2024 EMPLOYEE BENEFITS

HELLO FRESH

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2024 HELLOFRESH BENEFITS

At HelloFresh, we value your significant contributions and recognize the importance of providing a competitive Total Rewards program. We evaluate our benefit plans annually to ensure you have the care and resources to support your personal and financial health. Our people are our most important ingredient, and we're proud to offer you a comprehensive benefit menu! This is our commitment to you as you make a difference, and change the way people eat forever.

Key highlights:

- Benefits eligible Day 1.
- Enroll within 31 days of date of hire/conversion.
- 3 medical plans available through Cigna.
- HelloFresh is excited to offer a High Deductible Health plan (HDHP) which has a $0 employee payroll contribution for all coverage levels.
- Routine preventive care and screenings covered at no cost under all three medical plans with incentives.
- Free virtual care visits through MDLive when covered under any of the Cigna medical plans.
- 401(k) eligible after 3 months of employment with an employer match that is vested immediately!
- Free back-up care, virtual tutoring, virtual camps, and pet care through Bright Horizons.

This guide will navigate you through all of the HelloFresh benefit offerings to create the best recipe of whole health for you and your family.

2024 BENEFIT HIGHLIGHTS

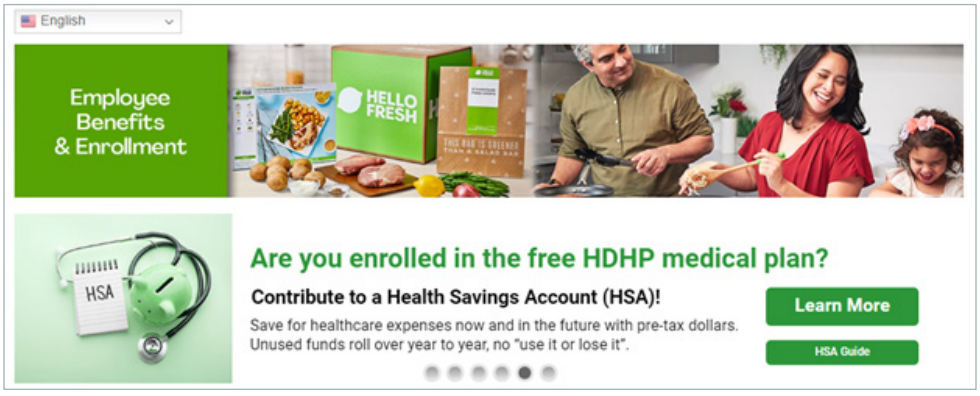
This guide provides information on all the benefits offered by HelloFresh and what you need to do to make your 2024 elections. Please refer to the back of this guide for the 2024 vendor contact information.

HelloFresh offers a variety of benefits that are free to you! All regular full-time employees receive basic life and accidental death and dismemberment (AD&D) insurance[1], short-term disability insurance, base long-term disability insurance, an employee assistance program (EAP), travel assistance and medical bill saver services. HelloFresh also offers the Cigna Medical HDHP Plan $1,600 at a $0 payroll contribution. Additionally, HelloFresh provides employees access to Bright Horizons, a service to provide family support and resources. Lastly, the HelloFresh 401(k) Plan offers a Safe Harbor match of 100% of your contribution up to 3% of compensation and then 50% of the next 2%.

[1] Under the tax law, the value of employer-provided group term life insurance in excess of $50,000 is taxable. The value is determined by your age and schedule established by the IRS If you make over $50,000 a year, this is added to your gross wages and is included on your form W-2 at the end of the year. Please see page 15 of IRS Publication 15-B for more information www.irs.gov/pub/irs-pdf/p15b.pdf.

MyHelloFreshBenefits.com

In addition to this guide, Myhellofreshbenefits.com is your one-stop shop for all the benefits that are offered to you. There is a separate tab with more information such as carrier flyers and videos to assist you and your family with making your benefit decisions for 2024. Please note, there is also a drop-down menu in the upper left-hand corner of the home page to choose your preferred language. Myhellofreshbenefits.com is a public website, you do not need to create an account, and it can be accessed via computer, tablet, or mobile phone, and is available year-round.



What Actions Do I Need to Take?

For new hires, you are encouraged to enroll within your first week to utilize your benefits as quickly as possible. If you do not enroll within 31 days of your date of hire, you will be unable to enroll until the next open enrollment period unless you have a qualifying event. For more information on qualifying events, please visit healthcare.gov/glossary/qualifying-life-event/.

- Review your 2024 New Hire Enrollment guide and additional benefits information on myhellofreshbenefits.com.
- Once you're ready to make your decisions, log-on to https://wd3.myworkday.com/hellofresh or call HelloFresh Benefits and Payroll Connect service center at **877.431.7867** to enroll.
- Beneficiary designations are required for your life insurance plans.
- Finish and submit your enrollment no later than 31 days after your hire date. ID cards will be sent to your home address on file approximately 2 weeks after you complete your enrollment.
- If you have any questions, contact HelloFresh Benefits and Payroll Connect service center at **877.431.7867** (Mon-Fri 8am - 5pm CST for phone and appointments, 8am - 7pm CST web chat).

Who is Eligible?

Benefits are available to all regular, full-time employees and their dependents. Eligible Dependents for this plan include your lawful spouse, domestic partner[1] and their children, biological/adopted/step children under age 26 as well as qualified disabled children over the age of 26. Ineligible dependents include, but are not limited to, grandchildren, other relatives, and children under an employee's legal guardianship.

[1]If you cover a domestic partner, you will need to complete an affidavit and the employee's share of the cost of that coverage must be paid on an after-tax basis (or if paid pretax must be imputed back to the employee as taxable income), and the employer's share of the cost of coverage of that individual is taxable income to the employee, and subject to appropriate federal income tax withholding and payroll taxes.

