2021

Summary of Benefits

talend

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WELCOME TO YOUR BENEFITS!

The investment in employee benefits is a very important way in which Talend Inc. is able to care for you and your family. We are pleased to provide a comprehensive benefits package centered around four important areas of wellness:

HEALTH CARE | **PRE-TAX BENEFITS** | **FINANCIAL SECURITY** | **WORK-LIFE BALANCE**

This document provides a high-level overview of the benefits available so that you can review your options for enrollment. Individual carrier documents provide more detail regarding coverage and benefits. These documents supersede any information provided here.

TALEND INC. + VITA

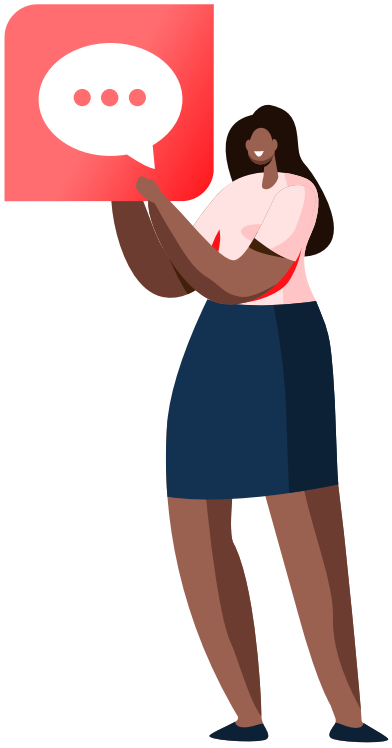
The Vita Concierge is here to help! Talend Inc. has partnered with Vita to assist you with your benefits needs. We can support you with a multitude of issues including those outlined below:

- Benefit plan enrollment
- Plan design inquiries
- ID cards and eligibility issues
- Health and pre-tax claims assistance
- Accessing pre-tax funds
- Enrollment guidance

Vita Concierge may be reached Monday – Friday 8:00 a.m. – 5:00 p.m. PST via phone, (650) 966-1492 or email talend@vitamail.com **.**

You may also reach out via Slack @Vita

Making sure your request is resolved to your satisfaction is our top priority. Please be aware that Vita complies with all Federal HIPAA privacy and security regulations to ensure your information is safe.



SIGNING UP AND MAKING CHANGES

ELIGIBILITY

Full-time employees working 30 or more hours per week are eligible for all benefits. Most of these benefits are effective on the first day of full-time employment. Please note that supplemental accident and hospital indemnity benefits are the exception. These are effective on the first day of the month following or coinciding with the first day of full-time employment. For life, disability, and FSA coverages, employees must be actively working on the date coverage begins. Please see 401(k) section for 401(k) eligibility.

ELIGIBLE DEPENDENTS

You may enroll spouses/registered domestic partners and children up to age 26 in your medical, dental, and vision plans. If your child is over 26 and disabled, you may be able to continue coverage. If enrolling a non-registered domestic partner, you must meet the criteria outlined in the "Domestic Partnership Declaration". A completed declaration must be submitted to HR prior to your enrollment being approved.

DOMESTIC PARTNERS

You will pay taxes on the employer paid premium and employee contribution for enrolled domestic partners and/or their children. State level tax exemptions may apply. Please see your tax advisor for more details. You will also need to fill out a DP declaration, you may download this form from Workday.

ENROLLMENT

The enrollment process is completed through Workday. You must complete your initial enrollment within 30 days of your eligibility date.

Commute benefits must be elected in the Optum system by the 10th of the month prior to your benefits taking effect. Elections may be changed on a monthly basis.

ADDITIONAL INFORMATION AND RESOURCES

Benefit summaries, detailed plan information, plan certificates, and forms are available through the landing page.

SPECIAL ENROLLMENT PERIOD/ADDING NEW DEPENDENTS

You may only enroll or make election changes mid-year if you experience a qualified life event such as marriage, birth or adoption of a new child, divorce, or an involuntary loss of coverage from another group plan (these events may be with a domestic partner also). **You must notify HR and submit the request for changes in Workday within 30 days of the life event.**

OPEN ENROLLMENT

Open Enrollment is your annual opportunity to enroll in or make changes to your benefits without a qualified life event. If you or your dependents do not enroll when you first become eligible, you will only be able to enter the plan during Open Enrollment. Open Enrollment is conducted in November/December each year, for changes to be effective January 1st.

COVERAGE TERMINATION

Medical, dental, and vision benefits terminate on the last day of the month following employment termination. All other benefits end on your last day of employment.

COBRA CONTINUATION

You and your covered dependents have a right to continue medical, dental, vision, and Health FSA coverage for a specified period of time after you terminate employment or for other qualified life events. You will be notified of your rights and responsibilities to continue coverage under Federal COBRA law.

EMPLOYEE COST SHARING

EMPLOYEE CONTRIBUTIONS PER PAY PERIOD

	EMPLOYEE ONLY	EMPLOYEE + SPOUSE/DP	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Kaiser HDHP (CA Only)	$19.00	$105.50	$77.00	$170.50
Kaiser HMO (CA Only)	$57.50	$160.50	$126.00	$238.00
UHC HDHP	$19.00	$105.50	$77.00	$170.50
UHC PPO	$93.50	$250.00	$198.00	$368.00
Dental	$6.00	$19.50	$14.50	$36.00
Vision	$0.50	$2.50	$2.50	$5.00
Accident	$4.66	$7.76	$8.57	$11.67
Hospital Indemnity	$13.14	$31.41	$20.29	$38.56
Life/Disability	No cost, paid by Talend			
Supplemental Life	Age banded rates, fully paid by you			
Critical Illness	Age banded rates, fully paid by you			
Pre-Tax Benefits	Self-directed up to IRS maximum			
401(k)	Self-directed up to IRS maximum			

HEALTH SAVINGS ACCOUNT (HSA) ENROLLMENT

- If you enroll in the HDHP, you will automatically be enrolled in an HSA.
- If you are not eligible to open and contribute to an HSA, you must notify Talend in writing within 30 days your medical election date.
- See HSA section for more details.

ID CARDS

You will receive an ID card for medical coverage only. Your ID card will arrive within 7-10 business days of your enrollment being processed by the insurance carrier. You can also download an electronic version of your ID card by registering directly on the carrier's website.

If you are enrolling in Kaiser and have been a Kaiser member in the past, you will use the same Medical Record Number (MRN) that you used previously. No new ID card will be issued.

Delta Dental and VSP Vision do not issue ID cards. Eligibility is verified for you and your eligible dependents using your name, date of birth, and last four digits of your social security number. Generic ID cards may be downloaded directly from the carrier's website once you have registered.

HOW TO FIND AN IN-NETWORK PROVIDER

We recommend that you contact your physicians directly to confirm participation in your network prior to seeking services. Locating the provider's name on the carrier's website does not guarantee they are part of the network, as provider participation is subject to change at any time.

UHC MEDICAL PLAN

www.myuhc.com

1. Go to the My UHC website and click on **Find a Provider.**
2. Select **Medical Directory > All UnitedHealthcare Plans > Select Plus.**
3. Type in the **zip code** and select "**People**." Then select the type of provider you would like to search.

