Employee Benefits Guide 2015
## LifeLock Benefits at a Glance

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>DESCRIPTION</th>
<th>WHO PAYS?</th>
</tr>
</thead>
</table>
| **Medical**                                  | Administered by Blue Cross Blue Shield (BCBS)  
Three choices:  
• PPO $750  
• PPO $500  
• High Deductible Health Plan (HDHP) | You and LifeLock         |
| **Health Savings Account (HSA)**             | Administered by HealthEquity  
• Available with the HDHP | You and LifeLock         |
| **Flexible Spending Accounts (FSAs)**        | Administered by HealthEquity  
• Health Care FSA  
• Dependent Care FSA | You                     |
| **Dental**                                   | Administered by Delta Dental  
Two choices:  
• Base Plan  
• Buy-Up Plan | You and LifeLock         |
| **Vision**                                   | Administered by VSP | You and LifeLock         |
| **Disability**                               | Administered by Hartford  
• Short-Term Disability (STD)  
• Long-Term Disability (LTD) | LifeLock                 |
| **Life and Accidental Death & Dismemberment (AD&D) Insurance** | Administered by Hartford  
• Basic Life & AD&D Insurance  
• Supplemental Life & AD&D Insurance  
• Dependent Life Insurance | LifeLock  
You  
You |
| **Employee Assistance Program (EAP)**        | Administered by American Behavioral | LifeLock                 |
| **Pet Healthcare Program**                   | Administered by United Pet Care | You                     |
Welcome to LifeLock’s Annual Open Enrollment for Benefits. This is your once-a-year opportunity to review the options for the coming year and select the coverage that will work best for you and your family. Your new benefit selections will be effective on January 1, 2015. Changes for the 2015 plan year are summarized in this guide. Be sure to take a fresh look at all of the benefit options available to you for the year ahead and use the tools and resources LifeLock provides to help you make your decisions.

Even though you do not need to actively enroll in most of your benefits this year, we want to make sure you are aware of the changes and all the benefits LifeLock has to offer.

LifeLock reviews benefit plans every year to make sure they remain comprehensive and competitive, while keeping our costs manageable. As with most companies, we share the cost of your benefits with you. Your benefit plans represent a large percentage of your Total Rewards package, so it’s important to understand all the out-of-pocket expenses you might have (your premium contributions, copays, deductibles and coinsurance), and the benefit levels each option provides. It makes good sense for you to reconsider your plan elections and understand what’s changing each year as well.

What’s New for 2015?

Effective January 1, 2015, LifeLock’s medical plans will be administered by Blue Cross Blue Shield. We will continue to offer three medical plan options; two Preferred Provider Organization (PPO) plans and one High Deductible Health Plan (HDHP) with an opportunity for a Health Savings Account (HSA). This book will highlight plan information and provide instructions on what you need to do to confirm your benefits and search for providers.

EAP carrier has changed to American Behavioral.

HSA bank accounts will be integrated through HealthEquity. There will be a transfer form in ADP that you will be responsible to fill out and send to Optum, so any money that is currently in your HSA after January 1, 2015 will be transferred over to your new HSA account with HealthEquity.

Flexible Savings Accounts (FSAs) and Dependent Care Accounts will also be administrated through HealthEquity. You will receive a new debit card in the mail after January 1, 2015.

The maximum annual FSA amount that can be elected for 2015 is $2,550 and LifeLock will be implementing the $500 carryover going into 2016.

<table>
<thead>
<tr>
<th>COVERAGE TIER</th>
<th>MEDICAL HDHP</th>
<th>MEDICAL PPO $750</th>
<th>MEDICAL PPO $500</th>
<th>DENTAL BASE PLAN</th>
<th>DENTAL BUY-UP PLAN</th>
<th>VISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$25.20</td>
<td>$32.43</td>
<td>$46.57</td>
<td>$2.95</td>
<td>$5.52</td>
<td>$.84</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$53.92</td>
<td>$69.40</td>
<td>$99.67</td>
<td>$12.08</td>
<td>$17.10</td>
<td>$2.71</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$50.39</td>
<td>$64.86</td>
<td>$93.15</td>
<td>$16.19</td>
<td>$22.00</td>
<td>$2.76</td>
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<tr>
<td>Employee + Family</td>
<td>$78.11</td>
<td>$100.54</td>
<td>$144.38</td>
<td>$22.20</td>
<td>$32.07</td>
<td>$4.46</td>
</tr>
</tbody>
</table>
Getting Started

It's Simple to Enroll!

Remember, Open Enrollment ends November 24th

1. Log in to ADP.

2. Update personal data such as address, home email address and phone

3. Review dependent Information. Go to Personal Information > Dependent Information

4. Do not add new dependents during the data wizard step. For best results, use the Benefits Enrollment Wizard, even if the addition of a dependent is simply for the purpose of beneficiaries. Come back and complete your beneficiaries later.

5. Start the Benefits Enrollment process by going to Benefits > Review/Change Benefits. This step will launch a Benefits Enrollment wizard.

The following three benefit enrollment options are available:

- *Walk me through this process*
- *I know the changes I want to make*
- *Review my benefits coverage*

Each option will walk you through the benefits, but we recommend that you select “Walk me through this process”. This option allows you to check your progress while you make changes and if you need to stop and return later, the system will remember your last step.

When you have completed the required steps, you will see a message that says “Changes Submitted Successfully!” If you have printer access, click View/Print Summary of Changes for a print-out of your elections.

Online enrollment is available 24 hours a day, seven days a week, throughout the enrollment period. Open enrollment will close at midnight Mountain Standard time on November 24th. You cannot make changes after the due date, so it is important to make any changes on time.

During the enrollment period, you may enroll and revise your elections as many times as you like, but the elections you have selected as of midnight November 24th will be your benefit elections in 2015.

If you do not enroll by the due date you will default to the same level of coverage you had in 2014 for medical, dental, vision and supplemental life/ad&d insurance coverage. Both the FSA and dependent FSA will default to no coverage.
Who Can Enroll?

You are eligible for benefits if you are a regular full-time or part-time employee scheduled to work 30 hours or more per week.

If you elect coverage, your dependents are also eligible for medical, dental, vision and supplemental life/ad&d insurance coverage. Eligible dependents include:

- Your lawful spouse
- Your lawful domestic partner (same or opposite sex: certain rules apply)
- Your lawful child(ren) up to age 26: includes your natural, adopted or foster child(ren), stepchild(ren), or any child for whom you have legal custody.
- Your lawful children with a mental or physical disability without regard to age (proof that the disability began before the child's 26th birthday is required).

