KEKER
VAN NEST
& PETERS

2024 Benefits - Staff

BENEFITS FOR EVERY STEP

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IMPORTANT PLAN INFORMATION

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.

GETTING STARTED

2024 Benefits

January 1, 2024 through
December 31, 2024

MEDICARE PART D NOTICE

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

No matter where you are in your career, Keker, Van Nest & Peters supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, as well as life, disability, retirement, and more benefits.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Take a look at what's available to make the most of your benefits package.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

In general, you are eligible if you are a full-time employee working 30 or more hours per week.

Eligible dependents

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse).
- Your same or opposite sex domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit. Please review the affidavit guidelines. The Cost of Coverage section explains the tax treatment of domestic partner coverage.
- Your children (including your domestic partner's children):
    - Under age 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

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

When you can enroll

Coverage for new full-time employees begins on the 1st of the month following date of hire. Existing employees can enroll during the annual open enrollment period.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment.

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

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

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

You must submit any changes within 31 days after the event.

ENROLLING FOR BENEFITS

DO I NEED TO ENROLL?

If you do not have any changes to make to your 2024 Benefits and you do not want to enroll in a 2024 Flexible Spending Account, **no action is required.**

Ease

Ease is an online system that enables you to make all your benefit decisions in one place. If you don't have access to a computer, you can access Ease from a tablet or smartphone.

Before you enroll

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

Getting started

- LOG IN to Ease:

  https://kvp.ease.com

  Username: Your company email

  Password: Your selected password
- ADD your personal and dependent information.
- SELECT your benefit plans for the coming year.
- REVIEW your choices and costs before finalizing.

THE EASY WAY TO GET BENEFITS INFO

Click to play video

GET MYBENEFITS.LIFE®

On the web:
keker.mybenefits.life

On your smartphone

Download from the App Store or Google Play.

