ILLUMINA, INC.

FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

ILLUMINA, INC.

FLEXIBLE BENEFITS PLAN

INTRODUCTION

We have amended and restated the "Flexible Benefits Plan" ("Plan") that we previously established for you and other eligible employees. Under this Plan, you will be able to choose among certain Benefits that we make available. The Benefits that you may choose are outlined in this Summary Plan Description ("SPD"). We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

Read this SPD carefully so that you understand the provisions of our Plan and the benefits you will receive. This SPD describes the Plan's Benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract and either the Plan document or this SPD, the insurance contract will control. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service ("IRS") or other federal agencies. We may also amend or terminate this Plan at any time. If the provisions of the Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your Benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About the Plan."

The capitalized terms used in this SPD are defined in Article I of the Plan document, which is incorporated herein by reference.

I
ELIGIBILITY

1. When can I become a participant in the Plan?

Before you become a Plan member (referred to in this SPD as a "Participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to submit an application through the Workday system before you can enroll in the Health Flexible Spending Account, Dependent Care Flexible Spending Account, or Health Savings Account Benefit.

2. What are the eligibility requirements for our Plan?

You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan. Of course, if you were already a Participant as of the effective date of this Plan, you will remain a Participant.

3. When is my entry date?

After you satisfy the eligibility requirements, you become a Participant by enrolling in the Plan as described in Section I.5 below. You may elect to join the Plan for all or the remainder of such Plan Year, provided you elect to do so within 31 days of satisfying the eligibility requirements. If you fail to enroll when you first become eligible to participate, you will not be able to elect any Benefits under this Plan until the next Election Period (unless a mid-year change in status event occurs, as explained in Section III below).

4. Are there any employees who are not eligible?

Yes, there are certain employees who are not eligible to join the Plan. They are:

-- Employees who are considered “2-percent shareholders” under the Federal tax law. “2-percent shareholders” are treated as “self-employed individuals” and therefore are not eligible to participate.

5. What must I do to enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for a portion of the Benefits you have elected.

However, if you are already covered under any of the insured Benefits, you will automatically participate in this Plan to the extent of your premiums unless you elect not to participate in this Plan.

You may terminate your participation in the Plan by notifying the Administrator in writing during the Election Period that you do not want to participate in the Plan for the next Plan Year. If you elect not to participate in the Plan for the Plan Year following the Election Period, you will have to wait until the next Election Period before you can elect to Participate in the Plan, except as provided in Section III below.

6. What can Participants use their contributions for and what are the tax implications of domestic partner coverage?

As a Participant, you will be permitted to (1) elect Plan Benefit options for which you are eligible, (2) receive any available nonelective contributions for which you are eligible in the manner set forth in the enrollment materials, (3) pay your share of the cost of your elected Benefits with Salary Redirection contributions, (4) if permitted under the terms of the Plan Benefit options and uniform rules adopted by the Administrator, pay your share of the costs of the elected Benefits with after-tax dollars (*e.g.*, if Salary Redirection contributions are not available or are insufficient to pay your share of the cost of the Benefit Plan Option), and (5) if you are enrolled in the Health Savings Account Benefit, make pre-tax contributions to a Health Savings Account.

In addition, as a Participant, you may be permitted to elect health coverage for an individual who is not your Spouse or Dependent if permitted under the terms of the Plan's Benefit options, and in accordance with uniform rules adopted by the Plan Administrator; provided, however, that the fair market value of such coverage will be included in your gross income to the extent required by applicable law.

II
OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the Benefits you have chosen. The Plan is intended to be designed and operated such that the portion of your pay that is deducted to pay for Benefits you elect under the Plan is not subject to Federal income or Social Security taxes. . However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled “General Information About Our Plan” for the definition of “Plan Year.”)

III
CONTRIBUTIONS AND PARTICIPANT ELECTIONS

1. How much of my pay may the Employer redirect?

Each year, we will automatically contribute on your behalf enough of your compensation to pay your share for the health coverage you elect, unless you elect to pay for that coverage on an after-tax basis. You may also elect to have us contribute on your behalf enough of your compensation to pay for any other benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year.

