax basis.
- Navia will issue you a Debit Card to pay for qualified expenses or you can elect to have your funds automatically loaded to your commuter smart card (i.e. Clipper card).
- Expenses must be paid using the Navia Debit or smart card, Navia will not reimburse your receipts.

You must update your contribution to this benefit each month directly on the Navia website. The company code is **FV9**.

To elector change your transportation savings account contributions:

1. Login/register as a participant to www.naviabenefits.com
2. Under My Tools, select "GoNavia Commuter Orders"
3. Select "Place an Order" for either GoNavia Transit Benefit or GoNavia Parking Benefit
4. Enter the dollar amount for your order
5. Select "single month" or "recurring monthly". If "recurring monthly", select the months you want to have your order recur.
6. Once you've verified everything, select "submit".

Elections must be made by the 20th to take effect for the following month.

401(k)

Retirement Savings Plan

Our 401(k) Retirement Savings Plan through Fidelity helps you save for retirement and offers both pre-tax and after-tax (Roth) options. You can access your retirement savings as early as age 59 ½, without penalty. You will just pay normal income taxes when you withdraw the money. Log into your account at www.401k.com.

You may contribute as little as 1% or as much as 80% of your paycheck. For information, contact (800) 835-5097.

Entry	First of the month following eligibility. Must be 21 years of age.
Maximum annual contributions	2024 Calendar Year - *$23,000; or $30,500 if you are age 50+
Employer match	100% of the first $500 you defer each quarter (up to $2,000 annually)
Rollover	You may rollover old retirement accounts into the 401(k), contact the number above
How do I enroll?	www.401k.com Be sure to properly designate and maintain your beneficiary with Fidelity
How do I make Contribution changes?	All contribution changes are made through Fidelity at www.401k.com and may take up to one additional pay period to be reflected
Vesting	Your personal contributions are always 100% vested
Deferral types	Five9 offers both Pre-tax (Traditional) and Post-tax (Roth)
Deferral type attributes	*Pretax (Traditional)* ❖ Contributions are made before taxes are applied, which reduces current tax burden. ❖ All capital gains, dividends, interest, etc. grow within the account on a tax-deferred basis. ❖ Account holder becomes eligible to withdraw at age 59 ½. Withdrawals will be taxed at then-current rates and total income levels. ❖ All withdrawals prior to eligibility are subject to limitations, taxes, and /or penalties. *Post tax (Roth)* ❖ Contributions are made after taxes have been applied. ❖ All capital gains, dividends, interest, etc. grow tax free in the account. ❖ Account holder becomes eligible to withdraw at age 59 ½. Withdrawals are not subject to taxes but funds must be held in account for at least five years.

***The Maximum annual contribution is a combination of all your contributions in a calendar year from all employers. It is your responsibility to notify Human Resources, by completing the 401(k) form provided to you as a new hire, of your previous contribution amount so your record can be updated properly to avoid excess contributions.**

Wellness

These programs can lend a helping hand when you need it or just make life a little easier.

Your well-being is important to us and we provide various Wellness initiatives to help give you the opportunity and resources to achieve overall wellness. These initiatives include Financial Wellness, Physical Wellness, Emotional Wellness and Social Wellness. Throughout the year watch for events, seminars and posted resources on our Employee Resource SharePoint site.

Spring Health Mental Well-being

Life is easier with the right support. You don't need to wait for a crisis to prioritize your mental health. Five9 partners with Spring Health to provide personalized care and resources to support you through any of life's challenges.

With Spring Health, you have access to:

- 6 free sessions with certified coaches
- 6 free sessions with licensed therapists
- Dedicated guidance through your Care Navigator
- Self-guided wellness exercises through the "Moments" content library
- Medication management – 2 of your covered therapy sessions can be used for medication management consultations with a doctor
- Expert guidance and resources to navigate legal or financial matters, childcare, elder care, pet care, travel, household services, and more
- Personalized care through short online assessments help identify your immediate needs and long-term goals

Visit Spring Health's website or download the Spring Health app in the Google Play Store (Android) or App Store (iOS) to get started, and enter code "five9". Contact Spring Health's support team with any questions at 855-629-0554.

Fertility Health Reimbursement Arrangement (HRA)

Five9 has partnered with Navia to help support family planning for you and your spouse/partner in the form of a fertility program.

To utilize this program, you will pay for fertility expenses out of pocket. You will then submit the expenses and itemized receipts to Navia, who will verify and reimburse your expenses, up to $5,000 per lifetime per family. Be sure to save and itemize your receipts.