Eligibility & Enrollment

After your initial new-hire eligibility period ends, you may only make changes to your elections during open enrollment each year or during the year if you experience a qualifying event. Qualifying events include, but are not limited to:

- Birth, legal adoption, or placement for adoption.
- Marital status.
- Dependent child reaches age 26.
- Spouse/Domestic Partner gains or loses benefits eligibility with current employer.
- Death of a covered dependent.
- Spouse/Domestic Partner or dependent becomes eligible or ineligible for Medicare/ Medicaid or CHIP.
- Change in residence that changes eligibility for coverage.
- Court-ordered change.

Changes to your coverage due to a qualifying life event must be made within 31 days of that life event. Proof of the qualifying life event is required (marriage certificate, divorce decree, birth certificate, loss of coverage letter, etc.). For more information on qualifying events please visit: healthcare.gov/glossary/qualifying-life-event/

Note: Any change you make to your coverage must be consistent with the change in status.

How to Enroll

HelloFresh is using Workday's portal to enroll in benefits. To sign up for benefits, visit wd3.myworkday.com or call HelloFresh Benefits and Payroll Connect service center at **877.431.7867** to enroll. For directions on how to enroll please see the "How To Enroll" section of this guide on page 33.

Enrollment Deadlines

Type of Employee/Dependent	Enrollment Opportunity	Coverage Effective Date
New Hire	**Enroll within 31 days of Date of Hire**	**On your Date of Hire**
Employees who experience a Qualified Life Event	**Changes must be made within 31 days of life event**	**Date of the Qualifying Event**

MEDICAL

To find an in-network provider please visit cigna.com or call 877.501.7990.

CIGNA HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

There are no employee contributions for the Cigna HDHP medical plan. The Cigna medical HDHP covers both in-network and out-of-network providers. You'll see significant savings when you use providers that are in the Cigna network. With this plan, the deductible must first be met before your plan begins to pay. You can contribute to a health savings account (HSA) in order to offset this cost.

To find out if your doctors and providers are in Cigna's network, visit Cigna.com. Cigna's network is Open Access Plus (OAP).

High Deductible Health Plan (HDHP)	Cigna Medical HDHP Plan $1,600 In-Network
Calendar Year Deductible (Single/Family)	$1,600[1] / $3,200[1]
Coinsurance % (You Pay)	10%
Annual Out-of-Pocket Maximum (Single/Family)	$4,000 / $8,000
Physician Office Visits	After Medical Deductible
Routine and Preventive Care	Covered at 100%[2]
Primary Care Physician	10% coinsurance
Specialist	10% coinsurance
Telemedicine (MDLive)	Covered at 100% [3]
X-rays and Labs	10% coinsurance
Prescription Drugs	After Medical Deductible
Retail 30-day supply (Tier 1 / Tier 2 / Tier 3)	$10 / $30 / $50
Mail Order 90-day supply (Tier 1 / Tier 2 / Tier 3)	$25 / $75 / $125
Outpatient Care	After Medical Deductible
Outpatient Surgery	10% coinsurance
Urgent Care	10% coinsurance
Hospital	After Medical Deductible
Inpatient	10% coinsurance
Emergency Room	$500 copay, and 10% coinsurance after deductible

1. The Cigna Medical HDHP Plan $1,600 has an aggregate deductible. Under an aggregate deductible, if you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.

2. Not all preventive care services are covered. For example, immunizations for travel are generally not covered. See your plan materials for a complete list of covered preventive care services.

3. If you are in the HDHP plan, virtual care through MDLIVE is free for all services through 12/31/24. After 12/31/24, preventive care will continue to be covered at 100%. For all other services, the plan will pay 100% after you have reached your deductible. You can see your specific cost on both myCigna and MDLIVE before making an appointment. Costs for an MDLive visit range from $55 - $125.

Please note: The above chart shows your medical plan benefits for in-network coverage only. Your plan offers out-of-network benefits; however, benefits are reduced when care is provided out-of-network. The chart above is a brief summary of your medical benefits and does not include all the details about benefit plan features and rules. For details and the terms of your medical and pharmacy plan benefits, refer to your Certificate of Insurance. If there are any inconsistencies between this document and the official Plan document and certificates of insurance, the Plan documents or certificates of insurance will prevail.

CIGNA TRADITIONAL OAP PLANS

Cigna medical traditional plans provide access to a large, national network of quality providers through the OAP network. For 2024, you have a choice of two Cigna traditional plans. One has a higher deductible with lower payroll contributions. The other has a lower deductible with higher payroll contributions. You'll pay less for services when using in-network providers.

To find in-network care near you, visit Cigna.com. Questions, call Cigna 24/7 at **877.501.7990**. Cigna's network is Open Access Plus (OAP).

Traditional Plans	Cigna Medical Traditional OAP Plan $4,000 In-Network[2]	Cigna Medical Traditional OAP Plan $1,500 In-Network
Calendar Year Deductible (Single/Family)	$4,000 / $8,000	$1,500 / $3,750
Coinsurance % (You Pay)	30%	20%
Annual Out-of-Pocket Maximum (Single/Family)	$7,350 / $14,700	$4,000 / $10,000
Physician Office Visits		
Routine and Preventive Care	Covered at 100%[1]	Covered at 100%[1]
Primary Care Physician	$50 copay	$35 copay
Specialist	$75 copay	$60 copay
Telemedicine (MDLive)	$0 copay	$0 copay
X-rays and Lab	30% coinsurance after deductible	20% coinsurance after deductible
Prescription Drugs		
Retail 30-day supply (Tier 1 / Tier 2 / Tier 3)	$10 / $40 / $60	$10 / $35 / $70
Mail Order 90-day supply (Tier 1 / Tier 2 / Tier 3)	$25 / $100 / $150	$25 / $88 / $175
Outpatient Care		
Outpatient Surgery	30% coinsurance after deductible	20% coinsurance after deductible
Urgent Care	$75 copay	$75 copay
Hospital		
Inpatient	30% coinsurance after deductible	20% coinsurance after deductible
Emergency Room	$500 copay, waive if admitted	$500 copay, waive if admitted

[1]Not all preventive care services are covered. For example, immunizations for travel are generally not covered. See your plan materials for a complete list of covered preventive care services.
[2]If you reside in Massachusetts, the Cigna Medical Traditional OAP Plan $4,000 will not be available to you.

