



2026

Summary of Benefits



TABLE OF CONTENTS

- Signing Up and Making Changes..... 2
- Employee Cost Sharing..... 3
- ID Cards..... 3
- How to Find an In-Network Provider 4
- HEALTH CARE 5**
- Understanding Your Medical Plan..... 6
- Side by Side Medical Plan Comparison..... 8
- Option 1: Cigna HDHP 9
- Option 2: Cigna PPO 11
- Option 3: Cigna EPO..... 13
- Dental Benefits: Guardian..... 15
- Vision Benefits: EyeMed..... 16
- PRE-TAX BENEFITS 17**
- Health Savings Account (HSA) Administration..... 19
- Flexible Spending Accounts (FSA): Vita Flex 20
- Commuter Benefits: Vita Flex Commute 22
- FINANCIAL SECURITY 23**
- Group Life and AD&D Benefits: Guardian..... 24
- Voluntary Life and AD&D Benefits: Guardian 25
- Disability Benefits: Guardian 26
- 401(k) Plan: The Standard..... 26
- WORK-LIFE BALANCE 28**
- Student Loan Benefit: Summer 29
- Employee Assistance Program (EAP): ComPsych 30
- Discount Programs: ADP/LifeMart..... 31
- Banking: Stanford Federal Credit Union..... 31
- Pet Insurance: Pets Best 31
- QUESTIONS AND HELP 32**

WELCOME TO YOUR BENEFITS!

The investment in employee benefits is a very important way in which PAVIR 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.

PAVIR + VITA

The Vita Concierge is here to help! PAVIR 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

**The Vita Benefits Team may be reached Monday - Friday
8:00 a.m. - 5:00 p.m. PT via phone, (650) 968-8811 or email,
pavir@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 of month following or coinciding with their date of hire. For life, disability, and FSA coverages, employees must be actively working on the date coverage begins. All employees (full-time *and* part-time) are eligible to participate in the commuter benefits.

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 enrollments are submitted online through [ADP](#). Additional enrollment instructions are available from your Human Resources Representative. 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 to view and download online. To access these documents, log into [ADP](#).

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 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 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

MEDICAL/DENTAL/VISION PLANS

- PAVIR pays the majority of coverage costs for employees and their eligible dependents.
- Contributions are taken via pre-tax payroll deductions over 24 pay periods.

LIFE, AD&D AND DISABILITY PLANS

- PAVIR pays 100% of the premiums for eligible employees.
- Voluntary Life and AD&D plans are also available and 100% employee paid.

HEALTH SAVINGS ACCOUNT (HSA) FUNDING

- If you enroll in the HDHP, you will automatically be enrolled in an HSA.
- PAVIR will contribute to your HSA on a monthly basis.
- See the HSA section for more details.

EMPLOYEE CONTRIBUTIONS PER PAY PERIOD

	EMPLOYEE ONLY	EMPLOYEE + SPOUSE/DP	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Cigna HDHP	\$27.50	\$198.00	\$159.50	\$316.25
Cigna PPO	\$52.25	\$302.50	\$247.50	\$489.50
Cigna EPO	\$44.00	\$286.00	\$236.50	\$462.00
Dental	\$7.50	\$20.00	\$35.00	\$47.50
Vision	\$3.50	\$4.00	\$4.00	\$6.00
Life/Disability	No cost, paid by PAVIR			
Voluntary Life	Age banded rates			
Pre-Tax Benefits	Self-directed up to IRS maximum			
401(k)	Self-directed up to IRS maximum			

ID CARDS

Cigna will not be automatically issuing physical ID cards. Members can register for access on the mycigna.com portal and download a digital copy or request a physical card be mailed.

Guardian Dental and EyeMed 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 along with PAVIR's group numbers. 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.

CIGNA MEDICAL PLANS | www.cigna.com

1. Click on **Find a Doctor** at the top of the page.
2. When prompted **How Are You Covered?**, click on **"Employer or School"**.
3. Enter your city & state or your ZIP code.
4. Select **Doctor Type** and select the type of doctor you wish to find.
5. Either login or register for your MyCigna portal or select **Continue as guest**. If continuing as guest, confirm your location and click **Continue**.
6. Select the appropriate plan/network: **Open Access Plus, Open Access Plus Tiered**
7. You will view the available doctors in your location. To further refine your search, use the filters at the top of the screen to narrow your choices.