Change in Your Coverage Mid-Year

The IRS provides strict regulations about changes to pre-tax elections during the plan year. If you experience a qualified IRS family status change mid-year, you are permitted to make a change within 31 days of the event.

If the change request is not completed within 31 days of the event, you will not be able to change your elections until the following year’s benefits open enrollment period. Below is a list of some of the more commonly known qualified family status changes:

- Marriage, divorce or annulment, or permanent separation
- Change in number of dependents
- Change in your employment status that affects benefits eligibility, including termination or commencement of employment, or change in residency (for you, your spouse, domestic partner, or dependents)
- You or your dependent becomes eligible or loses eligibility for Medicare or Medicaid

Dependent Verification of Eligibility

When you first enroll, or if you change coverage mid-year due to a qualified IRS family status change, you are required to provide documentation substantiating the eligibility of your dependent(s) within 31 days of the change or enrollment.

If documentation is not received within 31 days, Human Resources will contact you and request the documentation within a given deadline. Examples of events which require documentation to support the change include:

- Marriage
- Loss of other coverage
- Eligibility for another plan
- Loss of eligibility for a dependent

The change you request must be consistent with the qualifying event. Some mid-year changes require documentation which must also be provided within 31 days of the event.

If you have questions, please contact Human Resources.
Medical

Blue Cross Blue Shield (BCBS)

Your medical plans will be administered by Blue Cross Blue Shield. You are free to go to any provider you choose, however your benefits will be more cost effective if you stay within the network and utilize contracted providers. You are also not required to get a referral to see a specialist or get a second opinion.

BluePreferred PPO is your national provider network for each of the medical plans. To access the provider directory:

Member Services
In Arizona: (602) 864-4400
In California and Other States: (800) 232-2345
www.azblue.com
Click on "Find a Doctor"

The Blue Card Program

If you are searching for providers outside the state of Arizona, you still have access to Blue Plan’s PPO Network available with The Blue Card Program.

Visit: www.azblue.com
Choose “Outside of Arizona Providers”, and enter the alpha prefix from your BCBS ID card OR

BlueCard Access
(800) 810-BLUE (2583)

If you are outside the country and need to locate a doctor or hospital, or need medical assistance services, call the BlueCard Access at the number above or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

For more information and to learn about the claims process visit: www.bcbs.com/bluecardworldwide

Key Benefit Terms

Premiums: The amount automatically deducted, based on your election, from your paycheck pre-tax to enroll you in a medical plan through LifeLock.

Deductible: The amount you pay toward covered expenses each calendar year (January 1 – December 31) before the plan begins paying benefits. You are responsible for the full cost of all non-preventive care until your total costs exceed your deductible.

Coinsurance: The amount you share with the plan to pay for care received, up to the annual out-of-pocket maximum. After you meet your deductible, the plan will pay a portion of the cost of care received and you are responsible for the remaining cost.

Out-of-Pocket Maximum: The total amount (maximum) of expenses you are responsible for during a calendar year (includes deductibles and copays but does not include premiums deducted from your paycheck). If your costs for care exceed the out-of-pocket maximum, the plan will pay the full cost of covered benefits for the rest of the year.

Preventive Care: Routine health care services to maintain your health and prevent disease, including services such as annual physical exams, well-woman exams and certain immunizations.

Network: All plans offered utilize the BluePreferred PPO provider network, which is nationwide. Members and guests can visit www.azblue.com to search for a participating provider.
PPO Plan Choices

You may pay more in premiums for the Blue Cross Blue Shield (BCBS) Preferred Provider Organization (PPO) medical plans, but they have copays, a lower annual deductible and out-of-pocket maximum than the HDHP.

PPO Plan Highlights

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>BCBS PPO $750 In-Network</th>
<th>BCBS PPO $500 In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Individual/Family</td>
<td>$750 / $1,500</td>
<td>$500 / $1,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>You Pay 20%</td>
<td>You Pay 10%</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Deductible Individual/Family</td>
<td>$3,500 / $7,000</td>
<td>$3,000 / $6,000</td>
</tr>
</tbody>
</table>

How the PPO plans work:

1. All in-network preventive care is covered at 100%. No deductible or coinsurance is required for in-network providers.

2. You pay a copay to see a doctor or fill a prescription. Copay is the money you have to pay each time you see a doctor or fill a prescription.

3. You pay the deductible before the plan pays. The deductible is the amount of money you pay for covered services before your plan starts to pay. You will likely have a deductible for some higher cost services like a surgery.

4. If the deductible has been reached, coinsurance begins. Coinsurance is when the plan shares the cost of expenses with you. The plan will pay a percentage of each covered service, and you will pay the rest. For example, if your plan pays 90% of the cost, you will pay 10% of the cost.

5. You are protected with an out-of-pocket maximum. This is the most you will have to pay during a policy period (usually a year) for covered services. If you reach this limit, the plan will pay 100% of your covered services for the rest of the policy period (including copays).

For certain services, you may be required to have approval before those services can be covered by your plan. See your benefit plan documents for all of the coverage details.
High Deductible Health Plan (HDHP)

The High Deductible Health Plan (HDHP) through Blue Cross Blue Shield (BCBS) is a consumer-driven health plan with a Health Savings Account (HSA). It puts you in charge of how your health care dollars are spent. The HDHP covers in-network preventive care at 100%, so these services are not subject to the deductible or coinsurance. Under the HDHP, you will pay less in premiums and a lower out-of-pocket maximum but have a higher deductible than you would under the PPO $750 and $500 plans.

HDHP Highlights

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>BCBS HDHP In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Individual/Family</td>
<td>$1,500/$3,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>You Pay 10%</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$2,500/$5,000</td>
</tr>
<tr>
<td>Includes Deductible Individual/Family</td>
<td></td>
</tr>
<tr>
<td>Health Savings Account</td>
<td>Everyone who elects the HDHP will automatically have an HSA account opened for them through HealthEquity. LifeLock will contribute: Employee Only: up to $500. All other coverage tiers: up to $1,000</td>
</tr>
</tbody>
</table>

How the HDHP works:

1. All in-network preventive care and preventive medication is covered at 100%. No deductible or coinsurance is required.

2. Through your Health Savings Account with HealthEquity, start contributing pre-tax payroll deductions into your HSA bank account. LifeLock will contribute up to $500 for Employee Only (up to $1,000 for all other coverage tiers). By contributing as much as you are comfortable with, you maximize your tax savings and can build up funds in your account to use for eligible medical expenses.