Please note: The above chart shows your medical plan benefits for in-network coverage only. Your plan offers out-of-network benefits; however, benefits are reduced when care is provided out-of-network. The chart above is a brief summary of your medical benefits and does not include all the details about benefit plan features and rules. For details and the terms of your medical and pharmacy plan benefits, refer to your Certificate of Insurance. If there are any inconsistencies between this document and the official Plan document and certificates of insurance, the Plan documents or certificates of insurance will prevail.

Bi-Weekly Medical/Rx Employee Payroll Contributions

26 contributions per year

Cigna Medical HDHP Plan

	Cigna Medical HDHP $1,600
Employee	$0.00
Employee + Spouse or Domestic Partner	$0.00
Employee + Child(ren)	$0.00
Family	$0.00

Cigna Medical Traditional OAP Plans

	Cigna Medical Traditional OAP Plan $4,000	Cigna Medical Traditional OAP Plan $1,500
Employee	$29.52	$39.93
Employee + Spouse or Domestic Partner	$88.56	$117.11
Employee + Child(ren)	$75.28	$95.82
Family	$184.50	$199.63

CIGNA MEDICAL RESOURCES

You have a variety of medical tools and resources available to you if you are enrolled in one of the Cigna medical plans. Log in to myCigna.com to access the resources available to you.

Pharmacy

- Once you're a Cigna customer, you can log in to myCigna.com to find in-network pharmacies that are part of your plan.
- Find out if your medications are covered and which tier they are in. Lower-cost brand-name drugs and generics are usually in Tiers 1 and 2. You will save the most money when you use Tier 1 drugs.
- If you take medicines regularly or need them on a long-term basis, you can save time with home delivery. You may also save money. You can receive a 90-day supply of your drugs delivered to your door. Maintenance medicines can vary in amounts. Once you're a member, visit myCigna.com to sign up.
- Generic contraceptives and diaphragms are covered and available at no additional cost.
- If you have a complex health condition that requires specialty drugs for your treatment contact Cigna at **877.501.7990.**
- Discount sites like GoodRx can help you instantly save *(please note prescriptions acquired under these plans do not go through your insurance)*.

24/7 Health Information Line

877.501.7990

Call Cigna any time day or night to speak with a trained nurse, who can:

- Answer questions about health concerns.
- Help you decide where to go for care when your doctor, dentist, or eye doctor isn't available.
- Help you find providers and specialists in your area.
- Remind you about scheduling important screenings and exams, including dental check ups.

Cigna One Guide

Your Cigna One Guide team can help you:

- Understand how your plan works.
- Get answers to all your health plan questions.
- Find in-network providers.
- Get cost estimates to avoid surprises.
- Connect with health coaches for one-on-one support.

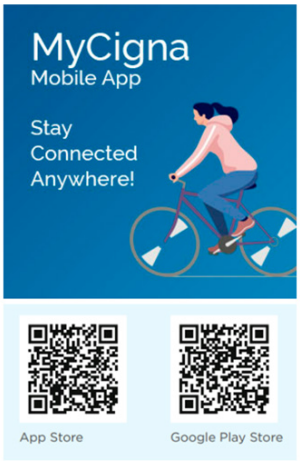
Call **877.501.7990** or click-to-chat with your personal guide on myCigna.com or the myCigna App.

myCigna App

The myCigna App makes it easy to access all your health plan information — all in one place. Log in anytime, anywhere to:

- View medical claims, access your ID card, and receive important details about your health plan benefits.
- Track your healthcare spending and find doctors and facilities in your plan's network.
- Check what your plan covers and how much you might pay.
- Access your HSA balance (if you have one).
- Listen to hundreds of podcasts in English and Spanish to help you stay informed about your health.

Download the myCigna App from the App Store® or Google Play™[1].



Complex and Chronic Conditions

All in with Autism Program

All in with Autism offers tips, toolkits and podcasts to help families deepen their understanding of autism and learn how to come together at every stage of development. Resources include a symptom checklist and activities to help your child build their abilities at home.

To learn more, visit Cigna.com.

Behavioral Health Resources

Your Cigna plan includes a wide national network of licensed therapists, psychiatrists, nurse practitioners and behavioral health specialists. Providers can diagnose, treat and prescribe medications for many common mental health conditions such as anxiety, depression and burnout during nonemergency situations.

To find a provider or to connect to virtual behavioral care, visit myCigna.com.

Comprehensive Oncology

The Comprehensive Oncology Program can help members who are diagnosed with cancer or at high-risk of developing cancer. Patients, families and caregivers can work one-on-one with a Cigna coach. These trained nurses can help you understand a diagnosis, evaluate providers and treatment options, and provide one-on-one emotional and social support.

Cigna may reach out to you if your lifestyle and/or family history put you at risk for developing cancer, and will share cancer prevention education and information.

This service is provided as part of your Cigna medical plan at no additional cost.

Family Planning

Whether you're trying to have a baby now or hope to someday, the Cigna Healthy Pregnancies, Healthy Babies® program is here to help.

Preconception Support

- Receive 24/7 planning and infertility support.
- Get help finding local fertility resources and available benefits.

[1]The downloading and use of the myCigna App is subject to the terms and conditions of the app and the online store from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

Pregnancy Support

- Pregnancy coaches with nursing experience are available by phone 24/7 to help you with questions from morning sickness to maternity benefits.
- Coaches will support you throughout your pregnancy, helping to keep you and your baby healthy and manage any health risks you might have.

What you'll receive:

- Unlimited coaching calls.
- When you enroll in Cigna Healthy Pregnancies, Healthy Babies and complete the program, including your postpartum check-in, you'll be eligible to receive $250 when enrolled in the 1st trimester or $125 if enrolled in the 2nd trimester.
- A breast pump through Cigna at no additional cost, once you reach your 28th week of pregnancy.[1]

Additional Family Planning Support

It is important to HelloFresh that our benefits program creates a more inclusive path to parenthood. For employees enrolled in a Cigna Medical plan, HelloFresh offers medically necessary infertility treatments and a conception benefit with a $10,000 lifetime maximum for those who do not have a diagnosis of infertility.

