O'REILLY®

2023 SUMMARY OF BENEFITS

MASSACHUSETTS

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WELCOME TO YOUR BENEFITS!

The investment in employee benefits is a very important way in which O'Reilly 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.

O'REILLY + VITA

The Vita Concierge is here to help! O'Reilly 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. PT via phone, (650) 966-1492 or email, help@vitamail.com.

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 regular employees working 30 or more hours per week are eligible for all benefits on the first day of the month following or coinciding with date of hire. 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/domestic partners and children up to age 26 in your medical, dental, and vision plans. If enrolling a non-registered domestic partner, you must meet the criteria outlined in the "Affidavit of Domestic Partnership". A completed affidavit 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.

ENROLLMENT

All benefits enrollments are processed via ADP: https://workforcenow.adp.com. You must complete your initial enrollment within 30 days of your eligibility date.

ADDITIONAL INFORMATION AND RESOURCES

Benefit summaries, detailed plan information, plan certificates, and forms are available through ADP as well.

https://workforcenow.adp.com

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. **You must notify HR and submit the request for changes in ADP 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 for medical benefits is conducted in November 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.

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EMPLOYEE COST SHARING

MEDICAL PLANS

- O'Reilly pays the majority of the premium for employees and eligible dependents.
- Contributions are taken via pre-tax payroll deductions over 26 pay periods.

DENTAL/VISION PLANS

- O'Reilly pays 100% of the premium for employees and eligible dependents.

LIFE, AD&D AND DISABILITY PLANS

- O'Reilly pays 100% of the premium for eligible employees.
- Voluntary Life is available and 100% employee paid.

EMPLOYEE CONTRIBUTIONS PER PAY PERIOD

	EMPLOYEE ONLY	EMPLOYEE + SPOUSE/DP	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Anthem HDHP	$27.47	$107.96	$91.67	$189.40
Anthem PPO	$102.13	$273.72	$245.13	$359.52
Tufts HMO	$78.63	$176.91	$167.09	$275.20
Dental	Fully funded by O'Reilly			
Vision	Fully funded by O'Reilly			
Basic Life/Disability	Fully funded by O'Reilly			
Voluntary Life	Rates based on age – See Voluntary Life Section			
Pre-Tax Benefits	Self-directed up to IRS maximum			
401(k)	Self-directed up to IRS maximum			

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.

Guardian 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.

ANTHEM MEDICAL PLAN

www.anthem.com/ca

1. Select ***Find Care***, on the top right of the screen.
2. Under ***Use Member ID for Basic Search,*** enter the first three letters of your member number under ***Identification number or alpha prefix***.
3. You may also click on ***Select a plan for basic search***.
4. Under ***Select the type of plan or network***, select ***Medical Plan or Network (may also include dental, vision, or pharmacy benefits).***
5. Under ***Select the state where the plan or network is offered***, select California.
6. Under ***Select how you get health insurance***, select ***Medical (Employer-Sponsored)***.
7. Under ***Select a plan/network***, choose the following:
    a. ***Blue Cross PPO (Prudent Buyer) – Large Group***
    b. ***National PPO (BlueCard PPO) –*** (if you are out*side of California*)
8. Then enter additional search criteria (ZIP and provider type) and results will auto populate.

TUFTS MEDICAL PLAN

https://tuftshealthplan.com

1. At the top right of the page, click on ***Find a Doctor or Hospital.***
2. Select the link under ***Search By Plan Name***.
3. Under ***Plan Types***, select ***Employer.***
4. Under ***Filter By***, select ***Massachusetts.***
5. Select ***HMO*** from the column on the left.
6. Choose the type of provider you are looking for under ***What are you searching for today?***
7. You may also use the ***Advanced Search*** link to refine your search.
8. Then click the magnifying glass icon to the right.

VSP VISION PLAN

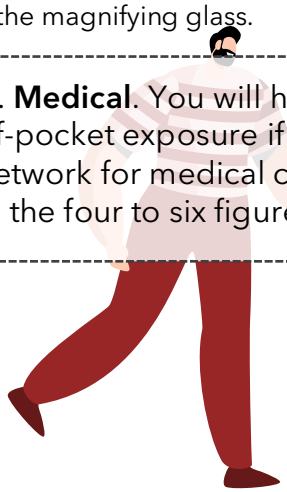
www.vsp.com

1. Click on ***Find a Doctor.***
2. Enter your zip code and click on ***Search***.
3. You can refine your preferences further, if desired, using the options on the left side of the screen

GUARDIAN DENTAL PLAN

www.guardiananytime.com

1. Click ***Find a dental provider*** in the ***Connect with us*** drop down box.
2. Select ***PPO: DentalGuard Preferred*** from the ***Plan Type*** list.
3. Enter your ***Location or Dentist Name*** and click on the magnifying glass.



