



2020

Benefit Plans **Comparison Chart**

Contents

This document provides an overview of costs and coverage under the NortonLifeLock Benefits Program. To navigate to a specific section within this document, just click a selection in the Contents box. You can also click on any web address to get additional information.

This document is not intended to be a complete description of these benefits. If there is any conflict between the information presented here and the official plan documents, the plan documents will govern. NortonLifeLock reserves the right to modify or terminate any of the benefits described in this document at any time.

The 2020 Medical Plans at a Glance

Plan Provisions	Collective Health Medical Plan Partner			Kaiser CA HMO
	Anthem Health Savings Account (HSA) Plan	Anthem PPO Plan	Anthem PPO 500 AZ, MA, NH only	
General Information				
Plan Overview	Lowest per-pay-period contributions of all Anthem options In-network and out-of-network benefits In-network preventive care covered at 100% Preventive generic drugs covered at 100% Deductibles for medical and prescription drugs are combined and must be met before pharmacy co-insurance and copays apply Highest deductible, but offset by Health Savings Account (HSA) funded by NortonLifeLock and you Fertility benefits, including egg freezing	In-network and out-of-network benefits In-network preventive care covered at 100% Preventive generic drugs covered at 100% Lowest in-network deductible of the Anthem options Fertility benefits, including egg freezing	In-network and out-of-network benefits In-network preventive care covered at 100% Preventive generic drugs covered at 100% Fertility benefits, including egg freezing	In-network only benefits In-network preventive care covered at 100% No deductible Lowest annual out-of-pocket maximum
Provider Choice	You may use any provider, but you'll pay less visiting in-network providers. Find an in-network provider at Collective Health: join.collectivehealth.com/nortonlifelock			You must use Kaiser doctors and facilities.

Employee Contributions

Amounts shown are deducted from your pay on a pre-tax basis (excluding contributions made for a domestic partner and/or a partner's children).

To calculate your annual contribution, multiply the per-pay-period rate by 24.

If you or your spouse/domestic partner uses tobacco products (e.g., cigarettes, e-cigarettes, pipes, cigars and smokeless tobacco, also known as chew, dip or snuff), your medical plan premium will be higher by \$50/pay period (employee only or spouse/domestic partner only) or \$100/pay period (employee + spouse/domestic partner). You and your spouse/domestic partner will need to self-identify as a tobacco user during the online enrollment process.

You will be asked to confirm if your spouse/domestic partner has access to medical coverage through his/her employer. If he/she does and you elect to cover him/her on the NortonLifeLock plan, an additional \$50 per month will be added to your paycheck contributions for your medical plan coverage.

	Per pay period contribution	Per pay period contribution	Per pay period contribution	Per pay period contribution
Employee	\$18.00	\$33.50	\$41.50	\$23.50
Employee + Spouse/ Domestic Partner	\$95.50	\$136.50	\$117.50 AZ \$152.50 MA/NH	\$123.00
Employee + Child(ren)	\$45.00	\$83.50	\$96.00	\$59.00
Employee + Family	\$173.00	\$234.50	\$170.00 AZ \$257.50 MA/NH	\$198.00

Under the Affordable Care Act you must have health insurance. If you do not carry health insurance, you may have to pay a tax penalty. For information on government health care plans, go to [healthcare.gov](https://www.healthcare.gov).