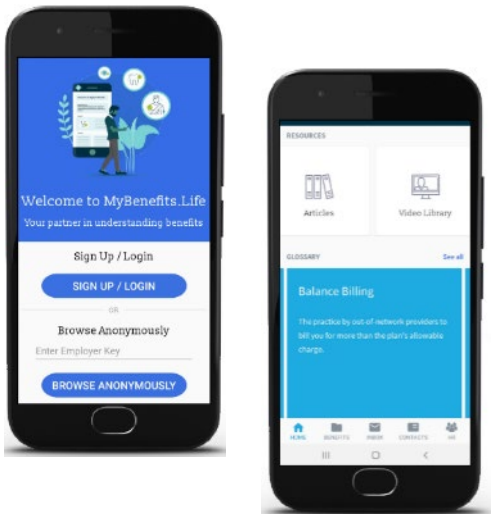
Login With Employer Key
keker

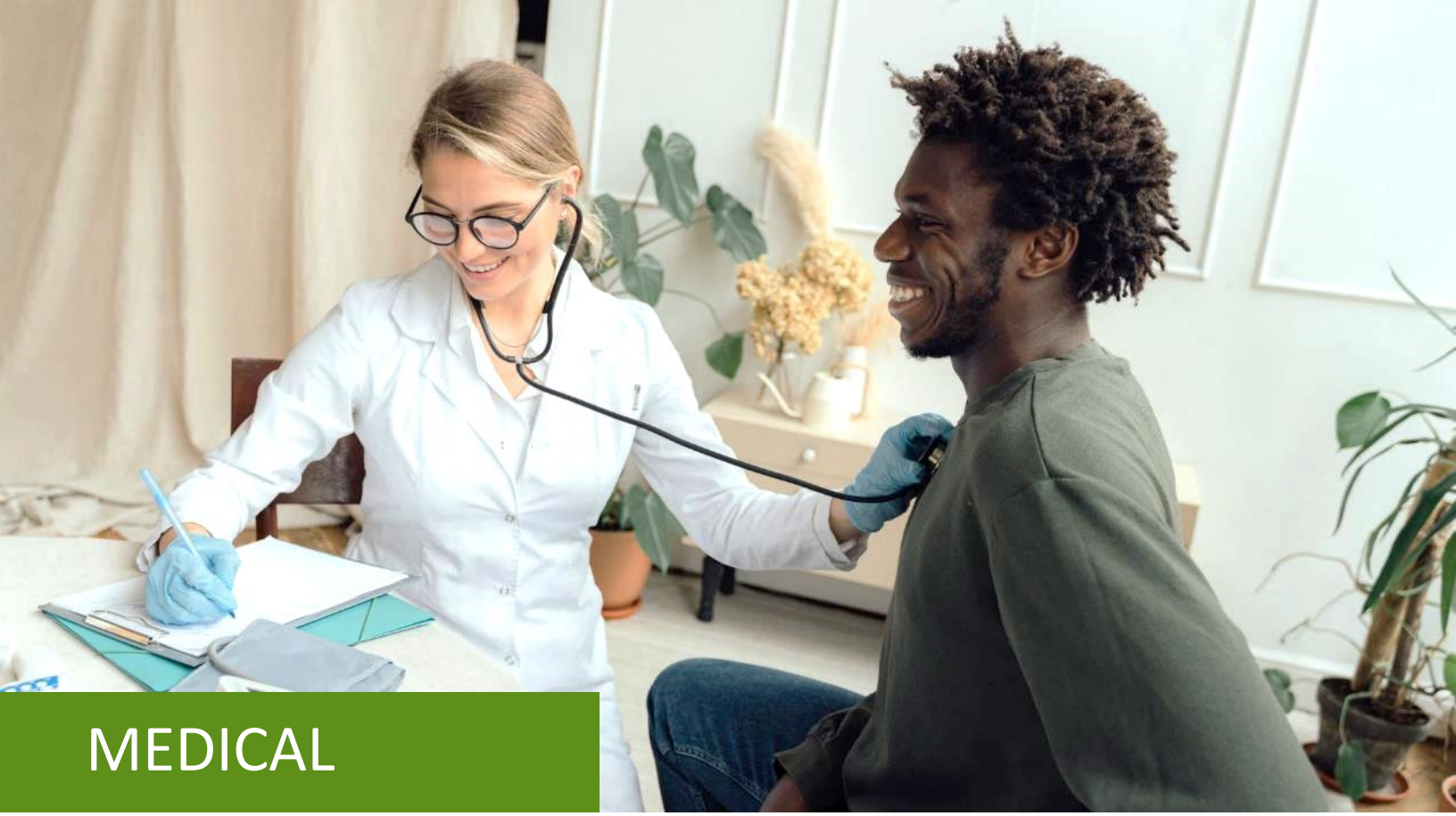
MyBenefits.Life® gives you all your benefits information in one place

You can do just about anything online these days. Why should accessing your benefits information be any different? MyBenefits.Life® is both a website and a mobile app that gives you access to the benefits information you need, when you need it.

Here's what you'll find on MyBenefits.Life®

Benefits	See benefit details and costs for all plans you're eligible for, including healthcare, disability, life insurance, and more.
Search	Can't find something? Just search the site
Articles & Video Library	Have two minutes? Increase your benefits IQ with short explainer articles and videos
Financial Wellness	Want to understand your finances better? Learn how in the Digital Financial Wellness Center, powered by Prudential
Glossary	HDHP? EOB? Coinsurance? Get the definitions in plain English
Documents	Read important benefit plan notices ("the fine print")
Contacts	Find HR, benefits, and carrier contacts
Get Help	Need help? Reach helpful resources





MEDICAL

OUR PLANS

Aetna PPO

Aetna HDHP

Aetna HMO

Kaiser HMO

Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Think about these factors when choosing your medical plan:

Do you like your doctors?

Check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more, consider a plan with out-of-network coverage.

What are your healthcare needs?

Compare how each plan covers the services you need most often, such as office visits, specialists, or prescriptions.

What's your budget?

What will you pay for coverage? Is there a deductible? What is your share of the cost for office visits and prescriptions? All of these factors together affect your total cost for healthcare.