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

O'Reilly offers employees a choice of three 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 ($)	Anthem: LiveHealth Online https://livehealthonline.com Tufts: Teladoc https://teladoc.com/tuftshealthplan
"I have a minor problem that may require a test/exam but my doctor isn't available."	Convenience Care Clinic ($$)	Find in-network facilities and providers using the How to Find a Network Provider instructions on page 4 or download the Anthem mobile app!
"I want routine care or have a minor, complex, or chronic problem."	Office Visit ($$)	
"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

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UNDERSTANDING YOUR MEDICAL PLAN (CONTINUED)

KEY PLAN DESIGN DIFFERENCES

	PPO	HMO
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.	

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 ANTHEM HDHP		MEDICAL OPTION 2 ANTHEM PPO	
Benefit	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$2,000 Single $4,000 Family	$6,000 Single $12,000 Family	$250 Single $750 Family	$500 Single $1,500 Family
Coinsurance	20%	40%	10%	30%
Office Visit	20%	40%	$20	30%
Hospital	20%	40%	10%	30%
Prescriptions (Tier 1a/1b/2/3)	$5 / $15 / $40 / $60	40% up to $250	$10 / $30 / $30	50% up to $250
Out-of-Pocket Max	$3,000 Single $6,000 Family	$9,000 Single $18,000 Family	$750 $2,250	$2,000 $6,000
Consider this Plan If…	• you have low medical and prescription utilization		• you are a moderate to heavy user of medical services and prescriptions • you want freedom of choice of providers	

HMO OPTION	MEDICAL OPTION 3 TUFTS HMO
Benefit	Tufts Facilities Only
Deductible	None
Copays/ Coinsurance	Various Copays
Office Visit	$20
Hospital	$250 per admit
Prescriptions	$10 / $20 / $35
Out-of-Pocket Max	$6,350 $12,700
Consider this Plan If…	• you are a heavy user of medical services and prescriptions • you are willing to use network providers most of the time

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OPTION 1: ANTHEM HDHP

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Network	Prudent Buyer PPO	
Reimbursement Basis	Anthem's contracted rate	Anthem's allowed amount. All charges in excess of the allowed amount are the member's responsibility.
Deductible	$2,000 Single / $4,000 Family	$6,000 Single / $12,000 Family
Out-of-Pocket Maximum	$3,000 Single / $6,000 Family	$9,000 Single / $18,000 Family
Office Visit	20%	40%
Virtual Visit (telehealth/PCP)	$10/20%	Not Covered/40%
Prescriptions (up to a 30-day supply)	$5 / $15 / $40 / $60	40% up to $250
Mail Order Prescriptions (up to a 90-day supply)	$12.50 / $37.50 / $120 / $180	Not Covered
Specialty Prescriptions	30% up to $250	40% up to $250
Preventive Care	No Charge (deductible waived)	40%
Basic Lab and X-ray	20%	40%
Complex Lab and X-ray	20%	40%
Urgent Care	20%	40%
Outpatient	20%	40%
Inpatient	20%	40%
Emergency Services	20%	
Physical Therapy	20%	40%
Chiropractic Services (30 visits max/year)	20%	40%
Acupuncture (20 visits max/year)	20%	40%
Durable Medical Equipment	50%	50%
Infertility	Not Covered	Not Covered
Lifetime Maximum	Unlimited	
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: ANTHEM 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.

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

The "allowed amount" is the amount that Anthem 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 Anthem 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 Anthem. You or your physician must call Anthem 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 Anthem. If you see an out-of-network provider, you may be required to submit the claim directly to Anthem 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: ANTHEM PPO