Find a Doctor in your Cigna Plan

Your Cigna medical HDHP and traditional plans include access to a wide national network of quality providers. If your current doctors are out-of-network, consider switching to one of our in-network providers so you can save on future health care costs. To find in-network care near you, use the provider directory on **Cigna.com**. Cigna's network is the Open Access Plus (OAP) network.

Virtual Care

MDLIVE for Cigna provides personalized care for hundreds of medical and behavioral health needs. Connect with an MDLIVE board-certified doctor, dermatologist, psychiatrist or licensed therapist from the comfort of home. Virtual Care is free if you are enrolled in one of the Traditional Plans.

If you are in the HDHP plan, virtual care through MDLIVE is free for all services through 12/31/24. After 12/31/24, preventive care will continue to be covered at 100%. For all other services, the plan will pay 100% after you have reached your deductible. You can see your specific cost on both myCigna and MDLIVE before making an appointment. Costs for an MDLive visit under the HDHP for 2025 will range approximately $55-$125.

Urgent Care

- Available on-demand, 24/7/365 or by appointment.
- Treats more than 80 minor medical conditions including sinus infections, UTIs, respiratory infections and the flu.

Primary Care

- Virtual wellness screenings: Appointments must be made a minimum of 3 days in advance so you can complete your required labs and biometrics at a local Quest or Labcorp. Virtual wellness screenings are covered 100% by your Cigna medical plan.
- Routine care: Get help managing a health condition and establish a relationship with a healthcare provider by phone or video. Appointments are made based on provider availability. During these appointments, providers can order lab testing as needed.

Dermatology Care

- Visits are held via online messaging and can be started 24/7.
- Simply describe your condition, take photos of the affected area and upload them to send to an MDLIVE dermatologist, who will respond with treatment plans within 24-hours.
- Dermatology care is offered for over 3,000 hair, skin and nail conditions, such as acne, dermatitis, eczema, rosacea, and suspicious spots and moles.

Behavioral Care

- Providers can diagnose, treat and prescribe medications for many common mental health conditions during nonemergency situations.
- Appointments are required. You have the option to select the same provider for every session.

Cigna members can easily connect to an MDLIVE provider by visiting **myCigna.com** > Talk to a Doctor.

[1] If ordering a hospital grade pump, a prescription will be required.

Wellness

Preventive Care

Achieving your health goals is a journey and to help you Cigna provides multiple programs and incentives to support your overall well-being with a focus on preventive care. The purpose of preventive care is maintaining wellness and good health before you feel sick or notice any symptoms and is designed to prevent or delay the onset of illness and disease. The Center for Disease Control (CDC) asserts that treatment for chronic diseases works best when they are detected early. Preventive care is important because it alerts you to obtain prompt treatment when necessary, and it can also help reduce your overall medical expenses.

Preventive care is covered at no cost to you when you seek care with an in-network doctor if you are enrolled in a HelloFresh medical plan.

Cigna Incentives

Program	Goal/Task	Incentive Amount
Health Assessment	Health Assessment Completion	$50
Preventive Care Goals	Annual Physical including MDLIVE virtual wellness screening or OB/GYN visit	$150[1]
	Colon Cancer Screening	$25
	Prostate Screening	$25
	Cervical Cancer Screening	$25
	Routine Mammogram	$25
Omada – Diabetes Prevention Program	Digital Coaching - Complete 16 of 16 Lessons in Omada	$250
Healthy Pregnancies, Healthy Babies	Enroll in First Trimester Engagement	$250
	Enroll in Second Trimester Engagement	$125

[1]The annual physical incentive is $150 through 3/31/2024, and then the $100 incentive resumes.

Instructions on viewing and redeeming rewards for Cigna's well-being and preventive care programs is available on www.myhellofreshbenefits.com!

Cigna Healthy Rewards

With Cigna Healthy Rewards, you can receive discounts on products and services that support your health and well-being. Get discounts on the health products and programs you use every day for: Fitness Memberships and Devices, Vision Care, Lasik Surgery, Hearing Aids, Alternative Medicine, Yoga Products and Virtual Workouts. Log into myCigna.com and navigate to Healthy Rewards Discount Program.

Hinge Health

Virtual Muscle and Joint Care Program

Living with pain or decreased mobility can be frustrating and discouraging. In addition, scheduling and traveling to physical therapy appointments can be challenging. To help you manage the treatment of muscle and joint problems, you can enroll in free virtual physical therapy through Hinge Health on any HelloFresh Cigna medical plan.*

Hinge Health is designed to make it easy to begin — and stick with — a physical therapy program right from the comfort of your home. It can address most types of back and joint issues, helping to reduce pain and improve strength and mobility as you recover from surgery, work to avoid surgery or try to reduce the need for medication.

With Hinge Health:

- Be matched with a licensed professional physical therapist to receive an evaluation and personalized treatment plan.
- Live virtual consultation and instruction will show you how to use sensors and monitors that provide real-time feedback to correct your form as you do prescribed exercises.
- Your physical therapist will review your progress and make adjustments to your program as needed.
- Watch educational videos, chat regularly with your physical therapist, and apply behavioral therapy strategies to help train your brain as you work your body.

*Hinge Health is free on the HDHP plan through 12/31/24.

ACCIDENT AND HOSPITAL INSURANCE

UNUM

Accident Insurance

Accident Insurance provides a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on or off the job. And it includes a range of incidents, from common injuries to more serious events. It can help you with out-of-pocket costs that your medical plan doesn't cover, such as co-insurance, co-pays and deductibles. The cost is conveniently deducted from your paycheck. You can keep your coverage if you change jobs or retire, and you will be billed directly by Unum.