KAISER MEDICAL PLAN

www.kp.org

1. Click on **Doctors and Locations** at the top of the page
2. Choose whether to search by **Doctors or Locations**
3. Select **California – Northern** under Region
4. Enter your **zip code** and remaining search criteria

DELTA DENTAL PLAN

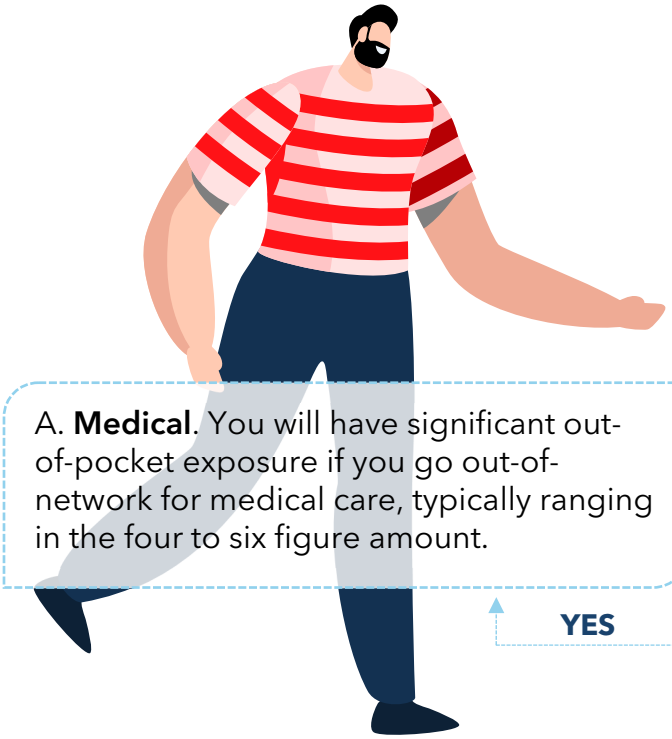
www.deltadentalins.com

1. Go to Delta Website
2. Go to **Find a Dentist** and type in your location.
3. Select **Network**: **Delta Dental PPO** shows In-Network Providers, **Delta Dental Premier** shows Out-of-Network Providers.
4. Type in **Dentist or Practice Name**.

VSP VISION PLAN

www.vsp.com

1. Go to the VSP website or call (800) 877-7195
2. If you are enrolling onto the VSP plan and verifying benefits, please make sure you have your Social Security Number on hand.



A. **Medical**. You will have significant out-of-pocket exposure if you go out-of-network for medical care, typically ranging in the four to six figure amount.

YES

Q: IS IT CRITICAL TO STAY IN-NETWORK?

NO

A. **Dental** and **Vision**. Your dental and vision coverage may be applied to out- of-network expenses, however staying in-network reduces your out-of-pocket costs.

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HEALTH CARE

UNDERSTANDING YOUR MEDICAL PLAN

Talend Inc. offers employees a choice of four medical plans. Before making your medical plan election, it is important to understand the differences between each of the plans, including how to access care and what your out of pocket costs will be under each plan.

KEY DEFINITIONS

- **Network Provider:** Physician/provider who has contracted with the insurance carrier and has agreed to a negotiated rate for services.
- **Annual Deductible:** Amount a member pays each calendar year for covered services before the plan's coinsurance (cost sharing) begins. The deductible resets every January 1st.
- **Copayment:** Member's flat dollar payment or "copay" at point of service.
- **Coinsurance:** Cost sharing element of the plan expressed as a percentage. Coinsurance payments are based on negotiated rates.
- **Out of Pocket Maximum (OOP):** Maximum amount a member will pay for covered services in a calendar year. Once met, the plan pays 100% for all covered services when in-network.
- **Preferred Drug List (PDL):** A list (formulary or preferred drug list) that outlines how a particular medication is covered under the different prescription tiers. PDLs change throughout the year, and members are notified by mail when and if a change will affect them.

CONTROLLING YOUR COSTS

Save yourself time and money by knowing where to direct your care!

SYMPTOM	WHERE TO GO	MORE INFORMATION
"I have a minor problem that won't require a test."	Virtual Visit ($)	UHC: www.doctorondemand.com www.teladoc.com Kaiser: www.kp.org/mydoctor/videovisits
"I have a minor problem that may require a test/exam but my doctor isn't available."	Convenience Care Clinic ($$)	Find in-network facilities and providers using the How to Find a Network Provider instructions on page 5 or download the UHC or Kaiser mobile app!
"I want routine care or have a minor, complex, or chronic problem."	Office Visit ($$)	
"It's not life threatening, but I need care quickly."	Urgent Care ($$$)	
"It's life threatening or very serious."	Emergency Room ($$$$)	
"Help! I don't know where to go."	Call the Nurse Help Line	See the back of your medical ID card for phone number

UNDERSTANDING YOUR MEDICAL PLAN (CONTINUED)

KEY PLAN DESIGN DIFFERENCES

	PPO	HMO
How is Kaiser different?	Kaiser requires that you go to a Kaiser facility in your service area. Care outside of Kaiser is only covered in a life-threatening emergency.	
Which health providers must I choose?	Whenever possible you should choose doctors, hospitals, and other providers that contract with the PPO network.	You must choose doctors, hospitals, and other providers that contract with the HMO network.
Do I need to have a primary care provider (PCP)?	No. You can receive care from any doctor you choose but you will pay more for out-of-network providers.	Yes. Your HMO will not provide coverage if you do not have a designated PCP or medical group.
How do I see a specialist?	You do not need a referral to see a specialist. However, some specialists will only see patients who are referred to them by a primary care doctor. Also, some PPOs require that you get a prior approval for certain expensive services, such as MRIs.	You need a referral from your PCP to see a specialist (such as a cardiologist or surgeon) except in emergency situations. Your PCP also must refer you to a specialist who is in the HMO network.
Do I have to file an insurance claim?	Not usually for in-network care. However, if you go out-of-network for services you may have to pay the provider in full and then file a claim with the health plan to get reimbursed.	No, unless in an emergency where an outside facility is used.
Can I seek care out of my service area?	Yes. Most PPOs have a nationwide network, meaning that you can find in-network providers in most states.	No. All care must be rendered within your Primary Medical Group, or pre-authorized by them.
Why do we have a High Deductible Health Plan (HDHP)?	An HDHP has a high deductible that you must meet before the insurance will start paying for your office visits, lab tests and prescriptions. The increased deductible helps control costs and therefore usually means a lower premium contribution out of your paycheck. Also, your employer may offset your expenditure by offering a Health Savings Account.	

SIDE BY SIDE MEDICAL PLAN COMPARISON

Following is a very brief side by side comparison of the key benefit features of each plan. **All benefits listed refer to the member's responsibility or cost share after the deductible is met, unless otherwise indicated.** As always, please refer to your carrier's Certificate of Coverage for more details.

PPO OPTIONS	MEDICAL OPTION 1 UHC HDHP		MEDICAL OPTION 2 UHC PPO	
Benefit	In-Network	Out-of-Network	In-Network	Out-of-Network
HSA Funding from Talend	Individual Coverage: $58.33/pay period Family Coverage: $116.67/pay period		N/A	N/A
Deductible **Individual** **Family**	 $2,800 $5,600	 $3,000 $6,000	 $250 $500	 $500 $1,000
Copays/Coinsurance	0%	30%	20%	40%
Office Visit	0%	30%	$20	40%
Prescriptions	$15/$40/$60	$15/$40/$60	$15/$35/$50	$15/$35/$50
Out-of-Pocket Max **Individual** **Family**	 $5,000 $10,000	 $10,000 $20,000	 $2,250 $4,500	 $4,500 $9,000
Consider this Plan If…	• you have low medical and prescription utilization • you want to receive employer funding into a Health Savings Account (HSA)		• you are a moderate to heavy user of medical services and prescriptions • you want freedom of choice of providers	

HMO OPTIONS	MEDICAL OPTION 3 KAISER HDHP	MEDICAL OPTION 4 KAISER HMO
Benefit	Kaiser Authorized Care	Kaiser Authorized Care
HSA Funding from Talend	Individual Coverage: $58.33/pay period Family Coverage: $116.67/pay period	N/A
Deductible **Individual** **Family**	$2,000/individual; $2,800/member in a family; $4,000/family	None
Office Visit	$30	$15
Hospital	$250 per admit	No Charge
Prescriptions	$10/$30	$15/$30
Out-of-Pocket Max **Individual** **Family**	 $3,000 $6,000	 $1,500 $3,000
Consider this Plan If…	• you have low medical and prescription utilization • you want to receive employer funding into a Health Savings Account (HSA)	• you prefer a one-stop location for your medical and prescriptions needs • you prefer simplified copay expenses