Your enrollment in the fertility program is dependent on your enrollment into one of Five9's medical plans. If you do not participate in a Five9 medical plan, you will not be eligible for the fertility reimbursement program. To remain eligible for the Health Savings Account (HSA), employees enrolled in the HDHP plan must satisfy their deductible before they can be reimbursed for fertility expenses.

Volunteer Program

Five9 helps provide resources, support and empowerment to those in need. We strive to give opportunities for our team members to make an impact for our local communities. We currently provide employees with 8 hours per year to volunteer to charities of their choice. Charities Five9 has supported in the past include: Make A Wish, National Kidney Foundation, Meals on Wheels, Contra Costa Food Bank, Feeding America, American Heart Association, and One Warm Coat. Event we have participated in include, canned food drives, and blood drives.

Employee Assistance Program (EAP)

There are times when everyone needs a little help or advice. The EAP through Guardian/ComPsych can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources. Best of all, it's completely confidential, free and available to any member of your immediate household.

- Unlimited free phone access 24/7.
- In-person help for short-term issues; up to 3 sessions per incident per family member per 6 months and 10 sessions for substance/alcohol issues.
- Unlimited web access 24/7 to helpful articles, resources, and self-assessment tools.

Contact the EAP 24/7/365

Phone: (855) 239-0743
Web: guidanceresources.com
Organization Web ID: Guardian

Travel Assistance

When You Travel Abroad on Business

When you travel internationally for business, be sure to have your Cigna Medical Benefits Abroad contact information handy. Business travel medical insurance provides benefits to assist you and your dependents while you're traveling for business for up to 180 days per trip. Benefits include medical care, accidental death and dismemberment, and assistance with returning to the US in the case of an emergency.

Policy ID	0627A-MBA (Cigna Payor ID# 62308)
Employee Eligibility	Full-time active employees traveling internationally or on permanent assignment, for the business or at the expense of the Policyholder for no more than 180 consecutive days per one trip.
Dependent Eligibility	Your spouse or domestic partner and dependent children (up to age 26 years) traveling internationally or on permanent assignment, with the covered employee for no more than 180 consecutive days per one trip. Dependents are not eligible for Accidental Death and Dismemberment coverage.
Contact Cigna	**Phone:** (800) 243-1348 (toll-free inside the US), 001.302.797.3535 (outside the US) **Web:** CignaEnvoy.com → Select "I am an international business traveler" **User ID:** 06274AMBA **Password:** Cigna1
Medical and Rx Maximum	$50,000
Deductible	$0
Coinsurance	0%

When You Travel Abroad for Pleasure

Regardless of whether you are covered under the Five9 Cigna or Kaiser plans, you will only have coverage outside of the United States in the case of emergencies. If you are traveling on business, please refer to the "When You Travel on Business" section above.

When you travel internationally for purposes other than work, you can rely on Travel Aid. This program offers referrals to an international network of participating doctors and hospitals for a broad range of medical care services. They can also help you prepare for upcoming travel and react to emergencies while you are away from home, including arrangement of evacuation and transportation. The center is available to all employees by phone 24/7 and is staffed with multilingual representatives who can help coordinate your medical care.

Contact Phone Numbers	(800) 527-0218 or (410) 453-6330
Website	ibhtravelaid.com

When Traveling Within the US for Any Reason

If you are covered under a Five9 Cigna plan, you will have coverage when seeking care through Cigna's national network of providers, even outside your home state.

If you are covered under the Five9 Kaiser plan, you will be able to receive urgent and emergent care from non-Kaiser facilities while traveling outside of the Kaiser provider area. All routine care will need to be done at a Kaiser facility to be covered.

Plan contacts

To address any matters regarding your health and well-being benefits, we encourage you to reach out to our dedicated Alliant Benefit Advocate at five9@alliant.com, or call (925) 658-1569 from 8:00 am - 5:00 pm Mon-Thu, 8:00 am – 4:30 pm Fri (Pacific Time).