You can elect coverage for yourself, spouse, domestic partner, and eligible dependent children.

Bi-Weekly Accident Insurance Payroll Contributions

	Low Plan	High Plan
Employee Only	**$3.18**	**$4.10**
EE + Spouse/Domestic Partner	**$5.79**	**$7.42**
EE + Children	**$7.13**	**$9.28**
EE + Family	**$9.74**	**$12.59**

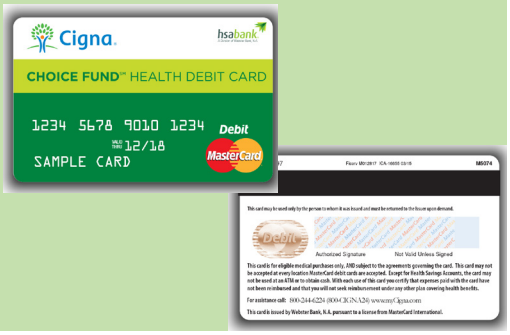
Hospital Insurance

Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness, or childbirth. The money is payable directly to you – not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, copays, and deductibles. The cost is conveniently deducted from your paycheck. You can keep your coverage if you change jobs or retire, and you will be billed directly by Unum.

You can elect coverage for yourself, spouse, domestic partner, and eligible dependent children.

Bi-Weekly Hospital Insurance Payroll Contributions

	Low Plan	High Plan
Employee Only	**$3.29**	**$6.01**
EE + Spouse/Domestic Partner	**$6.52**	**$11.91**
EE + Children	**$4.46**	**$8.13**
EE + Family	**$7.69**	**$14.04**



HEALTH SAVINGS ACCOUNT (HSA)

CIGNA Available to participants in the HDHP $1,600 medical plan.

If you are enrolled in the HDHP $1,600 medical plan, you have the option to contribute to a Health Savings Account (HSA) with HSA Bank through Cigna. Members can access the HSA Bank Customer website via myCigna.com. On myCigna, you can link to the HSA Bank Customer Website which gives you 24/7 online access to your account.

Now is the time to consider contributing to a Health Savings Account (HSA), since there are no employee payroll contributions for the HDHP $1,600 medical plan. An HSA is a tax-advantaged savings account that can be used to pay for qualified health care expenses as well as eligible pharmacy, dental and vision expenses. Or use the funds to save for future expenses. Please visit cigna.com/individuals-families/member-guide/eligible-expenses for a list of eligible HSA expenses.

An HSA provides triple tax benefits: The money you contribute is pre-tax, and the interest that accumulates in the account is tax-free. In addition, money withdrawn from an HSA isn't taxed, provided you use it for qualified health care expenses. Like a savings account, you will only be able to withdraw funds that are in the account.

How to get started: Set up your HSA payroll contributions during enrollment or any time throughout the year on Workday's enrollment portal. You can make changes at any time throughout the year.

You'll receive a debit card from HSA Bank: Your HSA Bank account balance earns interest, and once your balance reaches $1,000, you can invest it in mutual funds. There is no investment account fee.

Additionally, there is a $1.25 monthly fee for paper statements deducted from your account. The monthly paper statement can be started or stopped after the account has been opened by visiting myCigna.com. The online statements are always free of charge.

HSA ADVANTAGES

- You can use the account to pay for qualified healthcare expenses with pre-tax dollars.
- Unspent dollars roll over each year and are yours to keep if you retire or leave the company.
- You can invest your HSA funds, so your available healthcare dollars can grow over time.

You are eligible if:

- You are enrolled in the Cigna HDHP plan.
- You are not covered by any Traditional plan.
- No one else can claim you as a dependent
- You are not enrolled in Medicare, TRICARE or TRICARE for Life
- You have not received VA benefits in the past 3 months

How Much Can Be Deposited into an HSA in 2024?

<55[1]

- Up to **$4,150** for individual
- Up to **$8,300** for family[2]

[1]Not enrolled in Medicare

[2] If you have a domestic partner you are only eligible for the individual limit.

The maximum contribution increases by **$1,000**

[1]Not enrolled in Medicare

55+[1]

Note: If you enroll in this plan, you will not be able to make a healthcare FSA election.

FLEXIBLE SPENDING ACCOUNT (FSA)

FLORES

What is a Flexible Spending Account?

A flexible spending account (FSA) is an account that can reimburse you for qualified healthcare or dependent care expenses. You can pay for qualified expenses with pre-tax dollars deducted from your paychecks. You are eligible to participate in two separate FSA accounts, a Healthcare FSA and a Dependent Care FSA.

When electing an FSA, you will set an annual contribution amount. Healthcare FSA account balances over the limit of **$640** do not rollover year over year, so you will have until the end of your plan year to use the funds in your Healthcare FSA. Your Healthcare FSA plan year ends on December 31, 2024 or your termination date, whichever is sooner. Reimbursement claims for expenses incurred during the plan year must be submitted within 90 days of the plan year ending. For the Dependent Care FSA, a 2.5 month grace period is available and you have until March 14th, 2025 to incur new expenses towards your account. Any funds left in the account after the claims submission deadline of March 30, 2025 will be forfeited. When electing an amount to contribute to an FSA, the goal is to choose an amount that will cover healthcare or dependent care expenses, but that is not so high that the money will be forfeited at the end of the year.

You can choose to participate in one or both accounts, and it's not necessary to "sign up" specific family members for these accounts. You can manage your FSA accounts at flores247.com or on the Flores mobile app. If you are enrolled in the HDHP you are not eligible to participate in the Healthcare FSA.

Please note, you are unable to make changes to your FSA elections during the plan year unless you have a qualifying life event. Examples of qualifying events include changes in marital status such as a marriage or divorce or the birth or adoption of a child. Additionally, In the Dependent Care FSA, a change in your dependent's eligibility (for example, your child reaches age 13 and is no longer eligible) would also be considered a qualifying life event.