OPTION 1: UHC HDHP

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Network	Select Plus	
Reimbursement Basis	UHC's contracted rate	UHC's allowed amount. All charges in excess of the allowed amount are the member's responsibility.
HSA Funding from Talend	Single - $58.33/pay period ($1,400 over 12 months) Family - $116.67/pay period ($2,800 over 12 months)	
Deductible	$2,800/single; $5,600/family	$3,000/single; $6,000/family
Out-of-Pocket Maximum	$5,000/single; $10,000/family	$10,000/single; 20,000/family
Office Visit	0%	30%
Virtual Visit	Based on selected virtual visit provider; often $50 or less	
Prescriptions (up to a 30-day supply)	$15 / $40 / $60	$15 / $40 / $60
Mail Order Prescriptions (up to a 90-day supply)	$30 / $80 / $120	Not covered
Specialty Prescriptions	$60	$60 + excess charges
Preventive Care	No charge	Not covered
Basic Lab and X-ray	0%	Not covered
Complex Lab and X-ray	0%	Not covered
Urgent Care	0%	30%
Outpatient	0%	Limited
Inpatient	0%	30% (pre-auth may be required)
Emergency Services	0%	
Physical Therapy	0%	Not covered
Chiropractic Services (24 visits max/year)	0%	30% (pre-auth may be required)
Acupuncture (20 visits max/year)	0%	Not covered
Durable Medical Equipment	0%	Not covered
Infertility	Not covered	Not covered
Plan Details	See Additional Plan Notes section	

All benefits listed refer to the member's responsibility or cost share after the deductible is met, unless otherwise indicated. The benefit information above outlines the key components of this medical policy. Please refer to your carrier's Certificate of Coverage for additional details on plan benefits and limitations.

OPTION 1: UHC HDHP ADDITIONAL PLAN NOTES

ALL NON-PREVENTIVE EXPENSES APPLY TO THE DEDUCTIBLE

All benefits listed refer to the member's responsibility or cost share after the deductible is met, unless otherwise indicated. Talend's High Deductible Health Plan (HDHP) requires that all non-preventive expenses receive no reimbursement from insurance prior to the deductible being met. With that said, you will still get the benefit of negotiated discounts when using in-network providers.

GOING OUT-OF-NETWORK: "ALLOWED AMOUNT" DEFINED

The "allowed amount" is the amount that UHC will allow for a participating provider even when the services are rendered out-of-network. Out-of-network charges can be significantly greater than the allowed amount and you will be responsible for the difference between what the out-of-network provider charges and what UHC reimbursed. These balanced billed charges **do not** accumulate towards your out-of-network deductible or out-of-pocket maximum.

UTILIZATION REVIEW

All hospital confinements and surgeries must be preauthorized by UHC. You or your physician must call UHC prior to a hospital admission for non-emergency treatment. If you do not obtain this mandatory authorization, your benefits will be reduced or a penalty payment will apply. Please refer to your ID card for the utilization review phone number and required time frame for reporting.

CLAIMS

In-network providers will submit claims directly to UHC. If you see an out-of-network provider, you may be required to submit the claim directly to UHC for reimbursement.

BRAND NAME PRESCRIPTION DRUG BENEFIT

If you choose to receive a brand name drug when a generic equivalent is available, you will be responsible for the generic drug cost plus the difference in cost between the generic and the brand name negotiated rate.

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OPTION 2: UHC PPO

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Network	Select Plus	
Reimbursement Basis	UHC's contracted rate	UHC's allowed amount. All charges in excess of the allowed amount are the member's responsibility.
Deductible	$250/individual; $500/family	$500/individual; $1,000/family
Out-of-Pocket Maximum	$2,250/individual; $4,500/family	$4,500/individual; $9,000/family
Office Visit	$20 PCP or Specialist (deductible waived)	40%
Virtual Visit	$20 (deductible waived)	Not covered
Prescriptions (up to a 30-day supply)	$15 / $35 / $50 (deductible waived)	$15 / $35 / $50 (deductible waived) + excess charges
Mail Order Prescriptions (up to a 90-day supply)	$30 / $70 / $100 (deductible waived)	Not covered
Specialty Prescriptions	$15 / $35 / $50 (deductible waived)	$15 / $35 / $50 (deductible waived) + excess charges
Preventive Care	No charge	Not covered
Basic Lab and X-ray	No charge	Not covered
Complex Lab and X-ray	20%	Not covered
Urgent Care	$50 (deductible waived)	40%
Outpatient	20%	Limited
Inpatient	20%	40% (pre-auth may be required)
Emergency Services	$100 (deductible waived)	
Physical Therapy	$20 (deductible waived)	Not covered
Chiropractic Services (24 visits max/year)	$20 (deductible waived)	40% (pre-auth may be required)
Acupuncture (20 visits max/year)	$20 (deductible waived)	Not covered
Durable Medical Equipment	20%	Not covered
Infertility	Not covered	Not covered
Plan Details	See Additional Plan Notes section	

All benefits listed refer to the member's responsibility or cost share after the deductible is met, unless otherwise indicated. The benefit information above outlines the key components of this medical policy. Please refer to your carrier's Certificate of Coverage for additional details on plan benefits and limitations.

OPTION 2: UHC PPO ADDITIONAL PLAN NOTES

GOING OUT-OF-NETWORK: "ALLOWED AMOUNT" DEFINED

The "allowed amount" is the amount that UHC will allow for a participating provider even when the services are rendered out-of-network. Out-of-network charges can be significantly greater than the allowed amount and you will be responsible for the difference between what the out-of-network provider charges and what UHC reimbursed. These balanced billed charges **do not** accumulate towards your out-of-network deductible or out-of-pocket maximum.

UTILIZATION REVIEW

All hospital confinements and surgeries must be preauthorized by UHC. You or your physician must call UHC prior to a hospital admission for non-emergency treatment. If you do not obtain this mandatory authorization, your benefits will be reduced or a penalty payment will apply. Please refer to your ID card for the utilization review phone number and required time frame for reporting.

CLAIMS

In-network providers will submit claims directly to UHC. If you see an out-of-network provider, you may be required to submit the claim directly to UHC for reimbursement.

BRAND NAME PRESCRIPTION DRUG BENEFIT

If you choose to receive a brand name drug when a generic equivalent is available, you will be responsible for the generic drug cost plus the difference in cost between the generic and the brand name negotiated rate.

OPTION 3: KAISER HDHP

BENEFIT	IN-NETWORK
Network	Kaiser Northern or Southern California
Reimbursement Basis	All care must be rendered or authorized by your Primary Care Physician (PCP)
HSA Funding from Talend	Single - $58.33/pay period ($1,400 over 12 months) Family - $116.67/pay period ($2,800 over 12 months)
Deductible	$2,000/individual; $2,800/member in a family; $4,000/family
Out-of-Pocket Maximum	$3,000/individual; $3,000/member in a family; $6,000/family
Office Visit	$30 PCP; $30 Specialist
Virtual Visit	No charge (subject to deductible)
Prescriptions (up to a 30-day supply)	$10 / $30
Mail Order Prescriptions (up to a 90-day supply)	$20 / $60
Specialty Prescriptions	20% up to $150
Preventive Care	No charge
Basic Lab and X-ray	$10 per encounter
Complex Lab and X-ray	$50 per procedure
Urgent Care	$30
Outpatient	$150 per procedure
Inpatient	$250 per admission
Emergency Services	$100 per visit
Physical Therapy	$30
Chiropractic Services (20 visits max/year)	$15
Acupuncture	$30 (provider-referred)
Durable Medical Equipment	20%
Infertility	Not covered
Plan Details	See Additional Plan Notes section

All benefits listed refer to the member's responsibility or cost share after the deductible is met, unless otherwise indicated. The benefit information above outlines the key components of this medical policy. Please refer to your carrier's Certificate of Coverage for additional details on plan benefits and limitations.