The 2020 Medical Plans at a Glance

Plan Provisions	Anthem HSA Plan (Collective Health)		Anthem PPO Plan (Collective Health)		Anthem PPO 500 AZ, MA, NH only (Collective Health)		Kaiser CA HMO
	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	
Out-of-Pocket Costs							
NortonLifeLock's Contribution	NortonLifeLock contributes to your Health Savings Account (HSA) (to offset your deductible): \$500/employee \$1,000/employee + spouse/domestic partner \$1,000/employee + child(ren) \$1,500/employee + family		Not applicable		Not applicable		Not applicable
Deductible Your contribution before plan pays co-insurance Applies to medical, behavioral health, and prescription drugs Pharmacy charges count only toward the HSA deductible (not the PPO deductible)	\$1,500/employee \$3,000/employee + spouse/domestic partner ¹ \$3,000/employee + child(ren) ¹ \$4,500/employee + family ¹ <i>Deductible must be met before pharmacy co-insurance and copays apply</i>		\$350/employee ² \$700/employee + spouse/domestic partner ² \$700/employee + child(ren) ² \$1,050/employee + family ²	\$1,050/employee ² \$2,100/employee + spouse/domestic partner ² \$2,100/employee + child(ren) ² \$3,150/employee + family ²	\$500/employee ² \$1,000/employee + spouse/domestic partner ² \$1,000/employee + child(ren) ² \$1,500/employee + family ²	\$1,500/employee ² \$3,000/employee + spouse/domestic partner ² \$3,000/employee + child(ren) ² \$4,500/employee + family ²	No deductible
Out-of-Pocket Maximum Includes copayments Includes coinsurance Includes deductible Applies to medical and behavioral health Includes pharmacy charges	\$2,500/employee \$5,000/employee + spouse/domestic partner \$5,000/employee + child(ren) ³ \$6,850/employee + family ³	\$4,500/employee \$7,500/employee + spouse/domestic partner \$7,500/employee + child(ren) ³ \$10,500/employee + family ³	\$2,500/employee ⁴ \$5,000/employee + spouse/domestic partner ⁴ \$5,000/employee + child(ren) ⁴ \$7,500/employee + family ⁴	\$5,350/employee ⁴ \$10,700/employee + spouse/domestic partner ⁴ \$10,700/employee + child(ren) ⁴ \$16,050/employee + family ⁴	\$2,500/employee ² \$5,000/employee + spouse/domestic partner ² \$5,000/employee + child(ren) ² \$7,500/employee + family ²	\$4,500/employee ² \$7,500/employee + spouse/domestic partner ² \$7,500/employee + child(ren) ² \$10,500/employee + family ²	\$1,500/employee \$3,000/employee + family
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited

¹ HSA deductible: All enrolled family members contribute toward a collective, family deductible. The plan will not pay an individual's claims, less any co-insurance, until the total collective family deductible has been met.

² PPO deductible: After each enrolled individual meets his or her individual deductible, the plan will pay his or her claims, less any co-insurance amount. Note the deductible amount is lower in-network.

³ HSA out-of-pocket maximum: All enrolled family members contribute toward a collective, family out-of-pocket maximum. The plan will not pay 100% for covered services until the total collective family out-of-pocket maximum has been met. Note the out-of-pocket maximum amount is lower in-network.

⁴ PPO out-of-pocket maximum: Before the plan will pay 100% for covered services, each covered individual must meet his or her individual out-of-pocket maximum. Note the out-of-pocket maximum amount is lower in-network.

The 2020 Medical Plans at a Glance

Plan Provisions	Anthem HSA Plan (Collective Health)		Anthem PPO Plan (Collective Health)		Anthem PPO 500 AZ, MA, NH only (Collective Health)		Kaiser CA HMO
	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	

Percentages shown represent the amount the plan pays after you meet the deductible (unless otherwise noted) – you pay the remaining percentage (your co-insurance); flat amounts represent the amount you pay (your copayment). Preventive/well care is covered at 100% and not subject to a deductible.

