QuinStreet, Inc. Health and Welfare Benefit Plan

Master Summary Plan Description

Amended/Restated Effective January 1, 2025

This document, together with the additional documents provided along with it, constitute the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the notice reproduced in Appendix B for more details.

Table of Contents

1. Definitions

Capitalized terms used in this document have the following meanings:

"AD&D" means accidental death and dismemberment insurance.

“Affordable Care Act” means the Patient Protection and Affordable Care Act, as amended.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Company" means QuinStreet, Inc. or any successor thereto, and any affiliated entity within the same controlled group, as that term is defined under section 414(b) of the Internal Revenue Code, that participates in the plan.

"DCAP" means a dependent care assistance program that may be established by the Company under a separate document. The DCAP is a benefit program under the Plan. It may allow you to use pre-tax dollars to pay for the care of your eligible dependents while you are at work. It is not subject to ERISA.

"Employee" means any common-law employee of the Company who satisfies the eligibility provisions of in this document and is not excluded from participation by the terms of an applicable benefit program, except individuals classified or treated by the Company as independent contractors (regardless of any subsequent reclassification), or as an employee of an employment agency.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"Health FSA" means a health flexible spending account plan that may be established by the Company under a separate document. The health FSA is a benefit program under the Plan. It allows you to use before-tax dollars to pay for most medical and dental expenses not reimbursed under other programs.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

"Plan" means the Company Health and Welfare Benefit Plan and includes this document, written amendments and updates to this document, and the terms of all policies and component benefit programs listed in Section 15.

"Plan Administrator" means the Company.

"SPD" means the Summary Plan Description required by ERISA § 102 summarizing this Plan and includes this document, information booklets supplied by insurance carriers, and other benefits descriptions provided to participants with this document or at any other period as appropriate to provide updates to the document, such as during open enrollment.

"WHCRA" means the Women's Health and Cancer Rights Act of 1998, as amended.

2. Introduction

The Company maintains the Plan for the exclusive benefit of eligible Employees and eligible family members or “dependents.” It is important that you share this document and the materials referenced here in with your covered dependents. The Plan provides health and welfare benefits through the benefit programs listed in Section 15. See Section 15 for a listing of benefit programs and the entities that help administer the programs.

Each of these benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another document (a "Benefit Description"). A Benefit Description will be available from the insurer (if the benefit is fully-insured) or Plan Administrator (if the benefit is self-funded). Whether a benefit program is fully-insured or self-funded is noted in Section 15.

This document and its attachments constitute the plan document required by ERISA § 402. This document and its attachments, coupled with the information booklets and other descriptive materials provided for benefits as described in Section 15 constitutes the wrap Summary Plan Description as required by ERISA § 102.

3. General Information about the Plan

Plan Name:	QuinStreet, Inc. Health and Welfare Benefit Plan
Type of Plan:	Welfare plan providing coverages listed in Section 15. The Plan also includes funding through a cafeteria plan under Code § 125.
Plan Year:	January 1 to December 31.
Plan Number:	501
Effective Date:	September 1, 1999. The Plan has been amended several times since its original effective date, most recently as of January 1, 2025.
Funding Medium and Type of Plan Administration:	Some benefits under the Plan are self-funded, and some are fully-insured. See Section 15 for a description of the benefit programs and whether they are self-funded or fully-insured. For benefit programs which are fully-insured, benefits are insured under a group contract entered into between the Company and insurance companies or HMO. The insurance companies and/or HMO, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the insurance companies and/or HMO for administering these program benefits, as described below. For benefit programs which are self-funded, the Company is responsible for processing and paying appropriate claims. The

	Company may hire a third party administrator (a "TPA") to process claims. Premiums for Employees and their eligible family members may be paid in part by the Company out of its general assets and in part by Employees' pre-tax and/or post-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the benefit programs, as applicable. The Company provides Employees the opportunity to pay for benefits on a pre-tax basis through a cafeteria plan. Appendix C provides information with regard to such a plan.
Plan Sponsor:	The employer is the Plan Sponsor. QuinStreet, Inc. 950 Tower Lane, 12th floor Foster City, CA 94404 1-650-578-7700
Plan Sponsor's Employer Identification Number:	77-0512121
Insurance Companies/HMO:	See a complete list under the heading Plan Provider Information later in this document.
Plan Administrator:	Attention: Employee Benefits & Compliance QuinStreet, Inc. 950 Tower Lane, 12th floor Foster City, CA 94404 1-650-578-7700
Named Fiduciary:	QuinStreet, Inc. 950 Tower Lane, 12th floor Foster City, CA 94404 1-650-578-7700
Agent for Service of Legal Process:	QuinStreet, Inc. 950 Tower Lane, 12th floor Foster City, CA 94404 1-650-578-7700 Service for legal process may also be made on the Plan Administrator.

Benefits hereunder may be provided pursuant to an insurance contract or pursuant to a governing document adopted by the Company. If so, these contracts are made a part of this Plan document, and the contracts and Plan document should be construed as consistent, if possible. If the terms of this Plan document conflict with the terms of such insurance contract or other governing document, then the terms of the insurance contract or governing document will control, with the exception of defining eligible employees and dependents, which is determined by the Company, unless otherwise required by law.

4. Eligibility and Participation Requirements

Eligibility and Participation

An eligible Employee with respect to the Plan will be an Employee who is eligible to participate in and receive benefits under one or more of the benefit programs. To determine whether you or your family members are eligible to participate in a benefit program, please see Section 15. Reclassification from non-employee to employee status by a court or any agency or by the Company will not create any retroactive right to coverage.

Certain benefit programs require that you make an annual election to enroll for coverage. ***Generally, you cannot enroll, drop coverage, or change your or your dependents coverage under the plan except during annual Open Enrollment.*** However, you may be able to add or drop coverage for yourself or a dependent during the plan year if you experience an event that triggers a HIPAA Special Enrollment Right (see discussion below) or if you have a Status Change Event (see Appendix C for an explanation of Status Change Events). Please review the rules for changing your benefits elections described in Appendix C very carefully as the rules regarding making benefits changes mid-year must be strictly enforced.

Information about enrollment procedures is provided by the Company. Information about when your participation begins in various benefit programs is found under Section 15. You must follow any required enrollment procedures. ***Always make sure the Company has your current home address and other contact information for you and your covered dependent to correctly administer your benefits and to send you important benefits information.***

Eligible Dependent Status

Section 15 describes whether your spouse and or child can participate in a particular benefit program. Section 15 also describes any limits on such participation. For example, children covered under the Medical benefit program generally can be covered until the end of the month during which they reach age 26. However, coverage may end earlier for other benefits (or may not be available at all). For specifics on eligibility for each benefit offered refer to Section 15. Note that the definition of dependent may be different for the different benefits offered under the Plan.

You cannot be covered both as an employee and as a dependent under the plan.

Full Time Status and the ACA

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee who works on average 130 hours per month. Employers may also face penalties if they do not offer major medical coverage to substantially all full-time employees or if the coverage they offer is unaffordable or does not meet a minimum value standard. The Company determines full-time status using the “monthly” method. ACA full-time status is not a guarantee of major medical benefits eligibility. Benefits eligibility is described in Section 15.

Special Enrollment Provisions under HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a special enrollment period for the Medical benefit program (or similar benefit programs providing medical benefits) may be available, usually if you lose medical coverage under certain conditions or when you acquire a new dependent by marriage, birth, or adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you declined enrollment in the Plan for yourself or your dependents (including a spouse) because of coverage under Medicaid or a State Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

Finally, if you declined enrollment in the Plan for yourself or your dependents (including a spouse), and you or a dependent later becomes eligible for state “premium assistance” through Medicaid or a State Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance. ***Medicaid and State Children's Health Insurance Program premium assistance are not available with respect to coverage under a health FSA or a high-deductible health plan. Thus, this special enrollment event will not apply to such plans.***

Coverage during Certain Leaves of Absence

Certain Federal (and State) statutes like the Family and Medical Leave Act (FMLA) require that eligibility for medical benefits continue for employees on those protected leaves of absence under the same terms as active employees. When wages continue during such a leave, your contributions will be deducted from those wages on a pre-tax basis. When such leave is unpaid, QuinStreet offers several options for paying your premiums. You can opt to pre-pay your benefits on a pre-tax basis, by increasing the amount of your payroll deductions prior to taking a leave. You can request that QuinStreet pay your portion of the premiums while you are on leave then make-up any missed premiums via pre-tax payroll deductions when you return.

Alternatively, your portion of the premium may be paid as regular monthly intervals during the leave on a post-tax basis.

The Employee Benefits & Compliance team must determine whether or not you are eligible for a statutory or other leave of absence.

Terms of Participation

Your participation and the participation of your spouse and dependents in a benefit program will terminate according to the terms of the specific benefit program. Generally, coverage for most benefit programs terminates on the last day of the month in which you terminate employment, but certain benefit programs may provide coverage only through the date your employment terminates. Please see Section 15 for further information on the date participation in a specific benefit program will terminate.

Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below the required hourly threshold for the particular benefit, if you engage in fraud or make an intentional misrepresentation of a material fact, or for any other reason as set forth in the attached documents. You should consult Section 15 for a general summary and the attached documents for specific termination events and information.

Coverage may be terminated retroactively in the normal course of business due to a participant's termination of employment, nonpayment of premiums, loss of dependent eligibility or other, similar factors. When you or a dependent lose eligibility for benefits, regardless of whether or not you timely report that loss of eligibility, a change to any existing salary reduction election will be made automatically. To the extent that the coverage at issue does not allow for retroactive termination of that coverage and election to the date of the loss of eligibility, such changes will be prospective. If coverage can be terminated retroactively to the date of the loss of eligibility, or sometime thereafter, excess salary reduction contributions will be refunded on a post-tax basis to the date the termination of coverage can be made effective.

Any person claiming benefits under the Plan shall furnish the Company, any insurance company or other entity working on behalf of the Plan or a benefit program with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan or a benefit program. This may include but is not limited to providing social security numbers, birth certificates, marriage certificates, or proof of dependent eligibility. Failure to cooperate and provide such information will lead to a loss of eligibility for benefits.

Knowingly enrolling an ineligible dependent in plan benefits constitutes fraud and is considered a material misrepresentation that will result in termination of coverage as well as other disciplinary action up to and including termination of employment. Eligibility for benefits is described in Section 15. If you have questions about whether a dependent is eligible you must contact Employee Benefits & Compliance before enrolling that dependent.