OPTION 3: KAISER HDHP ADDITIONAL PLAN NOTES

REFERRALS

All medical treatment must be coordinated by your selected Primary Care Physician (PCP) in order to be covered by the plan. Your PCP will make any referrals to specialists, if needed. No referral is required when:

- Accessing care from an OB/GYN provider within your Primary Medical Group (PMG) for an annual well women's exam
- Accessing chiropractic care as long as you use an ASH provider

You may go to a satellite office of your PMG as long as your PCP authorizes your visit to that facility. Always call your PCP prior to any treatment

NON-AUTHORIZED TREATMENT

If you go to a Kaiser facility other than your selected PMG, to another Kaiser doctor, to a private doctor, or to a hospital without your PCP's authorization and it is not an acute, life threatening emergency, you will be responsible for all medical expenses you incur.

EMERGENCY TREATMENT

Kaiser defines an emergency as those services required for the alleviation of severe pain or immediate diagnosis and treatment of an unforeseen medical condition which, if not treated, would jeopardize, or impair your health.

In the case of a life-threatening emergency, obtain care immediately. After care is obtained, you must contact your PCP within 24 to 48 hours after the onset of the emergency. A family member, co-worker, etc. may make this call on your behalf. In the case of a non-life-threatening emergency, regardless of where you are, call your PCP prior to receiving care. If your PCP is not available, there should be another physician on call 24 hours who can assist you. If you do not consult a physician at your PMG first, you will be responsible for all charges for non-life threatening, but acute emergency services.

SELECTING A CLINIC

You may visit any of the Kaiser Permanente clinics or hospitals in the Northern California (for employees residing in Northern California) or the Southern California (for employees residing in Southern California) service area. You are encouraged, but not required, to select a PCP for yourself and each dependent. Only care provided by Kaiser physicians and hospitals are covered under the plan.

BRAND NAME PRESCRIPTION DRUG BENEFIT

If you choose to receive a brand name drug when a generic equivalent is available, you will be responsible for the generic drug cost plus the difference in cost between the generic and the brand name negotiated rate.

OPTION 4: KAISER HMO

BENEFIT	IN-NETWORK
Network	Kaiser Northern or Southern California
Reimbursement Basis	All care must be rendered or authorized by a Kaiser Permanente facility
Deductible	$0
Out-of-Pocket Maximum	$1,500/individual; $3,000/family
Office Visit	$15 PCP; $15 Specialist
Virtual Visit	$15
Prescriptions (up to a 30-day supply)	$15 / $30
Mail Order Prescriptions (up to a 90-day supply)	$30 / $60
Specialty Prescriptions	30% up to $150
Preventive Care	No charge
Basic Lab and X-ray	No charge
Complex Lab and X-ray	No charge
Urgent Care	$15
Outpatient	$15 per procedure
Inpatient	No charge
Emergency Services	$100 per visit
Physical Therapy	$15
Chiropractic Services (30 visits max/year)	$15
Acupuncture	$15 (provider-referred)
Durable Medical Equipment	No charge
Infertility	Coverage varies
Plan Details	See Additional Plan Notes section

The benefit information above outlines the key components of this medical policy. Please refer to your carrier's Certificate of Coverage for additional details on plan benefits and limitations.

OPTION 4: KAISER HMO ADDITIONAL PLAN NOTES

REFERRALS

All medical treatment must be coordinated by your selected Primary Care Physician (PCP) in order to be covered by the plan. Your PCP will make any referrals to specialists, if needed. No referral is required when:

- Accessing care from an OB/GYN provider within your Primary Medical Group (PMG) for an annual well women's exam
- Accessing chiropractic care as long as you use an ASH provider

You may go to a satellite office of your PMG as long as your PCP authorizes your visit to that facility. Always call your PCP prior to any treatment

NON-AUTHORIZED TREATMENT

If you go to a Kaiser facility other than your selected PMG, to another Kaiser doctor, to a private doctor, or to a hospital without your PCP's authorization and it is not an acute, life threatening emergency, you will be responsible for all medical expenses you incur.

EMERGENCY TREATMENT

Kaiser defines an emergency as those services required for the alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical condition which, if not treated, would jeopardize or impair your health.

In the case of a life-threatening emergency, obtain care immediately. After care is obtained, you must contact Kaiser within 24 to 48 hours after the onset of the emergency. A family member, co-worker, etc. may make this call on your behalf. In the case of a non-life-threatening emergency, regardless of where you are, call Kaiser prior to receiving care. If you do not consult a physician at Kaiser first, you will be responsible for all charges for non-life threatening, but acute emergency services.

SELECTING A CLINIC

You may visit any of the Kaiser Permanente clinics or hospitals in the Northern California (for employees residing in Northern California) or the Southern California (for employees residing in Southern California) service area. You are encouraged, but not required, to select a PCP for yourself and each dependent. Only care provided by Kaiser physicians and hospitals are covered under the plan.

BRAND NAME PRESCRIPTION DRUG BENEFIT

If you choose to receive a brand name drug when a generic equivalent is available, you will be responsible for the generic drug cost plus the difference in cost between the generic and the brand name negotiated rate.

DENTAL BENEFITS: DELTA DENTAL

OVERVIEW

The Delta dental plan includes a network of preferred dentists. If you receive treatment from a preferred dentist, you will receive enhanced benefits. However, you do have the option of receiving treatment from the dentist of your choice, even if the dentist is not within the preferred network. Benefits for treatment from non-preferred dentists will be paid at a lower reimbursement level and may be subject to benefit limitations.

BENEFIT	DELTA DENTAL PPO DENTISTS	DELTA PREMIER & NON-PREFERRED DENTISTS
Deductible • Waived for preventive care	$25 per member; 3 per family	$25 per member; 3 per family
Maximum Annual Benefit	$2,500 per covered member	
Preventive Care • Includes routine exams, teeth cleanings, x-rays, etc. • Cleanings covered twice per calendar year	0% (covered at 100%)	0% (covered at 100% of UCR)
Basic Care • Includes fillings, endodontics, periodontics, extractions, etc.	10% (covered at 90%)	20% (covered at 80% of UCR)
Major Care • Includes crowns, bridges, dentures, onlays, & dental implants	40% (covered at 60%)	50% (covered at 80% of UCR)
Orthodontia • Covers children and adults • Separate lifetime maximum of $2,000 per member	50% (covered at 50%)	50% (covered at 50% of UCR)

OUT-OF-NETWORK REIMBURSEMENT

Non-preferred benefits are based on the member's geographic location. Services rendered by a Delta Premier provider are reimbursed based on the lesser of the provider's submitted fee or the Delta Dental Premier contracted fee. Services rendered by a Non-Delta Dental provider are reimbursed based on the lesser of the provider's submitted fee or the program allowance. If you receive services from a non-preferred dentist, you are responsible for any charges that exceed the recognized amounts.

VISION BENEFITS: VSP

OVERVIEW

The VSP vision plan includes a network of optometrists and ophthalmologists. If you receive treatment from an in-network optometrist/ophthalmologist, you will receive enhanced benefits. While you do have the option of receiving treatment from out-of-network optometrists or ophthalmologists, you will only receive a limited reimbursement.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK REIMBURSEMENT
Network	VSP Choice	
Vision Exam	One exam covered every calendar year	
	$10 copay	Up to $45
Prescription Glasses: Lenses	One new set of prescription lenses covered every calendar year	
	$25 materials copay (lenses and frames) for single vision, lined bifocal, and lined trifocal lenses	Single vision: up to $30 Lined bifocal: up to $50 Lined trifocal: up to $65 Lenticular: up to $100
Prescription Glasses: Frames	One new set of frames covered every calendar year	
	$150 allowance + 20% discount on amount in excess of allowance	Up to $70
Contact Lenses	You may choose to purchase contact lenses in lieu of glasses calendar year (same as glasses lens schedule)	
	Up to $60 copay for exam (fitting and evaluation) $150 allowance	Up to $105
Laser Vision Correction	Laser vision correction surgery can be performed for substantial discounts when using a VSP certified provider. See VSP's website for more details.	
Buy-Up Options	VSP may offer additional allowances or discounts for lens options such as: • Blended lenses • Oversize lenses • Progressive lenses • Photochromatic or tinted lenses other than Pink 1 or 2 • Coated or laminated lenses	
Exclusions	The following services and supplies are not covered: • Orthoptics or vision training • Nonprescription lenses • Medical or surgical treatment of the eyes • Two pairs of glasses in lieu of bifocals • Lost or broken glasses will not be replaced except at the normal intervals	

PRE-TAX BENEFITS

HEALTH SAVINGS ACCOUNT (HSA) FACT SHEET

OVERVIEW

Participation in the combination of a High Deductible Health Plan (HDHP) and a Health Savings Account (HSA) allows you to save premium dollars and create a personally owned, tax advantaged savings account for your future medical expenses.