GUARDIAN DENTAL PLAN | www.guardianlife.com

1. Click **Find a dentist** at the top of the page.
2. Select **Find a dentist** under **Dental benefits bought through your workplace**.
3. Select **PPO: DentalGuard Preferred** from the **Plan Type** list.
4. Enter your **Location** or **Dentist Last Name or Office Name** and click on the magnifying glass.

EYEMED VISION PLAN | www.eyemedvisioncare.com

1. Click on **Find an eye doctor** at the top right of the page.
2. Under the **Choose Network** drop-down, select **Insight Network**.
3. Enter your **zip code**.
4. Click on **Get Results** (or do an **Advanced Search** if you want to narrow down your results).

Is it critical to stay in-network?

YES

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.

NO

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.

HEALTH CARE



UNDERSTANDING YOUR MEDICAL PLAN

PAVIR 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 (\$)	Cigna: mdliveforcigna.com
"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 Cigna 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

	Cigna PPO/HDHP	Cigna EPO
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 in the Cigna EPO network. Except for emergency care in certain situations, there are no out-of-network benefits under the plan.
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.	The plan does not require you to obtain a referral to see a specialist. However, some specialists choose to only see patients who are referred by them by a primary care doctor.
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?	Generally, you must pay an annual deductible before coinsurance (percentage cost sharing) begins. There are two typical exceptions in a traditional PPO: <ol style="list-style-type: none"> Preventive care (as determined by the Affordable Care Act guidelines) that is covered at 100%. Copays for office visits or prescriptions.	The plan has no deductible. Instead, the EPO is based on flat dollar copays for various services, which result in more predictable out of pocket costs.
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 CIGNA HDHP		MEDICAL OPTION 2 CIGNA PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible				
Individual	\$3,200	\$6,400	\$500	\$1,500
Family	\$6,400	\$12,800	\$1,500	\$4,500
Copays/Coinsurance	0%	30%	10%	30%
Office Visit	0%	30%	\$20/\$40	30%
Hospital	0%	30%	10%	30%
Prescriptions	\$15/\$40/\$60/30%	Not Covered	\$15/\$30/\$50/30%	Not Covered
Out-of-Pocket Max				
Individual	\$5,000	\$15,000	\$3,500	\$10,500
Family	\$10,000	\$30,000	\$7,000	\$21,000
Consider this Plan If...	<ul style="list-style-type: none"> • you have low medical and prescription utilization • you want to receive employer funding into a Health Savings Account (HSA) 		<ul style="list-style-type: none"> • you are a moderate to heavy user of medical services and prescriptions • you want freedom of choice of providers 	

EPO OPTION	MEDICAL OPTION 3 CIGNA EPO
Benefit	In-Network
Deductible	
Individual	None
Family	
Copays/Coinsurance	Various
Office Visit	\$20/\$40
Hospital	\$250 per admit
Prescriptions	\$15/\$30/\$50/30%
Out-of-Pocket Max	
Individual	\$2,000
Family	\$4,000
Consider this Plan If...	<ul style="list-style-type: none"> • you want to seek specialist care without referral • you prefer simplified copay expenses