3. You pay the full cost of all non-preventive care eligible expenses for you or your covered dependents (including prescription drugs) until you reach your deductible.

4. After you meet your deductible, the plan shares the cost of your eligible expenses through coinsurance up to the annual out-of-pocket maximum. Non-preventive prescription drugs will become copays until the annual out-of-pocket maximum is reached.

If you enroll in the HDHP, you cannot be covered by any other medical plan, including a spouse’s medical plan or health care flexible spending account, or you will not be eligible to contribute to an HSA (this includes LifeLock contributions made on your behalf).
The Health Savings Account (HSA) is a feature that becomes available when you enroll in the High Deductible Health Plan (HDHP). The account helps you save and pay for qualified health care expenses for this year and future years. If you enroll in the HDHP, an HSA Account with HealthEquity is automatically opened for you in order to receive the LifeLock HSA contribution.

Key Advantages of an HSA

- You can use it to pay for current or future qualified out-of-pocket health care expenses.
- This is a bank account and is not subject to the "use it or lose it" rule. Your funds remain in the account until you withdraw them.
- Because the account belongs to you, you take it with you if you change jobs, change your health plan, retire or change employment status without losing the money or the account.
- The money is yours to keep and spend on qualified health care expenses at any time.
- Your HSA contributions are tax-free, reducing your current taxable income. Your account may grow tax-free through investments. The money you withdraw from your HSA for qualified health care expenses is tax-free.

What Makes an HSA Unique?

1. The HSA is only available if you are enrolled in the HDHP. The money is yours, is held in an investment account and is portable; it goes with you to be used for qualified medical expenses if you leave LifeLock or when you retire.

2. If you are enrolled in the HDHP, you may not elect the Flexible Spending Account (FSA). However, you may still elect the Dependent Care FSA.

Additional HSA features

- Withdrawals from HSAs for qualified medical expenses are tax-free. If you withdraw money for any reason other than qualified medical expenses, you must pay income tax and are subject to an IRS tax penalty.
- You must have a balance in your account to make a withdrawal.
- The maximum you can contribute to an HSA in one year is set by the IRS (in 2015, $3,350 for single coverage and $6,650 for family coverage). If you are age 55 or older, you can contribute additional catch-up contributions. It is your responsibility to make sure your HSA contributions, including any employer contributions do not go over the IRS maximum.
- If you are age 55 or older, you may contribute an additional $1,000 annually.
- If you are enrolled in Medicare, you cannot contribute to an HSA.
Medical Plan Comparison

<table>
<thead>
<tr>
<th>PLAN TYPE</th>
<th>High Deductible Health Plan (HDHP)</th>
<th>Preferred Provider Organization (PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGHLIGHTS</td>
<td>Lower premium and out-of-pocket maximum, higher deductible and access to HSA contributions</td>
<td>Higher premium, lower deductible, higher out-of-pocket maximum and not eligible for HSA contributions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLAN NAME</th>
<th>BCBS HDHP</th>
<th>BCBS PPO $750</th>
<th>BCBS PPO $500</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLAN FEATURES</td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>Plan pays 100%</td>
<td>No coverage</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Family</td>
<td>$1,500</td>
<td>$3,000</td>
<td>$750</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000</td>
<td>$6,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>You pay 10%</td>
<td>You pay 50%</td>
<td>You pay 20%</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>Includes Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Family</td>
<td>$2,500</td>
<td>$5,500</td>
<td>$3,500</td>
</tr>
<tr>
<td>Family</td>
<td>$5,000</td>
<td>$10,000</td>
<td>$7,000</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>Deductible + 10%</td>
<td>Deductible + 50%</td>
<td>$20 Copay</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>Deductible + 10%</td>
<td>Deductible + 50%</td>
<td>$50 Copay</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Deductible + 10%</td>
<td>Deductible + 50%</td>
<td>$50 Copay</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>Deductible + 10%</td>
<td></td>
<td>$250 Copay</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>Deductible + 10%</td>
<td>Deductible + 50%</td>
<td>You pay 20%</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>Deductible + 10%</td>
<td>Deductible + 50%</td>
<td>You pay 20%</td>
</tr>
<tr>
<td>MRIs, PET &amp; CAT Scans</td>
<td>Deductible + 10%</td>
<td>Deductible + 50%</td>
<td>$250 per service</td>
</tr>
<tr>
<td>Prescriptions (30 day) Preventive Non-specialty Specialty</td>
<td>Covered at 100%</td>
<td></td>
<td>Same as copay</td>
</tr>
<tr>
<td></td>
<td>Deductible then: $10/$35/$60</td>
<td>Deductible then: 10%</td>
<td>$30 - $120</td>
</tr>
</tbody>
</table>

It is important to receive services from contracted, network providers. If you receive services from an out-of-network provider, the plans will only cover the coinsurance percentage based on 110% of Medicare’s allowable rate. A separate deductible and out-of-pocket maximum will apply. You will be responsible for any balance.
Prescription Drugs

Upon enrolling in a LifeLock medical plan, you will receive prescription drug benefits through Blue Cross Blue Shield. There is no need to enroll separately. Your cost for prescription drugs will depend on what type of prescription(s) you need: Level 1, 2 or 3 and/or Specialty Drugs Level A, B, C or D. The table below shows what your out-of-pocket cost will be for retail and mail order drugs.

BCBS Prescription Drug Coverage

| IN-NETWORK BENEFITS                  | BCBS HDHP           | BCBS PPO $750  
|--------------------------------------|---------------------|----------------
|                                      |                     | BCBS PPO $500 |
| Prescription Drugs (30-day supply)   | Covered 100%        | Level Copay   |
| Preventive                           |                     | $10           |
| Level 1                              | Deductible + $10    | $35           |
| Level 2                              | Deductible + $35    | $60           |
| Level 3                              | Deductible + $60    |               |
| Specialty Drugs                      | Deductible + 10%    | $30           |
| Level A                              |                     | $60           |
| Level B                              | Deductible + 10%    | $90           |
| Level C                              | Deductible + 10%    | $120          |
| Level D                              | Deductible + 10%    |               |
| Mail Order (90-day supply)           | Deductible + 2.5 x  | 2.5 x Copay   |

How Your Prescription Drug Coverage Works

Under the HDHP:

- Per IRS regulations, you are responsible for the full cost of your prescription drugs until you meet your medical deductible; then the copay applies.  
  *Note: Preventive medications are covered at 100%; no deductible applies.*

- Your prescription drug costs count toward your medical deductible AND out-of-pocket maximum.