Healthcare FSA

A Healthcare FSA reimburses employees for eligible medical, dental and vision expenses, up to the amount elected for the plan year. Eligible healthcare expenses include many of the out-of-pocket expenses you pay to maintain your health and well-being. You can also use the Healthcare FSA to reimburse eligible expenses for your dependents. Visit irs.gov for a full list of eligible expenses.

For 2024, you may contribute up to the limit of **$3,200** (funds will be available as of the plan effective date).

Dependent Care FSA

You may use pretax dollars from your Dependent Care FSA to pay expenses for the care of a dependent child up to age 13, spouse or elderly parent inside your home (from a qualified provider), and expenses outside your home, such as babysitters, nursery schools, or day care centers. The Dependent Care FSA DOES NOT reimburse dependent healthcare expenses.

You may contribute up to **$5,000** annually in 2024 (or **$2,500** if you are married and file a separate tax return). You can only be reimbursed up to the amount that you have contributed.

COMMUTER SPENDING ACCOUNTS

FLORES

Commuter Spending Accounts let you set aside a portion of your salary on a before-tax basis to pay public transportation and/or parking expenses that you incur commuting to and from work. By using pre-tax money, you lower your taxable income. Visit **flores247.com** for more information.

You will receive a debit card from Flores to use at the point of purchase to pay for your parking and/or transit expenses. Please note that your debit card will not allow you to spend more than you have contributed to date. You also cannot swipe the card for an amount that exceeds the IRS monthly maximum in a given month. Please note, you will receive one card from Flores for the flexible spending accounts and/or commuter spending account.

You are eligible to participate in two different accounts - parking or transit. You are eligible to participate in one account or both the parking and transit account. Please be aware that these funds only stay with you if you are an active employee. If you leave HelloFresh, you will no longer have access to your account. Reimbursement claims for expenses incurred while you were an active employee must be submitted to Flores within 90 days of your termination date. After this, any remaining funds will be forfeited.

These are two types of eligible expenses:

Commuter Parking	Expenses incurred by you to park your car on or near the business premises of your company and/or expenses incurred by you to park your car on or near a location from which you commute to work.
Commuter Transit	Expenses incurred commuting to and from work. Transit expenses can be used for items such as transit passes (bus/light rail/subway), tokens, fare cards, vouchers, vanpools or similar mass transit. You can not use this for tolls, UBER/Lyft or other items with your personal vehicle.

Contribution Limits

	Per Month
Commuter Parking	**$315**
Commuter Transit	**$315**

DENTAL

CIGNA

Cigna's Total DPPO Network offers convenient access to quality dentists and savings on covered dental services. Although you can choose any dental provider, you can save by using a dentist in your plan's network. To check if your dentist is in-network, use the provider directory on Cigna.com.

	Cigna Dental Plan
Annual Deductible (Individual / Family)	$50 / $150
Annual Plan Maximum	$1,500
Diagnostic and Preventive Services (Deductible Waived)	You pay nothing
Basic Services	You pay 20%/50% coinsurance depending on service
Major Services	You pay 50% coinsurance
Orthodontia (Dependent Children up to age 19)	$1,500 lifetime maximum , You pay 50% coinsurance

Your plan includes out-of-network benefits, see plan summary for additional details.
Please note, adult orthodontia is not covered under the dental plan.

Dental Virtual Care

Cigna Dental Virtual Care is offered through The TeleDentists. You and your covered family members can see a dentist from the comfort and safety of home via video call – with no copay or coinsurance costs (does count towards Annual Plan Maximum). With The TeleDentists, you can:

- Connect 24/7/365 with licensed dentists
- Get help with urgent dental needs, such as a toothache, an infection, swelling, bleeding and more
- Get advice and guidance for more involved care, if necessary
- Have a prescription sent directly to your pharmacy, if appropriate

Connect with The TeleDentists by visiting myCigna.com > Find Care & Costs.

VISION

EYEMED

HelloFresh offers you the opportunity to elect voluntary vision coverage through EyeMed. Our vision care benefits include coverage for eye exams, lenses and frames, contact lenses, and discounts for laser surgery. The vision plan is built around the EyeMed providers, who have higher benefits at a lower cost to you. When you need services, consider using an in-network provider for the most bang for your buck! When you use an out-of-network provider, you will be reimbursed for services according to the grid below. Your benefits are provided through the **Insight network** with EyeMed. To locate an in-network provider, visit eyemed.com.

	In-Network	Out-of-Network
Examination (Once every plan year)	$15 copay	$40 allowance
Lenses (Once every plan year)		
Single	Covered in full after $25 copay	$30 allowance
Bifocal	Covered in full after $25 copay	$50 allowance
Trifocal	Covered in full after $25 copay	$70 allowance
Frames (Once every other plan year)		
New Frames	$0 copay; 20% off balance over $130 allowance	$91 allowance
Contact Lenses (Once every plan year)		
Conventional	$0 copay; 15% off balance over $125 allowance	$91 allowance
Disposable	$0 copay; 100% of balance over $125 allowance	$91 allowance
Medically Necessary	$0 copay; paid in-full	$210 allowance

Plan allows member to receive either contacts and frame, or frame and lens services.

Bi-Weekly Dental and Vision Employee Payroll Contributions

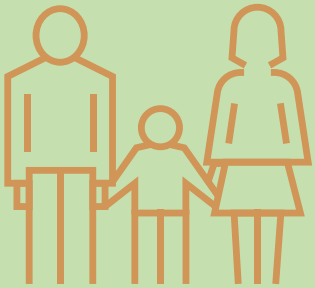
26 contributions per year

Dental

Cigna Dental Plan	
Employee	$1.91
Employee + Spouse or Domestic Partner	$7.42
Employee + Child(ren)	$8.82
Family	$17.26

Vision

EyeMed Vision Plan	
Employee	$0.66
Employee + Spouse or Domestic Partner	$1.82
Employee + Child(ren)	$1.68
Family	$2.93



LIFE AND DISABILITY INSURANCE

UNUM

Life Insurance

Please remember to add beneficiary information in Workday during enrollment.