OPTION 1: CIGNA HDHP

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
NETWORK	OPEN ACCESS PLUS	
Reimbursement Basis	Cigna's PPO contracted rate	Cigna's maximum reimbursable charge. All charges in excess of the maximum reimbursable charge are the member's responsibility.
Deductible	\$3,200/single; \$6,400/family (\$3,400 for individual w/in family)	\$6,400/single; \$12,800/family
Out-of-Pocket Maximum	\$5,000/single; \$10,000/family	\$15,000/single; \$30,000/family
Office Visit	0%	30%
Virtual Visits (PCP / Specialist)	Online visit w/ your doctor: 0% MD Live: 0%/0%	Online visit w/ your doctor: 30%
Prescriptions (up to a 30-day supply)	\$15/\$40/\$60	Not covered
Mail Order Prescriptions (up to a 90-day supply)	\$38/\$120/\$180	Not covered
Specialty Prescriptions	30% up to \$250	Not covered
Preventive Care	No charge (no deductible)	30%
Basic Lab and X-ray	0%	30%
Complex Lab and X-ray	0%	30%
Urgent Care	0%	30%
Outpatient	0%	30%
Inpatient	0%	30%
Emergency Services	0% for both In and Out of Network	
Physical Therapy	0%	30%
Chiropractic Services (25 visits max/year)	0%	30%
Acupuncture (20 visits max/year)	0%	30%
Durable Medical Equipment	0%	30%
Infertility	Coverage varies based on place of service	
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: CIGNA 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. Health Savings Account (HSA) qualified plans require 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 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 Cigna. You or your physician must call Cigna 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 Cigna. If you see an out-of-network provider, you may be required to submit the claim directly to Cigna for [reimbursement](#).

BRAND NAME PRESCRIPTION DRUG BENEFIT

Prescriptions must be filled by a participating pharmacy or mail program.

OPTION 2: CIGNA PPO

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
NETWORK	OPEN ACCESS PLUS	
Reimbursement Basis	Cigna's PPO contracted rate	Cigna's maximum reimbursable charge. All charges in excess of the maximum reimbursable charge are the member's responsibility.
Deductible	\$500/individual; \$1,500/family	\$1,500/individual; \$4,500/family
Out-of-Pocket Maximum	\$3,500/individual; \$7,000/family	\$10,500/individual; \$21,000/family
Office Visit	\$20 PCP (no deductible) \$40 Specialist (no deductible)	30%
Virtual Visits (PCP / Specialist)	Online visit w/ your doctor: \$0/\$40 (no deductible) MD Live: \$0/\$40 (no deductible)	Online visit w/ your doctor: 30%
Prescriptions (up to a 30-day supply)	\$15/\$30/\$50 (no deductible)	Not covered
Mail Order Prescriptions (up to a 90-day supply)	\$38/\$90/\$150 (no deductible)	Not covered
Specialty Prescriptions	30% up to \$250 (no deductible)	Not covered
Preventive Care	No charge (no deductible)	30%
Basic Lab and X-ray	0%	30%
Complex Lab and X-ray	10%	30%
Urgent Care	\$20 (no deductible)	30%
Outpatient	10%	30%
Inpatient	10%	30%
Emergency Services		\$150 + 10%
Physical Therapy	\$40 (no deductible)	30%
Chiropractic Services (25 visits max/year)	\$40 (no deductible)	30%
Acupuncture (20 visits max/year)	\$40 (no deductible)	30%
Durable Medical Equipment	10%	30%
Infertility	Coverage varies based on place of service	
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: CIGNA PPO ADDITIONAL PLAN NOTES

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

The "Maximum Reimbursable Charge" is the amount that Cigna 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 Cigna 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 Cigna. You or your physician must call Cigna 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 Cigna. If you see an out-of-network provider, you may be required to submit the claim directly to Cigna for [reimbursement](#).

PRESCRIPTION DRUG BENEFIT

Prescriptions must be filled by a participating pharmacy or mail program.

OPTION 3: CIGNA EPO

BENEFIT	IN-NETWORK
NETWORK	OPEN ACCESS PLUS
Reimbursement Basis	Cigna's PPO contracted rate
Deductible	None
Out-of-Pocket Maximum	\$2,000/individual; \$4,000/family
Office Visit	\$20 PCP \$40 Specialist
Virtual Visits (PCP / Specialist)	Online visit w/ your doctor: \$20/\$40 MD Live: \$20/\$40
Prescriptions (up to a 30-day supply)	\$15/\$30/\$50
Mail Order Prescriptions (up to a 90-day supply)	\$38/\$90/\$150
Specialty Prescriptions	30% up to \$250
Preventive Care	No charge
Basic Lab and X-ray	No charge
Complex Lab and X-ray	\$100
Urgent Care	\$20
Outpatient	\$125
Inpatient	\$250 per admission
Emergency Services	\$125
Physical Therapy	\$40
Chiropractic Services (25 visits max/year)	\$40
Acupuncture (20 visits max/year)	\$40
Durable Medical Equipment	0%
Infertility	Coverage varies based on place of service
Lifetime Maximum	Unlimited
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 3: CIGNA EPO ADDITIONAL PLAN NOTES

EMERGENCY AND OUT-OF-NETWORK TREATMENT

Cigna defines an emergency as sudden, serious, and unexpected illness or injury for which immediate medical attention is needed to avoid jeopardizing the health of the individual. In the case of a life-threatening emergency, obtain care immediately.