2. How much will the Employer contribute each year?

We will contribute to each Participant who is eligible for a Health Savings Account during a Plan Year an amount equal to $1,000 for a Participant without Dependents or a total of $1,500 for each Participant with any Dependents for each Plan Year. For newly hired Health Savings Account eligible Participants, the Employer shall prorate the annual Employer

Contribution to the Participant's Health Savings Account for the Plan Year. This contribution can be used for the Health Savings Account and will be made at the beginning of the Plan Year. If you elect not to participate, the Employer will not contribute to the Plan on your behalf.

3. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the Benefits you want and how much of the contributions should go toward each Benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered Benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year. In addition, you should also note that any previous Benefit payments made from any Account under the Plan that are unclaimed (*e.g.*, uncashed Benefit checks) by the end of the Plan Year following the period of coverage in which the qualifying expense was incurred will be forfeited to the Employer.

4. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the election period (defined below), and you generally cannot change your election after the election period ends. You must decide two things. First, which Benefits you want and, second, how much should go toward each Benefit.

Except for Flexible Spending Accounts which require a Participant's annual election during open enrollment, if you are already covered by any of the insured Benefits offered by this Plan, you will automatically become a Participant to the extent of the premiums for such insurance unless you elect, during the election period (defined below), not to participate in the Plan.

5. When is the election period for our Plan?

You will make your initial election on or before your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

6. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the election period ends. However, there are certain limited situations when you can change your elections after the beginning of the Plan Year. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. You may enroll yourself, your Spouse, and Dependents in the group health plan relating to a mid-year change in status provided that enrollment is requested within 31 days. However, if you gain a new Dependent through birth, adoption, or placement for adoption, you may enroll yourself and your Dependents in the group health plan provided that enrollment is requested within 60 days after the birth, adoption, or placement for adoption.

Currently, the following events are considered a change in status under federal law and the Plan:

-- Marriage, divorce, death of a Spouse, legal separation or annulment;

-- Change in the number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

-- Any of the following events for you, your Spouse or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for Benefits;

-- One of your Dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and

-- A change in the place of residence of you, your Spouse or Dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

However, with respect to the Health Savings Account, you may modify or revoke your elections without having to have a change in status.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your Spouse, or your Dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your Salary Redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another Benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your Spouse's, former Spouse's or Dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance or if you decide to participate in the Health Savings Account.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

You may revoke your coverage under the employer's group health plan outside of our open enrollment period, if your employment status changes from working at least 30 hours per week to less than 30 hours. This is regardless of whether the reduction in hours has resulted in loss of eligibility. You must show intent to enroll in another health plan.

You may also revoke your coverage under our Employer sponsored group health plan if you are eligible to obtain coverage through the health exchanges.

7. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the Election Period before a new Plan Year begins, we will assume you want your elections for Benefits only to remain the same and you will not be considered a Participant for the non-insured Benefit options under the Plan for the upcoming Plan Year.

The Election Period is the period during which you have an opportunity to participate under the Plan for the following Plan Year. Each year, the Administrator will notify you about the timing and duration of the Election Period. The Plan Year is the 12 months beginning on each January 1 and ending on December 31.

8. What if I am reemployed after termination?

If your employment is terminated for any reason other than death and then we rehire you, your participation in the Benefit options depends on the following:

- If you terminate employment and are rehired within 30 days of such termination, then you will be automatically reinstated into the Plan with the same elections in effect prior to termination of employment.

- If you are rehired more than 30 days after termination and otherwise eligible to participate in the Plan, you shall have the opportunity to make new Benefit elections under the Plan as if you were newly eligible for Benefits. The new elections must be made within 30 days of reemployment and will be effective as of the date of reemployment.

IV
BENEFITS

1. Health Flexible Spending Account

The Health Flexible Spending Account enables you to pay for expenses allowed under Code Sections 105 and 213(d) that are not covered by our medical plan. The Health Flexible Spending Account allows you to be reimbursed by the Employer for expenses incurred by you and your Dependents.