- After you meet your medical out-of-pocket maximum, the plan will cover the full cost of your prescription drugs for the rest of the calendar year.

Under the PPO Plans:

- You will start paying prescription drug benefits based on the copay for the appropriate tier (no deductible applies).

- The copay amount you pay will count towards meeting your annual out-of-pocket maximum.
Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) can help you save money on eligible out-of-pocket medical, prescription drug, dental, vision and dependent care expenses. You must enroll in these accounts each year during the open enrollment period.

You may elect to participate in the following accounts:

**Health Care FSA** – can be used to pay for eligible health care expenses not covered by your medical, prescription drug, dental and vision plans (e.g. copayments, deductibles, eyeglasses, hearing aids and contacts.) You may contribute up from $100 to $2,550 pre-tax per year into this account. Over-the-counter medications are not reimbursable unless prescribed by a physician. Note: You do not need to be enrolled in a LifeLock medical plan to be eligible to participate in the FSA. However, employees who enroll in the High Deductible Health Plan (HDHP) cannot participate in the Health Care FSA.

**Dependent Care FSA** – Use this account to pay for eligible dependent day care expenses for a child (e.g., child care for children up to the age of 13) or an elderly parent. You may contribute up to $5,000 pre-tax per year to this account.

**New this Year!** – LifeLock is allowing you to carryover any unused FSA dollars up to $500 (per a new regulation) into the 2016 plan year.

**How an FSA Works**

You contribute pre-tax dollars through payroll deduction to these accounts during the year, and then draw money out to reimburse yourself for eligible expenses as you incur them. You never pay taxes on the money you contribute to an FSA. If you don’t use the money in your FSA during the calendar year, you will lose any balance over $500, so plan carefully.

1. Money is set aside from each of your paychecks before Federal, State or Social Security taxes are taken out. The money is then placed into your FSA.

2. When you have eligible expenses, you can use the money you’ve set aside in your FSA to pay the cost. And if you’ve paid the expense out of your pocket, you can reimburse yourself from your FSA.

The entire amount you elected to set aside under your Health Care FSA is available to you on the first day of the plan year.

The Dependent Care FSA works differently. You can only use dependent care FSA dollars as money becomes available in the account.
Blue Cross Blue Shield Resources

BlueNet®
You can check claims status and details, track deductibles, review your benefits, compare hospitals and find a contracted health care provider by name, specialty or location.

To register, go to: www.azblue.com/Member

Care Comparison
Compare costs for the most common procedures and choose providers based upon alternative procedures or treatments that may lower your out-of-pocket costs.

Prescription Cost Calculator
Learn about prescription costs by drug and/or pharmacy, find generic alternatives (if applicable) and compare the cost of retail and mail order.

Blue 365® Discounts
Discount program to help members live a healthier life that includes a broad range of products and services such as: fitness, nutrition, vision, hearing, alternative medicine, Jenny Craig, SNAP Fitness, Davis Vision and more.

Healthy Blue® Beginnings
This maternity support program offers preconception education, counseling and a free pregnancy kit. It also provides access to a maternity nurse toll-free telephone support line, 24/7 until the baby is six weeks old. Dedicated maternity nurses are available for high-risk pregnancies.

Member Mobile App
Download the app for quick, simple access to your personalized benefit information, ID Card, provider search and more at the tap of a button.

Nurse On Call®
866-422-2729
A telephone triage service that lets you speak directly with a registered nurse who can answer questions and help make an informed healthcare decision. The service is available 24/7/365 in English, Spanish and over 140 other languages (via translated services).

HealthyBlue®
877-MyHBlue (694-2583)
Access this integrated program in the BlueNet member portal to receive health-related tools, resources and services.

My BluePrint®
This is the BCBS online health assessment tool available to members. The tool provides a member with a report based on their responses to health related questions.

Unlimited Health Coaching
Members receive unlimited access to a Health Coach, who will provide a member with support in achieving their health goals through lifestyle and behavior changes. The program includes one-on-one support and guidance with setting goals and learning to maintain healthy habits.

WalkingWorks®
Track your steps and activities and set personal wellness goals online. Program participation is not restricted to members and is open to non-BCBS members as well. The website includes tips and resources to help participants stay motivated so they can reach their personal fitness goals.
Dental

LifeLock offers two dental plans through Delta Dental to eligible employees and their dependents.

With the dental plan, you may use any dentist, but if the dentist is not in the Delta Dental network, you will be responsible for any charges above what Delta Dental has agreed to pay.

Tip: If you or your dependents require extensive dental treatment, you are encouraged to ask the treating provider to submit a pre-determination of benefits to Delta Dental which estimates treatment costs and fees in advance.

Dental Plan Highlights

<table>
<thead>
<tr>
<th>IN-NETWORK BENEFITS</th>
<th>DELTA DENTAL BASE PLAN</th>
<th>DELTA DENTAL BUY-UP PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$50</td>
<td>$25</td>
</tr>
<tr>
<td>Family</td>
<td>$150</td>
<td>$75</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning</td>
<td>Covered 100%; Deductible waived</td>
<td>Covered 100%; Deductible waived</td>
</tr>
<tr>
<td>Oral Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-rays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Care</td>
<td>Deductible + 20%</td>
<td>Deductible + 20%</td>
</tr>
<tr>
<td>Major Care</td>
<td>Deductible + 50%</td>
<td>Deductible + 50%</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>$1,000 per patient lifetime maximum</td>
<td>$1,500 per patient lifetime maximum</td>
</tr>
<tr>
<td>Adult and Child</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The above benefits are in-network only. Please see benefits summary for out-of-network benefits.

Delta Dental Mobile App Now Available!

- Find a Dentist
- View your claims and coverage
- Email your ID card

*You can download the free app from Google Play or the iTunes App Store*
Vision

Whether your vision is 20/20 or less than perfect, everyone needs regular vision care. Routine eye exams can detect a number of serious health conditions such as glaucoma, cataracts and diabetes. That’s why LifeLock offers a vision benefit to all eligible employees. Our vision plan, provided by VSP, also allows you to add dependent coverage at a reasonable cost.

To find a VSP participating provider, log on to www.vsp.com or call 800-877-7195. When you make your appointment, simply tell them you are a VSP member, and your doctor will handle the rest.