If you go to an out-of-network facility, doctor, or hospital and it is not an acute emergency, you will be responsible for all medical expenses you incur.

UTILIZATION REVIEW

All hospital confinements and surgeries must be preauthorized by Cigna. You or your physician must call Cigna 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.

PRESCRIPTION DRUG BENEFIT

Prescriptions must be filled by a participating pharmacy or mail program.

DENTAL BENEFITS: 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 <ul style="list-style-type: none"> Waived for preventive care 	\$50 per member; 3 per family	\$50 per member; 3 per family
Maximum Annual Benefit	\$2,000 per covered member	
Preventive Care <ul style="list-style-type: none"> Includes routine exams, teeth cleanings, x-rays, etc. Cleanings covered once every 6 months 	0% (covered at 100%)	0% (covered at 100% of UCR)
Basic Care <ul style="list-style-type: none"> Includes fillings, endodontics, periodontics, extractions, etc. 	10% (covered at 90%)	10% (covered at 90% of UCR)
Major Care <ul style="list-style-type: none"> Includes crowns, bridges, dentures, onlays, etc. 	40% (covered at 60%)	40% (covered at 60% of UCR)
Orthodontia <ul style="list-style-type: none"> 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.

MAXIMUM ROLLOVER ACCOUNT (MRA)

Your dental plan has a Maximum Rollover Account (MRA) feature. Guardian will automatically rollover a portion of each covered member's unused annual maximum benefit into their own MRA. The MRA will be used in future years if a member ever reaches the annual plan maximum. To qualify, you must incur at least one claim during the calendar year and you cannot exceed the claims threshold, illustrated below.

ANNUAL PLAN MAXIMUM	CLAIMS THRESHOLD	ROLLOVER AMOUNT	ROLLOVER AMOUNT (PREFERRED DENTISTS ONLY)	MRA LIMIT
\$2,000	\$700	\$350	\$500	\$1,250

VISION BENEFITS: EYEMED

OVERVIEW

The EyeMed 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	EYEMED INSIGHT NETWORK	
Vision Exam	One exam covered every 12 months	
	\$10 copay	Up to \$40
Prescription Glasses: Lenses	One new set of prescription lenses covered every 12 months	
	\$25 materials copay (lenses) for single vision, lined bifocal, and lined trifocal lenses	Single vision: up to \$30 Lined bifocal: up to \$50 Lined trifocal: up to \$70
Prescription Glasses: Frames	One new set of frames covered every 12 months	
	\$150 allowance	Up to \$105
Contact Lenses	You may choose to purchase contact lenses in lieu of glasses every 12 months (same as glasses lens schedule)	
	Contact Lens Fitting: Up to \$40	Up to \$105
Laser Vision Correction	Up to a 15% discount is available from US Laser Network providers.	
Buy-Up Options	EyeMed may offer additional allowances or discounts for lens options such as:	
	<ul style="list-style-type: none"> Blended lenses Progressive lenses 	<ul style="list-style-type: none"> Photochromatic or tinted lenses other than Pink 1 or 2 Coated or laminated lenses
Exclusions	The following services and supplies are not covered:	
	<ul style="list-style-type: none"> Orthoptics or vision training Nonprescription lenses Medical or surgical treatment of the eyes 	<ul style="list-style-type: none"> 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 PAVIR, 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 \$1,700 of the deductible (individual coverage) or \$3,400 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 2026 HSA contribution limits are as follows:

- **Single:** \$4,400
- **Family:** \$8,750

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>).