Your HSA balance rolls over year to year. If you terminate employment with Talend Inc., this account is yours to take with you. If, at a later date, you are no longer qualified to make contributions into the HSA, you can still use HSA funds for the reimbursement of medical expenses.

ELIGIBILITY RESTRICTIONS

In order to be eligible to make contributions into an HSA, you and your covered dependents must meet all of the following criteria:

- Covered by a qualified High Deductible Health Plan (HDHP)
- Not covered by any other health coverage, including a regular Flexible Spending Account (FSA)
- Cannot be claimed as a dependent on another person's tax return
- Not entitled to benefits under Medicare, including Medicare Part A

LIMITED PURPOSE HEALTH FLEXIBLE SPENDING ACCOUNT (HEALTH FSA)

If you participate in the HDHP and HSA and elect a Health FSA, your Health FSA is a Limited Purpose account. This means that eligible expenses for the health care FSA include dental and vision expenses, but cannot be used for medical.

HSA MAXIMUM CONTRIBUTIONS

Contribution maximum limits are determined each year by the IRS and are inclusive of both employer and employee funding. The 2021 HSA contribution limits are as follows:

- **Single**: $3,600
- **Family**: $7,200

If you are age 55 or turn age 55 during the calendar year, you may make an additional $1,000 "catch-up" contribution.

If you enroll in an HSA qualified HDHP plan after January 1 and contribute to the HSA, you may only contribute up to the IRS maximum if you will be covered by the plan for at least 13 consecutive months. If you will not be enrolled in an HSA qualified HDHP plan for at least 13 consecutive months, your maximum election is prorated. Your maximum election would be 1/12 of the annual election multiplied the number of months you are covered by the HDHP.

You, as the employee, own the HSA. You take the account with you after you terminate employment.

DOMESTIC PARTNERS

Health care expenses for Domestic Partners and their children are not eligible expenses under an HSA, unless the Domestic Partner and their children are a tax dependent under IRS Code and does not earn more than the personal exemption amount. However, a Domestic Partner can have their own HSA and make contributions up to the annual contribution maximum.

ADDITIONAL INFORMATION

For detailed information, rules, and restrictions on Health Savings Accounts, see IRS Publication 969 (https://www.irs.gov/pub/irs-pdf/p969.pdf).

HEALTH SAVINGS ACCOUNT (HSA) ADMINISTRATION

ADMINISTRATOR

Optum Bank

EFFECTIVE DATE

Your Optum Bank HSA becomes active as of the effective date of your enrollment into the HDHP plan offered by Talend Inc. You are eligible to incur qualified health-related expenses any time on or after this date.

You have the option to fund your Optum Bank HSA through pre-tax contributions. The pre-tax deductions will begin on the next available payroll date. Your HSA contribution may be changed at any time.

EMPLOYER FUNDING

If you are eligible to open and contribute to an HSA, Talend Inc. will make a monthly contribution to your Optum Bank HSA on your behalf. If you do not open a Optum Bank HSA within 60 days of your eligibility date, by the end of the calendar year in which you are first eligible, or prior to your termination date (whichever comes first), you will forfeit the employer contributions.

Each employee's HSA is personally owned by the employee. Deposits made by Talend Inc. into the account are tax-free under federal law. Once deposited into your HSA, these funds may be used at any time to fund eligible medical expenses on a tax preferred basis. Deposit amounts are as follows and are determined by Talend Inc. each January 1.

HSA COVERAGE TIER	PER PAY PERIOD*	OVER 12 MONTHS *
Employee (Emp)	$58.33	$1,400
Emp + Spouse	$116.67	$2,800
Emp + Child(ren)	$116.67	$2,800
Emp + Family	$116.67	$2,800

***Contribution from Talend Inc.**

TAX SAVINGS

If you make contributions through payroll reductions under your 125 plan, those contributions are exempt from federal income taxes and FICA taxes. You may also make direct contributions from your personal accounts into your HSA. Those contributions are deductible "above the line" (even by non-itemizers) and would be exempt from federal income tax.

Account contributions are tax-favored in three ways:

1. Contributions are tax deductible
2. Interest accrued in the account is not income taxable
3. Withdrawals for qualified medical expenses are tax-free

Please note: tax advantages apply at the federal level. Please check whether your state tax law conforms to the federal law. If it does not, you will still owe state income taxes on any contribution to your HSA.

ACCESSING FUNDS

There are three ways to access funds from your Optum Bank HSA to pay for eligible expenses. Expenses must be incurred on or after the effective date of the account.

- **Debit Card**: Use at time of service or to pay bills
- **Reimburse Yourself:** for a claim you have already paid
- **Online**: Submit a claim for reimbursement online at www.optumbank.com

FLEXIBLE SPENDING ACCOUNTS (FSA): UHC

OVERVIEW

A Flexible Spending Account (FSA) enables tax-free reimbursement of health-related or dependent care expenses. You decide how much you want to set aside for the year and a portion of that amount is deducted from your paycheck before taxes. When you or your dependents incur an eligible expense, you may be reimbursed for that expense with the money that you have put aside.

EFFECTIVE DATE

Your election becomes effective on either the date that you become benefits eligible or the date that you complete your enrollment, whichever is later.

ANNUAL ELECTION

The election that you make is irrevocable for the Plan Year (January 1 – December 31). This means that, in general, you cannot adjust or stop your contributions once the Plan Year has begun. It is important to note that elections do not carry forward year-to-year. You must actively make a new election during each Open Enrollment period, or your account will be made inactive.

PAYCHECK DEDUCTIONS

Your election is made as an annual election for the Plan year. Your annual election is then divided by the total number of paychecks during the Plan Year or by the number of remaining paychecks in the Plan Year if you are hired mid-year.

MID-YEAR CHANGES

Mid-year election changes are allowed this year without a qualifying life event due to extenuating circumstances. However, you may not decrease your election to an amount lower than what you've claimed for the year.

TERMINATION

Medical expenses are only eligible to the extent that they are incurred prior to or on your date of termination. The exception to this rule is that if you elect COBRA coverage for your Health FSA and continue to make contributions to your FSA (on a post-tax basis), claims may be incurred as long as the COBRA coverage is active. Dependent care expenses may be reimbursed after your termination date without electing COBRA, as long as the expense occurred in the current Plan Year.

USE IT OR LOSE IT

Under IRS guidelines, FSAs are subject to a "use it or lose it" provision. If your eligible expenses are not sufficient to exhaust your full FSA election, any unused funds are forfeited. In order to protect yourself against this, carefully consider your medical and dependent care expenses prior to making your election.

Your employer's plan includes a rollover feature. This feature allows up to $550 of unused funds (those left over after the claims submission deadline) to roll over into the new Plan Year as of March 31 of the following year (e.g. 3/31/2022). If your Health FSA balance is greater than $550 as of the deadline, any amount in excess of that figure is forfeited under the "use it or lose it" rule. Note that there is no rollover provision for the Dependent Care FSA.

LIMITED PURPOSE HEALTH FSA

If you participate in the HDHP and HSA and elect a Health FSA, your Health FSA will be deemed a Limited Purpose account. See Health Savings Account (HSA) Fact Sheet for more information.