Vision Plan Highlights

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>DESCRIPTION</th>
<th>COPAY</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Vision Exam</td>
<td>Focuses on your eyes and overall wellness</td>
<td>$20 for exam and glasses</td>
<td>Every calendar year</td>
</tr>
<tr>
<td>Prescription Glasses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frame</td>
<td>$150 allowance for a wide selection of frames</td>
<td>Combined with exam</td>
<td>Every calendar year</td>
</tr>
<tr>
<td></td>
<td>20% off amount over your allowance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenses</td>
<td>Single vision, lined bifocal, and lined trifocal lenses</td>
<td>Combined with exam</td>
<td>Every calendar year</td>
</tr>
<tr>
<td></td>
<td>Polycarbonate lenses for dependent children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lens Options</td>
<td>Standard progressive lenses</td>
<td>$55</td>
<td>Every calendar year</td>
</tr>
<tr>
<td></td>
<td>Premium progressive lenses</td>
<td>$95-$105</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Custom progressive lenses</td>
<td>$150-$175</td>
<td></td>
</tr>
<tr>
<td>Contacts (instead of glasses)</td>
<td>$150 allowance for contacts; copay does not apply</td>
<td>Up to $60</td>
<td>Every calendar year</td>
</tr>
<tr>
<td></td>
<td>Contact lens exam (fitting and evaluation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extra Savings and Discounts</td>
<td>Glasses and Sunglasses</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last Well Vision Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Laser Vision Correction</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The above benefits are in-network only. Please see benefit summary for out-of-network benefits.
Disability, Life and AD&D Insurance

LifeLock provides various disability and life insurance benefits so you have the resources you need to have "peace of mind" and critical financial protection for you and your family.

Basic Life and Accidental Death & Dismemberment (AD&D) Insurance coverage is provided through Hartford at no cost to you.

- Basic Life and AD&D Insurance is equal to one times your annual pay (as defined by the plan), rounded to the next $1,000 increment, up to $200,000.
- You can change your beneficiary designations at any time during the year by completing a Beneficiary Change through ADP.

What is AD&D Insurance?
Accidental Death and Dismemberment (AD&D) coverage pays a benefit equal to the Basic Life benefit amount if death was due to an accident. In this scenario, your beneficiary would receive both the Life and AD&D benefit. In addition, AD&D pays a benefit to you if a serious injury results in dismemberment.

Supplemental Life and AD&D
You have the option of purchasing additional Life and AD&D Insurance for yourself and dependents. If you waived coverage when you were first eligible and wish to enroll at a later date, you will have to submit an evidence of insurability (EOI) or have a qualifying event.

These benefits are 100% paid by you.

<table>
<thead>
<tr>
<th></th>
<th>EMPLOYEE</th>
<th>SPOUSE</th>
<th>DEPENDENT CHILD(REN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guarantee Issue</td>
<td>$200,000</td>
<td>$30,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Maximum Benefit</td>
<td>7 x base salary up to $500,000</td>
<td>50% of employee benefit</td>
<td>Elect $2,000, $5,000 or $10,000</td>
</tr>
<tr>
<td>Benefit Reduction Schedule</td>
<td>Age 65 – reduces 35% Age 70 – reduces 15%</td>
<td>Age 65 – reduces 35% Age 70 – reduces 15%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Guarantee Issue is only available to newly eligible employees enrolling in coverage for the first time.

Short-Term Disability (STD)
LifeLock provides Short-Term Disability (STD) at no cost to you. STD coverage provides a benefit equal to 60% of your base pay up to a weekly maximum of $2,000 for a period up to 180 days. If your claim for benefits is approved, the benefit is payable after a 7-day waiting period for injury and illness.

Long-Term Disability (LTD)
With Long-Term disability (LTD) coverage provided by LifeLock, you can receive a benefit equal to 60% of your base pay in the event you are unable to work due to a non-work-related injury or illness. With LTD, there is a 180-day elimination period. If the claim is approved, the coverage has a monthly maximum benefit of $10,000 and benefits are payable until age 65 or Social Security Normal Retirement Age (see Certificate of Coverage for specific details).
Other Benefits

Employee Assistance Program (EAP)

Available to all employees and eligible dependents at no cost to you.

For 2015, LifeLock is partnering with a new carrier, American Behavioral Employee Assistance Program (EAP).

This is a confidential assessment, counseling and referral service that can help you:

- Take charge of your finances
- Tackle legal issues
- Get a referral to a counselor
- Get help with childcare or eldercare
- Balance work and life

Online, video and telephone counseling is available. Each person can receive up to 6 face-to-face sessions per issue (up to two issues a year).

Pet Healthcare Program

Employees with household pets can sign up for this comprehensive pet healthcare program through United Pet Care.

There are three programs to choose from, ranging from a 10%-25% discount off vet services. Please visit http://lifelock.unitedpetcare.com for more information.
Contact Information

**MEDICAL**
Blue Cross Blue Shield (BCBS)
www.azblue.com
(602) 864-4400
(855) 801-4633

**HEALTH SAVINGS ACCOUNT (HSA)**
HealthEquity
www.helathequity.com
(866)-346-5800

**DENTAL**
Dental Delta
www.deltadentalaz.com
602-938-3131 option 1,
or 1-800-352-6132

**VISION**
VSP
www.vsp.com
800-877-7195

**FLEXIBLE SPENDING ACCOUNTS (FSAs)**
HealthEquity
www.helathequity.com
(866)-346-5800

**DISABILITY**
Hartford
www.thehartfordatwork.com
800-523-2233

**LIFE AND AD&D**
Hartford
www.thehartfordatwork.com
800-523-2233

**EMPLOYEE ASSISTANCE PROGRAM (EAP)**
American Behavioral
www.americanbehavioral.com (800) 925-5327

**PET HEALTHCARE PROGRAM**
United Pet Care
www.lifelock.unitedpetcare.com
AZ: (877) 872-8800
CA: (888) 781-6622
Important Compliance Notices

Important Notice from LifeLock, Inc. about your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with LifeLock, Inc. and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher premium.

LifeLock has determined that the prescription drug coverage offered through Blue Cross Blue Shield (BCBS), is on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current BCBS coverage will be affected. If you do decide to join a Medicare drug plan and drop your current BCBS coverage, be aware that you and your dependents may not be able to get this coverage back until the next open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with BCBS and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact the Human Resource Department for further information. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage under the LifeLock plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Women’s Health & Cancer Rights Act of 1998

As required by the Women’s Health & Cancer Rights Act of 1998, the medical plan options offered to you by LifeLock provides benefits for mastectomy-related services. These services include reconstruction of the breast involved in mastectomy, surgery and reconstruction of the remaining breast to produce symmetrical appearance, and prosthesis and treatment of physical complications at all stages of mastectomy (including lymphedemas). Please refer to your Summary Plan Description for details or contact your medical carrier at the number listed on your Medical ID card.