HEALTH SAVINGS ACCOUNT (HSA) ADMINISTRATION

ADMINISTRATOR

Vita Flex

ELIGIBILITY

If you and your eligible dependents choose to participate in the High Deductible Health Plan (HDHP) and are not covered by other disqualifying coverage, you are eligible to establish an HSA through PAVIR.

EFFECTIVE DATE

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

EMPLOYER FUNDING

PAVIR will make a monthly contribution to your Vita Flex HSA on your behalf. Each employee's HSA is personally owned by the employee. Deposits made by PAVIR 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 PAVIR each January 1.

HSA COVERAGE TIER	MONTHLY CONTRIBUTION FROM PAVIR
Employee Only	\$100.00
Employee + Spouse	\$100.00
Employee + Child(ren)	\$100.00
Employee + Family	\$100.00

EMPLOYEE CONTRIBUTIONS

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

ACCESSING FUNDS

There are three ways to access funds from your Vita Flex 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
- **Online:** Submit a claim for reimbursement online at www.VitaFlex.net
- **Mobile App:** Upload claims for reimbursement through the Vita Flex mobile app



FLEXIBLE SPENDING ACCOUNTS (FSA): VITA FLEX

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. 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 you to rollover your unused Health FSA funds up to the IRS allowed maximum rollover amount (\$660 for 2026) into the next plan as of March 31 of the following year (e.g. 3/31/27). Any amount in excess of that maximum is forfeited under the "use it or lose it" rule. Rollover amounts less than \$50 will be forfeited if an election is not made for the following plan year.

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.

FLEXIBLE SPENDING ACCOUNTS (CONTINUED)

	HEALTH FSA	DEPENDENT CARE FSA
PLAN YEAR	JANUARY 1 ST THROUGH DECEMBER 31 ST	
Minimum Election	\$100/year	\$100/year
Maximum Election	\$3,400/year (per employee)	\$7,500/year (per household)
Claims Incurred Deadline	December 31 or your employment termination date	December 31
Claims Submission Deadline	March 31 after Plan Year ends	
Rollover	Up to \$680	No rollover
Eligible Dependents	<ul style="list-style-type: none"> • Yourself • Your spouse • Your children under age 26 (or who have not attained age 27 as of the end of the tax year) 	<ul style="list-style-type: none"> • Children through age 12 • Spouse or dependent child over 12 that is physically or mentally disabled
Filing Claims	<p>Full annual election available immediately</p> <ul style="list-style-type: none"> • Debit Card (save your receipts!) • Online: www.Vita Flex.net • Mobile App • Email: claims@vitamail.com (claim form required) • Fax: (650) 964-3539 (claim form required) 	<p>Funds available as contributed</p> <ul style="list-style-type: none"> • Online: www.Vita Flex.net • Mobile App • Email: claims@vitamail.com (claim form required) • Fax: (650) 964-3539 (claim form required)
Common Eligible Expenses	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Vitamins/herbal supplements • Toiletries • Massage therapy for general health (without diagnosis) • Cosmetic dentistry 	<ul style="list-style-type: none"> • Tutoring/language programs • Lessons for piano, gymnastics, etc. • Sports classes or leagues • Overnight camps

COMMUTER BENEFITS: VITA FLEX COMMUTE

OVERVIEW

Set aside pre-tax payroll deductions to pay for eligible commuting expenses. You will receive a debit card that will be loaded with funds each pay period for your elected transit and/or parking amounts. Elections may be modified at any time throughout the year and elections made before the end of a pay period will be effective the pay date following the date of the election change.

PLAN PROVISIONS

	TRANSIT	PARKING
Monthly Pre-Tax Maximum	\$340	\$340
	You may elect above the pre-tax maximum as an after tax expense	
Eligible Expenses	<ul style="list-style-type: none"> • Train and subway • Bus • Ferry • Eligible Vanpool 	<ul style="list-style-type: none"> • Parking near office • Parking near mass transit for commute to work
Accessing Funds	Debit card only	Debit card or submit expenses for reimbursement online at www.VitaFlex.net within 60 days of the expense date

Attention Caltrain and BART riders: Due to Federal regulations, your debit card will not work at Caltrain and BART terminals. You will need to use your debit card to fund your Clipper card via www.clippercard.com.