Drug costs, including insulin, over-the-counter medications, and menstrual care products may be reimbursed.

You may not be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

For 2024, the most you can contribute to a Health Flexible Spending Account is $3,200. After 2024, the dollar limit may increase for cost of living adjustments. The minimum amount that you may contribute to the Health Flexible Spending Account each Plan Year is $1. In addition, you will be eligible to carryover unused amounts in your Health Flexible Spending Account, up to $640 into 2025. Amounts in excess of $640 will be forfeited. This means that amounts you do not use during a Plan Year can be carried over to the next Plan Year and used for expenses incurred in the next Plan Year. To be eligible for the carryover amount, you must maintain an active election in the Health Flexible Spending Account for the Plan Year to which the carryover applies. If you will be a Health Savings Account Eligible Individual in the immediately following Play Year, you are not eligible for the carryover and any unused funds will be automatically forfeited. The Plan is allowed to treat claims as being paid first from the current year amounts, and then from the carryover amounts.

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. We will also provide you with a debit or credit card to use to pay for medical expenses. The Administrator will provide you with further details. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to change coverage.

2. Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care costs as allowed under section 129 of the Internal Revenue Code. If you are married, you can use the account if you and your Spouse both work or, in some situations, if your Spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements that qualify include:

(a) A dependent care center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;

(b) An educational institution for pre-school children. For older children, only expenses for non-school care are eligible; and

(c) An individual who provides care inside or outside your home: The individual may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your Spouse's actual or deemed earned income (a Spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Ask your tax adviser which is better for you.

3. Health Savings Account Benefit

A Health Savings Account allows an Employee to make pre-tax contributions to a Health Savings Account established and maintained outside of the Plan with the Employee's Health Savings Account trustee/custodian. Benefits provided under the Health Savings Account, which consist solely of the ability to contribute to the Health Savings Account on a pre-tax Salary Redirection basis are called Health Savings Account Benefits.

A Health Savings Account is not an employer-sponsored employee benefit plan – it is an individual trust or custodial account that you open with an Health Savings Account trustee/custodian to be used primarily for reimbursement of "eligible medical expenses" as set forth in Code Section 223. Consequently, a Health Savings Account trustee/custodian, not us, will establish and maintain your Health Savings Account. The Health Savings Account trustee/custodian will be chosen by you, as the Participant, and not by us. We may, however, limit the number of Health Savings Account providers to whom we will forward pre-tax Salary Redirections, a list of whom will be provided upon request. Any such list of Health Savings Account trustees/custodians, however, shall be maintained for administrative simplification and shall not be an endorsement of any particular Health Savings Account trustee/custodian. We have no authority or control over the funds deposited in your Health Savings Account.

If you elect Health Savings Account Benefits, then you will be able to provide a source of pre-tax contributions by entering into a Salary Redirection Agreement. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and Federal Insurance Contributions Act (Social Security) taxes.

To participate in the Health Savings Account Benefits, you must be an Health Savings Account Eligible Individual. This means that you are eligible to contribute to a Health Savings Account under the requirements of Code Section 223 and that you have elected qualifying high deductible health plan coverage offered by us and have not elected any disqualifying non-high deductible health plan coverage offered by us. (High deductible health plan means the high deductible health plan option offered by us that is intended to qualify as a high deductible health plan under Code Section 223(c)(2). If you elect Health Savings Account Benefits, you will be required to certify that you meet all of the requirements under Code Section 223 to be eligible to contribute to a Health Savings Account. These requirements include such things as not having any disqualifying coverage – and you should be aware that coverage under a Spouse's plan, including a Spouse's health Flexible Spending Account, could make you ineligible to contribute to a Health Savings Account. To find out more about Health Savings Account eligibility requirements and the consequences of making contributions to a Health Savings Account when you are not eligible (including possible excise taxes and other penalties), see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans). In order to elect Health Savings Account Benefits under the Plan, you must establish and maintain a Health Savings Account outside of the Plan with a Health Savings Account trustee/custodian, and you must provide sufficient identifying information about your Health Savings Account to facilitate the forwarding of your pre-tax Salary Redirections through our payroll system to your designated Health Savings Account trustee/custodian.