Newborns’ and Mothers’ Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following...
a Caesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother and her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain an authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information
When key parts of the health care law took effect in 2014, there were new ways to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January 1st of the following year.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.

An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. LifeLock’s health plan meets this criteria.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact humanresources@lifelock.com or call 480-457-5380.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

- Employer name: LifeLock, Inc.
- Identification Number (EIN): 56-2508977
- Employer address: 60 E Rio Salado Pkwy, 4th Fl, Tempe, AZ 85281
- Employer phone number: 480-457-5380
- Who can we contact about employee health coverage at this job?
  - Human Resources
  - Email address: humanresources@lifelock.com

As your employer, we offer a health plan to you if you are a full-time active employee (works at least 30 hours per week).

With respect to dependents, we offer coverage to your spouse, your eligible domestic partner, your children and your domestic partners children (up to age 26), your children of any age who are unable to support themselves due to a mental or physical disability.

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

HIPAA Notice of Privacy Practices
Amended and Restated Effective September 23, 2013
This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access To This Information. Please Review It Carefully.

Background
The Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act of 2009 (collectively “HIPAA”) and the implementing regulations govern group health plans use and disclosure of protected health information. HIPAA requires group health plans to maintain the
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privacy of your personally identifiable protected health information. In general terms, protected health information or "PHI" is health information that contains information like a name or social security number that reveals who the person is. In more detail, PHI means information that is created or received by a covered entity, including a "group health plan" and relates to a past, present or future physical or mental health or condition (including genetic information); the provision of health care; or the past, present or future payment for the provision of health care; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual.

LifeLock, Inc. (the "Company" or "LifeLock") sponsors and maintains certain benefit programs that meet the definition of "group health plan" under HIPAA. These include medical, pharmacy, dental, vision, and EAP benefits and the health care flexible spending account. Currently all of the health care components are provided through an HMO or insurance contract, except the medical plans and health care flexible spending accounts, which are self-funded. This Notice describes the privacy practices of the self-funded benefits sponsored by LifeLock, (currently only the health care flexible spending account but subject to change in future), and referred to in this Notice as the "Health Plan". Individuals receiving health care benefits through an HMO or insurance contract should receive a notice of privacy practices directly from the appropriate HMO or insurance company.

The Notice informs you about: (i) the Health Plan's uses and disclosures of PHI; (ii) your individual rights with respect to your PHI; and (iii) the Health Plan's legal duties with respect to your PHI. This Notice applies to the PHI the Health Plan maintains uses or discloses and the Health Plan is required to abide by the terms of this Notice. Again, your HMO, personal doctor, health care provider or insurance company may have different policies or notices regarding use and disclosure of your PHI. Also, it is important to note that these rules apply to the Health Plan, not LifeLock as an employer. Different policies may apply to other LifeLock benefit programs or data unrelated to the Health Plan.

NOTICE OF PHI USES AND DISCLOSURES

HOW THE HEALTH PLAN MAY USE AND DISCLOSE YOUR PHI

The Health Plan and it properly authorized business associates are required to disclose PHI to you (upon your request) and to the Secretary of Health and Human Services when the Secretary is investigating our compliance with HIPAA. We will also use and disclose PHI as we are permitted to by HIPAA. When using or disclosing PHI or when requesting PHI from another covered entity, we will make reasonable efforts to use, disclose or request the "minimum necessary" to accomplish the purpose. However, the “minimum necessary” standard does not apply to the following: (i) uses or disclosures made to you; (ii) uses or disclosures made pursuant an authorization; (iii) disclosures made to the Secretary of Health and Human Services; (iv) uses or disclosures required by law; (v) disclosures to or requests by a health care provider for treatment; (vi) uses or disclosures that are required for the Health Plan’s compliance with the Privacy Rule. Listed below are brief descriptions of uses and disclosures, including some examples.

To Business Associates. The Health Plan contracts with entities known as “business associates” to perform various functions or provide certain services. In order to perform these functions or provide these services, business associates will receive, create, maintain, transmit, use, and/or disclose PHI, but only after they agree in writing to implement appropriate safeguards regarding PHI. For example, PHI may be disclosed to a business associate to process a claim for benefits or reimbursements.

For Treatment. PHI may be used or disclosed to facilitate medical treatment or services by providers, including, coordination or management of health care and consultations and referrals between one or more of your providers. For example, the Health Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

For Payment. PHI may be used and disclosed for payment purposes, such as obtaining premiums, facilitating payments, making coverage determinations, coordinating coverage, or determining or fulfilling the Health Plan’s responsibilities for providing benefits. For example, the Health Plan may tell a provider whether you are eligible for specific benefits or share PHI with another entity to assist with the coordination of benefits.

For Health Care Operations. PHI may be used and disclosed for health plan operations such as, underwriting, premium rating, and other activities relating to coverage; conducting quality assessment and improvement activities; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general administrative activities. However, genetic information will not be used for underwriting purposes.

To Plan Sponsor. PHI may be disclosed to certain employees of LifeLock, the Plan Sponsor, to carry out plan administrative functions. Those employees will only use or disclose PHI as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you authorize further disclosures. Also, enrollment or de-enrollment information and "summary health information" (claims information for which names and other identifying information has been removed) for purposes of obtaining premium bids or for modifying, amending or terminating the Health Plan may also be disclosed to LifeLock. PHI cannot be used for employment purposes without your specific authorization.

As Required By Law, Law Enforcement, Lawsuits & Disputes. PHI may be disclosed when required by federal, state or local law, for example, when required by law enforcement (e.g. to identify/locate a suspect), a court or administrative order, subpoena, discovery request.

For Workers’ Compensation. PHI may be released for workers’ compensation or similar work-related injury or illness programs, to the extent necessary to comply with such law.

For Organ and Tissue Donation. PHI may be released to organizations that handle organ or tissue procurement, as necessary to facilitate organ or tissue donation and transplantation.

For Military Activity & National Security. PHI may be disclosed to authorized military authorities, authorized federal officials for intelligence, counterintelligence, and other national security activities.
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authorized by law.

For Health or Safety, Public Health Risks, Health Oversight Activities. PHII may be released when necessary to prevent a serious threat to health and safety, for public health activities as required or authorized by law, or to a health oversight agency for the government to monitor the health care systems, government programs, and compliance with civil rights laws, such as, audits, investigations, inspections, and licensure.