Routine Care: Note that well child care includes immunizations provided in accordance with age frequency guidelines

Routine Physical	Plan pays 100% (no deductible)	Plan pays 70%	Plan pays 100% (no deductible)	Plan pays 60%	Plan pays 100% (no deductible)	Plan pays 70%	Plan pays 100%
Doctors' Office Visit (non-preventive)	Plan pays 90%	Plan pays 70%	Plan pays 85%	Plan pays 60%	You pay: \$20 PCP copay \$40 SPC copay	Plan pays 70%	You pay \$20 (PCP) or \$35 (specialist)/visit
LiveHealth Online (virtual doctor visit)	Plan pays 90%	Not applicable	Plan pays 85%	Not applicable	You pay \$20 copay	Not applicable	Not applicable
Well Baby/Well Care	Plan pays 100% (no deductible)	Plan pays 70%	Plan pays 100% (no deductible)	Plan pays 60%	Plan pays 100% (no deductible)	Plan pays 70%	Plan pays 100%

Hospital Care and Surgery

Pre-authorization	All inpatient stays and certain procedures require pre-authorization (except for emergencies); you must obtain pre-authorization when using out-of-network providers.						Not applicable
Semi-private Room & Board	Plan pays 90%	Plan pays 70%	Plan pays 85%	Plan pays 60%	Plan pays 90%	Plan pays 70%	You pay \$250/confinement
Emergency Room	Plan pays 90%		Plan pays 85%		You pay \$250/visit	You pay \$250/visit	You pay \$100/visit (waived if admitted)
Urgent Care	Plan pays 90%		Plan pays 85%		You pay \$50/visit	Plan pays 70%	You pay \$20/visit
Surgery (outpatient/inpatient)	Plan pays 90%	Plan pays 70%	Plan pays 85%	Plan pays 60%	Plan pays 90%	Plan pays 70%	You pay \$100/outpatient \$250/inpatient

Other Medical Care

Acupuncture	Plan pays 90%	Plan pays 70%	Plan pays 85%	Plan pays 60%	You pay \$40/visit	Plan pays 70%	You pay \$20/visit Physician-referred, up to 20 visits
	Benefits limited to 20 visits per calendar year		Benefits limited to 20 visits per calendar year		Benefits limited to 20 visits per calendar year		
Allergy Testing & Treatment	Plan pays 90%	Plan pays 70%	Plan pays 85%	Plan pays 60%	Plan pays 90%	Plan pays 70%	You pay \$20/visit for testing; \$5/visit for treatment

The 2020 Medical Plans at a Glance

Plan Provisions	Anthem HSA Plan (Collective Health)		Anthem PPO Plan (Collective Health)		Anthem PPO 500 AZ, MA, NH only (Collective Health)		Kaiser CA HMO
	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	
Chiropractic	Plan pays 90%	Plan pays 70%	Plan pays 85%	Plan pays 60%	You pay \$40/visit	Plan pays 70%	Not covered; see kp.org for discounts
	Benefits limited to 20 visits per calendar year		Benefits limited to 20 visits per calendar year		Benefits limited to 20 visits per calendar year		
Fertility Benefits	Offered through Progyny		Offered through Progyny		Offered through Progyny		You pay \$20/outpatient, \$250/inpatient Limited services are covered; contact Kaiser for details.
	Plan pays 90%	Plan pays 70%	Plan pays 85%	Plan pays 60%	Plan pays 90%	Plan pays 70%	
	You pay \$35/prescription self-injectable	You pay \$35/prescription self-injectable	You pay \$45/prescription self-injectable	You pay \$45/prescription self-injectable	You pay \$45/prescription self-injectable	You pay \$45/prescription self-injectable	
	Comprehensive infertility coverage, including fertility preservation, limited to 2 Smart Cycles/lifetime & \$15,000/lifetime for Rx self-injectables. Contact a Progyny Patient Care Advocate at 833-838-5852 to learn more.		Comprehensive infertility coverage, including fertility preservation, limited to 2 Smart Cycles/lifetime & \$15,000/lifetime for Rx self-injectables. Contact a Progyny Patient Care Advocate at 833-838-5852 to learn more.		Comprehensive infertility coverage, including fertility preservation, limited to 2 Smart Cycles/lifetime & \$15,000/lifetime for Rx self-injectables. Contact a Progyny Patient Care Advocate at 833-838-5852 to learn more.		
Physical, Occupational & Speech Therapy (short-term rehab and cognitive therapy) and Pulmonary Rehab	Plan pays 90%	Plan pays 70%	Plan pays 85%	Plan pays 60%	You pay \$20/visit	Plan pays 70%	You pay \$20/visit
	Benefits limited to combined 180-day maximum for all therapy types each calendar year		Benefits limited to combined 180-day maximum for all therapy types each calendar year				
X-ray & Lab	Plan pays 90% (Plan pays 100% with no deductible for routine care)	Plan pays 70%	Plan pays 85% (Plan pays 100% with no deductible for routine care)	Plan pays 60%	Plan pays 90%	Plan pays 70%	Plan pays 100%
Behavioral Health Treatment							
Outpatient Therapy	Plan pays 90%	Plan pays 70%	Plan pays 85%	Plan pays 60%	You pay \$20/visit	Plan pays 70%	You pay \$20/visit for individual therapy You pay \$10/visit for group mental health and \$5/visit for group chemical dependency
Outpatient Facility	Plan pays 90%	Plan pays 70%	Plan pays 85%	Plan pays 60%	Plan pays 90%	Plan pays 70%	You pay \$100/visit
Inpatient	Plan pays 90%	Plan pays 70%	Plan pays 85%	Plan pays 60%	Plan pays 90%	Plan pays 70%	You pay \$250/confinement
Autism (Applied Behavior Analysis [ABA] therapy)*	Plan pays 90%	Plan pays 70%	Plan pays 85%	Plan pays 60%	Plan pays 90%	Plan pays 70%	Services covered under the applicable co-pay; refer to the Evidence of Coverage for details

