# 2021 Benefit Plans Comparison Chart

COBRA

## 2021 Medical Plans

| Plan Provisions | Collective Health Medical Plan Partner | | | Kaiser CA HMO Plan |
|---|---|---|---|---|
| | Anthem Health Savings Account (HSA) Plan | Anthem PPO Plan | Anthem PPO 500 Plan (Arizona only) | |
| **GENERAL INFORMATION** | | | | |
| **Provider Choice** | You can use any provider, but you'll pay less by visiting in-network providers; Find an in-network provider at Collective Health: join.collectivehealth.com/nortonlifelock | | | You must use Kaiser doctors and facilities |
| **COBRA MONTHLY CONTRIBUTION** | | | | |
| **Individual** | $777.97 | $835.33 | $854.75 | $610.49 |
| **Individual + Spouse/Partner** | $1,549.04 | $1,663.60 | $1,702.29 | $1,220.97 |
| **Individual + Child(ren)** | $1,145.72 | $1,253.00 | $1,282.12 | $915.73 |
| **Individual + Family** | $2,238.76 | $2,409.05 | $2,465.05 | $1,721.57 |

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.

# 2021 Medical Plans

| Plan Provisions | Anthem HSA Plan (Collective Health) | | Anthem PPO Plan (Collective Health) | | Anthem PPO 500 Plan (Arizona only) (Collective Health) | | Kaiser CA HMO Plan |
|---|---|---|---|---|---|---|---|
| | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK | |
| **NortonLifeLock's HSA CONTRIBUTION** | | | | | | | |
| **Individual** | Not applicable | | Not applicable | | Not applicable | | Not applicable |
| **Individual + Spouse/Partner** | | | | | | | |
| **Individual + Child(ren)** | | | | | | | |
| **Individual + Family** | | | | | | | |
| **DEDUCTIBLE** | | | | | | | |
| **Individual** | $1,500 | | $350[2] | $1,050[2] | $500[2] | $1,500[2] | No deductible |
| **Individual + Spouse/Partner** | $3,000[1] | | $700[2] | $2,100[2] | $1,000[2] | $3,000[2] | |
| **Individual + Child(ren)** | $3,000[1] | | $700[2] | $2,100[2] | $1,000[2] | $3,000[2] | |
| **Individual + Family** | $4,500[1] | | $1,050[2] | $3,150[2] | $1,500[2] | $4,500[2] | |
| **ANNUAL OUT-OF-POCKET MAXIMUM** | | | | | | | |
| **Individual** | $2,500 | $4,500 | $2,500[4] | $5,350[4] | $2,500[4] | $4,500[4] | $1,500 |
| **Individual + Spouse/Partner** | $5,000 | $7,500 | $5,000[4] | $10,700[4] | $5,000[4] | $7,500[4] | $3,000 |
| **Individual + Child(ren)** | $5,000[3] | $7,500[3] | $5,000[4] | $10,700[4] | $5,000[4] | $7,500[4] | |
| **Individual + Family** | $6,850[3] | $10,500[3] | $7,500[4] | $16,050[4] | $7,500[4] | $10,500[4] | |

[1] HSA deductible: All enrolled family members contribute toward a collective family deductible. The plan will not pay an individual's claims, less any coinsurance, until the total collective family deductible has been met.
[2] PPO deductible: After each enrolled individual meets their individual deductible, the plan will pay his or her claims, less any coinsurance amount.
[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.
[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.

# 2021 Medical Plans

Percentages shown are after the deductible has been met, unless otherwise noted. Copays are before the deductible has been met.