COBRA Rights

You may be eligible for COBRA continuation coverage or conversion policies when your coverage for a medical benefit program under this Plan terminates. Information about continuation coverage or conversion is contained in Appendix A. If you have questions about this law or these rights, please contact the Plan Administrator (for benefit programs that are self-

funded) or the insurance carrier (if the benefit is fully-insured). You can determine whether a benefit program is self-funded or fully-insured by consulting Section 15.

For the Health FSA benefit program, COBRA continuation coverage is available if your account is underspent (if the COBRA premium for the account (the monthly salary reduction election + 2%) for the remainder of the coverage period is less than the account's balance) but generally cannot extend beyond the end of the Plan Year (including any 2½ month grace period). COBRA continuation coverage will not be offered with respect to the Health FSA benefit program if your Health FSA is overspent, unless otherwise required by applicable law.

5. Summary of Plan Benefits

Benefits and Contribution

The Plan provides you and your eligible spouse and dependents with the benefit programs listed in Section 15. A summary of each benefit program provided under the Plan may be provided in the attached documents (such as a certificate of insurance booklet, summary plan description for a specific benefit program or other governing document).Note that some of the attached documents may be labeled as a "summary plan description." If so, that document will only be a summary of the specific benefit program to which it relates. Notwithstanding any of the terms of such a document, that document is not the formal, single "Summary Plan Description" for this Plan. Rather, this document constitutes the formal, single "Summary Plan Description."

The cost of the benefits provided through the benefit programs may be funded in part by Company contributions and in part by pre-tax and/or post-tax employee contributions. The Company will determine and periodically communicate your share of the cost, if any, of the benefit programs. The Company reserves the right to change that determination.

The Company will make its contributions, if any, in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and your contributions to any insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to, or on behalf of, you or your eligible family members from the Company's general assets. Your contributions toward the cost of a particular benefit program will be used in their entirety prior to using Company contributions to pay for the cost of such benefit program.

Medical benefits under this Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, annual or lifetime limits, pre-authorization requirements or utilization review. There may also be limitations on the selection of primary care or network providers, limits on emergency medical care, or limited coverage for preventive services, drugs, medical tests, medical devices or medical procedures. These limitations are set forth in the attached documents.

Certain prescription drug benefits are considered “Creditable Coverage” under Medicare Part D. The attached documents provide details regarding this coverage and an annual notice (attached and incorporated by reference in Appendix B) explains how this creditable coverage works for these prescription drug benefit programs.

The Plan will provide benefits in accordance with the requirements of all applicable Federal laws regulating group health plans, such as COBRA, HIPAA, NMHPA,WHCRA and the Affordable Care Act. A brief summary of some of these laws is below.

Newborns' and Mothers' Health Protection Act (NMHPA) 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 cesarean 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 or 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 authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act (WHCRA) of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

Qualified Medical Child Support Orders

Group health plans and health insurance issuers generally must provide benefits as required by any qualified medical child support order, or "QMCSO." The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Lifetime and Annual Limits

Lifetime or annual limit on the dollar value of "essential health benefits" are no longer permitted under the major medical plans offered by the Plan. For more information on "essential health benefits" refer to the terms of policies and benefit program materials listed in Section 15. These documents are provided to you during enrollment and are available from Employee Benefits & Compliance, the insurer (if the benefit is fully-insured), or Plan Administrator (if the benefit is self-funded).

6. Grandfathered Status under the Affordable Care Act

Non-Grandfathered Benefit Programs under the Affordable Care Act

The following benefit programs that provide health benefits are not “grandfathered health plans” under the Affordable Care Act:

- Cigna CDHP
- Cigna PPO
- Cigna EPO
- Kaiser HMO (CA)
- Kaiser HMO (OR)

These benefit programs must, under the Affordable Care Act, provide additional protections. The protections provided by the Affordable Care Act include the following:

Preventive Services covered at 100%

In-network preventive care services will be covered at 100% with no cost sharing (e.g., copayment, coinsurance percentage, deductible, etc.). Preventive services include those services outlined in the US Preventive Services Taskforce recommendations (services rated “A” or “B”). Please see the attached documents for the preventive services included at no cost share.

Non-Network Emergency Services covered as In-Network

Emergency services must be covered without the need for prior authorization, regardless of the participating status of the provider or facility, and at the in-network cost sharing level.

Access to Primary Care Physicians

The Affordable Care Act generally allows participants the right to designate any primary care provider who participates in the network and who is available to accept the participant and his or her family members. If the benefit program requires that a primary care provider be designated, but one is not designated, the benefit program or a health insurance issuer will designate one until the participant or family member makes such a designation.

- For children, you may designate a pediatrician as the primary care provider.
- You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

7. How the Plan Is Administered

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The Plan Administrator is a named fiduciary within the meaning of ERISA § 402 and has full discretionary authority to administer the Plan, to interpret the Plan, and to determine eligibility for participation and for benefits under the terms of the Plan. However, insurers and parties that have entered into administrative service agreements (Third Party Service Providers or TPAs) assume sole responsibility for their performance under applicable policies or administrative services agreements and, under ERISA, may be fiduciaries with respect to their performance.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. (However, as noted below, one or more insurance companies may have these responsibilities with respect to fully-insured benefits.)

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Power and Authority of Insurance Company

As detailed in Section 15, certain benefits under the Plan may be fully insured. The insurance companies are responsible for: (1) determining eligibility for and the amount of any benefits payable under their respective benefit programs, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective benefit programs.

Questions

If you have any general questions regarding the Plan, or your eligibility for or the amount of any benefit payable under any benefit program, please contact the Plan Administrator or the appropriate insurance company as applicable.

8. Circumstances Which May Affect Benefits

Denial or Loss of Benefits

Your benefits (and the benefits of your eligible spouse and dependents) will cease when your participation in the Plan terminates. See Section 15. Your benefits will also cease on termination of the Plan.

Right to Recover Benefit Overpayments and Other Erroneous Payments

The Plan and its benefit programs (including any insurance company on behalf of a benefit program) have all necessary or helpful rights to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan, the recipient of such benefit (the "Recipient") shall be responsible for refunding the overpayment to the Plan or insurance company to the fullest extent permitted by law. In addition, if the Plan or insurance company makes any payment that, according to the terms of the Plan, policy or contract should not have been made, the insurance company, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurance company's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Plan Administrator or insurance company, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Any benefit payments or reimbursements made by check must be cashed or deposited within one year after the check is issued. If any check or other payment for a benefit is not cashed or deposited within one year of the date of issue, the Plan will have no liability for the benefit payment and the amount of the check will be deemed a forfeiture. No funds will escheat to any state.

9. Amendment or Termination of the Plan

Amendment or Termination

The Plan and any benefit program under the Plan may be amended or terminated at any time, in the sole discretion of the Company as Plan sponsor, by a written instrument signed by an authorized individual. Some benefit programs may also be amended or terminated by an insurance carrier, as more fully described in any attached documents from an insurance carrier. The policies and agreements may also be amended or terminated at any time in accordance with their terms. No individual (including a retired employee) shall have a right to continuing benefits except to the extent required by law.

10. No Contract of Employment

The Plan is not intended to be, and may not be construed as, constituting a contract or other arrangement between you and the Company to the effect that you will be employed for any specific period of time.

11. No Assignment

Except as may otherwise be specifically provided in this Plan, the benefit programs, or applicable law, an individual's rights, interests or benefits under this Plan or the benefit programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the benefit programs, and any such attempt shall be void.

Specifically, participants and beneficiaries covered under this plan cannot assign their rights to medical providers to pursue direct payment of claims either as the participant or beneficiaries' agent or under power of attorney. Under the terms of this plan, medical providers cannot take action enforcing a patient's right to recover benefits under ERISA or assert any claims under ERISA on behalf of patients, even where the patient(s) have assigned their rights to their medical providers.

12. Claims Procedure

Claims for Fully-Insured Benefits

For purposes of determining of the amount of, and entitlement to, benefits of the benefit programs provided under insurance contracts or policies, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to benefits.

To obtain benefits from the insurer of a benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form.

The insurance company will decide your claim in accordance with its reasonable claims procedures as required by ERISA.

See the appropriate certificate of insurance or booklet for details regarding the insurance company's claims procedures. You must fully follow and exhaust these claims procedures before you can file a lawsuit in state or federal court. You may have a right to seek external review of your claims, if so noted in the applicable insurance contract or policy.

Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the benefit programs which are self-funded, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan.

To obtain benefits from a benefit program which is self-funded you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence, as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. You may have a right to seek external review of your claims, if so noted in the applicable attached document for the self-funded benefit program.

See the appropriate benefits description for information about how to file a claim and for details regarding the claims procedures applicable to your claim. You must fully follow and exhaust these claims procedures before you can file a lawsuit in court.

The Role of Authorized Representatives

Under ERISA and the ACA participants and beneficiaries have the right to designate an Authorized Representative for certain purposes. These purposes are generally limited to requesting documents or other information on behalf of a participant or beneficiary or acting on their behalf during claims and appeals procedures that can follow an adverse benefits determination. In any situation that does not constitute an urgent care claim, to designate any third party as an Authorized Representative a participant or beneficiary must use the signed statement included as an appendix of this document with the required witness signature. A medical provider will not become a participant or beneficiary's Authorized Representative as a result of an attempt to secure an assignment of benefits. The Plan does not guarantee that any purported assignment will be valid under the terms of the Plan.

13. Statement of ERISA Rights

This Statement of ERISA Rights applies to those benefit programs which are subject to ERISA. Not all benefit programs which are part of this Plan will be subject to ERISA. The following benefit programs are not subject to ERISA: Cafeteria plan and DCAP.

Your Rights

As a participant in an ERISA plan you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;
- obtain copies of the benefit program documents and other program information on written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies);
- receive a summary of the Plan's annual financial report, if any (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report);
- continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the

documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Fiduciary Obligations

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the benefit program. These people, called "fiduciaries" of the program, have a duty to operate the program prudently and in the interest of you and other program participants. Fiduciaries who violate ERISA may be removed and may be required to reimburse the Plan for any losses they have caused the program.

No Discrimination

No one, including the Company or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.

Right to Review

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan Administrator review and reconsider your claim.

Filing Suit

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan 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 Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a court.

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of the internal claims and appeals procedure is required prior to filing suit.

If it should happen that benefit program fiduciaries misuse the Program'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 (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Questions

If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, 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. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

14. General Information

COBRA

Benefit programs which provide health benefits generally are subject to the federal law known as COBRA. COBRA generally allows covered participants and beneficiaries to continue in the benefit program, even after a "qualifying event" occurs. For more information about COBRA please see Appendix A. You may also have state law continuation or conversion rights.