*Mental Health outpatient benefits include coverage of Applied Behavioral Analysis related to the treatment of autism spectrum disorders (including Autistic Disorder, Asperger's disorder, Pervasive Developmental Disorder not otherwise specified, Rett's Disorder and Childhood Disintegrative Disorder). **Prior authorization is required to obtain benefit.**

The 2020 Medical Plans at a Glance

Plan Provisions	Anthem HSA Plan (Collective Health)		Anthem PPO Plan (Collective Health)		Anthem PPO 500 (Collective Health)		Kaiser CA HMO
	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	
Prescription Drug Benefits (including oral contraceptives)							
Deductibles	Deductible must be met before pharmacy co-insurance/copays apply		Deductible does not need to be met before pharmacy co-insurance/copays apply		Deductible does not need to be met before pharmacy coinsurance/copays apply		No deductible
Retail	Maintenance medications may be filled at a Retail pharmacy up to three times (30-day supply). After that, to avoid paying 100% of the cost, you must fill a 90-day supply of your maintenance medications at a CVS pharmacy.						Not applicable
Generic	You pay \$10 (30-day supply) Preventive generic drugs covered at 100%		You pay \$10 (30-day supply) Preventive generic drugs covered at 100%		You pay \$10 (30-day supply) Preventive generic drugs covered at 100%		You pay \$10 (30-day supply)
Preferred Brand Name	You pay 20% co-insurance (30-day supply) (maximum you pay is \$50)		You pay 25% co-insurance (30-day supply) (maximum you pay is \$80)		You pay 25% co-insurance (30-day supply) (maximum you pay is \$80)		You pay \$30 (30-day supply)
Non-Preferred Brand Name	You pay 30% co-insurance (30-day supply) (maximum you pay is \$100)		You pay 35% co-insurance (30-day supply) (maximum you pay is \$120)		You pay 35% co-insurance (30-day supply) (maximum you pay is \$120)		Not applicable
Specialty	You pay \$35 (30-day supply)		You pay \$45 (30-day supply)		You pay \$45 (30-day supply)		Not applicable
Mail Order	Maintenance medications may be filled in a 90-day supply through home delivery from the Express Scripts Pharmacy or at a CVS retail pharmacy in the Smart90 network using a 90-day prescription from your doctor.						Not applicable
Generic	You pay \$20 (90-day supply) Preventive generic drugs filled through Home Delivery Pharmacy Service covered at 100%		You pay \$20 (90-day supply) Preventive generic drugs filled through Home Delivery Pharmacy Service covered at 100%		You pay \$20 (90-day supply) Preventive generic drugs filled through Home Delivery Pharmacy Service covered at 100%		You pay \$20 (100-day supply)
Preferred Brand Name	You pay \$60 (90-day supply)		You pay \$75 (90-day supply)		You pay \$75 (90-day supply)		You pay \$60 (100-day supply)
Non-Preferred Brand Name	You pay \$130 (90-day supply)		You pay \$150 (90-day supply)		You pay \$150 (90-day supply)		Not applicable
Specialty	You pay \$35 (30-day supply), \$45 (60-day supply), or \$55 (90-day supply)		You pay \$45 (30-day supply), \$55 (60-day supply), or \$65 (90-day supply)		You pay \$45 (30-day supply), \$55 (60-day supply), or \$65 (90-day supply)		Not applicable