Aetna PPO & Aetna HDHP

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

	Aetna PPO		Aetna HDHP	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Annual Deductible	$500, up to $1,000/family	$1,000, up to $2,000/family	$3,200, up to $6,000/family	$5,000, up to $10,000/family
Annual Out-of-Pocket Max	$2,500 up to $5,000/family	$5,000, up to $10,000/family	$6,000, up to $12,000/family	$8,000, up to $16,000/family
Lifetime Max	Unlimited		Unlimited	
Office Visit				
Primary Provider	$15 copay	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible
Specialist	$25 copay	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible
Preventive Services	No charge	You pay 30% after deductible	No charge	You pay 30% after deductible
Chiropractic Care	$25 copay (limited to 20 visits/year, combined with out-of-network)	You pay 30% after deductible (limited to 20 visits/year, combined with in-network)	You pay 10% after deductible (limited to 20 visits/ year, combined with out-of-network)	You pay 30% after deductible (limited to 20 visits/ year, combined with in-network)
Lab and X-ray	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible
Inpatient Hospitalization	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible
Outpatient Surgery	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible
Emergency Room	You pay 10% after $250 copay; deductible waived; copay waived if admitted		You pay 10% after deductible	
Pharmacy			Medical deductible applies before copays	
Generic	$10 copay	Not covered	$10 copay	Not covered
Preferred Brand	$30 copay	Not covered	$30 copay	Not covered
Non-preferred Brand	$50 copay	Not covered	$50 copay	Not covered
Specialty RX	30% to $250 per RX	Not covered	30% to $250 per RX	Not covered
Supply Limit	30 days	Not covered	30 days	Not covered
Mail Order				
Generic	$20 copay	Not covered	$20 copay	Not covered
Preferred Brand	$60 copay	Not covered	$60 copay	Not covered
Non-preferred Brand	$100 copay	Not covered	$100 copay	Not covered
Supply Limit	90 days	Not covered	90 days	Not covered

Aetna HMO & Kaiser HMO

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

	Aetna HMO	Kaiser HMO
	In-Network	**In-Network**
Annual Deductible	None	None
Annual Out-of-Pocket Max	$2,500, up to $5,000 per family	$1,500, up to $3,000 per family
Lifetime Max	Unlimited	Unlimited
Office Visit		
Primary Provider	$25 copay	$20 copay
Specialist	$50 copay	$20 copay
Preventive Services	No charge	No charge
Chiropractic Care	$15 copay (limited to 20 visits per year)	Not covered
Lab and X-ray	Lab & X-ray: No charge; Advanced imaging: $150 copay	Lab & X-ray: $10 copay; Advanced imaging: $50 copay
Inpatient Hospitalization	$750 copay	No charge
Outpatient Surgery	$200 copay	$20 per procedure
Emergency Room	$150 copay per admission (waived if admitted)	$100 copay, waived if admitted
Pharmacy		
Generic	$10 copay	$15 copay
Preferred Brand	$30 copay	$35 copay
Non-preferred Brand	$50 copay	$35 copay (prior authorization required)
Specialty RX	30% to $250 per RX	$35 copay
Supply Limit	30 days	30 days
Mail Order		
Generic	$20 copay	$30 copay
Preferred Brand	$60 copay	$70 copay
Non-preferred Brand	$100 copay	$70 copay (prior authorization required)
Supply Limit	90 days	100 days

HEALTH SAVINGS ACCOUNT (HSA)

Click to play video

ARE YOU ELIGIBLE?

The HSA is not for everyone. You're eligible only if you are:

1. Enrolled in the Aetna HDHP Plan.
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.
4. Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future. Please note that expenses incurred prior to opening an HSA are ineligible for reimbursement.

How the PayFlex HSA works

- Your HSA account is set up automatically after you enroll.
- To help you get started, Keker, Van Nest & Peters contributes to your HSA:

  Individual: $1,600, plus $1,000 bonus contribution
  Family: $3,000, plus $1,000 bonus contribution*

  * Bonus contributions are prorated based on the percentage of the year worked.
- You can contribute up to the limit set by the IRS (includes company amount).

  Individual: $4,150 per year
  Family: $8,300 per year
  Are you age 55+? You can contribute an additional $1,000 per year
- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save the money to use in the future..
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free. You can also use it for regular living expenses, which will be taxable but without penalties.

Find out more

- Payflex.com
- Eligible Expenses
- Ineligible Expenses

PROSPECTIVE PARENT BENEFITS - HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Your “allowance” for healthcare expenses

A Health Reimbursement Arrangement (HRA) is a supplementary health plan that will reimburse you for the cost of medical expenses that are eligible for reimbursement under the plan. The HRA is provided for you by Keker, Van Nest & Peters at no cost to you. As with other Work/Life Benefits, these benefits are available to all non-attorney professional staff (and/or their partners) regardless of marital/partnership status, gender, or sexual orientation if covered on a Keker, Van Nest & Peters primary medical plan. You can enroll in the HRA at any time with FlexToday, but you can only claim expenses in the year you are enrolled.