Subrogation and Reimbursement

If an individual has a claim for benefits under this Plan or any benefit program, and that individual acquires any right or action against a third party for the person's injury, sickness or other illness which is so covered, then: (a) the Plan shall be entitled to reimbursement for such benefits from such third party up to 100% of the benefits paid by the Plan; and (b) the Plan is automatically subrogated to all such rights or claims of the covered person. The covered person shall cooperate fully with the Plan in the enforcement of the Plan's subrogation and reimbursement rights. In addition, the person shall permit suit to be brought in the person's name under the direction of and at the expense of the Company if the Company so chooses. The Plan shall not be liable for such a person's attorney's fees absent prior written approval from the Plan. The Plan Administrator may require the receipt of a signed and dated subrogation and reimbursement agreement from the person before advancing any monies.

The failure or refusal of a covered person to fully cooperate with the Plan in the enforcement of the Plan's subrogation and reimbursement rights shall result in a forfeiture of all benefits payable to that person, even if such benefits have already been paid, in which event the Company shall retain a right to recover paid benefits which are forfeited in such a manner.

The Company, on behalf of this Plan, shall have a first priority right to recover from and a lien against any payment, whether designated as a payment for medical benefits or any other type of damages, from the proceeds of any recovery, including but not limited to any settlement, award or judgment which results from a claim or lawsuit by or on behalf of a covered person who received benefits under this Plan (even if such covered person is not made whole). The plan is not required to contribute to any expenses or fees (including attorney's fees or costs) incurred in obtaining the funds. The plan's recovery will not be limited or reduced by doctrines (equitable or other) including but not limited to, the make-whole doctrine, contributory or comparative negligence, or the common fund doctrine. The plan's right to full recovery is not reduced if settlement funds or other payments to you are spent or no longer in an individual's possession or control. Notice of the Plan's claim shall be sufficient to establish this Plan's lien against the third party or insurance carrier. The Company shall be entitled to deduct the amount of the lien from any future claims payable to or on behalf of the covered person or payee if the covered person or payee fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to this Plan's subrogation and reimbursement rights.

In the event that the Plan obtains a recovery against a third party in excess of payments made to or on behalf of the covered person and reasonable out of pocket expenses of the recovery, then the Plan shall pay to the covered person that excess amount recovered by the Plan.

In the event of any direct conflict between this Section 13 and the subrogation and reimbursement provisions in any benefit program, the subrogation and reimbursement provisions in the benefit program shall control. Otherwise, the provisions of this Section 13 shall apply and may supplement those contained in any benefit program.

The above provisions of this "Subrogation and Reimbursement" section apply with respect to a benefit program that is self-funded and does not, in its governing documents (but excluding this Plan document) have a subrogation and reimbursement section. If the benefit program does have such a section that section shall control. With respect to a fully-insured benefit program, the contract or policy from the insurer shall control with respect to subrogation and reimbursement matters.

No Vesting of Benefits

Nothing in the Plan, nor anything in any benefit program, shall be construed as creating any vested rights to benefits in favor of any employee, former employee or covered person.

Waiver and Estoppel

No term, condition, or provision of this Plan or any benefit program shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan or benefit program, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No covered person other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purposes.

Effect on Other Benefit Plans

Amounts credited or paid under this Plan or any benefit program shall not be considered to be compensation for purposes of any benefit program hereunder or any qualified or nonqualified pension plan maintained by the Company unless expressly provided in such benefit program or qualified or nonqualified pension plan, as applicable, or if required by applicable law. The treatment of amounts paid under this Plan or any benefit program for purposes of any other employee benefit plan maintained by the Company shall be determined under the provisions of the applicable employee benefit plan.

Severability

If any provision of this Plan or any benefit program is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

Rebates

In some situations, a rebate may be paid by an insurance company which provides coverage under the Plan. For example, a rebate may be provided under the Medical Loss Ratio ("MLR") rules, which are part of the Affordable Care Act. Except as specifically and unambiguously provided in a Benefit Description, or as otherwise required by applicable law, any rebate from any source will be:

☐ Considered an asset of the Company, not the Plan. The Company does not need to use such a rebate to benefit Employees, participants or beneficiaries. The Company can use such a rebate for the Company's own purposes

☒ An asset of the Plan in proportion to how much of the rebate relates to Employee, participant, or beneficiary contributions. The portion relating to Company contributions shall not be considered a Plan asset. The Company will have the ability to make certain assumptions or minor changes (such as rounding to the nearest $1 or $10) when determining the amount which is considered a plan asset. The Company shall have discretion to determine how to use all amounts. Amounts which are plan assets will be used to benefit individuals selected by the Company. This group of individuals may not be identical to the group which relates to the rebate. In addition, certain individuals can receive the rebate (or the benefit of the rebate) even if the rebate related to a different benefit, to the extent allowed by applicable law.

☐ The entire amount shall be an asset of the Plan, to be used for the benefit of individuals covered by the Plan.

In all situations where ERISA applies the use of any ERISA-covered plan assets will be governed by applicable law, including but not limited to U.S. Department of Labor Technical Release 2011-04.

Controlling Law

This Plan shall be administered, construed, and enforced according to the federal law and the laws of the State of California, to the extent not preempted by federal law. However, with respect to a fully-insured benefit program, the applicable insurance policy or contract will control with respect to which state's laws apply.

15. Benefit Program Information

Summary of Eligibility and Participation Provisions

Note: If you have any questions about eligibility or participation, contact the Plan Administrator

Provider Plan funding	Plan coverage type	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends[1]	To File a Claim, Contact:
Kaiser Foundation Health Plan, Inc. Fully Insured	Medical HMO (CA)	602550	Full time employees regularly working 30+ hours per week.	First day of month following date of hire	End of month following date of termination	Kaiser at: P.O. Box 12923 Oakland, CA 94604-2923 (800) 464-4000
Kaiser Foundation Health Plan, Inc. Fully Insured	Medical HMO (OR)	19880	Full time employees regularly working 30+ hours per week.	First day of month following date of hire	End of month following date of termination	Kaiser at: 500 NE Multnomah Street, Suite 100 Portland, OR 97232 (800) 813-2000
Cigna Health and Life Insurance Company Fully insured	Medical CDHP, EPO, PPO	3345397	Full time employees regularly working 30+ hours per week.	First day of month following date of hire	End of month following date of termination	Cigna at: P.O. Box 182223 Chattanooga, TN 37422-7223 (800) 244-6224
Cigna Fully insured	Dental PPO	3345397	Full time employees regularly working 30+ hours per week.	First day of month following date of hire	End of month following date of termination	Cigna Dental at: P.O. Box 188037 Chattanooga, TN 97422-8037

[1] Other Events (such as fraud or intentional misrepresentation of a material fact) can also terminate coverage -- see the benefit program details.

Provider Plan funding	Plan coverage type	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends[1]	To File a Claim, Contact:
						(800) 244-6224
Vision Service Plan Fully insured	Vision	12135824	Full time employees regularly working 30+ hours per week.	First day of month following date of hire	End of month following date of termination	VSP at: 3333 Quality Drive - Mailstop 131 Rancho Cordova, CA 95670 (800) 877-7195
ACI Specialty (via Reliance) Fully insured	EAP	RSLI859	Full time employees regularly working 30+ hours per week. All members of household are generally covered under the plan	First day of month following date of hire	End of month following date of termination	ACI at: (855) 775-4357
Reliance Standard Life Insurance Company Fully insured	Life AD&D STD LTD	GL135744 VAR205646 158041 109640	Full time employees regularly working 30+ hours per week	First day of month following date of hire	Date of termination	Reliance Standard at: (800) 351-7500
Chubb/Europ Assistance Self funded	Business Travel Accident	9908-93-99	Full time employees regularly working 30+ hours per week	First day of month following date of hire	Date of termination	Chubb at: U.S: 1 (800) 243-6124 Outside U.S: 1 (202) 659-7803
Navia Benefit Solutions Self funded	Flexible Spending Account	QUI	Full time employees regularly working 30+ hours per week	First day of month following date of hire	Date of termination	Navia at: P.O. Box 53250 Bellevue, WA 98015 (800) 669-3539
Spring Health Fully Insured	Mental Health	QuinStreet	Full time employees regularly working 30+ hours per week	First day of month following date of hire	End of month following date of termination	Spring Health at: careteam@springhealth.com (855) 629-0554

Appendix A: COBRA Continuation

The following pages contain the COBRA Initial Notice.

Navia Benefit Solutions
COBRA INFORMATION ENCLOSED
P.O. Box 3961
Seattle, WA 98124

5/19/2020

Jelly Bean & Family
123 Anywhere
Renton, WA 98057

Dear Jelly Bean & Family:

GENERAL NOTICE OF YOUR RIGHTS
GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

THIS LETTER IS FOR YOUR INFORMATION ONLY. PLEASE RETAIN FOR FUTURE REFERENCE.
THERE HAS NOT BEEN A CHANGE IN YOUR STATUS WITH YOUR COMPANY.

This letter contains important information about your employee benefits plan(s). Please read the entire letter.

On April 7, 1986, a federal law called COBRA was enacted (Public Law 99-272, Title X), requiring that most employers sponsoring group health plans offer employees and their families (qualified beneficiary/ies) the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights as a qualified beneficiary and obligations under COBRA. Both you and your spouse, if applicable, should take the time to read this notice carefully. This notice does not fully describe COBRA or other rights under the NaviGators group health plan ("Group Health Plan"). For additional information you should review the Group Health Plan's "Summary Plan Description" or contact the NaviGators Plan Administrator at (111) 111-1111. Also, you may visit the Department of Labor website (www.dol.gov) for more information on COBRA. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Qualifying Events

If you are an employee of NaviGators covered by the Group Health Plan, you have a right to choose COBRA if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the Group Health Plan, you have the right to choose COBRA for yourself if you lose group health coverage under the Group Health Plan for any of the following reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with NaviGators;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by the Group Health Plan, he or she has the right to choose COBRA if the Group Health Plan is lost for any of the following reasons:

1. The death of the employee;
2. A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment with NaviGators;
3. The employee's divorce or legal separation;
4. The employee became entitled to Medicare prior to his/her qualifying event; or
5. The dependent child ceases to be a dependent child under the Group Health Plan.

Sometimes, filing a bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to NaviGators and that bankruptcy results in the loss of coverage of any retired employee under the Group Health Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Group Health Plan.

You may have other options available to you 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.