Step Therapy	<p>Step therapy is a program for prescription drugs taken regularly to treat a medical condition, such as arthritis, asthma or high blood pressure. Step therapy requires you to try a first-line medicine before a second-line medicine is covered:</p> <ul style="list-style-type: none"> - First-line medicines – Are the first step, typically generic and lower-cost brand-name medicines. Proven to be safe, effective, and affordable. In most cases, they provide the same health benefit as more expensive medicines, but at a lower cost. - Second-line medicines – Are the second and third steps, typically brand-name medicines. Best suited for the few patients who don't respond to first-line medicines, but at a higher cost. <p>You may review the 2020 preferred drug list (to see which drugs are identified as Step Therapy*) at nortonlifelock.com/us/en/benefits. Preventive drugs are covered at 100%. Prescription smoking cessation drugs are covered at 100%.</p>						Not applicable
Dispense as Written (DAW) policy	You pay the difference in cost if there is an equivalent generic available and you request the brand. This only applies if the prescriber hasn't required the brand name drug (i.e. via a prior authorization approval or DAW-1 documentation on the prescription).						Not applicable

* Note that pharmacy charges do not count toward deductible for the PPO Plan and PPO 500 Plan.

The 2020 Dental Plans at a Glance

The three Dental Plans, administered by Delta Dental, all feature the preferred dentist program network (PDP providers) – your out-of-pocket costs are less when you use PDP dentists as benefits are based on negotiated fees instead of the “reasonable and customary” (R&C) amount. Find a PDP provider at Collective Health: join.collectivehealth.com/nortonlifelock.

Plan Provisions	Delta Dental 1.0 Plan	Delta Dental 2.0 Plan	Delta Dental 3.0 Plan
General Information			
Provider Choice	You may use any licensed dental provider, but your out-of-pocket costs will be less when you use a preferred dentist program provider (PDP dentists).		
Annual Deductible (individual/family)	\$50/\$150	\$50/\$150	\$40/\$120
Annual Benefit Maximum (per individual)	\$1,000	\$1,500	\$2,500

Employee Contributions: Amounts shown are deducted from your pay on a pre-tax basis (excluding contributions made for a domestic partner and/or a partner's children). To calculate your annual contribution, multiply the per pay period rate by 24.

	Per pay period	Per pay period	Per pay period
Employee	\$2.50	\$5.50	\$12.00
Employee + Spouse/Domestic Partner	\$7.00	\$13.50	\$30.00
Employee + Child(ren)	\$4.50	\$8.00	\$18.00
Employee + Family	\$8.50	\$16.50	\$36.00

Covered Service: The annual deductible applies to all services except as otherwise noted

	Delta Dental 1.0 Plan	Delta Dental 2.0 Plan	Delta Dental 3.0 Plan
Preventive Care	100% (no deductible)	100% (no deductible)	100% (no deductible)
Basic Care	80%	80%	90%
Major Care (includes oral surgery)	50%	60%	80%
Orthodontia Treatment	Not covered	50%, up to a lifetime benefit of \$2,000/individual (no deductible)	50%, up to a lifetime benefit of \$2,500/individual (no deductible)

The 2020 Vision Plans at a Glance

Both Vision Plans, offered through Vision Service Plan (VSP), feature the Choice Network of preferred VSP providers – your out-of-pocket costs are less when you use VSP providers. To confirm or locate a preferred VSP provider, visit: join.collectivehealth.com/nortonlifelock.