Please note: If you've elected a Flexible Spending Account (FSA) and/or a Health Savings Account (HSA), the same debit card will be used for your pre-tax Commute elections. Funds will be pulled from the applicable account based on where the debit card is used and what is being purchased. If you haven't elected an FSA and/or HSA, you will receive a new debit card in the mail following your first election.

MAKING AN ELECTION

Elections are made in the ADP system. Your election will be a monthly recurring order unless you actively choose to log back into the system to change your election to \$0. Elections submitted by the last day of the pay period will be available on the next pay date (e.g. elections made by the 15th would be available around the 22nd).

TERMINATION

Upon termination, your debit card will be deactivated, and you will no longer have access to any unused transit funds. If you are submitting parking expenses for reimbursement, you have up to 60 days from your date of termination to submit expenses incurred prior to your date of termination.

FINANCIAL SECURITY



GROUP LIFE AND AD&D BENEFITS: GUARDIAN

BENEFIT

Each employee is covered for term Life and AD&D insurance equal to a flat \$100,000 benefit. No medical examination or health history disclosure is required for timely applicants.

AGE REDUCTIONS

At age 70, benefits will reduce by 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

VOLUNTARY LIFE AND AD&D BENEFITS: GUARDIAN

BENEFIT

Each employee can choose to purchase the following:

Employee: You may elect coverage in \$25,000 increments up to \$200,000.

Spouse: You may elect coverage up to \$100,000, not to exceed 50% of the employee's election. Spouse Voluntary Life and AD&D will terminate on the plan's anniversary after the spouse turns 70.

Child(ren): You may elect coverage up to \$10,000 for your child(ren), not to exceed 10% of the employee's election. Children are covered from 14 days to age 26.

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	\$0.09	\$0.09
25-29	\$0.09	\$0.09
30-34	\$0.10	\$0.10
35-39	\$0.13	\$0.13
40-44	\$0.19	\$0.19
45-49	\$0.29	\$0.29
50-54	\$0.42	\$0.42
55-59	\$0.68	\$0.68
60-64	\$1.07	\$1.07
65-69	\$1.68	\$1.68
70-99	\$2.77	\$2.77
Child	\$0.19 per \$1,000	

To calculate your per pay period rate, first find your rate based on your age above. Then plug into this formula:

$[(\text{Election Amount}/\$1,000) \times \text{Rate}]/2 = \$X.XX$
per paycheck

Example for a 45 year old elected \$200,000:
 $[(\$200,000/\$1,000) \times \$0.29]/2 = \29.00 per pay period

AGE REDUCTIONS

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

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. Amounts over \$25,000 for your spouse, or any amount applied for yourself or spouse after your initial eligibility period will be subject to medical underwriting. Coverage will only be effective if approved by Guardian. For more information on the application process, please contact Vita.

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: 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 60% of your base annual earnings.

	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 \$2,309 per week.	The maximum payable benefit from all sources combined will not exceed \$10,000 per month.
Duration of Benefits	Benefits are payable for a maximum of 12 weeks.	Benefits are payable to age 65, Standard ADEA 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.

FINANCIAL SECURITY

401(K) PLAN: THE STANDARD

OVERVIEW

The PAVIR 401(k) Plan allows employees to contribute a portion of their paycheck into a tax-advantaged investment account. Employees have a variety of investment options to choose from, allowing for a personalized approach to saving for the future.

ELIGIBILITY

You are eligible to participate in the 401(k) plan immediately.

CONTRIBUTIONS

Employees can make contributions as pre-tax or Roth. Pre-tax contributions are made before taxes are deducted from your paycheck. This lowers your taxable income today, but you'll pay taxes on the contributions and earnings when you withdraw the money in retirement. Roth contributions are made after taxes have already been taken from your paycheck. This means you won't pay taxes on your contributions or their earnings when you withdraw the money in retirement, as long as certain conditions are met.

Eligible employees may elect to defer up to 75% of their paycheck, up to the IRS maximum, which is \$24,500 for 2026. If you are age 50 or over, you may elect to defer an additional \$8,000 in "Catch-up Contributions," as allowed by the IRS. There is an additional increase in the catch-up contribution limit for participants turning age 60-63, allowing for an amount greater than the age 50 catch-up contribution. If you are turning 60-63 in 2026, you can contribute an additional \$11,250 as your catch-up contribution in 2026.