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Network	Prudent Buyer PPO	
Reimbursement Basis	Anthem's contracted rate	Anthem's allowed amount. All charges in excess of the allowed amount are the member's responsibility.
Deductible	$250 Single / $750 Family	$500 Single / $1,500 Family
Out-of-Pocket Maximum	$750 Single / $2,250 Family	$2,000 Single / $6,000 Family
Office Visit	$20 (deductible waived)	30%
Virtual Visit (telehealth/PCP)	$10 / $20 (deductible waived)	30%
Prescriptions (up to a 30-day supply)	$10 / $30 / $30	50% up to $250
Mail Order Prescriptions (up to a 90-day supply)	$10 / $30 / $30	Not Covered
Specialty Prescriptions	$30	50% up to $250
Preventive Care	No Charge (deductible waived)	30%
Basic Lab and X-ray	Free Standing: No Charge Hospital: 10%	30%
Complex Lab and X-ray	Free Standing: No Charge Hospital: 10%	30%
Urgent Care	$20 (deductible waived)	30%
Outpatient	10%	30%
Inpatient	10%	30%
Emergency Services	$100 (waived if admitted) + 10%	
Physical Therapy	10%	30%
Chiropractic Services (24visits max/year)	10%	30%
Acupuncture	10%	30%
Durable Medical Equipment	10%	30%
Infertility ($25,000 lifetime max)	10%	30%
Lifetime Maximum	Unlimited	
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: ANTHEM PPO ADDITIONAL PLAN NOTES

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

The "allowed amount" is the amount that Anthem 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 Anthem 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 Anthem. You or your physician must call Anthem 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 Anthem. If you see an out-of-network provider, you may be required to submit the claim directly to Anthem 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 3: TUFTS HMO

BENEFIT	IN-NETWORK
Network	Tufts Health HMO Plan
Reimbursement Basis	All care must be rendered or approved by your Primary Care Physician (PCP)
Deductible	None
Out-of-Pocket Maximum	$6,350 Single / $12,700 Family
Office Visit	$20 Primary / $20 Specialist
Virtual Visit (PCP / telehealth)	$20 / $0
Prescriptions (up to a 30-day supply)	$10 / $20 / $35
Mail Order Prescriptions (up to a 90-day supply)	$20 / $40 / $70
Specialty Prescriptions	Tiered Copay
Preventive Care	No Charge
Basic Lab and X-ray	No Charge
Complex Lab and X-ray	No Charge
Urgent Care	$20
Outpatient	$250 copay
Inpatient	$250 copay
Emergency Services	$100 copay
Physical Therapy	$20
Chiropractic Services (12 visits max/year)	$20
Acupuncture	$20
Durable Medical Equipment	30%
Infertility	Please Refer to Carrier
Lifetime Maximum	Unlimited
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: TUFTS 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

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 facility other than your selected PMG, to another Tufts 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

Tufts Health Plan 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.

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DENTAL BENEFITS: THE GUARDIAN

OVERVIEW

The Guardian 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	PREFERRED DENTISTS	NON-PREFERRED DENTISTS
Deductible • Waived for preventive care	$50 per member; 3 per family	$50 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 12 months	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, etc.	40% (covered at 60%)	50% (covered at 50% of UCR)
Orthodontia • Covers children and adults • Separate lifetime maximum of $1,500 per member	50% (covered at 50%)	50% (covered at 50% of UCR)

USUAL, CUSTOMARY, AND REASONABLE (UCR) DEFINED

Non-preferred benefits are based on the member's geographic location. Guardian pays non-preferred dentists based on the 90th percentile, or what nine out of ten dentists charge for a procedure in a given geographic location. If you receive services from a non-preferred dentist, you are responsible for any charges that exceed the recognized UCR amounts.

VISION BENEFITS: VISION SERVICE PLAN (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 Signature	
Vision Exam	One exam covered every 12 months	
	$25 copay	Up to $50
Prescription Glasses: Lenses	One new set of prescription lenses covered every 12 months	
	Copay combined with exam (lenses and frames) for single vision, lined bifocal, and lined trifocal lenses	Single vision: up to $50 Lined bifocal: up to $75 Lined trifocal: up to $100
Prescription Glasses: Frames	One new set of frames covered every 24 months	
	$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 every 12 months (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	

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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 O'Reilly, 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 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 expenses until you've met a portion of the plan deductible. Once you've met $1,500 of the deductible (individual coverage) or $3,000 of the family deductible, your FSA account can then be used for medical expenses such as additional deductibles or coinsurance.

MAXIMUM CONTRIBUTIONS

Contribution maximum limits are determined each year by the IRS and are inclusive of both employer and employee funding. The 2023 HSA contribution limits are as follows:

- **Single**: $3,850
- **Family**: $7,750

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.

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).

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FLEXIBLE SPENDING ACCOUNTS (FSA): VITAFLEX

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

You may only change your election mid-year in certain limited circumstances, and even then, changes are subject to restrictions. In order to change your election mid-year, you must experience a qualified status change (birth, marriage, etc.) or other approved exception. All change requests must be made within 30 days of the status change date.