If you elect Health Flexible Savings Account Benefits, you cannot also elect Health Savings Account Benefits (or otherwise make contributions to a Health Savings Account.

In the event that an expense is eligible for reimbursement under both the Health Flexible Spending Account and the Health Savings Account, you may seek reimbursement from either the Health Flexible Spending Account or the Health Savings Account, but not both.

The Plan Administrator will maintain records to keep track of Health Savings Account contributions that you make via pre-tax Salary Redirections, but it will not create a separate fund or otherwise segregate assets for this purpose.

The amount you elect must not exceed the statutory maximum amount for Health Savings Account contributions applicable to your high deductible health plan coverage option (*i.e.*, single or family) for the calendar year in which the contribution is made. ($4,150 for single and $8,300 for family are the statutory maximum amounts for 2024.) An additional catch-up contribution of $1,000 may be made if you are age 55 or older.

4. Premium Expenses

You may elect to use pre-tax dollars to pay for certain premium expenses under various insurance programs and other benefits that we offer you. These premium expenses include:

-- Health care premiums under our self-funded medical plan.

-- Dental insurance premiums.

-- Vision insurance premiums.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any contracts providing benefits described above. Also, your coverage will end when you leave employment, are no longer eligible under the terms of any coverage, or when coverage terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

5. May I direct Plan contributions to my Health Savings Account?

Yes. Any monies that you do not apply toward available benefits can be contributed to your Health Savings Account, which enables you to pay for expenses which are not covered by our medical plan and save taxes at the same time. Please see your Plan Administrator for further details.

V
BENEFIT PAYMENTS

1. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a Benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. The provisions of the insurance contracts will control what benefits will be paid and when. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

2. What happens if I don't spend all Plan contributions during the Plan Year?

Any monies left at the end of the Plan Year will be forfeited, except for $640 that can be carried over into the next Plan Year for the Health Flexible Spending Account or, except for amounts contributed to your Health Savings Account. Qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. For the Health Flexible Spending Account and Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully. Remember, you must decide which Benefits you want to contribute to and how much to place in each account before the Plan Year begins. If you will be a Health Savings Account Eligible Individual in the immediately following Plan Year, you will not be eligible for the carryover and any unused funds will be automatically forfeited.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance and the Health Flexible Spending Account. If your coverage in these Benefits terminates, due to your revocation of the Benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Flexible Spending Account, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect $1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from $100 per month to $150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone.

For example, if you elect $1,200 for the year and are out on leave for 3 months, your amount will be reduced to $900. The expenses you incur during the time you are not in the Health Flexible Spending Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

5. What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to Benefits will be determined in the following manner:

(a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

(b) You will still be able to incur claims and request reimbursement for qualifying dependent care expenses incurred during the remainder of the Plan Year from the balance remaining in your Dependent Care Flexible Spending Account at the time of termination of employment. However, no further Salary Redirection and contributions will be made on your behalf after you terminate. You must submit claims within 90 days after the end of the Plan Year in which termination occurs.

(c) Your Health Savings Account amounts will remain yours even after your termination of employment.

(d) For health Benefit coverage and Health Flexible Spending Account coverage on termination of employment, please see the Article entitled "Continuation Coverage Rights Under COBRA." Upon your termination of employment, your participation in the Health Flexible Spending Account will cease, and no further Salary Redirection and contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made. No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such accounts shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such account as of the end of such period shall be forfeited and deposited in the Benefit plan surplus after the expiration of the filing period. Your further participation will be governed by "Continuation Coverage Rights Under COBRA."

6. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free Benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

7. Qualified Reservist Distributions

If you are a member of a reserve unit and if you are ordered or called to active duty, then you may request a Qualified Reservist Distribution (QRD). A Qualified Reservist Distribution is a distribution of all or a portion of the amounts remaining in your Health Flexible Spending Account. You can only request this distribution if you are called to active duty for a period of 180 days or more or for an indefinite period. The distribution must be made during the period beginning on the date of the call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of the call.

You can receive the amount you have actually contributed minus any reimbursements you have already received (or are in process). The amount you request may be adjusted if needed to conform with your actual account balance. You must request the QRD before the last day of the Plan Year. You can only request 2 QRDs for a Plan Year.

VI
HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid.

If you are within these categories, the amount of contributions and Benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their Spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable Benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VII
PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a Benefit. Remember, you may want to spend all the money you have designated for a particular Benefit by the end of the Plan Year to avoid forfeiting it.

VIII
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

Illumina, Inc. Flexible Benefits Plan is the name of the Plan.

Plan Number 501 is assigned to your Employee Benefits Plan.

The provisions of your amended and restated Plan become effective on January 1, 2025. Your Plan was originally effective on January 1, 1999.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

2. Employer Information

Your Employer's name, address, and identification number are:

Illumina, Inc.
5200 Illumina Way
San Diego, California 92122-4616
33-0804655

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Illumina, Inc.
5200 Illumina Way
San Diego, California

92122-4616
858-202-4500

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Illumina, Inc.
5200 Illumina Way
San Diego, California 92122-4616

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:

HealthEquity Inc.
15 W Scenic Pointe Drive, Suite 100
Draper, UT 84020

IX
ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. For those benefits subject to ERISA, these laws provide that Participants, eligible employees and all other employees are entitled to:

(a) examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration;

(b) obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies;

(c) continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage; and

(d) review this summary plan description and the documents governing the plan on the rules governing COBRA continuation rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining documents from the Administrator, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210, or visit the EBSA website at www.dol.gov/ebsa/. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. Claims Process

You should submit all reimbursement claims during the Plan Year. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Any claims submitted after that time will not be considered.

Claims that are insured or self-funded will be handled in accordance with procedures contained in the insurance policies or contracts. All other general requests should be directed to the Administrator of our Plan. If a dependent care claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

In the case of a claim for medical expenses under the Health Flexible Spending Account, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim:	
Notification to Participant	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

(a) The specific reason or reasons for the denial;

(b) Reference to the specific Plan provisions on which the denial was based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review;

(e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and

(f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

(a) was relied upon in making the claim determination;

(b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

A civil action related to a claim for benefits must be filed within one year from the date on which the Plan Administrator provides notice to the claimant of the denial of an appeal, regardless of any state or federal statutes establishing provisions relating to limitations of actions.

3. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a Participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

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CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. While the Plan itself is not a group health plan, it does provide health benefits. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health Flexible Spending Account.

1. What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. Although a Domestic Partner is not considered a Spouse for COBRA purposes, a Domestic Partner shall be entitled to COBRA-like continuation coverage, and all of the terms and conditions of COBRA described below similarly apply to a Domestic Partner for COBRA-like continuation coverage. The right to COBRA or COBRA-like continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary, including a Domestic Partner, had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

There may be other options available when you lose group health coverage**.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

2. Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(a) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse or Domestic Partner of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the

relationship to the individual. Although a Domestic Partner is not considered a Spouse for COBRA purposes, Domestic Partners shall be treated as a Qualified Beneficiary for purposes of COBRA-like continuation coverage.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

3. What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (*i.e.*, cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA or COBRA-like continuation coverage:

(a) The death of a covered Employee.

(b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(c) The divorce or legal separation of a covered Employee from the Employee's Spouse, or dissolution of a domestic partnership of a covered Employee and Domestic Partner. If the Employee reduces or eliminates the Employee's Spouse's or Domestic Partner's Plan coverage in anticipation of a divorce, legal separation, or dissolution of a domestic partnership, and a divorce, legal separation, or dissolution of a domestic partnership later occurs, then the divorce, legal separation, or dissolution of a domestic partnership may be considered a Qualifying Event even though the Spouse's or Domestic Partner's coverage was reduced or eliminated before the divorce, legal separation, or dissolution of a domestic partnership.