Coverage Provided

Under COBRA, the employee or a family member has the responsibility to inform the NaviGators Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Group Health Plan within 60 days of the date of the event. NaviGators has the responsibility to notify the administrator of the employee's death, termination, and reduction in hours of employment or Medicare entitlement. When the administrator is notified that one of these events has happened, the administrator will in turn notify you that you have the right to choose COBRA. Under COBRA, you have at least 60 days from the later of the date you would lose coverage because of one of the qualifying events described above or the date of notification of your rights under COBRA, whichever is later, to inform the NaviGators Plan Administrator that you want to continue coverage under COBRA.

If you elect COBRA, NaviGators is required to give you and your covered dependents, if any, coverage that is identical to the coverage provided under the plan to similarly situated employees or family members. Under COBRA, you may have to pay all or part of the premium for your continuation coverage. If you do not choose COBRA on a timely basis, your group health insurance coverage will end.

Period of Coverage

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA requires that you be afforded the opportunity to maintain coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required COBRA period is 18 months. Also, if you or your spouse gives birth to or adopts a child while on COBRA, you will be allowed to change your coverage status to include the child. The 18-month period may be extended to 29 months if an individual is determined by the Social Security Administration (SSA) to be disabled (for Social Security purposes) as of the termination or reduction in hours of employment or within 60 days thereafter. To benefit from this extension, a qualified beneficiary must notify the NaviGators Plan Administrator of that determination within 60 days and before the end of the original 18-month period. The affected individual must also notify the NaviGators Plan Administrator within 30 days of any final determination that the individual is no longer disabled. If the original event causing the loss of coverage was a termination (other than for gross misconduct) or a reduction in hours, another extension of the 18-month continuation period may occur, if during the 18 months of COBRA coverage, a qualified beneficiary experiences certain secondary qualifying events:

1. Divorce or legal separation
2. Death
3. Medicare entitlement
4. Dependent child ceasing to be a dependent

If a second qualifying event does take place, COBRA provides that the qualified beneficiary may be eligible to extend COBRA up to 36 months from the date of the original qualifying event. If a second qualifying event occurs, it is the qualified beneficiary's responsibility to inform the NaviGators Plan Administrator within 60 days of the event. In no event, however, will COBRA last beyond three years from the date of the event that originally made the qualified beneficiary eligible for COBRA.

Health FSA Information

COBRA coverage under the NaviGators Health FSA will be offered only to Qualified Beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for the NaviGators Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the NaviGators Health FSA coverage in force at the time of the qualifying event. The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and the COBRA coverage for the FSA plan will terminate at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the NaviGators Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact Navia Benefit Solutions at (425) 452-3490 during business hours for more information.

Alternate Recipients Under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by NaviGators during the covered employee's period of employment with NaviGators is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Are there other coverage options besides COBRA Continuation Coverage

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family 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.

Plan Contact Information

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

To ensure that all covered individuals receive information properly and timely, it is important that you notify our Customer Service Department at (425) 452-3490 of any change in dependent status or any address change of any family member as soon as possible. Certain changes must be submitted to us in writing. Failure on your part to notify us of any changes may result in delayed notification or loss of continuation of coverage options.

If you have any questions about COBRA, please contact our Customer Service Department at (425) 452-3490 during business hours.

Sincerely,

Navia Benefit Solutions

NaviGators
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT WAIVER OF ENROLLMENT NOTIFICATION REVISED 11/97

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you and/or your dependents, if any, waive coverage due to coverage under another plan, and desire to participate in the plan offered at a later date, coverage may be subject to treatment as a late enrollee. If you decline enrollment for yourself or your dependents (including your spouse), you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after such marriage, birth of a child or placement of a child for adoption.

PRE-EXISTING CONDITION EXCLUSION

A pre-existing condition is an injury or sickness which was diagnosed or treated or for which prescription medications or drugs were prescribed or taken within the six months ending on the person's date of hire. A pre-existing condition does not include pregnancy or apply to newborn children or newly adopted children. To shorten or eliminate the period of time during which the pre-existing condition applies, you have the right to provide evidence of continuous creditable coverage. Any or all of the plans that provide prior coverage must give you a Certificate of Creditable Coverage. If necessary, the insurance carrier of this employer will assist in obtaining this certificate from the prior coverage. You will be notified of any pre-existing condition exclusion period, if one applies, upon receipt of a Certificate of Creditable Coverage. Limited or no coverage is provided for eligible expenses which result from a pre-existing condition until the earlier of the date you have had continuous creditable coverage for a period of six consecutive months and have not received treatment for the pre-existing condition or the date you have had continuous creditable coverage for 12 months. (NOTE: Under the Affordable Care Act, a group health plan must eliminate any pre-existing condition limitations as of the first day of the plan year that begins in 2014.)

CERTIFICATE OF CREDITABLE COVERAGE

If you have a Certificate of Creditable Coverage you should attach it to your enrollment form and submit it to your group administrator for processing. If you receive the certificate after submitting your enrollment form, please forward it to your group administrator at your first opportunity.

If you have any questions about COBRA, please contact our Customer Service Department at (425) 452-3490 during business hours.

Sincerely,

Navia Benefit Solutions

Appendix B: Cafeteria Plan and FSA Provisions

The following pages contain the FSA Summary Plan Description.

QUINSTREET, INC. HEALTH AND WELFARE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

VIII
GENERAL INFORMATION ABOUT OUR PLAN

IX
ADDITIONAL PLAN INFORMATION

X
CONTINUATION COVERAGE RIGHTS UNDER COBRA

XI
SUMMARY

QUINSTREET, INC. HEALTH AND WELFARE BENEFIT PLAN

INTRODUCTION

We have amended the "Flexible Benefits 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. We will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary Plan Description carefully so that you understand the provisions of our amended 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 Summary Plan Description, 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. 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."

I
ELIGIBILITY

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

Before you become a Plan member (referred to in this Summary Plan Description 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 complete certain application forms before you can enroll in the Health Care Flexible Spending Arrangement or Day Care Flexible Spending Arrangement.

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 before this amendment, you will remain a participant.

3. When is my entry date?

You can join the Plan on the same day you can enter our group medical plan.

4. 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 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.

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 portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. 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

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 for the insurance coverage provided unless you elect not to receive any or all of such coverage. 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. 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.

3. 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). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

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.

4. 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.)

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

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. 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. Currently, Federal law considers the following events to be a change in status:

-- 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 Day Care Flexible Spending Arrangement, then there is a change in status if your dependent no longer meets the qualifications to be eligible for Day 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 Care Flexible Spending Arrangement, and you may not change your election to the Health Care Flexible Spending Arrangement 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 Day Care Flexible Spending Arrangement if the cost change is imposed by a Day 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.

6. 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 insured 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.

IV
BENEFITS

1. Health Care Flexible Spending Arrangement

The Health Care Flexible Spending Arrangement enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan and save taxes at the same time. The Health Care Flexible Spending Arrangement allows you to be reimbursed by the Employer for expenses incurred by you and your dependents.

However, if you participate in a HSA, you can only be reimbursed by the Employer for out-of-pocket dental, vision or preventive care expenses incurred by you and your dependents.

If you are a HSA participant, drug costs, including insulin, may be reimbursed if they are considered for dental, vision or preventive care expenses.

You may be reimbursed for "over the counter" drugs only if those drugs are prescribed for you. You may not, however, 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.

The most that you can contribute to your Health Care Flexible Spending Arrangement each Plan Year is $2,600. After 2017, the dollar limit may increase for cost of living adjustments. In addition, you will be eligible to carryover amounts left in your Health Care Flexible Spending Arrangement, up to $500. 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.

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. Reimbursement from the fund shall be paid at least once a month. 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.

Newborns' and Mothers' Health Protection Act: Group health plans 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 cesarean 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 or 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 authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

2. Day Care Flexible Spending Arrangement

The Day Care Flexible Spending Arrangement enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. 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 Day Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Day Care arrangements which qualify include:

(a) A Dependent (Day) 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 Day 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 Day Care Flexible Spending Arrangement. 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 Day 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 Day Care Flexible Spending Arrangement under our Plan. Ask your tax adviser which is better for you.

3. Premium Conversion Benefit

A Premium Conversion Benefit allows you to use tax-free dollars to pay for certain premiums under various insurance programs that we offer you. These premiums include:

-- Health care premiums under our insured group medical plan.

-- Dental insurance premiums.

-- Vision insurance premiums.

Under our Plan, we will establish sub-accounts for you for each different type of insurance coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance 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.

4. 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 insured 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. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Day Care Flexible Spending Arrangement 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 $500 that can be carried over into the next Plan Year or, except for amounts contributed to your Health Savings Account. Obviously, 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 Care Flexible Spending Arrangement, you must submit claims no later than 90 days after the end of the Plan Year. For the Day Care Flexible Spending Arrangement, 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 and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

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 Care Flexible Spending Arrangement. 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 Care Flexible Spending Arrangement, 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 Care Flexible Spending Arrangement 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 Care Flexible Spending Arrangement 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 request reimbursement for qualifying Day Care expenses incurred during the remainder of the Plan Year from the balance remaining in your Day Care account at the time of termination of employment. However, no further salary redirection 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 Care Flexible Spending Arrangement 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 Care Flexible Spending Arrangement will cease, and no further salary redirection 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 Care Flexible Spending Arrangement have already been made. 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.

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. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

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. Plan Balances

The Administrator will provide you with the ability to view your account balance online anytime during the Plan Year that shows your account balance. It is important review this information periodically so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

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

QuinStreet, Inc. Health and Welfare Benefit Plan is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The provisions of your amended Plan become effective on January 1, 2017. Your Plan was originally effective on March 1, 2002.

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:

Quinstreet, Inc.
950 Tower Lane, 6th Floor
Foster City, California 94404
77-0512121

3. Plan Administrator Information

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

Quinstreet, Inc.
950 Tower Lane, 6th Floor
Foster City, California 94404
(650) 578-7738

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:
Quinstreet, Inc.
950 Tower Lane, 6th Floor
Foster City, California 94404

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:

Navia Benefit Solutions, Inc.
PO Box 53250
Bellevue, Washington 98015

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) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) 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 Care Flexible Spending Arrangement, you must submit claims no later than 90 days after the end of the Plan Year. For the Day Care Flexible Spending Arrangement, 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 will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Administrator of our Plan. If a Claim under the Plan is denied in whole or in part, you 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. .

A level one appeal must be submitted within 180 days of receipt of the denial. Any such request should be accompanied by documents or records in support of your appeal. You may review pertinent documents and submit issues and comments in writing. The claims administrator will review the claim and provide, within 30 days, a written response to the appeal (extended by reasonable time if necessary). In this response, the claims administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. If you disagree with the level one appeal decision you may submit a request for a level two appeal to be determined by the Employer. You must submit a request for a level two appeal within 60 days of receipt of the level one notice. You will be notified within 30 days after the Employer receives the appeal (extended by reasonable time if necessary). The Employer has the exclusive right to interpret the appropriate plan provisions. Decisions of the Employer are conclusive and binding.