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 (unless there is a rollover provision, outlined on the next page). In order to protect yourself against this, carefully consider your medical and dependent care expenses prior to making your election.

FLEXIBLE SPENDING ACCOUNTS (CONTINUED)

	HEALTH FSA	DEPENDENT CARE FSA
Plan Year	January 1st through December 31st	
Minimum Election	$260/year	$260/year
Maximum Election	$3,050/year (per employee)	$5,000/year (per household)
Claims Incurred Deadline	December 31 or your employment termination date	December 31
Claims Submission Deadline	March 31st after Plan Year ends	
Rollover	Yes, up to $610	No rollover
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 through age 12 • Spouse or dependent child over 12 that is physically or mentally disabled
Filing Claims	Full annual election available immediately • Debit Card (save your receipts!) • Online: www.vitaflex.net • Mobile App • Email: claims@vitamail.com (claim form required) • Fax: (650) 964-3539 (claim form required)	Funds available as contributed • Online: www.vitaflex.net • Mobile App • Email: claims@vitamail.com (claim form required) • Fax: (650) 964-3539 (claim form required)
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 • Mental health with medical diagnosis	• Licensed day care provider • Pre-school • In-home day care • Nanny care • After-school care custodial/recreational • Summer day camps custodial/recreational
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

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HEALTH REIMBURSEMENT ARRANGEMENT (HRA): VITAFLEX

O'Reilly Media offers a Medical Travel Health Reimbursement Arrangement (HRA) for benefit eligible employees and/or their dependents who are enrolled in any medical plan. This account is designed to be used for reimbursement of travel expenses associated medical treatment when traveling more than 50 miles from home.

	HRA
Employer Contribution	$2,500
Claims Incurred Dates	Claims must be incurred between January 1 through December 31, 2023 in order to be reimbursed from the HRA.
Funds Availability	Funds will be refreshed each year while you are an active employee. Unused funds will not rollover from the previous year.
Reimbursement Method	After you have incurred the eligible travel expenses, you will follow the steps below to be reimbursed. Please do not complete any of these steps prior to incurring any medical travel expenses: • Complete the opt-in form. • Once eligibility is confirmed (typically 3-4 business days), you will receive a Vita Flex welcome email. Please follow the instructions within that email to register your online account in the Vita Flex Consumer Portal at www.vitaflex.net. • Once logged into your online account, enter your direct deposit details by clicking on your name at the top of the page, then **Banking/Cards**. Click on **Add Bank Account** and follow the prompts. All reimbursements are made via direct deposit to your bank account, so it is critical that you enter your bank account information. • Once your account information is entered, you can file a claim in the Consumer Portal. • On the home page, select the blue **File a Claim** button. This is found under the **"I want to …"** section. • Next, choose the **Medical** option. • Complete all required fields, including all supporting documentation for your claim. To ensure ease of claim processing, please review our detailed Documentation Requirements.
Claims Submission Deadline	All fully documented claims must be submitted by March 31,2024 for expenses incurred in the prior calendar year.

Eligible Expenses

Transportation Expenses:

Amounts paid for transportation to another city to receive medical treatment are eligible. The expenses must be primarily for, and essential to, receiving medical care and not include any element of travel for personal reasons. This includes:

- Bus, taxi, train, or airplane fares
- Mileage reimbursement for driving a personally owned car
- Car services, such as taxis, Uber, Lyft, or another similar rideshare service
- Car expenses associated with driving to receive medically necessary treatment. Actual mileage traveled must be documented.
- Tolls and parking expenses when incurred specifically to receive the medical care
- Combination of transportation expenses. If transportation to treatment requires multiple modes of transportation, all such expenses would be eligible. For example, the costs for taking an Uber to the airport, the airplane ticket cost, the cost for taking a taxi to the hotel, etc. would all be considered eligible travel expenses, assuming they were necessary in the course of receiving the medical treatment.
- Transportation expenses of a parent who must accompany a child (under the age of 18) who needs qualifying medical care
- Transportation expenses of a nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get qualified medical care and is unable to travel alone

Lodging Expenses :

- The cost of lodging while away from home receiving medical care is eligible if all the following requirements are met:
- The lodging is primarily for, and essential to, medical care
- The medical care is provided by a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital
- The lodging is not lavish or extravagant under the circumstances
- There is no significant element of personal pleasure, recreation, or vacation in the travel away from home

Examples of eligible lodging include a hotel or Airbnb-type lodging service.