EMPLOYER MATCH

PAVIR provides an employer match up to 6% of deferrals, and eligible employees can also receive a discretionary profit-sharing contribution following one (1) year of service (historically 3% of eligible compensation).

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



STUDENT LOAN BENEFIT: SUMMER

OVERVIEW

Many individuals are carrying student loan debt or know someone close to them who is. Student loan debt can make life difficult and affect job performance. PAVIR acknowledges this burden and cares about your financial and mental well-being. There are numerous federal programs that aid in forgiveness and repayment, but the administrative requirements can make the application process difficult to navigate. The purpose of the Summer (Student Loan Benefit) is to help you understand the resources available to you and find aid that suits your financial needs to effectively plan repayment and eliminate student loan debt.

Summer is a free, end-to-end student loan platform helping employees efficiently lower payments and achieve forgiveness. The platform equips employees with the tools to achieve financial freedom through government repayment programs such as Public Service Loan Forgiveness (PSLF) and Income-Driven Repayment (IDR), educational resources, and on-demand student loan experts. Utilizing Summer may help reduce or forgive your monthly student loan payment.

BENEFITS

- Sync and track your student loans
- Compare repayment plans
- Digitally apply for federal and private programs with 95% acceptance rate
- Access loan rehabilitation
- Future college expense planning
- Gain financial literacy through robust resource library
- 1-on-1 expert advice via email, live chat, or scheduled consultation

ACCESS

This benefit is available to you and up to 3 family members!

Visit app.meetsummer.org/vita and use the access code **pavirsaves** to register.

EMPLOYEE ASSISTANCE PROGRAM (EAP): COMPSYCH

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 ComPsych Matters. 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 **(855) 239-0743**, guidanceresources.com, or the Guidance Now app. Please use Web ID: Guardian to register.

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 **(855) 239-0743** 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.

DISCOUNT PROGRAMS: ADP/LIFEMART

OVERVIEW

PAVIR employees and dependents can take advantage of our employee discount program where you can save on events and online shopping. You can register via the ADP portal by logging onto ADP, clicking "Myself", "Benefits", and finally "Employee Discounts - LifeMart". The link will push you to the LifeMart page, where you can register using your PAVIR email address.

BANKING: STANFORD FEDERAL CREDIT UNION

OVERVIEW

Stanford Federal Credit Union offers reward banking for PAVIR employees. Services include a \$100 bonus when you open your free checking account with a \$500 minimum monthly direct deposit, free consultation with Stanford Federal Investment Services advisor, high yield certificate rates, auto loans, mortgage loans, Visa Platinum credit card with no annual fee, no foreign transaction fees and no cash advance fees.

If interested, please contact Stanford Federal Credit Union Customer service at 1 (888) 723-7328 or visit www.sfcu.org

PET INSURANCE: PETS BEST

OVERVIEW

PAVIR employees can now cover the cost of pet bills with Pets Best pet health insurance! Choose from Essential, Plus, or Elite coverage.

To Enroll:

- Call: (888) 984-8700
- Visit: www.petsbest.com/paloaltopets

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
Cigna Medical Plan <i>Group #00637563</i>	(800) 244-6224 www.cigna.com
Guardian Dental Plan <i>Group #506364</i>	(800) 541-7846 www.guardiananytime.com
EyeMed Vision Plan <i>Group #1041712</i>	(866) 939-3633 www.eyemed.com
Summer Student Loan Service <i>Access Code: pavirsaves</i>	app.meetsummer.org/vita
ComPsych EAP <i>Web ID: Guardian</i>	(855) 239-0743 guidanceresources.com
Vita Benefits Team <i>For questions regarding your healthcare benefits</i>	(650) 968-8811 pavir@vitamail.com
Vita Concierge <i>For questions regarding your FSA, HSA, or Commuter benefits</i>	(650) 966-1492 help@vitamail.com
Vita Planning Group <i>401(k) advisors</i>	(650) 567-9300 planning@vitamail.com

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.