In the case of a claim under Flexible Spending Arrangement, 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

Denial or insufficient information on the claim:

Notification of: 15 days

Response by Participant: 45 days

Review of claim denial: 30 days

You must file your appeal by submitting a written request by email, fax, or mail. Indicate either level one or level two appeal on the email, fax, or letter.

Email: claims@naviabenefits.com

Fax: 425-451-7002 or 866-535-9227

Mail: Navia Benefit Solutions, Inc. PO Box 53250 Bellevue, Washington 98015

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.

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.

X
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 Care Flexible Spending Arrangement.

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. The right to COBRA 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 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 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.

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 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. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(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 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 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, 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 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 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 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 continuation coverage to Qualified Beneficiaries 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 employee and spouse 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 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:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Quinstreet, Inc.
950 Tower Lane, 6th Floor
Foster City, California 94404

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**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

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 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 continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse 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 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 coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA 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 COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

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

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA 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 continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, 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 at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA 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 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 continuation coverage?

For any period of COBRA 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 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 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 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 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 continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA 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. How is my participation in the Health Care Flexible Spending Arrangement affected?

You can elect to continue your participation in the Health Care Flexible Spending Arrangement for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Care Flexible Spending Arrangement 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 Care Flexible Spending Arrangement. 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.

XI
SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

Appendix C: Notice of HIPAA Privacy Practices

QUINSTREET, INC.
PRIVACY PRACTICES NOTICE

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Our Privacy Practices

We may use and disclose your protected health information ("medical information"), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We may disclose to your employer whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose summary health information to your employer for certain limited purposes. We may disclose your medical information to your employer to administer your group health plan if your employer explains the limitations on its use and disclosure of your medical information in the plan document for your group health plan.

Except for certain legally-approved uses and disclosures, we will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

Contact Information

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Contact Office.

Contact Office: Employee Benefits & Compliance

Telephone: 1-650-578-7700

Address: 950 Tower Lane, 12th floor, Foster City, CA 94404

Health Plans Covered by this Notice

This notice applies to the privacy practices of the health plans listed below. They may share with each other your medical information, and the medical information of others they service, for the health care operations of their joint activities.

- Navia FSA

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information ("medical information"). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **January 1, 2023** and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

Uses and Disclosures of Your Medical Information

Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan’s or provider’s health care quality assessment and improvement activities,

competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We generally may use or disclose any psychotherapy notes we hold only with your authorization.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing medical information related to your care or payment is in your best interest under the circumstances.

Your medical information remains protected by us for at least 50 years after you die. After you die, we may disclose to a family member, or other person involved in your health care prior to your death, the medical information that is relevant to that person's involvement, unless doing so is inconsistent with your preference and you have told us so.

Your Employer: We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan (this is sometimes called "underwriting"). Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the summary health information as yours. We are expressly prohibited from using or disclosing any health information containing your genetic information for underwriting purposes.

We may disclose your medical information and the medical information of others enrolled in your group health plan to your employer to administer your group health plan. Before we may do that, your employer must amend the plan document for your group health plan to establish the limited uses and disclosures it may make of your medical information. Please see your group health plan document for a full explanation of those limitations.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Your Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You should submit your request **{in writing}** to our Contact Office.

Your medical information may be maintained electronically. If so, you can request an electronic copy of your medical information. If you do, we will provide you with your medical information in the electronic form and format you requested, if it is readily producible in such form and format. If not, we will produce it in a readable electronic form and format as we mutually agree upon.

You may request that we transmit your medical information directly to another person you designate. If so, we will provide the copy to the designated person. Your request must be in writing, signed by you and must clearly identify the designated person and where we should send the copy of your medical information.

Disclosure Accounting: You have the right to a list of instances from the prior six years in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the end of this notice. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before the plan's effective date (if the plan was created less than six years ago).

Amendment. You have the right to request that we amend your medical information. You should submit your request to the contact at the end of this notice.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request, except for certain required restrictions, described below. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. We will agree to (and not terminate) a restriction request if:

1. the disclosure is to a health plan for purposes of carrying out payment or health care

operations and is not otherwise required by law; and

2. the medical information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should submit your request to the contact at the end of this notice.

We will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Notification may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Contact Office to obtain this notice in written form.

Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may complain to our Contact Office.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Appendix D: Authorized Representatives

Appointment of Authorized Representative

I, _____

[name of claimant]

hereby appoint_____ to act on my behalf

[name of Authorized Representative]

or on behalf of_____

[name of patient: plan participant or beneficiary]

in connection with any claim for coverage or benefits, including receipt of any approvals or authorizations that are required before medical services are provided under the plan named above (“Plan”). I authorize my representative to receive any and all information that is provided to me, and to act for me and for my covered spouse or dependent, if named above as the patient, in providing any information to the Plan that relates to any claim for coverage or benefits under the Plan.

This form does not constitute an assignment of rights for direct payment.

□ Distribute to me and to my Authorized Representative: All information and notifications should be distributed to me and to my Authorized Representative.

_____ _____

Claimant's signature Date

Accepted:_____ _____

Authorized Representative's signature Date

Witness:_____ _____

Witness signature Date

Appendix E: Summary of Material Modification (SMM)

The following pages contain the 2025 Summary of Material Modification.

2025

Employee Benefits Overview

QuinStreet

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TABLE OF CONTENTS

Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Notices section of this guide for more details.

At QuinStreet, Inc. we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

A list of plan contacts is included at the back of this guide.

The benefits in this summary are effective:

January 1, 2025 - December 31, 2025

Who Can You Cover?

WHO IS ELIGIBLE?

In general, full-time employees working 30 or more hours per week are eligible for the benefits outlined in this overview. In order to comply with the Affordable Care Act (ACA), QuinStreet generally determines your eligibility for medical coverage using the Monthly Measurement Method. Refer to the Monthly Measurement Method section of this guide for additional information on how your eligibility is determined.

You can enroll the following family members in our medical, dental and vision plans*.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse).
- Your registered domestic partner (as required by legislation, contact the Employee Benefit & Compliance (EBC) Department for details). The Cost of Coverage section explains the tax treatment of domestic partner coverage.
- Your children (including your eligible domestic partner's children):
  - Under age 26 are eligible to enroll in medical, dental and vision coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.

**Knowingly enrolling an ineligible dependent constitutes insurance fraud, will be deemed a material misrepresentation warranting retroactive termination of benefits, and employees who knowingly enroll ineligible dependents not in the categories listed above will be financially responsible for any claims paid on behalf of the ineligible individual*

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Any individual who is covered as an employee of QuinStreet cannot also be covered as a dependent.
- Employees who work fewer than 30 hours per week, contract employees, or employees residing outside the United States.

ENROLLMENT PERIODS

Coverage for new full-time employees begins on the 1st of the month following date of hire.

After that, Open Enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Notify the Employee Benefits & Compliance (EBC) Department (quinstreet_EBC@quinstreet.com) if you have a qualifying life event and need to add or drop dependents outside of Open Enrollment. These changes will need to be made within 30 days of the qualifying life event. Life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage or divorce

Cost of Coverage

QuinStreet pays the full cost for employee only coverage on the Cigna CDHP Medical, Cigna Dental, and VSP Vision plan as well as basic Life, AD&D, STD, and LTD coverage. You share in the cost of coverage for other plans and coverage levels.

You pay for health coverage before federal, state, and social security taxes are withheld, so you pay less in taxes. Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify QuinStreet if your domestic partner is your tax dependent.

PER PAY PERIOD EMPLOYEE CONTRIBUTIONS

Cigna CDHP + VSP Vision	Employee Contribution (Per semi-monthly pay period)
Employee Only	$0.00
Employee + Spouse/DP	$107.50
Employee + Children	$90.50
Employee + Family	$227.00
Cigna PPO + VSP Vision	
Employee Only	$104.00
Employee + Spouse/DP	$342.00
Employee + Children	$272.50
Employee + Family	$563.50
Kaiser HMO + VSP Vision — Available in CA & OR, Cigna EPO + VSP Vision	
Employee Only	$40.50
Employee + Spouse/DP	$212.00
Employee + Children	$166.00
Employee + Family	$373.00
Cigna Dental	
Employee Only	$0.00
Employee + Spouse/DP	$9.00
Employee + Children	$9.00
Employee + Family	$18.00

About Our Medical Plans

QuinStreet offers a choice between medical plans. The table below highlights the similarities and differences between our medical plan options. All Cigna plans utilize the Open Access Plus (OAP) Network for in-network providers and services. Refer to pages 10-13 for a comparison of what's covered.

	Consumer Directed Health Plan (CDHP)	Preferred Provider Organization (PPO)	Health Maintenance Organization(HMO)	Exclusive Provider Organization (EPO)
Plan Providers ***(by location)***	Cigna (All locations)	Cigna (All locations)	Kaiser Permanente (CA & OR only)	Cigna (All locations)
Description	A PPO-style plan offering a combination of in- and out-of-network providers.	A combination of in- and out-of- network providers. In-network doctors and facilities have agreed to offer services at reduced, contracted fees.	A restricted group of doctors and facilities that have contracted with the HMO to offer services at a discounted rate.	Predominantly in network providers.
Accessing Care	You can choose between in- and out-of-network benefits each time and do not need referrals or Primary Care Physician (PCP) authorization for specialists.	You can choose between in- and out-of-network benefits each time and do not need referrals or Primary Care Physician (PCP) authorization for specialists.	When you enroll in the Kaiser HMO, you and your eligible dependents each select a Primary Care Physician (PCP) to coordinate all your medical care within the provider's network. All services must be provided by Kaiser physicians at Kaiser facilities in order to be covered, except in emergencies.	The non-network coverage is *very* limited. We encourage EPO enrollees to seek in-network benefits and/or consult Cigna before using any out-of-network services.
Restrictions	To receive in-network benefits, you must use the provider's network of doctors and facilities.	PPO members should utilize in-network doctors and facilities when receiving care to have maximum benefits covered but may have some coverage when going out- of-network.	All services must be provided by Kaiser physicians at Kaiser facilities in order to be covered, except in emergencies.	EPO members should utilize in-network doctors and facilities when receiving care to have maximum benefits covered but may have minimal coverage when going out- of-network.
Out-of-Pocket Costs	The deductible is higher than a traditional PPO. However, QuinStreet is contributing a sizeable amount of the deducible via a Health Savings Account.	There are annual deductibles, copays and coinsurance. If you visit doctors and hospitals within the provider network, you will typically benefit from lower costs.	Services are generally paid for with copays. There are no deductibles.	No network deductible applies.