The maximum amount for lodging is $50 per person per night. For example, if a parent is traveling with a child, up to $100 per night would be considered an eligible medical expense for lodging. Note that you can include lodging for an eligible caregiver traveling with the person receiving the medical care; however, the same restrictive rules apply for defining an eligible travel partner as outlined above for transportation expenses.

Also Have a Health Savings Account?

When an employee is covered under a High Deductible Health Plan (HDHP), reimbursements under a pre-tax medical travel HRA must be made after the statutory deductible has been satisfied to preserve the ability to make contributions to an HSA. The Vita Flex medical travel HRA platform will not retain information on the specific type of medical plan coverage for each eligible employee. Therefore, at the time of claim, employees will need to self-attest whether they are covered under an HDHP plan and making contributions to an HSA. If the employee attests to being covered under an HDHP plan, expenses will only be reimbursed after the statutory deductible has been met. A copy of the medical plan Explanation of Benefits showing the date the statutory deductible was met will be required. The employee will bear the sole responsibility for tax liability pursuant to accurate representation of whether they are subject to the statutory deductible to preserve their ability to make HSA contributions.

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FINANCIAL SECURITY

GROUP LIFE AND AD&D BENEFITS: THE GUARDIAN

BENEFIT

Each employee is covered for term Life and AD&D insurance equal to two (2) times your annual earnings (including bonuses and commissions averaged over 12 months) rounded up to the nearest thousand. The maximum benefit is $400,000. No medical examination or health history disclosure is required for timely applicants.

AGE REDUCTIONS

At age 75, benefits will reduce to 50% of the original amount.

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.

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VOLUNTARY LIFE BENEFIT: THE GUARDIAN

BENEFIT

Each employee can choose to purchase coverage in $25,000 increments up to $200,000, not to exceed 5 times your basic annual earnings.

MONTHLY RATES

AGE BRACKET	RATE PER $1,000
Under 25	$0.040
25-29	$0.040
30-34	$0.040
35-39	$0.070
40-44	$0.090
45-49	$0.149
50-54	$0.229
55-59	$0.429
60-64	$0.659
65-69	$1.269
70+	$2.059

AGE REDUCTIONS

Benefits will be reduced by 35% of the pre-age 65 amount at age 65, and additionally by 60% at age 70, by 75% at age 75 and by 85% at age 80. Benefits terminate at retirement.

APPLICATION PROCESS

Any amounts that you apply for up to $200,000 are guaranteed issue (no health questions or exams required) at your initial eligibility period. For employees ages 65-69, the guaranteed issue amount is $50,000 and $10,000 for employees age 70 and older. Any amount applied for after your initial eligibility period will be subject to medical underwriting. Coverage will only be effective if approved by Guardian.

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: THE GUARDIAN

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 2/3% of your annual earnings. Annual earnings include base salary, bonuses and commissions averaged over 12 months.

TAXATION

O'Reilly pays 100% of the premium, which makes disability benefits taxable as regular income to the employee.

	SHORT –TERM DISABILITY	LONG-TERM DISABILITY
Elimination Period	7 days	180 days
Coverage Amount	66.67% of salary	66.67% of salary
Maximum Benefit	The maximum payable benefit from all sources combined will not exceed $3,500 per week.	The maximum payable benefit from all sources combined will not exceed $20,000 per month.
Duration of Benefits	Benefits are payable for a maximum of 26 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.

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BUSINESS TRAVEL ACCIDENT (BTA): ARCH INSURANCE

OVERVIEW

Receive trip assistance and access to emergency medical services while traveling for business more than 100 miles away from home. If you were to die due to an accidental cause while traveling in the course of business, benefits are payable to a beneficiary of your choosing.

401(K) PLAN: EMPOWER RETIREMENT

ELIGIBILITY

You are automatically enrolled in the 401(k) plan on your first active day at work.

CONTRIBUTIONS

Eligible employees may elect to defer up to 100% of their eligible compensation, up to the IRS maximum of $22,500. If you are age 50 or over, you may elect to defer an additional $7,500 in "Catch-up Contributions" as allowed by the IRS. Your default deferral upon enrollment is 8% of pay.

You may defer your contributions on a pre-tax or a Roth (after-tax) basis.

EMPLOYER MATCH

O'Reilly will match $0.30 per $1.00 on your deferral up to 8% per pay period.

ADDITIONAL INFORMATION

You may contact Vita Planning Group for additional information about the 401(k) Plan. Contact information may be found in the Questions and Help Section of this Summary.