To Coroners, Medical Examiners & Funeral Directors. The Health Plan may release PHII to coroners, medical examiners or funeral directors as necessary to carry out their duties.

For Research. PHII may be disclosed to researches when individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information.

To Family & Friends. In certain cases, PHII can be disclosed to a family member or other person you identify who is involved in your care. Information about your location, general condition, or death may be provided to a similar person (or entity authorized to assist in disaster relief). You'll generally be given the chance to agree or object (although exceptions may be made, e.g., if you are not present or you are incapacitated). In addition, your PHII may be disclosed to your legal representative. With only limited exceptions, we send all mail to the employee's address, including mail relating to the employee's spouse and other family members.

OTHER USES OF YOUR PHI REQUIRE YOUR AUTHORIZATION

Other uses and disclosures of your PHII not covered by this Notice or applicable law will be made only with your written authorization. You may revoke such authorization in writing at any time. Once your revocation has been received and recorded, no further use or disclosure of the PHII covered by the authorization will be made. You understand that any use or disclosure made prior to the effective date of your revocation was authorized, cannot be undone, and that the Health Plan is required by HIPAA to retain records of such use and disclosure.

YOUR INDIVIDUAL RIGHTS

This section outlines your individual rights and how you can exercise those rights. In exercising your rights, you will generally need to make a written request directly to the appropriate business associate. Please contact the Benefits Department of LifeLock to obtain the appropriate business associate contact information or to exercise your rights directly with the Health Plan please submit your request or complaint in writing at Benefits Department c/o LifeLock, Inc., 60 E. Rio Salado Parkway, 4th Floor, Tempe, AZ 85281, (480) 457-538-2100. If you are exercising rights with respect to benefits provided through an HMO or insurance company you should make your request in writing to the appropriate entity in accordance with the procedures set forth in the notice you received from that HMO or insurance company.

Right to Inspect and Copy. You have the right to inspect and copy certain PHII maintained by the Health Plan. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format that you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your PHII, you must submit your request in writing as described above. If you request a copy of the information, you may be charged a reasonable fee for the costs of copying, mailing or other supplies associated with your request. Your request to inspect and copy may be denied, in certain limited circumstances. If your request is denied, you will be notified of the denial and of your rights, including your right to appeal the denial.

Right to Amend. If you feel that the PHII that the Health Plan has about you in a designated record set is incorrect or incomplete, you may request that it be amended. You have the right to request an amendment for as long as the information is kept by or for the Health Plan. To request an amendment, you must submit your request in writing as described above. Your request for an amendment must include a reason that supports your request. Your request may be denied if it does not include a reason supporting the request. In addition, your request may be denied if you ask to amend information that: (i) is not part of the information kept by, or for the Health Plan; (ii) was not created by the Health Plan unless the person or entity that created the information is no longer available to make the amendment; (iii) is not part of the information which you would be permitted to inspect and copy; or (iv) is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures made by the Health Plan during the 6 years prior to the date of your request. Your request must state the time period you want covered and indicate the form (e.g. paper or electronic) you want the accounting. However, such accounting is not required to include disclosures made to: (i) carry out treatment, payment or health care operations; (ii) to you about your own PHII; (iii) pursuant to an authorization; (iv) disclosures made to friends or family in your presence or because of an emergency; (v) incident to a permitted or required use or disclosure; (vi) for national security or intelligence purposes; and (vii) to correctional institutions or law enforcement officials, under certain circumstances. Your request for an accounting must be in writing as described above. The first list you request within a 12 month period will be free. There may be a charge for additional lists. If there is a charge, you will be notified in advance and you may modify or withdraw your request before any costs are incurred.

Right to Request Restrictions on PHI Uses and Disclosures. You are entitled to request, in writing, that the Health Plan restrict uses and disclosures of your PHII. However, except as provided below, the Health Plan is not required to agree to your request, and in order to appropriately manage your benefits, we generally do not to agree to requests for restrictions. However, under HIPAA we (as well as your health care provider) must comply with your request that health information regarding a specific health care item or service not be disclosed to the Health Plan for purposes of payment or health care operations (but not with respect to your treatment) if you have paid for the item or service, in full out of pocket. Should you wish to request restrictions, submit a written request to the appropriate party as described above.
Important Compliance Notices

Right to Request Confidential Communications. You have the right to request to receive communication of PHI by alternative means or at alternative locations (e.g. at work or a P.O. Box), if the disclosure of all or part of that information could endanger you. To request confidential communications, you must make your request in writing as outlined above. You will not be asked the reason for your request but may be asked to certify that you could be endangered. The Health Plan will accommodate all reasonable requests. You must specify how or where you wish to be contacted.

Right to be Notified of a Breach. You have the right to be notified in the event that the Health Plan, or a business associate, discovers a breach of unsecured PHI.

Your Right to File a Complaint with Plan or the Secretary of HHS. If you believe your privacy rights have been violated, you may file a complaint in writing with the Health Plan in care of the HIPAA Complaint Officer, c/o Benefits Department at LifeLock, Inc., 60 E. Rio Salado Parkway, 4th Floor, Tempe, AZ 85281. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services through the appropriate Office for Civil Rights. Further information may be obtained on the web at www.hhs.gov. The Health Plan will not retaliate against you for filing a complaint.

Right to a Paper Copy of this Notice. You may obtain a copy of this notice at our website http://intralock2.lifelock.com/bu/hr/Benefits/Forms/Benefit%20Type.aspx

You have the right to a paper copy of this notice. To obtain a paper copy of this notice, contact the LifeLock Benefits Department at humanresources@lifelock.com / 480-457-5380.

Who to Contact at the Health Plan for More Information. If you have any questions about this Notice or the subjects addressed in it, please contact the LifeLock Benefits Department at humanresources@lifelock.com / 480-457-5380.

RESERVATION OF RIGHT TO CHANGE THIS NOTICE

The Health Plan reserves the right to amend or change its privacy practices and this Notice. The Health Plan reserves the right to make the revised or changed privacy practices and Notice apply to any PHI received or maintained prior to the Effective Date as well as any information received or maintained in the future. If the Notice is revised it will be posted at http://intralock2.lifelock.com/bu/hr/Benefits/Forms/Benefit%20Type.aspx and provided to you in the Health Plan’s next annual distribution.