LIFETIME MAXIMUM

Employee	$45,000 lifetime maximum

USING YOUR MONEY

The HRA covers 100% of your out-of-pocket fertility related expenses, including but not limited to the following:

- Diagnosis and Treatment of Infertility
- In Vitro Fertilization
- Adoption Fees*
- Surrogacy Services*
- Prescription Fertility Drugs
- Collection & Storage Fees

*Adoption and surrogacy expenses should be directed to the firm for reimbursement and are included in the $45,000 lifetime maximum

Benefits can be for copayments associated with expenses covered under the medical plans or for non-covered expenses.

Documentation of the above expenses being incurred is required, but receipt of benefits is not contingent on proof of medical necessity or satisfying any precondition to embarking on any of the above efforts.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in a high deductible health plan (like our Aetna HDHP plan), you can only participate in the **Limited Purpose FSA** for dental and vision expenses.

Find out more

- Flextoday.com
- Eligible Expenses – now include more over-the-counter items!
- Ineligible Expenses

Do you pay for dependent care?
Look in the Financial Wellness section for information on tax savings through the Dependent Care FSA.

Set aside healthcare dollars for the coming year

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

How the FlexToday FSA works

- You estimate what you and your dependents' out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, and even eligible drugstore items.
- You can contribute up to $3,200, the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Estimate carefully!

If you don't spend all the money in your account, you can roll over up to $640 to use the following year. Any additional remaining balance will be forfeited.

FSA TAX SAVINGS EXAMPLE

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

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

$120,000 Annual Pay, with $2,850 FSA Contribution

$684 24% Federal income tax	**$219** 7.65% FICA tax	**$903** Annual FSA tax savings

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

DENTAL

OUR PLAN

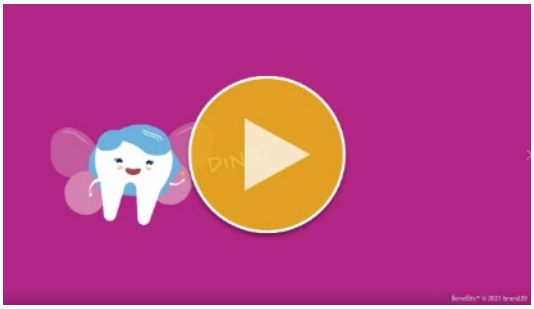
Aetna Dental PPO

Why sign up for dental coverage?

Brushing and flossing are great, but regular exams catch dental issues early. If there's a problem, our dental plan makes it easier and less expensive to get the care you need to maintain your smile.

Find out how it works!

Click to play video



Aetna Dental PPO

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

	Aetna Dental PPO	
	In-Network	**Out-Of-Network***
Calendar Year Deductible	$50, up to $150 per family (combined with out-of-network)	$50, up to $150 per family (combined with in-network)
Annual Plan Maximum	$2,000 (combined with out-of-network)	$2,000 (combined with in-network)
Diagnostic and Preventive	No charge	No charge
Basic Services		
Fillings	You pay 10% after deductible	You pay 10% after deductible
Root Canals	You pay 10% after deductible	You pay 10% after deductible
Periodontics	You pay 10% after deductible	You pay 10% after deductible
Major Services	You pay 40% after deductible	You pay 40% after deductible
Orthodontic Services		
Orthodontia	You pay 50%	You pay 50%
Lifetime Maximum	$1,000 (combined with out-of-network)	$1,000 (combined with in-network)
Eligible Members	Dependent Children and Adults, Full-time Students	Dependent Children and Adults, Full-time Students

*Out-of-Network plan payments are based on the 95th percentile of prevailing charges for the geographic area. Amounts in excess of what Aetna pays is your responsibility.

VISION

OUR PLAN

VSP Vision

Click to play video

Why sign up for vision coverage?

Even if you have 20/20 vision, an annual eye exam checks the health of your eyes and can detect other health issues. If you do need glasses or contacts, vision coverage helps with the cost.

Visit the plan's website for extra savings on services like LASIK and PRK, and rebates on contact lenses.