We provide Basic Life and Accidental Death and Dismemberment (AD&D) insurance at no cost to you!

Insurance Coverage	Benefit
Basic Life and AD&D[2,3]	**1X annual earnings up to $500,000[1]**

[1]Annual earnings are rounded to the next higher $1,000
[2]Evidence of Insurability (EOI) is not required for basic life and AD&D coverage.
[3] Under the tax law, the value of employer-provided group term life insurance in excess of $50,000 is taxable. The value is determined by your age and schedule established by the IRS If you make over $50,000 a year, this is added to your gross wages and is included on your form W-2 at the end of the year. Please see page 15 of IRS Publication 15-B for more information www.irs.gov/pub/irs-pdf/p15b.pdf.

If you would like additional coverage, Voluntary Life and AD&D insurance is available to you, your spouse, domestic partner and your eligible dependent children. You must enroll in coverage for yourself in order to cover your spouse, domestic partner or children. If you don't enroll in Voluntary Life when it's first available to you, or elect an amount over the Guaranteed Issue, you will be required to complete an Evidence of Insurability (EOI) form. If you previously elected coverage and want to elect an additional amount up to the guaranteed issue during Open Enrollment, you will not be required to complete an EOI form. Evidence of Insurability (EOI) is when you provide information on you or your dependent's health conditions in order to be granted eligibility for coverage. You can fill out an EOI form when you go through enrollment on Workday.

Insurance Coverage	Benefit
Voluntary Employee Life and AD&D	Amounts in $10,000 increments are available up to a maximum of 6X annual earnings or $500,000, whichever is less. You can elect up to $150,000 in coverage, with guaranteed issue, without EOI.
Voluntary Spouse Life and AD&D	Amounts in $5,000 increments are available up to a maximum of 100% of employee life or $250,000, whichever is less. You can elect up to $25,000 in coverage, guarantee issue, without EOI.
Voluntary Child Life and AD&D	▪ Live birth to 14 days: $1,000 ▪ 14 days to 6 months: $2,000 ▪ 6 months to 19 years (or 26 if FT student): Amounts in $2,000 increments are available up to a maximum of $10,000

Disability

HelloFresh provides you Short-Term and Long-Term Disability coverage at no cost to you. HelloFresh also offers employees who make over $50,000 per year the option of purchasing enhanced Long-Term Disability coverage. These plans give you income protection in the event you are ill or injured in a non-work related injury, and can't come to work. If you don't enroll in the long-term disability buy-up plan when it's first available to you, you will be required to complete an Evidence of Insurability (EOI) form. You can fill-out an evidence of insurability form when you go through enrollment on Workday.

	Short-Term Disability Benefits (ER Paid)	Long-Term Disability Base (ER Paid)	Long-Term Disability Buy-Up (EE Paid)
Elimination Period	14 days	180 days	180 days
Benefit	60% of weekly earnings	60% of monthly salary	60% of monthly salary
Maximum Benefit	$2,500 per week	$2,500 per month	$10,000 per month
Maximum Benefit Period	24 weeks	Social Security Normal Retirement Age (SSNRA)	Social Security Normal Retirement Age (SSNRA)

Bi-Weekly Life and Disability Employee Payroll Contributions

26 contributions per year

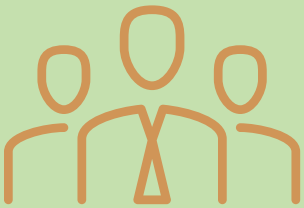
Voluntary Life and AD&D

Age	Employee Life per $10,000 of Coverage	Spouse Life per $5,000 of Coverage
15-24	$0.166	$0.083
25-29	$0.189	$0.095
30-34	$0.254	$0.127
35-39	$0.378	$0.189
40-44	$0.577	$0.288
45-49	$0.895	$0.448
50-54	$1.320	$0.660
55-59	$1.883	$0.942
60-64	$2.418	$1.209
65-69	$3.443	$1.722
70-74	$6.512	$3.256
75+	$20.132	$10.066
	Employee AD&D per $10,000 of Coverage	Spouse AD&D per $5,000 of Coverage
	$0.070	$0.040
Child Life Rate per $2,000	$0.166	

Buy-Up Disability

Buy-Up Long-Term Disability	
Bi-Weekly Rate	$0.0485

Buy-Up Long-Term Disability			
Annual Salary	$	/ 12 months =	$ (Maximum = $16,668)
Monthly Earnings	$	/ $100 =	(Maximum = $166.68)
Benefit Rates	$	X (.04855) =	(your bi-weekly deduction)



EMPLOYEE ASSISTANCE PROGRAM

HEALTH ADVOCATE THROUGH UNUM

HelloFresh is pleased to offer an Employee Assistance Program (EAP) through Health Advocate to assist you and your family through difficult times. Health Advocate's EAP services are available to all full-time employees and their spouses or domestic partners, dependent children, parents, and parents-in-law. The EAP includes 3 visits with a licensed professional counselor or work/life specialist per incident.

Employee Assistance Program

Your EAP is designed to help you lead a happier and more productive life at home and at work. Call for confidential access to a Licensed Professional Counselor[1] who can help you with the following issues and more:

- Stress, depression, anxiety
- Relationship issues, divorce
- Anger, grief and loss
- Job stress, work conflicts
- Family and parenting problems

Work/Life Balance

You can also reach out to a specialist for help with balancing work and life issues. Just call and one of our Work/Life Specialists can answer your questions and help you find resources with the following and more:

- Child care
- Elder care
- Financial services, debt management, credit report issues
- Identity theft
- Legal questions
- Reducing your medical/dental bills

Help is easy to access:

- Phone- 1-800-854-1446
- Online Support- unum.com/lifebalance
- In-Person Support- You can get up to three visits per incident, available at no additional cost to you with a Licensed Professional Counselor. Your counselor may refer you to resources in your community for ongoing support.

[1] The counselors must abide by federal regulations regarding duty to warn of harm to self or others. In these instances, the consultant may be mandated to report a situation to the appropriate authority. Unum's Employee Assistance Program and Work/Life Balance services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details. Insurance products are underwritten by the subsidiaries of Unum Group.