DEBIT CARDS

A debit card will be issued if you elect either the Health or Dependent Care FSA and will be labeled "Health Care Spending Card". You may use the same debit card for both plans.

FLEXIBLE SPENDING ACCOUNTS (CONTINUED)

	HEALTH FSA	DEPENDENT CARE FSA
Plan Year	January 1st through December 31st	
Minimum Election	$240/year	$240/year
Maximum Election	$2,750/year (per employee)	$5,000/year (per household)
Claims Incurred Deadline	December 31st or your employment termination date	December 31st
Claims Submission Deadline	March 31st after Plan Year ends	
Rollover	Yes, up to $550	No
Eligible Dependents	• Yourself • Your spouse • Your children under age 26 (or who have not attained age 27 as of the end of the tax year)	• Children under age 12* • A spouse or dependent over 12* who is physically or mentally incapable of caring for himself/herself
Filing Claims	Full annual election available immediately • Debit Card (save your receipts!) • Online: www.myuhc.com • Fax: (866) 262-6354 (claim form required) • Mail: Health Care Account Service Center P.O. Box 981506 El Paso, TX 79998-1506	Funds available as contributed • Debit Card (save your receipts!) • Online: www.myuhc.com • Fax: (866) 262-6354 (claim form required) • Mail: Health Care Account Service Center P.O. Box 981506 El Paso, TX 79998-1506
Common Eligible Expenses	• Medical and prescription copays and coinsurance • Over-the-counter items (may need prescription) • Dental expenses including orthodontia • Vision copays, prescription glasses and contacts • Chiropractor, acupuncture and physical therapy	• Licensed day care provider • Pre-school • In-home day care • Nanny care • After-school care custodial/recreational • Summer day camps custodial/recreational • Mental health with medical diagnosis
Common Ineligible Expenses	• Vitamins/herbal supplements • Toiletries • Massage therapy for general health (without diagnosis) • Cosmetic dentistry	• Tutoring/language programs • Lessons for piano, gymnastics, etc. • Sports classes or leagues • Overnight camps
Registration	**All members** can register directly on myuhc.com. **Non-UHC members** will need the following information: Group number (919573), SSN, hire date, dependents, email address	

***For 2021 plan year, there is a pandemic-related extension allowing for claims through the end of the plan year in which a dependent turns 13.**

COMMUTER BENEFITS: OPTUM

OVERVIEW

Set aside pre-tax payroll deductions to pay for eligible commuting expenses. Elections may be modified at any time throughout the year. Elections made by the 10th of the month will take effect the following month. Deductions will be taken once a month to fund the following benefit month.

PLAN PROVISIONS

	TRANSIT	PARKING
Monthly Pre-Tax Maximum	$270	$270
Eligible Expenses	• Train and subway • Bus • Ferry • Eligible Vanpool	• Parking near office • Parking near mass transit for commute to work
Accessing Funds	Sign into Optum Bank and initiate payment to vendor.	Sign into OptumBank and initiate payment to vendor. Submit expenses for reimbursement online at www.optumbank.com within 60 days of the expense date

MAKING AN ELECTION

Elections are made in Optum (www.optumbank.com). Your election will be a monthly recurring order unless you actively choose to log back into system to change your election to $0. You must elect by the 10th of the month for the future benefit month (i.e. elect by June 10 for a July benefit month).

TERMINATION

Upon termination, your fund availability depends on the type of pass you have ordered. Commuter Check Prepaid MasterCards will be closed no later than the first of the month following your termination. Please note, you will not be able to purchase future cards after your termination.

FINANCIAL SECURITY

GROUP LIFE AND AD&D BENEFITS: UNUM

BENEFIT

Each employee is covered for term Life and AD&D insurance equal to two times your base annual earnings rounded up to the nearest thousand. The maximum benefit is $625,000. No medical examination or health history disclosure is required for timely applicants.

AGE REDUCTIONS

At age 65, benefits will reduce to 35% of the original amount then to 50% of the original amount at age 70.

BENEFICIARIES

A personal beneficiary of your choosing must be named for the proceeds of your life insurance, however, it is not recommended to list a minor as your beneficiary. You may change your beneficiaries at any time.

NOTE ON TAXATION

The value of up to $50,000 of employer paid group term life insurance is tax exempt. However, the value of any coverage in excess of $50,000 is taxable to the employee per the IRS guidelines. This is called Table I Taxation. The following schedule is used to calculate the taxable benefit of the group term life insurance in excess of $50,000.

AGE BRACKET	COST PER $1,000 PER MONTH
Under 25	$0.05
25-29	$0.06
30-34	$0.08
35-39	$0.09
40-44	$0.10
45-49	$0.15
50-54	$0.23
55-59	$0.43
60-64	$0.66
65-69	$1.27
70+	$2.06

Sue Smith is 33 years old with an annual income of $75,000. Her life insurance benefit is $150,000. The first $50,000 of the group life insurance benefit is tax-free. She has a remaining $100,000 subject to Table I taxation. The monthly taxable amount that will be added to Sue's income is $8.00 [($100,000 x $0.08) / $1,000 = $8.00]. If Sue worked the entire year, she would have $96.00 ($8.00 x 12) add to her W2. Her actual tax would be less than half this amount.

SUPPLEMENTAL LIFE AND AD&D BENEFITS: UNUM

BENEFIT

Each employee can choose to purchase the following:

Employee: You may elect coverage in $25,000 increments up to $300,000, not to exceed 5 times your basic annual earnings.

Spouse: You may elect coverage in $25,000 increments up to $100,000.

Child(ren): You may elect one of three benefit options for your child(ren): $5,000/$10,000. Children are covered from birth to age 26 (to age 25, if full time student). The benefit for children from birth to 6 months is $1,000, and from 6 months to age 26, the above benefit options apply. Additional children are covered at no additional charge.

You may not elect coverage for your dependent(s) without electing coverage for yourself.

MONTHLY RATES

AGE BRACKET	EMPLOYEE * RATE PER $1,000	SPOUSE RATE PER $1,000
Under 25	$0.061	$0.061
25-29	$0.061	$0.061
30-34	$0.113	$0.113
35-39	$0.139	$0.139
40-44	$0.191	$0.191
45-49	$0.295	$0.295
50-54	$0.503	$0.503
55-59	$0.919	$0.919
60-64	$1.361	$1.361
65-69	$2.193	$2.193
70+	$4.065	$4.065
Child	$0.206 per $1,000	

*Spouse rates based on employee age.

AGE REDUCTIONS

Benefits for both employees and spouses will be reduced by 35% of the pre-age 70 amount when the employee reaches age 70 and by 55% of the pre-age 70 amount at age 75.

APPLICATION PROCESS

Any amounts that you apply for up to $150,000 are guaranteed issue (no health questions or exams required) at your initial eligibility period. Amounts over $150,000 for you or amounts over $25,000 for your spouse, or any amount applied for after your initial eligibility period will be subject to medical underwriting. Coverage will only be effective if approved by UNUM.

BENEFICIARIES

A personal beneficiary of your choosing must be named for the proceeds of your life insurance; however, it is not recommended to list a minor as your beneficiary. You may change your beneficiaries at any time.

DISABILITY BENEFITS: UNUM

BENEFIT

These plans provide partial income replacement should you be unable to work due to an illness or injury. The plans integrate with other social sources (State Disability Insurance, Workers Compensation, Social Security, etc.) to provide a combined benefit of 66.7% of your base annual earnings and 12-month average bonus/ commissions.