VSP Vision

Your vision checkup is fully covered after your exam copy. After any materials copay, the plan covers frames, lenses, and contacts as described below.

	VSP Vision	
	In-Network	**Out-Of-Network**
Examination		
Benefit	No Charge	Reimbursed up to $50
Frequency	Every 12 months	Every 12 months
Materials	$20 copay	Reimbursed up to plan allowance after applicable copay
Eyeglass Lenses		
Single Vision Lens	No charge after materials copay	Reimbursed up to $50 after materials copay
Bifocal Lens	No charge after materials copay	Reimbursed up to $75 after materials copay
Trifocal Lens	No charge after materials copay	Reimbursed up to $100 after materials copay
Frequency	Every 12 months	Every 12 months
Frames		
Benefit	Coverage limited to $140 “featured frame” allowance or $120 after materials copay	Reimbursed up to $70 after materials copay
Frequency	Every 24 months	Every 24 months
Contacts (Elective)		
Benefit	Coverage limited to $120 (separate exam/fitting copay, never to exceed $60)	Reimbursed up to $105
Frequency	Every 12 months in lieu of frames & lenses	Every 12 months in lieu of frames & lenses

ENGAGE

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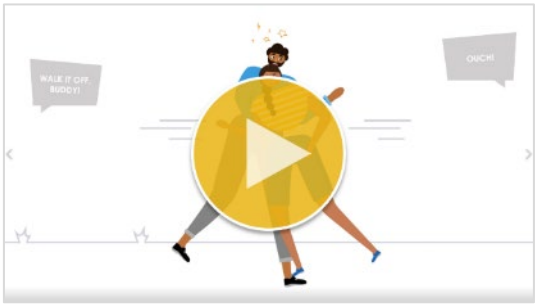
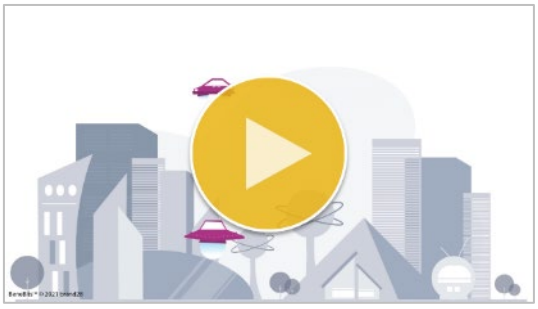


Urgent Care vs ER



Virtual Healthcare

Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs

KNOW WHERE TO GO

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

Type	Examples
Nurse line (24/7—$0) Quick answers from a trained nurse	Identifying if immediate care is needed Home treatment options and advice
Online visit (24/7—$) Many nonemergency health issues	Cold, flu, allergies, headache, migraine Skin conditions, rashes Minor injuries Mental health concerns
Office visit ($$) Routine medical care and management	Preventive care Illnesses, injuries Managing existing conditions
Urgent care ($$$) Non-life-threatening conditions requiring prompt attention	Stitches, sprains Animal bites High fever, respiratory infections
Emergency room (24/7—$$$$) Life-threatening conditions needing immediate care	Suspected heart attack or stroke Major bone breaks Excessive bleeding Severe pain Difficulty breathing

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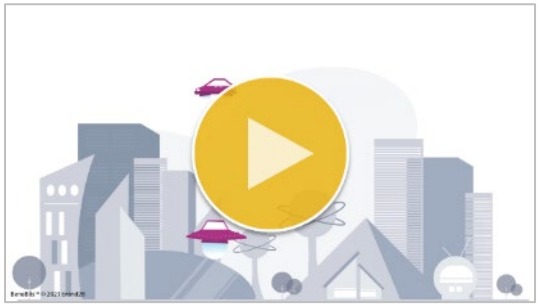
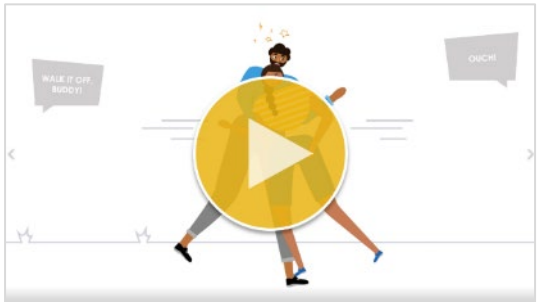


Virtual Healthcare



Urgent Care vs ER

ALTERNATIVE FACILITIES

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

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

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, and similar services on your plan's website, or call member services for assistance. Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings.

Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

PREVENTIVE CARE

TYPICAL SCREENINGS FOR ADULTS

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

You take your car in for maintenance; why not do the same for yourself?

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

Health plans are required to cover a set of preventive services at no cost to you, even if you haven't met your deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Be aware: Not all exams and tests are considered preventive care

Certain screenings may be considered diagnostic, rather than preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

In addition, exams performed by specialists are generally not considered preventive care and may not be covered at 100%.

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

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

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

Understanding the formulary can save you money

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

What is a formulary?

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

Get the most from your coverage

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

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

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

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

Is your family protected?

Life, AD&D and disability insurance can fill financial gaps due to a loss of income. Consider your day-to-day costs and bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (housing, education, loans, credit cards, etc.) after the death of a spouse or partner.

COMPANY-PROVIDED LIFE AND AD&D INSURANCE

WHAT'S GUARANTEED ISSUE?

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

A NOTE ABOUT TAXES

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

Basic Life and AD&D

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

Unum Basic Life and AD&D

2x your annual salary up to a maximum of $300,000.

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

SHORT-TERM DISABILITY INSURANCE

EXPECT THE UNEXPECTED

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

STD Benefits

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

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

This benefit is only available to employees residing in California. If you are a non-California employee, please review individual options in your state. Please note that partners are ineligible for short-term disability.

California SDI

Weekly benefit amount	Maximum of $1,540 per week

LONG-TERM DISABILITY INSURANCE

3 THINGS TO KNOW ABOUT LTD INSURANCE

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

LTD benefits cushion the financial impact of a disability

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

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

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

Unum LTD

Monthly benefit amount	60% of your monthly earnings up to a maximum of $15,000
Benefits begin	After 90 days of disability
Maximum payment period	Up to the Social Security (SS) normal retirement age

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

Click to play video

EVERY OPPORTUNITY TO SAVE

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

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

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

Here's how the FlexToday Dependent Care FSA works

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

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

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

SAVE ON COMMUTE EXPENSES

CAN I OPT OUT OR CHANGE MY ELECTION IF MY WORK SCHEDULE OR LOCATION CHANGES?

Yes. Commuter Benefits can be changed throughout the year as your needs change.

Transportation Savings Account—up to $630 per month tax-free

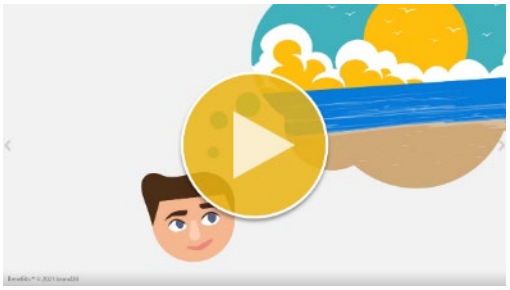
Do you have out-of-pocket commuting expenses for public transportation, van pooling, or for worksite parking? If so, you can save on taxes by enrolling in our transportation savings account, administered by Edenred.

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

Set aside up to $315 per month for work-related parking expenses and up to $315 per month for work-related commute expenses.

SAVE NOW, ENJOY LATER

Click to play video



WHAT ARE YOUR PLANS?

Many of us can't plan past the weekend, never mind thinking about a retirement nest egg. Our 401(k) retirement plan will help you set a retirement savings goal and stick to it.

The important thing is to start now and set aside what you can, even if you think it's too small an amount.

With the company match and compound interest, that "small amount" can grow over time. You'll be a retirement saver before you know it.

401(k) Retirement Savings Plan—up to $23,000 per year (or more)

Our 401(k) Retirement Savings Plan helps you save for retirement. The plan offers tax savings NOW through pre-tax contributions. Visit the Milliman website at millimanbenefits.com to manage your account, investments and contributions.

Milliman offers a variety of quality investment options. You'll also have access to special services such as automatic account rebalancing and personal investment assistance from a licensed investment counselor.