IMPORTANT MEDICAL PLAN NOTES

- For the Cigna CDHP, PPO and EPO plans, out-of-network reimbursements are subject to the out-of-network reimbursement limits of customary charges for a service.
- Under the CDHP, PPO and EPO plans, prior to any testing, hospitalization, or surgical procedure, it is the responsibility of the plan participant to have the services authorized. Failure to comply will likely result in additional out of pocket expenses to you as the member.

Medical

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. Medical coverage also provides important financial protection if you have a serious medical condition.

	Cigna CDHP		Cigna PPO	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Annual Deductible	$1,650 per individual, $3,300 for individual within a family; $3,300 per family	$4,500 per individual, $4,500 for individual within a family; $9,000 per family	$250 per individual, $750 per family	$750 per individual, $2,250 per family
Annual Out-of-Pocket Max (Includes deductible)	$3,300 per individual, $3,300 for individual within a family; $6,600 per family	$9,000 per individual, $9,000 for individual within a family; $18,000 per family	$2,500 per individual, $5,000 per family	$7,500 per individual, $15,000 per family
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited
Office Visit				
Primary Provider	You pay 10% after deductible	You pay 30% after deductible	$20 copay (deductible waived)	You pay 30% after deductible
Specialist	You pay 10% after deductible	You pay 30% after deductible	$40 copay (deductible waived)	You pay 30% after deductible
Preventive Services	No charge (deductible waived)	You pay 30% after deductible	No charge (deductible waived)	You pay 30% after deductible
Chiropractic Care (limits combined in and out-of-network)	You pay 10% after deductible (up to 30 days per calendar year)	You pay 30% after deductible (up to 30 days per calendar year)	$20 copay (up to 30 days per calendar year, deductible waived)	You pay 30% after deductible (up to 30 days per calendar year)
Acupuncture Care (limits combined in and out-of-network)	You pay 10% after deductible (up to 20 visits per calendar year)	You pay 30% after deductible (up to 20 visits per calendar year)	$20 copay (up to 20 days per calendar year, deductible waived)	You pay 30% after deductible (up to 20 days per calendar year)
Lab and X-ray	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible
Inpatient Hospitalization	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible
Outpatient Surgery	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible	You pay 30% after deductible
Urgent Care	You pay 10% after deductible	You pay 30% after deductible	$20 copay (deductible waived)	You pay 30% after deductible
Emergency Room	You pay 10% after deductible	You pay 10% after deductible	$150 copay + 10% after deductible (copay waived if admitted)	$150 copay + 10% after deductible (copay waived if admitted)

Important Plan Notes:

- Out-of-network reimbursements are subject to the out-of-network reimbursement limits.
- Prior to any testing, hospitalization, or surgical procedure, it is the responsibility of the plan participant to have the services authorized. Failure to comply will likely result in additional out-of-pocket expenses to you as the member.
- Please refer to your plan documents for a full list of limitations and exclusions.

Medical, continued

	Cigna EPO	Kaiser HMO (CA)	Kaiser HMO (OR)
	In-Network	In-Network	In-Network
Annual Deductible	None	None	None
Annual Out-of-Pocket Max	$2,500 per individual $5,000 per family	$1,500 per individual $3,000 per family	$1,500 per individual $3,000 per family
Lifetime Max	Unlimited	Unlimited	Unlimited
Office Visit			
Primary Provider	$20 copay	$20 copay	$20 copay ($5 copay for first 3 visits)
Specialist	$20 copay	$20 copay	$20 copay
Preventive Services	No charge	No charge	No charge
Chiropractic Care	$20 copay (up 30 days per calendar year)	$15 copay (up to 30 visits per calendar year, combined with acupuncture care)	$15 copay (up to 30 visits per calendar year)
Acupuncture Care	$20 copay (up to 20 days per calendar year)	$15 copay (up to 30 visits per calendar year, combined with chiropractic care)	$15 copay (up to 12 visits per calendar year)
Lab and X-ray	Lab/ X-ray: No charge; Advanced: $100 copay per test	Lab/X-ray: $10 copay per encounter; Advanced: $50 copay per test	Lab: $10 copay per visit; X-ray: $20 copay per visit; Advanced: $50 copay per visit
Inpatient Hospitalization	$250 copay per admission	$250 copay per admission	$250 copay per admission
Outpatient Surgery	$125 copay per visit	$100 copay per visit	$100 copay
Urgent Care	$20 copay	$20 copay	$20 copay
Emergency Room	$125 copay (waived if admitted)	$50 copay (waived if admitted)	$50 copay (waived if admitted)

Important Plan Notes:

- Advanced lab and X-ray refer to, but is not limited to procedures such as MRI, PET, and CAT scans.
- Please refer to your plan documents for a full list of limitations and exclusions.
- Out-of-network benefits under the EPO are available, however, are limited to 50% and higher deductibles ($3,000 individual / $9,000 family) and out-of-pocket maximums ($9,000 individual / $18,000 family).

Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. Here are the prescription drug benefits that are included with our medical plans.

	Cigna CDHP		Cigna PPO	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Prescription Drug Deductible	Plan deductible applies	N/A	N/A	N/A
Annual Out-of-Pocket Limit	Applied towards Medical OOP max	N/A	Applied towards Medical OOP max	N/A
Pharmacy				
Generic	$5 copay	Not covered	$5 copay	Not covered
Preferred Brand	$40 copay	Not covered	$30 copay	Not covered
Non-preferred Brand	$60 copay	Not covered	$50 copay	Not covered
Specialty	You pay 30% up to $250	Not covered	You pay 30% up to $250	Not covered
Supply Limit	30 days	N/A	30 days	N/A
Mail Order				
Generic	$15 copay	Not covered	$15 copay	Not covered
Preferred Brand	$120 copay	Not covered	$90 copay	Not covered
Non-preferred Brand	$180 copay	Not covered	$150 copay	Not covered
Specialty	You pay 30% up to $250	Not covered	You pay 30% up to $250	Not covered
Supply Limit	90 days	N/A	90 days	N/A

Important Plan Notes:

- Specialty medication is limited to a 30-day supply through mail order.
- Please refer to your plan documents and pharmacy link for additional information.

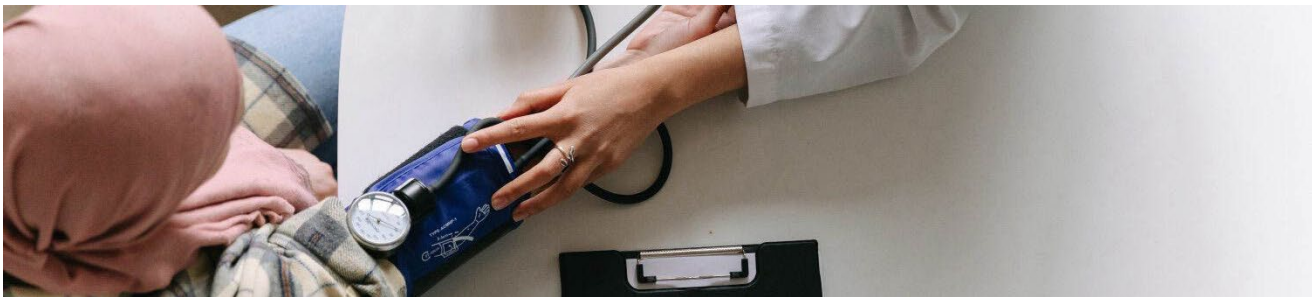
Prescription Drugs, continued

	Cigna EPO	Kaiser HMO (CA)	Kaiser HMO (OR)
	In-Network	In-Network	In-Network
Prescription Drug Deductible	N/A	N/A	N/A
Annual Out-of-Pocket (OOP) Limit	Applied towards Medical OOP max	Applied towards Medical OOP max	Applied towards Medical OOP max
Pharmacy			
Generic	$5 copay	$15 copay	$10 copay
Preferred Brand	$30 copay	$35 copay	$20 copay
Non-preferred Brand	$50 copay	$35 copay (prior authorization required)	$40 copay
Specialty	You pay 30% up to $250	$35 copay	Applicable generic, preferred brand and non-preferred brand drug costs shares apply
Supply Limit	30 days	30 days	30 days
Mail Order			
Generic	$15 copay	$30 copay	$20 copay
Preferred Brand	$90 copay	$70 copay	$40 copay
Non-preferred Brand	$150 copay	$70 copay (prior authorization required)	$80 copay
Specialty	You pay 30% up to $250	$35 copay	Applicable generic, preferred brand and non-preferred brand drug costs shares apply
Supply Limit	90 days	100 days	90 days

Important Plan Notes:

- Cigna specialty medication is limited to a 30-day supply through mail order.
- Please refer to your plan documents and pharmacy link for additional information.

Getting Care When You Need It



WHEN TO USE THE ER

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life-threatening condition that requires immediate attention or treatment that is only available at a hospital.

WHEN TO USE URGENT CARE

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

WHEN YOU NEED CARE NOW

What do you do when you need care right away, but it's not an emergency?

Cigna Plan Participants

- Call Cigna's 24/7 Health Information Line by dialing the number on the back of your Cigna ID card
- Find an urgent care center by visiting myCigna.com

Kaiser Permanente Plan Participants

- Call Kaiser's 24/7 NurseLine at
  - CA: 866-454-8855
  - OR: 833-574-2273
- Find an urgent care center by visiting kp.org

GET A VIDEO HOUSE CALL

Cigna and Kaiser members can video chat with a doctor from the comfort of their own homes, without an appointment. Physicians can treat a host of common illnesses quickly and effectively through a real-time video visit. They can even send prescription orders to your local pharmacy.

For Cigna members, log into myCigna.com and click "Talk to a doctor" to access virtual visits through MDLIVE. For Kaiser CA members, visit kp.org/mydoctor/videovisits to initiate a video visit.

PREVENTIVE OR DIAGNOSTIC?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms.

Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change.

Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.

Health Savings Account (HSA)

Do you want to save money on taxes? A Health Savings Account is a tax-advantaged, portable (you own it!) savings account that is offered if you select the Consumer Directed Health Plan (CDHP) for your medical coverage and enroll in our HSA Plan.

You (optional) and QuinStreet contribute pre-tax money to your account to save for out-of-pocket healthcare expenses. Any money that you don't spend grows year after year and can be used in the future. HSA Bank administers this account.