| Plan Provisions | Anthem HSA Plan (Collective Health) | | Anthem PPO Plan (Collective Health) | | Anthem PPO 500 Plan (Arizona only) (Collective Health) | | Kaiser CA HMO Plan |
|---|---|---|---|---|---|---|---|
| | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK | |
| **ROUTINE CARE** (after deductible unless otherwise noted) | | | | | | | |
| **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% |
| **Doctor's Office Visit (nonpreventive)** | Plan pays 90% | Plan pays 70% | Plan pays 85% | Plan pays 60% | You pay: PCP: $20 copay Specialist: $40 copay | Plan pays 70% | You pay: PCP: $20 copay Specialist: $40 copay |
| **LiveHealth Online (virtual doctor visit)** | Plan pays 90% | Not applicable | Plan pays 85% | Not applicable | You pay $20 copay | Not applicable | Not applicable |
| **HOSPITAL CARE AND SURGERY** | | | | | | | |
| **Semiprivate Room and Board** | Plan pays 90% | Plan pays 70% | Plan pays 85% | Plan pays 60% | Plan pays 90% | Plan pays 70% | You pay $250 per confinement |
| **Emergency Room** | Plan pays 90% | | Plan pays 85% | | You pay $250 per visit | You pay $250 per visit | You pay $100 per visit (waived if admitted) |
| **Urgent Care** | Plan pays 90% | | Plan pays 85% | | You pay $50 per visit | Plan pays 70% | You pay $20 per visit |
| **Surgery** | 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 (20 visits per year)** | Plan pays 90% | Plan pays 70% | Plan pays 85% | Plan pays 60% | You pay $40 per visit | Plan pays 70% | You pay $20 per visit; must be referred by PCP |
| **Allergy Testing and Treatment** | Plan pays 90% | Plan pays 70% | Plan pays 85% | Plan pays 60% | Plan pays 90% | Plan pays 70% | You pay $20 per visit for testing; $5 per visit for treatment |
| **Chiropractic (20 visits per year)** | Plan pays 90% | Plan pays 70% | Plan pays 85% | Plan pays 60% | You pay $40 per visit | Plan pays 70% | Not covered; see **kp.org** for discounts |

# 2021 Medical Plans

| Plan Provisions | Anthem HSA Plan (Collective Health) | | Anthem PPO Plan (Collective Health) | | Anthem PPO 500 Plan (Arizona only) (Collective Health) | | Kaiser CA HMO Plan |
|---|---|---|---|---|---|---|---|
| | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK | |
| **OTHER MEDICAL CARE (CONTINUED)** | | | | | | | |
| **Fertility Benefits** | Offered through Progyny. Benefits limited to $15,000 per lifetime for medical procedures and $15,000 per lifetime for prescription self-injectable drugs. Contact Progyny at 1-833-838-5852 to learn more. | | | | | | You pay $20 per outpatient visit and $250 per inpatient visit<br>Limited services are covered; contact Kaiser for details |
| | Plan pays 90%<br>You pay $35 per prescription self-injectable | Plan pays 70%<br>You pay $35 per prescription self-injectable | Plan pays 85%<br>You pay $45 per prescription self-injectable | Plan pays 60%<br>You pay $45 per prescription self-injectable | Plan pays 90%<br>You pay $45 per prescription self-injectable | Plan pays 70%<br>You pay $45 per prescription self-injectable | |
| **Physical, Occupational, and Speech Therapy and Pulmonary Rehab** | Plan pays 90% | Plan pays 70% | Plan pays 85% | Plan pays 60% | You pay $20 per visit | Plan pays 70% | You pay $20 per visit |
| | Combined 180-day annual maximum for all therapy types | | Combined 180-day annual maximum for all therapy types | | | | |
| **X-ray and Lab** | Plan pays 90% (100% for routine care) | Plan pays 70% | Plan pays 85% (100% 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 per visit | Plan pays 70% | You pay $20 per visit per individual therapy<br>You pay $10 per visit for group mental health and $5 per 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 per visit |
| **Inpatient** | Plan pays 90% | Plan pays 70% | Plan pays 85% | Plan pays 60% | Plan pays 90% | Plan pays 70% | You pay $250 per confinement |
| **Autism (Applied Behavior Analysis [ABA] therapy); prior authorization required** | Plan pays 90% | Plan pays 70% | Plan pays 85% | Plan pays 60% | Plan pays 90% | Plan pays 70% | Services covered under the applicable copay |