(d) A covered Employee's enrollment in any part of the Medicare program.

(e) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse, Domestic Partner or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA or COBRA-like coverage, if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, Domestic Partner or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA or COBRA-like continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

4. What factors should be considered when determining to elect COBRA continuation coverage?

When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a Spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a Spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Medicare Eligibility:** You should be aware of how COBRA or COBRA-like coverage coordinates with Medicare eligibility. If you are eligible for Medicare at the time of the Qualifying Event, or if you will become eligible soon after the Qualifying Event, you should know that you have 8 months to enroll in Medicare after your employment –related health coverage ends. Electing COBRA or COBRA-like coverage does not extend this 8-month period. For more information, see medicare.gov/sign-up-change-plan**.**

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

5. What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

6. What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

7. Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA or COBRA-like continuation coverage to Qualified Beneficiaries , including Domestic Partners, only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(a) the end of employment or reduction of hours of employment,

(b) death of the employee,

(c) commencement of a proceeding in bankruptcy with respect to the Employer, or

(d) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the covered Employee and Spouse, or dissolution of a domestic partnership of the covered Employee and Domestic Partner, or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse, Domestic Partner or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

You may provide notice to our COBRA Administrator, Vita, by any of the following methods:

- Phone: (650) 966-1492
- Email: help@vitamail.com
- Mail: P.O. Box 2167, Omaha, NE 68103-2167

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation of the Participant and Spouse, or dissolution of a domestic partnership of a Participant and Domestic Partner**, your notice must include **a copy of the divorce decree, the legal separation agreement, dissolution of a domestic partnership**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA or COBRA-like continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA or COBRA-like continuation coverage for their Spouses or Domestic Partners, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA or COBRA-like continuation coverage, such coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse, Domestic Partner or dependent

children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

8. Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA or COBRA-like continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

9. Is COBRA or COBRA-like coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA or COBRA-like continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which such coverage is elected. However, a Qualified Beneficiary's COBRA or COBRA-like coverage will terminate automatically if, after electing such coverage, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

10. When may a Qualified Beneficiary's COBRA or COBRA-like continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA or COBRA-like continuation coverage. Except for an interruption of coverage in connection with a waiver, continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(a) The last day of the applicable maximum coverage period.

(b) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(d) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(e) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(1) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

11. What are the maximum coverage periods for COBRA or COBRA-like continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary including, for COBRA-like coverage, a Domestic Partner, as shown below.

(a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(b) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(1) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(2) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

12. Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries including, for COBRA-like coverage, a Domestic Partner at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA or COBRA-like maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

13. How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary, including, for COBRA-like coverage, a Domestic Partner in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

14. Does the Plan require payment for COBRA or COBRA-like continuation coverage?

For any period of COBRA or COBRA-like continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA or COBRA-like continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA or COBRA-like continuation coverage as of the first day of any period for which timely payment is not made.

15. Must the Plan allow payment for COBRA or COBRA-like continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

16. What is Timely Payment for COBRA or COBRA-like continuation coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees, or

Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA or COBRA-like continuation coverage for a Qualified Beneficiary, including a Domestic Partner for COBRA-like coverage, earlier than 45 days after the date on which the election of COBRA or COBRA-like continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

17. Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA or COBRA-like continuation coverage?

If a Qualified Beneficiary's COBRA or COBRA-like continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

18. How is my participation in the Health Flexible Spending Account affected?

You can elect to continue your participation in the Health Flexible Spending Account for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Flexible Spending Account if you have elected to contribute more money including any carryover amounts than you have taken out in claims. For example, if you elected to contribute an annual amount of $500 and, at the time you terminate employment, you have contributed $300 but only claimed $150, you may elect to continue coverage under the Health Flexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the $500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

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QUESTIONS

If you have any questions, please contact the Administrator.