ACCOUNT CONTRIBUTIONS

	Annual QuinStreet Contributions	You Can Contribute	Annual IRS Contribution Limit
Employee	$825 ($34.37 per pay period)	$3,475 ($144.79 per pay period)	$4,300 ($179.17 per pay period)
Employee + SP/DP or Children	$1,650 ($68.75 per pay period)	$6,900 ($287.50 per pay period)	$8,550 ($356.25 per pay period)
Employee + Family	$2,150 ($89.58 per pay period)	$6,400 ($266.67 per pay period)	$8,550 ($356.25 per pay period)
Catch Up Contributions			Additional $1,000 per year at age 55+ ($41.66 per pay period)

Your contributions, including any eligible catch-up contribution, must be elected via ADP or by contacting quinstreet_ebc@quinstreet.com.

USING YOUR MONEY

You can use your account to pay for qualified medical expenses that are not paid for by your Cigna consumer deductible health plan, CDHP. In general, your HSA can be used for these expenses:

- Medically necessary expenses that are not covered by your health plan including deductibles and coinsurance
- Dental care services
- Vision care services
- Prescription drugs
- Eligible over-the-counter (OTC) medications
- Certain medical equipment

When possible, use your HSA debit card to pay for expenses. Make sure that you keep records of your receipts in case the IRS requests them.

ELIGIBILITY

You are **not** eligible to open or contribute to an HSA account if you are:

- Covered by a non-high deductible health plan (e.g., HMO, PPO)
- If either you or your spouse are enrolled in a regular healthcare flexible spending account
- Covered under Medicare, Medicaid or Tricare
- Someone else's tax dependent

Flexible Spending Account (FSA)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. Reimbursements from your FSA accounts are tax-free. You must re-enroll in this program each year-which is administered by Navia.

IMPORTANT CONSIDERATIONS

- There's no "crossover" spending allowed between the healthcare and dependent care accounts.
- Expenses must be incurred between 01/01/25 and 12/31/25 and submitted no later than 03/31/26.
- Elections cannot be changed during the plan year unless you have a qualified change in family status (and the election change must be consistent with the event).
- You can keep (roll-over) up to $660* of unused money for use in the next plan year. Unused amounts above $660* will be lost, so it is very important that you plan carefully before making your election. You can access any 2025 carry over funds by the end of January 2026.
- FSA funds can be used for eligible expense incurred by you, your spouse, and your tax dependents only. Your spouse or tax dependent children do not have to be covered on a QuinStreet health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).
- Keep your receipts as proof that your expenses were eligible for IRS purposes.

*Amounts are set by the IRS each year and subject to change.

TAX-FREE HEALTHCARE FSA

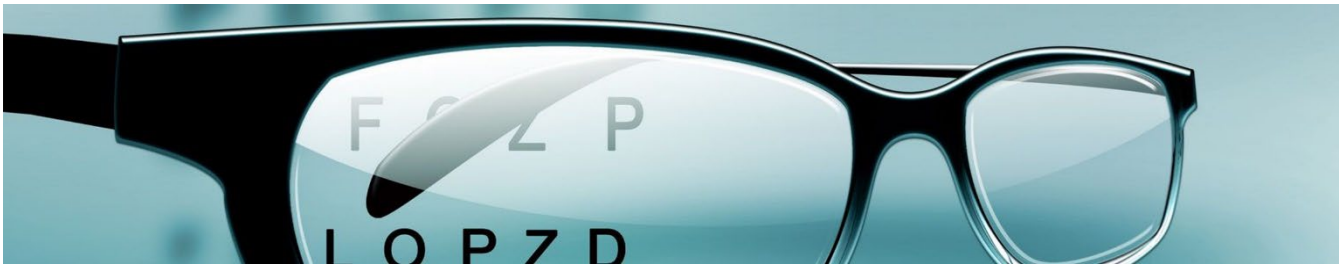
Eligible expenses include medical, dental, and vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. You may access your entire annual election from the first day of the plan year and you can set aside up to $3,300* per year. If you are enrolled in the Cigna CDHP, you can participate in our Limited Purpose Healthcare FSA which covers out-of-pocket vision and dental expenses ONLY.

TAX-FREE DEPENDENT CARE FSA

Eligible expenses may include daycare centers, in-home childcare, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can set aside up to $5,000 per household for eligible dependent care expenses for the year.

Vision



Routine vision exams can not only correct vision, but also detect more serious health conditions. **Even though this benefit is contingent upon whether or not you have medical coverage, a separate enrollment for the vision benefit will need to be completed as part of the election process.**

	VSP Vision	
	In-Network	**Out-Of-Network**
Examination		
Benefit	$10 copay	Reimbursed up to $50 after applicable copay
Frequency	Once every 12 months	Once every 12 months
Materials	$20 copay	Reimbursed up to benefit schedule after $20 copay
Eyeglass Lenses		
Single Vision Lens	No charge after applicable copay	Reimbursed up to $50 after applicable copay
Bifocal Lens	No charge after applicable copay	Reimbursed up to $75 after applicable copay
Trifocal Lens	No charge after applicable copay	Reimbursed up to $100 after applicable copay
Frequency	Once every 12 months	Once every 12 months
Frames		
Benefit	Coverage limited to $120 then plan pays 20% off remaining balance	Reimbursed up to $70
Frequency	Once every 24 months	Once every 24 months
Contacts (Elective)		
Benefit	Coverage limited to $120	Reimbursed up to $105 (applies to exam and contact lenses)
Frequency	Once every 12 months (in lieu of frames & lenses)	Once every 12 months (in lieu of frames & lenses)

Dental

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

QuinStreet provides you with comprehensive coverage through Cigna.

Cigna Dental PPO

	In-Network	Out-Of-Network
Calendar Year Deductible	$50 per individual, up to $150 per family (combined with out-of-network)	$50 per individual, up to $150 per family (combined with in-network)
Annual Plan Maximum	$1,500 per person (combined with out-of- network)	$1,500 per person (combined with in- network)
Diagnostic and Preventive	No charge (deductible waived)	No charge (deductible waived)
Basic Services		
Fillings	You pay 10% after deductible	You pay 20% after deductible
Root Canals	You pay 10% after deductible	You pay 20% after deductible
Periodontics	You pay 10% after deductible	You pay 20% after deductible
Major Services	You pay 40% after deductible	You pay 50% after deductible
Orthodontic Services		
Orthodontia (adults and children)	You pay 50%	You pay 50%
Lifetime Maximum	$1,500 (combined with out-of-network)	$1,500 (combined with in-network)

Out-of-network Reimbursement: For services provided by an out-of-network dentist, Cigna will reimburse according to the Maximum reimbursable Charge (MRC). The MRC is calculated at the 90th percentile of all provider submitted amounts in the geographic area, previously 51st percentile under Delta Dental. Your dentist may balance bill you up to their usual fees.

Life Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security and pay for large expenses such as housing and education, as well as day-to-day living expenses.

LIFE AND AD&D

Basic life insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by the company. Coverage is provided by Reliance Standard Life Insurance Company.

Basic Life Amount	2x salary up to a maximum of $400,000
Basic AD&D Amount	2x salary up to a maximum of $400,000

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

Taxes: A life insurance benefit of $50,000 or more is a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck and W-2.

Travel and Medical Assistance Program

Chubb/Europ Assistance provides coverage for Business Travel Accident insurance and can help you feel more at ease if an emergency arises while working overseas. Your benefits include access to global travel assistance that provides emergency medical, emergency travel, and pre-trip information services. Reach out to 1-800-243-6124 when working inside the U.S., and 1-202- 659-7803 when working from other international locations.

Concierge Life

For employees interested in purchasing individual/additional life insurance, QuinStreet offers Concierge Life, a comprehensive resource for education and advice in life insurance planning. All employees, regardless of benefits eligibility status, are eligible to engage Concierge Life. Concierge Life provides access to consultants and life insurance providers to help you determine the appropriate level of coverage to protect yourself and your family. Once you have determined the amount of life insurance you would like to purchase, Concierge Life will assist you with obtaining the best coverage at the lowest premium. Life insurance coverage purchased through Concierge Life is an individual policy and will continue beyond your employment with QuinStreet (as long as you continue to pay the premiums). This resource is available to all employees and their family members. To get help from Concierge Life, contact Brian Maguire at 888-466-4446 or email brian.maguire@summitalliance.net and indicate you are a QuinStreet employee.

Disability Insurance

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind. If you are ever in a situation where you must file a short term, long term, or family medical leave claim, you can reach out to the Reliance Standard partner – Matrix who can help coordinate your leave of absence. Matrix is an outsourcing service that can assist you with filing a claim 24 hours a day, 7 days a week at the following phone number: 877-202-0055.

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability (STD) coverage pays you a benefit if you temporarily can't work because of an injury, illness, or maternity leave. Benefits may be reduced by income from other income sources such as paid time off. Your doctor and the insurance company will work together to determine how long benefits are payable, based on your condition. Coverage is provided by Reliance Standard Life Insurance Company.

Weekly Benefit Amount	Plan pays 60%
Maximum Weekly Benefit	$2,309 (offset by CA SDI)
Benefits Begin After:	
Accident	7 days of disability
Sickness	7 days of disability
Maximum Payment Period*	12 weeks

*Maximum payment period is based on the first day you are disabled, not when benefits begin.

LONG-TERM DISABILITY INSURANCE

Long-Term Disability (LTD) coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security. Coverage is provided by Reliance Standard Life Insurance Company.

Monthly Benefit Amount	Plan pays 60%
Maximum Monthly Benefit	$12,000
Benefits Begin After:	
Accident	90 days of disability
Sickness	90 days of disability
Maximum Payment Period*	Generally to age 65 but varies for disabilities starting after age 61

*The age at which the disability begins may affect the duration of the benefits.

Commuter Benefits

TRANSPORTATION SAVINGS ACCOUNT

Do you have out-of-pocket commuting expenses for public transportation or for worksite parking? If so, you can save on taxes by enrolling our Transportation Savings Account (also known as a Section 132 plan.)

A Transportation Savings Account lets you set aside money—before it's taxed—through payroll deductions. You may enroll and/or stop participating in this program at any time. Monies in this account can be used in future months or plan years. If you leave QuinStreet, any unused account balance will be lost. Navia administers this program.

Here are the maximum amounts of money you can set aside*:

Parking ExpenseAccount	Up to $325 per month*
Transportation Expense Account	Up to $325 per month*

*These amounts are evaluated annually by the IRS and are subject to change. You need to re-enroll in this program each year.