# 2021 Medical Plans

| Plan Provisions | Anthem HSA Plan (Collective Health) | | Anthem PPO Plan (Collective Health) | | Anthem PPO 500 Plan (Arizona only) (Collective Health) | | Kaiser CA HMO Plan |
|---|---|---|---|---|---|---|---|
| | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK | |
| **PRESCRIPTION DRUG BENEFITS** (including oral contraceptives) | | | | | | | |
| **Deductibles** | Deductible must be met before pharmacy coinsurance and copays apply | | No deductible | | No deductible | | No deductible |
| **Retail** | **Maintenance medications can be filled at a retail pharmacy up to 3 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% coinsurance (30-day supply) (maximum you pay is $50) | | You pay 25% coinsurance (30-day supply) (maximum you pay is $80) | | You pay 25% coinsurance (30-day supply) (maximum you pay is $80) | | You pay $30 (30-day supply) |
| Non-Preferred Brand Name | You pay 30% coinsurance (30-day supply) (maximum you pay is $100) | | You pay 35% coinsurance (30-day supply) (maximum you pay is $120) | | You pay 35% coinsurance (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 can 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 |
| **Dispense as Written (DAW) Policy** | You pay the difference in cost if there is an equivalent generic available and you or the prescriber requests the brand | | | | | | Not applicable |

# 2021 Dental Plans

Your out-of-pocket costs are less when you use preferred dentist program (PDP) dentists. Find a PDP provider at Collective Health: **join.collectivehealth.com/nortonlifelock**.

| Plan Provisions | Delta Dental 1.0 Plan | Delta Dental 2.0 Plan |
|---|---|---|
| **GENERAL INFORMATION** | | |
| Provider Choice | You can 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 (per individual/family) | $50/$150 | $50/$150 |
| Annual Benefit Maximum (per individual) | $1,000 | $1,500 |
| **COBRA MONTHLY CONTRIBUTION** | | |
| Individual | $38.26 | $57.64 |
| Individual + Spouse/Partner | $76.53 | $114.67 |
| Individual + Child(ren) | $57.38 | $86.99 |
| Individual + Family | $110.99 | $167.33 |
| **COVERED SERVICE** | | |
| The annual deductible applies to all services except as otherwise noted. | | |
| Preventive Care | 100% (no deductible) | 100% (no deductible) |
| Basic Care | 80% | 80% |
| Major Care (includes oral surgery) | 50% | 60% |
| Orthodontia Treatment | Not covered | 50%, up to a lifetime benefit of $2,000 per individual (no deductible) |

# 2021 Vision Plans

Your out-of-pocket costs are less when you use VSP providers. To confirm or locate a 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 per individual | | $10 per individual (1st pair), $10 per individual (2nd pair) | |
| **COBRA MONTHLY CONTRIBUTION** | | | | |
| **Individual** | $9.69 | | $29.18 | |
| **Individual + Spouse/Partner** | $19.39 | | $61.04 | |
| **Individual + Child(ren)** | $14.55 | | $43.78 | |
| **Individual + Family** | $28.11 | | $84.65 | |
| **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 can receive 1 comprehensive exam each calendar year | | You can receive 1 comprehensive exam each calendar year | |
| | 20% off additional complete pairs of glasses and nonprescription sunglasses; includes noncovered lens options. During your eye exam with a VSP provider, you can receive a 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 can receive 1 frame every other calendar year | | You can 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, and $100 for lenticular lenses | 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 lenses, and $50 for progressive lenses |
| | You can receive 1 set of lenses each calendar year | | You can receive 2 sets of lenses 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.

# 2021 Vision Plans

| Plan Provisions | VSP 1.0 Plan | | VSP 2.0 Plan | |
|---|---|---|---|---|
| | VSP Providers | Non-VSP Providers | VSP Providers | Non-VSP Providers |
| **COVERED SERVICE (CONTINUED)**<br>The plan pays benefits after the deductible is met. | | | | |
| **Contacts** | Plan pays 100% up to $250 per 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 per year | Plan pays 100% up to $400 per 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 per year |
| | You can receive 1 set of lenses or contacts each calendar year. Frames can be chosen 1 calendar year from the date contact lenses are obtained. | | You can 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 former 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 former 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, and $100 for lenticular lenses | 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, and $100 for lenticular lenses |
| | You can receive 1 pair of CVC glasses each calendar year | | You can receive 1 pair of CVC glasses each calendar year | |