Plan type	Provider	Phone	Web	Policy #
Medical PPO OAP	Cigna	(800) 244-6224	Cigna.com	3346257
Medical HDHP	Cigna	(800) 244-6224	Cigna.com	3346257
Medical OAPIN	Cigna	(800) 244-6224	Cigna.com	3346257
Medical HMO	Kaiser	(800) 464-4000	kp.org	651834
Health Savings Account	HSA Bank	(800) 357-6246	hsabank.com	N/A
Dental PPO	Cigna	(800) 244-6224	Cigna.com	3346257
Vision	VSP (Direct)	(800) 877-7195	vsp.com	30098659
Life and AD&D	Guardian	(800) 525-4542	guardianlife.com	477224
Voluntary Life/AD&D	Guardian	(800) 525-4542	guardianlife.com	477224
Short Term Disability (STD)	Guardian	(800) 268 2525	guardianlife.com	477224
Long Term Disability (LTD)	Guardian	(800) 538-4583	guardianlife.com	477224
Mental Well-Being	Spring Health	(855) 629-0554	springhealth.com/support	Work-life code: five9
Employee Assistance Program (EAP)	ComPsych	(855) 239-0743	Guidanceresources.com	Organization Web ID: Guardian
Business Travel Medical (BTM)	Cigna	Inside US: (800) 243-1348 Outside US: 001.302.797.3535	Cignaenvoy.com Select: "I am an international business traveler" User ID: 06274AMBA Password: Cigna1	06274A
Flexible Spending Accounts	Navia	(800) 669-3539	naviabenefits.com	FV9
Transit/Parking Administration	Navia	(800) 669-3539	naviabenefits.com	FV9
Fertility Reimbursement Program	Navia	(800) 669-3539	naviabenefits.com	FV9
Telehealth	Cigna	(888) 726-3171	Access MDLIVE through the myCigna.com website	See Medical above
	Kaiser	KP Preventive Care App	kp.org/mydoctor/videovisits	
401(k)	Fidelity	(800) 835-5097	401k.com	29534

Important plan notices & documents

Health plan notices

These notices must be provided to plan participants on an annual basis and are available on the on the benefits portal/are available at the end of this guide:

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

COBRA continuation coverage

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

Plan documents

Important documents for our health plan and retirement plan are available on the on the Intranet, select Department → HR → Benefits → US Benefits. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact Vanessa Ortiz at (925) 658-1569.

SUMMARY PLAN DESCRIPTIONS

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

- Five9, Inc. Health and Welfare Benefit Plan

SUMMARY OF BENEFITS AND COVERAGE

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format.

- Cigna HDHP
- Cigna PPO OAP
- Cigna OAPIN
- Kaiser HMO
- Navia Fertility Health Reimbursement Arrangement (HRA)

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Five9, Inc. Health and Welfare Benefits Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Medicare Part D Notice

Important Notice from Five9, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Five9, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Five9, Inc. has determined that the prescription drug coverage offered by the Five9, Inc. Health and Welfare Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your Five9, Inc. coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Five9, Inc. Health and Welfare Benefits Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Five9, Inc. prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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

You should also know that if you drop or lose your current coverage with Five9, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further at HR.US@Five9.com. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Five9, Inc. changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

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

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

Date:	06/01/2024
Name of Entity/Sender:	Five9, Inc.
Contact-Position/Office:	HR Department
Address:	3001 Bishop Ranch, Suite 350 San Ramon, CA 94583
Phone Number:	(925) 201-2000

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at (925) 201-2000.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (925) 201-2000.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Five9, Inc.'s health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Five9, Inc.'s health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Five9, Inc.'s health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Five9, Inc. describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting HR.US@Five9.com.

Notice of Choice of Providers

The Kaiser 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 Kaiser at (800) 464-4000.

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

You do not need prior authorization from Kaiser or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network 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 Kaiser at (800) 464-4000.

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, 2024. Contact your State for more information on eligibility:

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ | Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp

Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share

Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, 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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 of your modified adjusted household income.

Illinois Consumer Coverage Disclosure Act

The Consumer Coverage Disclosure Act requires employers to notify Illinois employees which of the Essential Health Benefits listed below are and are not covered by their employer-provided group health insurance coverage. Refer to the Access to Care and Treatment Benchmark Plan and the Pediatric Dental Plan to reference the pages listed below.

Employer Name:	Five9, Inc.
Employer State of Situs:	California
Name of Issuer:	Cigna
Plan Marketing Name:	Cigna PPO OAP
Plan Year:	2024

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2022 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				**Employer Plan Covered Benefit?**
Item	**EHB Benefit**	**EHB Category**	**Benchmark Page # Reference**	
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	No
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	No
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes

11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Yes
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes
Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.				

Employer Name:	Five9, Inc.
Employer State of Situs:	California
Name of Issuer:	Cigna
Plan Marketing Name:	Cigna HDHP
Plan Year:	2024

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2022 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	No
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	No
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes

24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Yes
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes
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Rev. May 28, 2024