	SHORT –TERM DISABILITY	LONG-TERM DISABILITY
Elimination Period	7 days	90 days
Maximum Benefit	The maximum payable benefit from all sources combined will not exceed $3,750 per week.	The maximum payable benefit from all sources combined will not exceed $14,000 per month.
Duration of Benefits	Benefits are payable for a maximum of 12 weeks.	Benefits are payable to Social Security Normal Retirement Age while you continue to be disabled.
Pre-Existing Conditions	None	A disability resulting from any condition that existed, or for which you were treated, during the three (3) months immediately preceding your coverage effective date is **not covered** unless you have been actively at work and continuously covered under the plan for 12 consecutive months.
Special Limitations	None	There is a 24-month lifetime benefit maximum for disabilities resulting from mental/nervous conditions and alcohol or substance abuse.

SUPPLEMENTAL ACCIDENT: UNUM

OVERVIEW

Accident insurance helps pay for out-of-pocket expenses due to accidental injuries. Benefits can be used to cover deductibles and copays. A $50 wellness benefit is available annually for each covered member.

BENEFIT

Covered services include: ambulance, Emergency Room treatment, hospitalization, outpatient surgery, etc. Please refer to your plan documents for more details.

SUPPLEMENTAL CRITICAL ILLNESS: UNUM

OVERVIEW

Critical illness insurance helps protect you against those costs associated with serious diagnosis and treatment that are not covered by medical insurance. A lump sum benefit is provided upon the diagnosis of major conditions, including: cancer, stroke, heart attack, and organ failure. To see if other conditions are covered, please refer to the plan benefit summary. A $50 wellness benefit is available annually for each covered member.

BENEFIT

$20,000 for you, 50% of your amount for your spouse and/or your child(ren).

SUPPLEMENTAL HOSPITAL CONFINEMENT INDEMNITY: UNUM

OVERVIEW

Hospital confinement indemnity insurance is designed to supplement your existing medical insurance coverage. This is available to you in a lump sum benefit to help you pay for both medical and non-medical expenses associated with a hospital stay. Eligible expenses include deductibles and copayments. A $50 wellness benefit is available annually for each covered member.

BENEFIT

Hospital/ICU Admission: $2,500 per admit, limited to 1 admission per insured.

Hospital/ICU Confinement: $100 per day, limited to 60 days per benefit year.

SUPPLEMENT TO COMPREHENSIVE MEDICAL INSURANCE

Accident, Critical Illness, and Hospital Indemnity benefits are *not* a replacement for comprehensive medical insurance. Comprehensive/major medical insurance should be maintained if you choose to enroll in any of these options.

MEDICARE

This coverage may not be available to any person who is 65 years of age or older, is covered by Medicare Part A *and* Part B *and* a Medicare Supplement insurance policy if purchasing the coverage would result in coverage for medical benefits for more than 100% of actual medical expenses. Before you buy this insurance, review the information from your Medicare policies.

401(K) PLAN: FIDELITY

GENERAL INFORMATION

Talend sponsors a 401(k) retirement plan for all eligible employees that offers a participant an opportunity to save for retirement. Eligible participants may contribute to the plan via pre-tax contributions or may also contribute to an after-tax ROTH 401(k) account (it's your choice).

CONTRIBUTIONS AND MATCHING

Your payroll contributions are always 100% vested (vested = belongs to you) and grow tax-deferred until you start to receive income (usually at retirement). It is important to recognize that Talend matches your eligible contributions monthly (dollar for dollar) up to 4% of your compensation (also vested!). If you choose not to contribute to the plan, there will be no Employer Contribution. Additionally, if you stop contributing mid-year (by choice or because you reach the IRS maximum), your Employer Contribution will also stop.

Within Fidelity's website, you may designate contributions from both your regular/standard pay and your bonus/commission pay.

ITEMS TO REMEMBER

Your enrollment in the Talend 401(k) plan is automatic and initially set for 4% of your pre-tax salary on the first day of the month following sixty days of employment. Please contact the Benefits team manager to receive a detailed enrollment booklet if you'd like a paper copy.

Once you become eligible, please visit the Fidelity website to complete your investment instructions and beneficiary designations. After your enrollment is complete, you may roll over funds from an IRA or your previous employer's retirement plan. You may take a loan from your 401(k) after one year of participation. Please note: you may not withdraw funds from your account until age 59 ½ unless special circumstances exist or you separate from service.

ADDITIONAL INFORMATION

Participants should visit Fidelity www.401k.com to finalize their online enrollment and give investment and beneficiary instruction. Indicate where you would like to invest your funds from the investment options available in your booklet or choose a pre-selected allocation online. Your initial payroll deduction will be 4% unless you adjust or withdraw. You may change payroll deductions online.

Participants may access their account at www.401k.com only after creating their username and password. Paper statements are mailed each quarter, but you may access your account 24/7 online.

- Beneficiaries can include your children, grandchildren, nieces, nephews, friends, or even yourself

WORK-LIFE BALANCE

EMPLOYEE ASSISTANCE PROGRAM (EAP): OPTUM HEALTH & UNUM

OVERVIEW

Everyone faces difficult periods in his or her life. Personal problems are part of what it means to be human, and effectively dealing with them makes us better prepared to overcome future ones. When a personal problem is making life difficult for you, it can also affect your job performance. The purpose of the Employee Assistance Program (EAP) is to help you deal with life's rough spots. When you seek help with a personal problem, your home life improves, work goes better and everyone benefits.

Your EAP is a free, professional, ***confidential*** consultation service provided by Optum Health & UNUM. All counselors and consultants are experienced, licensed professionals who have specialized training in employee assistance consultation. *Everything discussed in consultation is kept completely confidential*. The Employee Assistance Program can be contacted at **(800) 854-1446**.

OPTIONS

Talend employees have access to two EAP Programs with specific coverage details outlined below.

- ✓ Optum (Domestic and International)
- ✓ UNUM (Domestic Only)

OPTUM (DOMESTIC AND INTERNATIONAL)

DESCRIPTION OF PROGRAM

Optum offers comprehensive work and life services to help you manage daily responsibilities and challenging life events. The website provides a variety of interactive tools. Care is available both domestically and internationally.

TYPES OF SUPPORT OFFERED

- Anxiety and depression
- Parenting and family issues
- Relationship problems
- Workplace changes
- Living with chronic conditions
- Substance use
- Child and eldercare support

ADDITIONAL RESOURCES – ONLINE AND MOBILE APP

You and your family have 24-hour confidential access to liveandworkwell.com (Domestic) and livewell.optum.com (International). These websites are interactive and offer several tools you can utilize to help strengthen your work life, health, and emotional wellbeing. You can check your benefit information, search for available online clinicians, utilize virtual help centers, access financial calculators, and so much more! You may also access services via the mobile app (available from the App Store or Google Play).

BENEFITS

U.S. Employees: You may call (866) 374-6061 to seek assistance 24 hours a day. Counselors can assist with any type of personal situation. If you choose to pursue additional outpatient consultation, additional benefits may be payable by your medical plan. Access liveandworkwell.com and use access code ***talend*** to obtain more information about your benefits. You may also download the mobile app – myLiveandworkwell – and use the access code above.

Additional resources are available for you and your family members if you are unable to attend a call or are seeking more in-depth support. You will find details on these options offered through Optum in the attached flyers.

- **Talkspace**
  A safe and secure online therapy, with Talkspace you can access a licensed clinician through in-app chat, voice or video messaging. Optum EAP offers a total of five 45-minute sessions through the app. Use one of your Optum EAP visits to call (866) 374-6061 to receive a personalized authorization code.
  Register for an account; Organization Name: Optum
- **Sanvello**
  A fun and interactive application created by psychologists, Sanvello offers on-demand help for stress, anxiety and depression.
  Regitser for an account; Company Code: talend

International Employees: You may call the number on your wallet card to seek assistance 24 hours a day. Counselors can assist with any type of personal situation. Access livewell.optum.com and use access code ***talendglobal*** to obtain more information about your benefits. You may also download the mobile app – myLivewell – and use the access code above.

UNUM (DOMESTIC ONLY)

DESCRIPTION OF PROGRAM

The UNUM EAP provides support and guidance for matters that range from personal issues you might be facing to providing information on every day topics that affect your life.