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if your or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents’ other coverage). However, you must request enrollment within 31 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also exist in the following circumstances:

• If you or your dependents experience a loss of eligibility for Medicaid or your State Children’s Health Insurance Program (SCHIP) coverage;

• If you or your dependents become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee’s portion of the health insurance premium.

Note: In the two above listed circumstances only, you or your dependents will have 60 days to request special enrollment in the group health plan coverage.

As stated earlier in this notice, a special enrollment opportunity may be available in the future if you or your dependents lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph above, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

To request special enrollment or obtain more information, contact your HR Department.

Premium Assistance under Medicaid and the Children’s Health Insurance Program

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for
Important Compliance Notices

premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2014. You should contact your State for further information on eligibility.

ALABAMA – Medicaid
Website:  http://www.medicaid.alabama.gov
Phone:  1-855-692-5447

ALASKA – Medicaid
Website:  http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage):  1-888-318-8890
Phone (Anchorage):  907-269-6529

ARIZONA – CHIP
Website:  http://www.azahcccs.gov/applicants
Phone (Outside of Maricopa County):  1-877-776-5437
Phone (Maricopa County):  602-417-5437

COLORADO – Medicaid
Medicaid Website:  http://www.colorado.gov/
Medicaid Phone (In state):  1-800-866-3513
Medicaid Phone (Out of state):  1-800-221-3943

FLORIDA – Medicaid
Website:  https://www.flmedicaidtplrecovery.com/
Phone:  1-877-357-3268

GEORGIA – Medicaid
Website:  http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone:  1-800-869-1150

IDAHO – Medicaid
Medicaid Website:  http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx
Medicaid Phone:  1-800-926-2588

INDIANA – Medicaid
Website:  http://www.in.gov/fssa
Phone:  1-800-889-9949

IOWA – Medicaid
Website:  www.dhs.state.ia.us/hipp/
Phone:  1-888-346-9562

KANSAS – Medicaid
Website:  http://www.kdheks.gov/hcf/
Phone:  1-800-792-4884

KENTUCKY – Medicaid
Website:  http://chfs.ky.gov/dms/default.htm
Phone:  1-800-635-2570

LOUISIANA – Medicaid
Website:  http://www.lahipp.dhh.louisiana.gov
Phone:  1-888-695-2447

MAINE – Medicaid
Website:  http://www.maine.gov/dhhs/ofi/public-assistance/index.html
TTY 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP
Website:  http://www.mass.gov/MassHealth
Phone:  1-800-462-1120

MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone:  1-800-657-3629

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone:  573-751-2005

MONTANA – Medicaid
Website:  www.ACCESSNebraska.ne.gov
Phone:  1-800-383-4278

NEBRASKA – Medicaid
Website:  www.ACCESSNebraska.ne.gov
Phone:  1-800-383-4278

NEVADA – Medicaid
Medicaid Website:  http://dwss.nv.gov/
Medicaid Phone:  1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website:  http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone:  603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:  http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone:  609-631-2392
CHIP Website:  http://www.njfamilycare.org/index.html
CHIP Phone:  1-800-701-0710

NEW YORK – Medicaid
Website:  http://www.nyhealth.gov/health_care/medicaid/
Phone:  1-800-541-2831

NORTH CAROLINA – Medicaid
Website:  http://www.ncdhhs.gov/dma
Phone:  919-855-4100
<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
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<tbody>
<tr>
<td>NORTH DAKOTA – Medicaid</td>
<td><a href="http://www.nd.gov/dhs/services/medicalserv/medicaid">Website</a></td>
<td>1-800-755-2604</td>
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<td>OKLAHOMA – Medicaid and CHIP</td>
<td><a href="http://www.insureoklahoma.org">Website</a></td>
<td>1-888-365-3742</td>
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<td>OREGON – Medicaid</td>
<td><a href="http://www.oregonhealthykids.gov">Website</a></td>
<td><a href="http://www.hijossaludablesoregon.gov">Website</a></td>
<td>1-800-699-9075</td>
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<td>PENNSYLVANIA – Medicaid</td>
<td><a href="http://www.dpw.state.pa.us/hipp">Website</a></td>
<td>1-800-692-7462</td>
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<td>RHODE ISLAND – Medicaid</td>
<td><a href="http://www.ohhs.ri.gov">Website</a></td>
<td>401-462-5300</td>
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<td>SOUTH CAROLINA – Medicaid</td>
<td><a href="http://www.scdhhs.gov">Website</a></td>
<td>1-888-549-0820</td>
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<td>SOUTH DAKOTA – Medicaid</td>
<td><a href="http://dss.sd.gov">Website</a></td>
<td>1-888-828-0059</td>
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<td>TEXAS – Medicaid</td>
<td><a href="https://www.gethipptexas.com/">Website</a></td>
<td>1-800-440-0493</td>
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<td>UTAH – Medicaid and CHIP</td>
<td><a href="http://health.utah.gov/upp">Website</a></td>
<td>1-866-435-7414</td>
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<td>VERMONT – Medicaid</td>
<td><a href="http://www.greenmountaincare.org/">Website</a></td>
<td>1-800-250-8427</td>
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<td>VIRGINIA – Medicaid and CHIP</td>
<td><a href="http://www.coverva.org/programs_premium_assistance.cfm">Website</a></td>
<td>Medicaid Phone: 1-800-432-5924&lt;br&gt;CHIP Phone: 1-866-873-2647</td>
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<td>WASHINGTON – Medicaid</td>
<td><a href="http://hrsa.dshs.wa.gov/premiumytmnt/Apply.shtm">Website</a></td>
<td>1-800-562-3022 ext. 15473</td>
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<td>WEST VIRGINIA – Medicaid</td>
<td><a href="http://www.dhhr.wv.gov/bms/">Website</a></td>
<td>1-877-598-5820, HMS Third Party Liability</td>
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<td>WISCONSIN – Medicaid</td>
<td><a href="http://www.badgercareplus.org/pubs/p-10095.htm">Website</a></td>
<td>1-800-362-3002</td>
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<td>WYOMING – Medicaid</td>
<td><a href="http://health.wyo.gov/healthcarefin/equalitycare">Website</a></td>
<td>307-777-7531</td>
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To see if any more States have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, you can contact either:

- **U.S. Department of Labor**<br>Employee Benefits Security Administration<br>[Website](http://www.dol.gov/ebsa)<br>1-866-444-EBSA (3272)

- **U.S. Department of Health and Human Services**<br>Centers for Medicare & Medicaid Services<br>[Website](http://www.cms.hhs.gov)<br>1-877-267-2323, Ext. 61565