WORK-LIFE BALANCE

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EMPLOYEE ASSISTANCE PROGRAM (EAP): WORKLIFEMATTERS

OVERVIEW

Everyone faces difficult periods in their 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 WorkLifeMatters. 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) 386-7055**.

TYPES OF PROBLEMS

- 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) 386-7055** 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.

PORTAL ACCESS

www.ibhworklife.com

Password: wlm70101

GENETIC TESTING: COLOR

OVERVIEW

Color is a health service that helps you understand your genetic risk for common hereditary cancers, including breast, ovarian, colorectal, prostate, pancreatic cancer, and more. Services include:

- **Comprehensive analysis of 30 genes:** Analysis of 30 genes associated with common hereditary cancers: breast, colorectal, melanoma, pancreatic, prostate, ovarian, stomach, and uterine.
- **Informative results:** Clear, thorough communication of the presence of any risk-increasing mutations, including mutation details and the impact on cancer risks. Provides detailed information on how your mutation status might affect relatives as well as screening guidelines created by experts to discuss with your healthcare provider.
- **Coordination with your healthcare providers:** Access your results online at color.com and optionally share your results with your provider from the online tool.
- **Complimentary genetic counseling:** Provides access for you and your healthcare provider to Color's team of board-certified genetic counselors to answer any questions you may have about your results.

PRICING

O'Reilly Media Inc. is covering the full cost of Color's Hereditary Cancer Test (retail price $249).

ENROLLMENT

Get started at color.com/go/oreillymedia. Enter your oreilly.com email address to authenticate that you are an eligible O'Reilly employee. This benefit is available to O'Reilly employees and their family members (spouse and adult dependents).

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PET INSURANCE: PETS BEST INSURANCE

OVERVIEW

Pets Best offers accident only plans as well as comprehensive coverage for accidents and illnesses. In addition, Pets Best has two tiers of routine care coverage that can be added to one of their pet health insurance plans for additional premium at the time you enroll, within 30 days of enrolling, or at your annual renewal. Benefits are available to you the day of your policy start date, so you can start using your routine care plan as soon as your policy goes into effect.

PRICING AND BILLING

Pricing is based on location, age, breed of your cat or dog, and level of coverage selected. You will be billed directly by Pets Best for the cost of your pet insurance.

ENROLLMENT

You may enroll any time at www.petsbest.com/oreilly or you may call 888-984-8700 and use referral/discount code OREILLY. You can receive up to a 10% discount using O'Reilly's discount code.

WORKING ADVANTAGE DISCOUNT PROGRAM

OVERVIEW

Working Advantage provides easy online access to a focused program of movie ticket discounts and other perks and shopping discounts. Discounts include:

- Movie Tickets
- Amusement Park Tickets
- Sporting Events
- Family Events
- Zoos & Aquariums
- Merchant Gift Certificates
- Ski Tickets
- Hotels
- Museums
- Recreational Activities
- Broadway Tickets
- Online Shopping & Service Discounts

REGISTRATION

To receive up to 60% in discounted savings go to http://www.workingadvantage.com and register.

To register click on the ***Register*** button at the top right of the page. Complete the registration process and enter the Company I.D. **# 888204470** for access to discount programs and shopping. Working Advantage can also be contacted by calling **(800) 565-3712.**

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
Anthem Medical Plans *HDHP PLAN (Out of State): **#1876*** *HDHP PLAN (California): **#1730*** *PPO PLAN: **#1730***	(855) 383-7248 www.anthem.com/ca
Tufts HMO Health Plan ***Group #88189***	(800) 462-0224 https://tuftshealthplan.com
The Guardian Dental Plan ***Group #506352***	(800) 541-7846 www.guardianantytime.com
VSP Vision Plan ***Use Employee SSN for ID***	(800) 877-7195 www.vsp.com
The Guardian Life and Disability Plans ***Group #545510***	(800) 541-7846 www.guardianantytime.com
WorkLife Matters EAP ***User ID: Matters | Password: wlm70101***	(800) 386-7055 www.ibhworklife.com
Pets Best	(888) 984-8700 www.petsbest.com/oreilly
Working Advantage Discount Program ***Company ID: #888204470***	(800) 565-3712 www.workingadvantage.com
Vita Planning Group ***401(k) advisors***	(650) 567-9300 planning@vitamail.com
The Vita Companies ***For questions regarding your healthcare benefits or FSA benefits***	(650) 966-1492 help@vitamail.com

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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.