Maximum annual contribution limit	Up to $23,000 per year. If you're age 50+, save an additional $7,500 per year. IRS limits are evaluated annually and may change.
Eligibility Requirements	Eligible employees over the age of 21 can join the 401(k)-plan following their first pay period with the firm. Any elections to begin, discontinue or change the amount of your salary deferral may be made at any time and will take effect on the next payroll period that is within a reasonable time after Milliman receives your election.
Automatic Enrollment	Upon eligibility, and unless you elect otherwise, 6% of your pay will be contributed automatically on a pre-tax basis to your 401k plan account. On each January 1, your automatic enrollment salary deferral percentage will increase by an additional 1% up to a maximum of 10%.

MODERN HEALTH

CONTACT MODERN HEALTH

help@modernhealth.com

MODERN HEALTH

Modern Health

Modern Health is a platform that provides you resources for mental wellbeing so you can be the best version of yourself, at home and at work. Modern Health is free for you and your household members. Through the Modern Health app, you have access to:

- Licensed therapists and certified coaches that specialize in your needs
- Unlimited texting via the Modern Health app to your coach/therapist 24/7
- Up to 8 therapy visits and 8 coaching sessions per calendar year for you and your dependents
- Unlimited access to website resources

To Get started, Scan the QR Code. After your download is complete, select "Join Now" from the welcome page from the mobile app.

Use your first and last name on file with Keker Van Nest & Peters.

Enter Keker Van Nest & Peters LLP , then your company email, and a password of your choice.

Select "Register on the web" or "Agree and Join" on the Mobile app to complete registration.

Modern Health provides support for all aspects of life:

ADDITIONAL WELLBEING

Employee Assistance Program

Keker, Van Nest & Peters offers an employee assistance program (EAP) to all benefit-eligible employees and their eligible dependents, free of charge. The EAP, administered by Work-Life Balance under the Unum insurance policy, offers a completely confidential counseling and referral service for issues that may affect your personal life or job performance. The EAP can help you in balancing the demands of work and home in areas such as:

- Marriage, family, and relationship issues
- Emotional, personal, and stress-related concerns
- Alcohol and drug abuse
- Child and elder care resources
- Financial and credit assistance
- Legal assistance

The EAP provides up to 3 visits per incident each year. If you need further assistance beyond the EAP sessions, a counselor can refer you to other community services and additional resources available through your medical plan. Counselors are available 24 hours a day, seven days a week. To get help from the EAP, call (800) 854-1446. You can also visit the EAP website at http://www.unum.com/LifeBalance

Gym & Yoga

Keeping healthy helps bring the rest of your life into balance. We offer an onsite, complementary gym with state of the art equipment, including a Peloton bike. Subsidized yoga classes are held at noon on Wednesdays in the firm's yoga studio. Contact Christina Blais to be added to the YOGA email distribution list.

TIME AWAY FROM WORK

Paid time off policies

There is no perfect, one-size-fits-all balance between work and home . We provide time off so you can take time to relax, recover from illness, take care of personal and family business, or whatever else you need. Our time off benefits include:

- Flexible work schedules
- Paid time off for vacation and illness
- Time off for jury duty and voting
- Bereavement leave
- Maternity, paternity and adoption leave.

Refer to your employee handbook for information on eligibility and specific leave policies.

2024 paid holidays

Keker, Van Nest & Peters provides 12 paid holidays per year for all full-time, benefit eligible employees. Additional holidays may be designated at the company's discretion.

New Years' Day	Monday, January 1
Martin Luther King, Jr. Day	Monday, January 15
Presidents' Day	Monday, February 19
Memorial Day	Monday, May 27
Juneteenth	Wednesday, June 19
Independence Day	Thursday, July 4
Day After Independence Day	Friday, July 5
Labor Day	Monday, September 2
Thanksgiving	Thursday, November 28
Day after Thanksgiving	Friday, November 29
Christmas	Wednesday, December 25
Your Birthday	

IMPORTANT PLAN INFORMATION

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

- Your medical, dental and vision benefit contributions for 2024
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

YOUR MONTHLY BENEFIT COSTS

Keker, Van Nest & Peters pays the majority of the cost of employee's medical dental and vision coverage, and you pay a greater portion of dependent insurance premiums. Keker, Van Nest & Peters pays the full cost of your Life, AD&D, and LTD coverage. You pay for benefit premiums on a pretax basis. Since your health care contributions are subtracted from your gross pay before federal, state, and Social Security taxes are withheld, you pay less in taxes. Because this tax advantage reduces your reported taxable wages, your Social Security benefits could be slightly reduced when you become eligible to receive them.