Plan Provisions	VSP 1.0 Plan		VSP 2.0 Plan	
	VSP Providers	Non-VSP Providers	VSP Providers	Non-VSP Providers
General Information				
Annual Deductible	\$25/individual		\$10/individual (1st pair), \$10/individual (2nd pair)	
Employee Contributions: Amounts shown are deducted from your pay on a pre-tax basis (excluding contributions made for a domestic partner and/or a partner's children). To calculate your annual contribution, multiply the per pay period rate by 24.				
	Per pay period		Per pay period	
Employee	\$1.50		\$11.00	
Employee + Spouse/ Domestic Partner	\$4.50		\$27.50	
Employee + Child(ren)	\$3.00		\$16.50	
Employee + Family	\$5.50		\$33.00	
Covered Service: The Plan pays benefits after the deductible is met.				
Eye Exam	Plan pays 100%	Plan pays up to \$45	Plan pays 100%	Plan pays up to \$45
	You may receive 1 comprehensive exam each calendar year		You may receive 1 comprehensive exam each calendar year	
	20% off additional complete pairs of glasses and non-prescription sunglasses; includes non-covered lens options. During your eye exam with a VSP provider, you can receive digital retinal screening for a \$20 copayment.			
Frames	Plan pays 100% up to \$210 retail allowance*	Plan pays up to \$70	Plan pays 100% up to \$250 retail allowance*	Plan pays up to \$70
	You may receive 1 frame every other calendar year		You may receive 2 frames every calendar year	
Lenses	Plan pays 100% for single vision, lined bifocal and lined trifocal lenses**	Plan pays up to \$30 for single vision lenses, \$50 for bifocals**, \$65 for trifocals**, \$100 for lenticular	Plan pays 100% for single vision, lined bifocal and lined trifocal lenses.** For progressive lenses you pay \$40, then plan pays 100%	Plan pays up to \$30 for single vision lenses, \$50 for bifocals**, \$65 for trifocals**, \$100 for lenticular and \$50 for progressive lenses
	You may receive 1 set of lenses each calendar year		You may receive 2 sets of lenses each calendar year	
Contacts	Plan pays 100% up to \$250/year. For contact lens exam (fitting and evaluation) you pay up to \$60 then the Plan pays 100%.	Plan pays 100% for contacts and contact lens exam up to \$105/year	Plan pays 100% up to \$400/year. For contact lens exam (fitting and evaluation) you pay up to \$60 then the Plan pays 100%.	Plan pays 100% for contacts and contact lens exam up to \$105/year
	You may receive 1 set of lenses or contacts each calendar year. Frames may be chosen one calendar year from the date contact lenses are obtained.		You may receive 2 sets of contacts each calendar year in lieu of lenses and frames (or you can choose to receive 1 set of contacts and 1 pair of glasses).	
Laser Eye Surgery (available to employees only)	Not covered		Plan pays \$1,000 per eye per lifetime. VSP's Laser VisionCare Program provides you with discounts for PRK, Lasik, and Custom Lasik, with an average of 15% off or 5% off if the laser center is offering a promotional price.	
Computer Vision Care (CVC) Benefit (available to employees only)	You pay \$10; Plan then pays 100% up to \$90 retail frame allowance	You pay \$10; Plan then pays 100% up to \$14 for an exam, \$45 for frames, \$30 for single vision lenses, \$50 for bifocals**, \$65 for trifocals**, \$100 for lenticular	You pay \$10; Plan then pays 100% up to a \$90 retail frame allowance	You pay \$10; Plan then pays 100% up to \$14 for an exam, \$45 for frames, \$30 for single vision lenses, \$50 for bifocals**, \$65 for trifocals**, \$100 for lenticular
	You may receive 1 pair of CVC glasses each calendar year		You may receive 1 pair of CVC glasses each calendar year	

* Frames allowance at participating Costco Optical is \$115 (instead of \$210) on the 1.0 Plan and \$135 (instead of \$250) on the 2.0 Plan.