To enroll, visit **www.naviabenefits.com**, and select the "register" link located in the top right corner of the page. You will need the company code "QUI". Once logged in, select the link to "GoNavia Commuter Benefits". Select "My Order" and enter the dollar amount for your order. Confirm your order then click "Submit". All orders and changes must be completed by 11:59pm PT on the 20th day of the month prior to the month you would like to make changes to or receive your benefit.

Retirement Savings Plan

In addition to benefits that provide security for today, QuinStreet helps you plan for your future with a 401(k) plan that allows you to save tax-deferred dollars toward your retirement. New hires are automatically enrolled in the 401(k) Plan per the terms outlined in the 401(k) Summary Plan Description (SPD). The automatic enrollment level is 3% of your base salary. You have the opportunity to change the automatic enrollment to less/more than 3% or cancel it completely either before the applicable date provided by Fidelity (these are outlined in the notices Fidelity provides eligible participants via US mail or on a monthly basis).

Your contributions are automatically deducted from your paycheck on a pre-tax basis, so you save money in two ways: 1) you put away money for your future and 2) you pay less in current taxes. You decide how to invest your account among several fund options offered by the plan. QuinStreet also has a ROTH 401(k) option where participants pay income taxes on contributions up front (i.e., contributions do not reduce taxable income), but the money in the Roth 401(k) grows tax free and participants won't have to pay any tax on withdrawals, including any investment earnings, when they retire. Certain qualifications have to be met to enroll so please see the 401(k) Summary Plan Description (SPD) for further information.

Maximum Annual Contributions*	The lesser of 60% of your annual earnings or the IRS annual limit on contributions Up to $23,500* in 2025 or Up to $31,000* if you are 50+ or Up to $34,750* if you are 60-63**

*Amounts are set by the IRS each year and subject to change.

** Pending 2025 IRS approval.

Additional Programs

EMPLOYEE STOCK PURCHASE PLAN (ESPP)

You may contribute up to 15% of eligible compensation each year up to $25,000 of the undiscounted value of shares in accordance with applicable tax regulations. Participants are able to lock-in a discounted purchase price for QuinStreet stock for the term of the plan (i.e., 2 years). Stock is purchased at 85% of the fair market price on either the first day of the six-month offering period or the last day of the period, whichever is lower. Each plan has 4 purchase dates (i.e., every 6 months).

WELLNESS PROGRAMS

Your wellbeing is important to us. That's why we promote a healthy culture here at QuinStreet. We continue to evaluate new options for employees and their families. If you'd like to learn more and find new ways to engage with your health, just contact us at quinstreet_ebc@quinstreet.com.

MENTAL WELLBEING

Mental wellness is just as important as physical wellness, and ensuring your mental well-being is supported is essential to living a happier, healthy life. Spring Health provides tools to assist in prioritizing your mental wellness. Spring Health is **100% confidential** and provided at no cost to you.

Spring Health offers:

- Dedicated support to receive guidance from a personal Care Navigator
- Book therapy and coaching sessions with trusted providers
- Up to 6 counseling sessions and 6 coaching sessions per eligible family member per year
- Coaching tips for managing stress, increasing focus, and more
- In-app wellness exercises to support your mental fitness on-the-go with exercises in meditation, better sleep, and more

To sign up, visit quinstreet.springhealth.com to activate your benefits. Additionally, the Spring Health mobile app may be found through the App Store or Google Play store by searching "Spring Health".

In addition to mental wellness, Spring Health can support you with work-life topics like legal issues, parenting questions, financial counseling, and dependent care resources. The benefit is completely confidential, free and available to you and your dependents.

- Unlimited free phone access 24/7
- Limited phone consultations with a financial coach and legal services
- Unlimited access to helpful articles, resources, and self-assessment tools

To use Spring Health, call 240-558-5796.

MENTAL WELLBEING

There are times when everyone needs a little help, advice, or assistance with a serious concern. The EAP through ACI Specialty Benefits can help you handle a wide variety of personal issues such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and elder care resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate family. Call (855) 775-4357 or visit rsli.acieap.com. Register for an account using company code RSLI859.

TIME OFF

There is no perfect, one-size-fits-all balance between work and home. We provide time off so you can relax, recover from illness, and take care of personal business. Our time off benefits include:

- Vacation and sick leave
- Bereavement leave
- Leave of Absences

PARENTAL LEAVE

QuinStreet offers leave options for all new parents—whether you are caring for a newborn or newly adopted child—regardless of the parent's gender or location.

For more information on available leaves please refer to the leave section of the Employee Handbook. This will provide details about the different types and lengths of leave we offer depending on your specific situation. Parental Leaves will need to be requested through Matrix. Please reach out to the EBC team for more information.

2025 PAID HOLIDAYS

QuinStreet will provide 11 paid holidays for calendar year 2025 to all full-time, benefit eligible employees. Additional holidays may be designated at the company's discretion. The holiday schedule may vary if you are a call center employee or work outside the US.

New Year's Day (Observed)	January 1
Martin Luther King, Jr. Day	January 20
President's Day	February 17
Memorial Day	May 26
Juneteenth	June 19
Independence Day	July 4
Labor Day	September 1
Thanksgiving Day	November 27
Day after Thanksgiving	November 28
Christmas Holidays (Observed)	December 25-26

More comprehensive information on these time off benefits and other types of leaves are outlined in the Employee Handbook. For further information please refer to the handbook or contact the EBC team.

Plan Contacts

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website	Policy/Group #
Medical PPO, EPO, and CDHP	Cigna	(800) 244-6224	mycigna.com	3345397
Medical HMO	Kaiser CA	(800) 464-4000	kp.org	602550
Medical HMO	Kaiser OR	(800) 813-2000	kp.org	19880
Dental	Cigna	(800) 244-6224	mycigna.com	3345397
Vision	VSP	(800) 877-7195	vsp.com	12135824
Life Insurance	Reliance Standard	(800) 351-7500	rsli.com	Life: GL 135744 AD&D: VAR 205646
Business Travel Accident	Chubb / Europ Assistance	U.S: 1 (800) 243-6124 Outside U.S: 1 (202) 659-7803	chubbtravelassistance.com	9908-93-99
Disability Insurance	Reliance Standard	(800) 351-7500	rsli.com	STD: 158041 LTD: 109640
Commuter Benefits	Navia	(800) 669-3539	naviabenefits.com	QUI
Flexible Spending Accounts	Navia	(800) 669-3539	naviabenefits.com	QUI
Health Savings Accounts	HSA Bank	(800) 357-6246	mycigna.com	
Mental Wellbeing	Spring Health	(240) 558-5796	quinstreet.springhealth.com	
Employee Assistance Program	ACI Specialty Benefits	(855) 775-4357	rsli.acieap.com	RSLI859
401(k) Plan	Fidelity	(800) 835-5097	401k.com	46346
Leave of Absence	Matrix	(877) 202-0055	matrixabsence.com	STD: 158041 LTD: 109640

YOUR BENEFITS PORTAL

Information about benefit plan coverage, forms, summary plan descriptions and more is available on QuinStreet Benefits Center website.

To access the portal, go to: https://quinstreet.mybenefits.life/

Words You Need to Know

Health insurance seems to have its own language. You will get more out of your plans if understand the mostcommon terms, explained below in plain English.

MEDICAL

OUT-OF-POCKET COST - A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

DEDUCTIBLE - The amount of healthcare expenses you have to pay for with your own money before yourhealth plan will pay. The deductible does not apply to preventive care and certain other services.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost ofcovered expenses. Coinsurance is always a percentage totaling 100%. For example, if the planpays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when yousee your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest ofthe bill for that service.

IN-NETWORK / OUT-OF-NETWORK – Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed tocharge lower fees to plan members, as negotiated intheir contract with the health plan. Services from out-of-network providers can cost you more becausethe providers are under no obligation to limit their maximum fees. With some plans, such as HMOs, services from out-of-network providers are not covered at all. Out-of-network reimbursements are subject to the out-of-network reimbursement limits (typically a percentage of customary charges for a service).

OUT-OF-POCKET MAXIMUM - The most you wouldpay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the planyear.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarkedname. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay ahigher copay for brand name drugs.

GENERIC DRUG - A drug that has the same active ingredients as a brand name drug but is sold undera different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

DENTAL

BASIC SERVICES - Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTIC AND PREVENTIVE SERVICES - Generally include routine cleanings, oral exams, x- rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES - Complex or restorative dental work such as crowns, bridges, dentures, inlays, and onlays.

Monthly Measurement Method

You and your dependents are eligible for the plan if you are a full-time employee. A full-time employee is generally an employee who works on average 130 hours per month, as defined by the ACA. Hours that count toward full-time status include each hour for which an employee is paid or entitled to payment for the performance of duties for the employer, and each hour for which an employee is paid or entitled to payment for aperiod of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.

ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefitseligibility. QuinStreet uses the monthly measurement method to determine whether an employee meets this eligibility threshold.

Important Plan Notices and Documents

CURRENT HEALTH PLAN NOTICES

Notices must be provided to plan participants on an annual basis and are available on our benefits website and include:

- Medicare Part D Notice
  Describes options to access prescription drug coverage for Medicare eligible individuals.
- Women's Health and Cancer Rights Act
  Describes benefits available to those that will or have undergone a mastectomy.
- Newborns' and Mothers' Health Protection Act
  Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery.
- HIPAA Notice of Special Enrollment Rights
  Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.
- HIPAA Notice of Privacy Practices
  Describes how health information about you may be used and disclosed.
- Notice of Choice of Providers
  Notifies you about the plan's requirement that you name a Primary Care Physician (PCP).
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
  Describes availability of premium assistance for Medicaid eligible dependents.

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this Notice carefully to make sure you understand your rights and obligations.

CURRENT PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available on our benefits website and include:

SUMMARY PLAN DESCRIPTIONS

A Summary Plan Description (SPD) is the legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries. The following Summary Plan descriptions are available:

- QuinStreet, Inc. Health and Welfare Benefit Plan
- QuinStreet, Inc. 401(K) Retirement Plan

SUMMARY OF BENEFITS AND COVERAGE

A Summary of Benefits and Coverage (SBC) is a document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. The following SBCs are available on the "Benefits" tab on the Benefits Center site:

- Cigna CDHP
- Cigna PPO 250
- Cigna EPO
- Cigna Dental PPO
- Kaiser HMO CA
- Kaiser HMO OR

Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact your EBC team at (650) 578-7700 or quinstreet_ebc@quinstreet.com.

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the QuinStreet, Inc. Health and Welfare Benefit Plan. It is meant to supplement and/or replacecertain information in the SPD, so retain it forfuture reference along with your SPD. Please share these materials with your covered family members.

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QuinStreet

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