Employees wishing to decline medical coverage will receive $200 a month opt-out credit with proof of other medical coverage. This credit is considered taxable compensation.

	Monthly Contribution	Firm Monthly Contribution	Total Monthly Cost
Aetna HDHP w/ VSP			
Employee Only	$133.00	$1,192.42	$1,325.42
Employee + Spouse	$526.00	$2,127.83	$2,653.83
Employee + Children	$469.00	$1,909.28	$2,378.28
Employee + Family	$761.00	$3,074.07	$3,835.07
Aetna PPO w/ VSP			
Employee Only	$173.00	$1,556.90	$1,729.90
Employee + Spouse	$690.00	$2,772.79	$3,462.79
Employee + Children	$617.00	$2,485.31	$3,102.31
Employee + Family	$1,000.00	$4,008.07	$5,008.07
Aetna HMO w/ VSP			
Employee Only	$135.00	$1,215.88	$1,350.88
Employee + Spouse	$538.00	$2,166.76	$2,704.76
Employee + Children	$482.00	$1,941.86	$2,423.86
Employee + Family	$780.00	$3,128.90	$3,908.90

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

YOUR MONTHLY BENEFIT COSTS, continued

	Monthly Contribution	Firm Monthly Contribution	Total Monthly Cost
Kaiser HMO w/ VSP			
Employee Only	$89.00	$796.13	$885.13
Employee + Spouse	$387.00	$1,560.70	$1,947.70
Employee + Children	$352.00	$1,421.27	$1,773.27
Employee + Family	$528.00	$2,117.39	$2,645.39
Aetna Dental			
Employee Only	$6.00	$59.40	$65.40
Employee + Spouse	$24.00	$126.78	$150.78
Employee + Children	$21.00	$115.25	$136.25
Employee + Family	$38.00	$188.18	$226.18
VSP Vision without medical enrollment			
Employee Only	$1.00	$12.01	$13.01
Employee + Spouse	$4.00	$25.04	$29.04
Employee + Children	$4.00	$25.04	$29.04
Employee + Family	$4.00	$25.04	$29.04

PLAN CONTACTS

Plan Type	Provider	Phone Number	Website	Policy/Group #
Medical HMO: Medical PPO/HDHP:	Aetna Aetna	(800) 445-5299 (877) 204-9186	aetna.com	143141
Medical	Kaiser	(800) 464-4000	kp.org	23558
Dental	Aetna Dental	(877) 238-6200	aetna.com	143141
Vision	VSP	(800) 877-7195	vsp.com	12108463
Life and Disability	Unum	(800) 421-0344	unum.com	403291
FSA, HRA, COBRA	FlexToday	(800) 995-5373	Flex.FlexToday.com	N/A
Mental Health	Modern Health		help@modernhealth.com	Keker Van Nest & Peters LLP
Back-up Care	Bright Horizons	(877) 242-2737	brighthorizons.com	N/A
EAP	Unum	(800) 854-1446	lifebalance.net	N/A
Commuter Benefit	Edenred	(888) 235-9223	commuterbenefits.com	N/A
401k	Milliman	N/A	millimanbenefits.com	N/A

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Note: Beginning January 1, 2022 the "No Surprises Act" provides protections against surprise billing for emergency services, air ambulance services, and certain services provided by a non-participating provider at a participating facility. For these services, the member's cost are generally limited to what the charge would have been if received in-network, leaving any balance to be settled between the insurer and the out-of-network provider. Consult your health plan documents for details.

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, X-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

GLOSSARY

High Deductible Health Plan (HDHP)
A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more, or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located on the Benefits Center:

- **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.

DEADLINE FOR FILING LAWSUIT UNDER ERISA AFTER EXHAUSTION OF ALL CLAIMS PROCEDURES

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan specific statute of limitations.

PLAN DOCUMENTS

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

SUMMARY PLAN DESCRIPTIONS (SPD)

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

- Keker, Van Nest & Peters Health and Welfare Plan

SUMMARY OF BENEFITS AND COVERAGE (SBC)

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

- Aetna PPO
- Aetna HDHP
- Aetna HMO
- Kaiser HMO
- Aetna Dental PPO

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Keker, Van Nest & Peters Health and Welfare 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.

KEKER
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& PETERS