**Bifocals and trifocals have a visible horizontal line in the center of the lens. This is considered a lined bifocal or lined trifocal. Lenses without the line are considered an option.

Diabetic Eyecare Benefit VSP Providers: Plan pays for eyecare services related to diabetic eye disease, glaucoma, age-related macular degeneration and retinal screening for eligible members with diabetes. You pay \$20.

Non-VSP Providers: Not covered.

The 2020 Flexible Spending Accounts (FSAs) at a Glance

FSAs enable you to use tax-free money to pay for certain eligible expenses.

Provision	Health Care FSA	Limited Purpose FSA	Dependent Care FSA
Medical Plan Eligibility	Anthem PPO Plan Anthem PPO 500 Plan (AZ, MA, NH) Kaiser CA HMO Plan	Anthem HSA Plan only	N/A
Covered Expenses	<p>Health care (medical, dental, or vision care) expenses that you incur, either on behalf of yourself or your eligible dependents (spouse and/or children), regardless of whether you or your dependents are covered under any NortonLifeLock health care plans. Eligible expenses are those that are not (fully or partially) reimbursed through other health care plans including:</p> <ul style="list-style-type: none"> Deductibles Copayments and co-insurance amounts Charges made by providers above the amount recognized by your plan Over-the-counter medications (must be prescribed by a physician) Other allowable health care expenses (see IRS Publication 502 for details) 	<p>Dental or vision care expenses only that you incur, either on behalf of yourself or your eligible dependents (spouse and/or children), regardless of whether you or your dependents are covered under any NortonLifeLock health care plans. After your HSA deductible is met, eligible medical expenses are covered. Sample expenses include:</p> <ul style="list-style-type: none"> Dental and vision deductibles Copayments and co-insurance amounts Charges made by providers above the amount recognized by your plan Orthodontia treatment Eyeglass frames and lenses 	<p>Dependent care (such as day care) expenses you incur on behalf of an eligible dependent (child or adult) – these expenses must be necessary in order for you (or you and your spouse) to work or look for work. Eligible expenses include care provided in or outside your home; see IRS Publication 503 for details.</p> <p>To be considered an eligible expense, care must be provided to an eligible dependent who is dependent upon you for support, such as:</p> <ul style="list-style-type: none"> A dependent child under the age of 13 A disabled spouse who is unable to work
Contribution limits	<p>\$2,700/year</p> <p>Your spouse/domestic partner can also contribute \$2,700 to a health care FSA through his/her employer, even if you both work at NortonLifeLock.</p> <p>WageWorks will automatically carryover up to \$500 of unused FSA funds into the next plan year's account. If you would like to set aside additional funds for the next plan year, you'll need to re-enroll during Open Enrollment.</p>	<p>\$2,700/year</p> <p>Your spouse/domestic partner can also contribute \$2,700 to a health care FSA through his/her employer, even if you both work at NortonLifeLock.</p> <p>WageWorks will automatically carryover up to \$500 of unused FSA funds into the next plan year's account. If you would like to set aside additional funds for the next plan year, you'll need to re-enroll during Open Enrollment.</p>	<p>\$5,000/year if single, or married and filing federal taxes jointly</p> <p>\$2,500/year if married and filing federal taxes separately</p> <p>Annual non-discrimination testing may limit the ability for employees earning greater than \$120,000 to contribute the maximum annual goal amount.</p>