TYPES OF SUPPORT OFFERED

- Marriage and family problems
- Work-related problems
- Stress, anxiety, depression and other emotional problems
- Difficulty with relationships
- Loss and death
- Alcohol or drug problems affecting you or your family
- Difficulty adjusting to a new culture or environment
- Any other personal concern which may benefit from a professional consultation

BENEFITS

You may call **(800) 854-1446** to seek assistance 24 hours a day. Counselors can assist with any type of personal situation. You are entitled to up to three (3) sessions per issue with the options of face-to-face counseling, telephonic, or web-video. If you choose to pursue additional outpatient consultation, additional benefits may be payable by your medical plan.

MEDICAL BILL SAVER: UNUM

OVERVIEW

Medical Bill Saver is offered by Talend at no additional cost and covers eligible employees and their dependents under the Employee Assistance Program. When a covered employee receives a medical or dental bill which totals over $400 in out-of-pocket costs, UNUM's Medical Bill Saver team works with the provider(s) to obtain a discount on covered services. Successful negotiations have the potential to save employees hundreds and sometimes even thousands of dollars in medical and dental expenses. The Medical Bill Saver team can also demonstrate how to keep bills lower in the future (e.g. by using in-network providers).

WELLNESS BENEFITS BY UNITEDHEALTHCARE

SimplyEngaged is a personal health and wellness program which allows you to earn rewards through UnitedHealthcare when you complete these health and wellness actions. It's easy to start earning rewards.

Access the Reward Program Overview through Rally™ when you log in to www.myuhc.com for specific details regarding your wellness incentive program.

EARN A REWARD

Participate in a biometric health screening and get a $75 reward.

- Learn more about your important health numbers: total cholesterol, blood pressure, and Body Mass Index (BMI).

Complete an online health survey through Rally when you log into www.myuhc.com within 90 days of the start of the program and get a $25 reward.

- Answer all of the survey questions to personalize your overall experience.
- Complete the survey and receive.

Get a $20 reward each month that you visit a participating fitness center at least 12 times per month.

- Register at a participating fitness center or YMCA through the Health and Wellness tab on www.myuhc.com.
- You must present your fitness ID card each time you go to the gym.

Complete a telephone-based health coaching program and get a $75 reward

- Complete the health survey in order to participate in this health coaching program.
- Call the Health Coach at 1 (800) 478-1057 to begin working on your personal health improvement plan.
- Plan accordingly. A telephone-based health coaching session takes three to five months to complete.

Complete at least 3 missions through the Rally experience and get a $50 reward.

- Plan accordingly. Each mission can take at least four weeks to complete.

Estimate health care costs on www.myuhc.com and get a $25 reward.

- Perform at least one cost estimate on an upcoming procedure.

Notes:

- *Employees and covered spouses on UHC plans are eligible and can earn rewards separately.*
- *Log into www.myuhc.com with your username and password. If you are not registered, you can follow the steps under "Register Now". After you are logged into www.myuhc.com, click on the Health and Wellness tab to access the Rally experience.*

WELLNESS BENEFITS BY KAISER

SELF-CARE RESOURCES

Kaiser members are able to tap into the power of self-care with additional resources available at http://kp.org/selfcareapps

- **Calm**: an app for daily use that uses meditation and mindfulness to help lower stress, reduce anxiety, and improve sleep quality

- **myStrength**: personalized programs with interactive activities, daily health trackers to monitor and maintain your progress, in-the-moment coping tools, and more.

ADDITIONAL PROGRAMS

Kaiser has a variety of healthy lifestyle programs to help make good health a part of your daily habits. Complete a Total Health Assessment to get personalized advice, encouragement, and tools for various topics, including: eating healthy, losing weight, moving more, sleeping better, reducing stress, and quitting smoking. Go to https://kp.org/healthylifestyles to get started

NEW BENEFITS – ID SANCTUARY AND LIFELOCK

OVERVIEW

Talend has installed a plan for employees to have access to identity theft management services. Such services include credit monitoring, fraud alerts and protection, step-by-step guidance on identity restoration for victims of fraud and identity theft, and document replacement assistance when identity documents are lost or stolen.

ID Sanctuary Enhanced monitors one credit bureau, public records, court records, address changes, social media channels, and cyber internet surveillance. There is also an upgrade to LifeLock Ultimate, which monitors all three credit bureaus.

ENROLLMENT

This program is available to employees on a direct billing basis (not via payroll deductions). If you wish to enroll, please register using the following link: https://tvc1.secureenrollment.com. Please note that coverage is effective the date you register using this online enrollment tool.

TIME OFF BENEFITS

Full-time employees will accrue Paid Time Off (PTO) as described below. Part-time employees accrue PTO on a pro rata basis. Vacation accrual will continue until max annual accrual (1.5x the # of days accrued annually, up to 240 hrs max) is met for the specific tenure band. Employees can borrow up to 24 hrs of sick time & up to 40 hrs of vacation time. For new hires annual vacation time and sick time is prorated. **Unused vacation & sick time rolls over year to year, up to the annual maximums**, other types of time off do not carry over. **Full accrual details for all PTO & leave can be found in Workday.**

VACATION

YEARS OF SERVICE	DAYS ACCRUED (PER YEAR)	YEARS OF SERVICE	DAYS ACCRUED (PER YEAR)
0 year	15 days	4 years	21 days
1 year	15 days	5 years	23 days
2 years	17 days	5 or more years	25 days
3 years	19 days		

ADDITIONAL PAID TIME OFF (PTO)

MATERNITY LEAVE*	8 weeks paid @ 100% salary
PARENTAL LEAVE (INCL. ADOPTION)	8 weeks paid @ 100% salary
BEREAVEMENT LEAVE	3 days
JURY/CIVIC DUTY	10 days
SICK TIME	80 hours (10 days)

**Birth mothers are eligible to take Maternity + Paternity Leave, totaling 16 weeks*

QUESTIONS AND HELP

Following is a listing of the current contact information for each insurance company/vendor. Many of the websites listed below contain useful information on general health topics as well as information on how the plans operate.

CARRIER/VENDOR	CONTACT INFORMATION
UHC Medical Plan ***Group #913319***	Customer Service: (866) 633-2446 24 Hour Nurse Line: (888) 887-4114 www.myuhc.com
Kaiser Medical Plan ***Group #230642 and #604441***	Customer Service: (800) 464-4000 24 Hour Nurse Line: (888) 576-6225 www.kp.org
Delta Dental Plan ***Group #19185***	Customer Service: (800) 765-6003 www.deltadentalins.com
VSP Vision Plan ***Group #30095332***	(800) 877-7195 www.vsp.com
UNUM ***Life/LTD/STD: Group #652067*** ***Vol Life Group: #652068*** ***Accident/Crit. Illness/Hosp. Indem.: Group #652070***	Customer Service: (866) 679-3054 www.unum.com
Optum Bank HSA ***Group #HB870A***	Customer Service: (844) 326-7967 www.optumbank.com
UHC FSA and Optum Commute ***Group #0919573***	Customer Service: (866) 314-0335 myUHC Help Desk (for technical support): 1 (877) 844-4999 FSAs: www.myuhc.com Commute: www.optumbank.com
Fidelity 401(k)	Customer Service: (800) 835-5097 www.401K.com
Optum EAP	Customer Service (U.S.): (866) 374-6061 Customer Service (International): See wallet card www.liveandworkwell.com U.S. Access code: talend International Access code: talendglobal
Vita ***For questions regarding your healthcare benefits, FSA, or Commuter benefits***	(650) 966-1492 talend@vitamail.com Slack #ext-us-benefits

NOTES

NOTE: The initial plan description is intended for general information purposes only; it is NOT to be considered a Summary Plan Description nor is it a contract. It provides only a very brief summary of benefits and does not replace or supersede the actual plan provisions as defined in the master plan documents. It is not all-inclusive and it is not a contract. Every attempt has been made to ensure the accuracy of this summary, but in the event of a discrepancy between this summary and the plan contract, benefits will be governed solely by the respective plan contracts.