Legal

Visit your EAP+WorkLife site (**unum.com/lifebalance**) for state-specific templates and step-by-step instructions on creating a will. Your Personalized Legal Center also contains state-specific templates for power of attorney, trusts, estate planning, and more as well as access to a legal library.

You have access to a variety of personal and business-related topics at no cost to you:

- Wills
- Living Trusts
- Personal Service Agreements
- Promissory Notes
- Copyright & Trademark
- Power of Attorney
- Landlord/Tenant Agreement
- Name Change
- Incorporation
- Premarital Agreements

ADDITIONAL BENEFITS

Benefit	Description	Contact Information	Who pays?
Medical Bill Saver	**Medical Bill Saver is available to HelloFresh employees and gives employees a place to turn when faced with unplanned medical or dental expenses. Medical Bill Saver will:** ▪ Contact doctors, dentists, hospitals, surgery centers and other providers on employees' behalf to negotiate discounts on the balance due and/or payment plans. ▪ Obtain provider signoff on payment terms and conditions. ▪ Provide a Savings Results Statement summarizing the outcome.	**Health Advocate through UNUM** **866.799.2655**	Employer Paid
Travel Assistance Program	**Whenever you travel 100 miles or more from home — to another country or just another city — travel assistance can help you locate hospitals, embassies and other "unexpected" travel destinations.** **Use your travel assistance phone number to access:** ▪ Hospital admission assistance and Emergency medical evacuation. ▪ Prescription replacement assistance. ▪ Transportation for a friend or family member to join a hospitalized patient and care and transport of unattended minor children. ▪ Assistance with the return of a vehicle. ▪ Referrals to Western-trained, English-speaking medical providers. ▪ Legal and interpreter referrals. ▪ Passport replacement assistance.	**Assist America through UNUM** **Within the US: 1.800.872.1414** **Outside the US: 609.986.1234** **Email:** **medservices@assistamerica.com** **Reference Number:** **01-AA-UN-762490**	Employer Paid

BRIGHT HORIZONS

HelloFresh has partnered with Bright Horizons to provide free back-up care and education needs for you and your family. For more detailed information, visit the HelloFresh benefits website www.myhellofreshbenefits.com.

Child Care Resources

Get an edge in your search for convenient, high-quality child care. Jump ahead on the waiting list at select highly desirable Bright Horizons child care centers nationwide with preferred enrollment access. Your registration fee will get waived when you sign up. Or, take advantage of exclusive tuition discounts (up to 10%) at participating high-quality network centers across the country.

Back-Up Care Benefits for Your Whole Family

Whether school's closed or a regular caregiver is unavailable, rely on Bright Horizons Back-Up Care™ and get high-quality child care in a center or care in your home for your child or adult/elder relative, whenever you need an extra hand. To register visit https://backup.brighthorizons.com. Employer Username: hellofresh | Password: hfcares

Help with Tutoring and Test Prep

Bright Horizons provides access to high-quality tutoring and test prep providers offering a variety of online and in-person options with exclusive discounts for children ages 5-18. Delivered by trusted professionals, Bright Horizons helps students succeed by boosting academic performance and reducing family stress.

Virtual Camp Overview

Looking for new activities for your child while you focus on work when you're at home? HelloFresh has you covered! Virtual camps will be offered weekdays from 9:00am – 6:00pm ET and available for children ages 3-12. These camps offer a range of activities including crafts, Roblox, fitness, Minecraft, digital art, space exploration, mathletes, acting games and more!

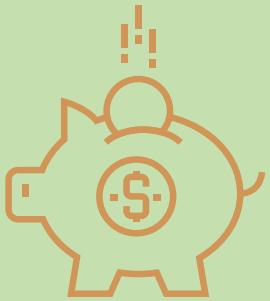
Pet Care

Bored pets? Not on our watch! Access walkers, sitters, daycare, overnight boarding, and more through your Bright Horizons Back-Up Care™ benefit.

Additional Resources

With Bright Horizons, you are also able to access the following family support resources. Please visit clients.brighthorizons.com/hellofresh to learn more.

- Discounted Nanny Placement
- Search For Sitters, Nannies & Housekeepers
- Find Elder Care Resources
- Search for Quality Pet Care



401(k) PLAN

Start Your Prep for Retirement Today

What's the number one most important thing you can do when it comes to retirement? It's very simple; get started by enrolling in the HelloFresh 401(k) Retirement Savings Plan through Voya!

When You Can Join

You can join the plan as an active participant immediately after you meet the following requirements:

- You are an eligible employee
- You are age 21 or older, and
- You have completed 3 consecutive months of employment.

401(k) Elective Deferral Contributions

When you sign up, you decide how much you want to defer. Your 401(k) elective deferral contribution will be a pre-tax elective deferral contribution unless you designate all or a portion as Roth after-tax elective deferral contribution. You are able to update your election at any time throughout the year, and updates will be reflected within 1 to 2 pay cycles.

Matching Contributions

HelloFresh's matching contributions give you an additional return on the amount you defer. The plan offers a Safe Harbor match of 100% of your contribution up to 3% of compensation and then 50% of the next 2%. If you contribute 5% or more of your compensation into the 401(k) you will receive the full employer match of 4%. You will receive the HelloFresh matching contribution for each pay period that you contribute.

Limits

401(k) Elective Deferral Limits: The IRS sets each year's contribution limit. For 2024 the employee salary deferral limit is **$23,000** plus if you will be at least age 50 by the end of the year, you are eligible to make an additional **$7,500** catch up contribution.

Withdrawals from Your Account

There are specific scenarios where you can withdraw funds from your account. If you are separated from service or are age 59 1/2 or older, you may withdraw all or any part of your vested account under certain circumstances.

Vesting in Your Account

You are always **100%** vested in the part of your account resulting from the following: 401(k) elective deferral contributions, qualified non-elective roll-over contributions and the Safe Harbor match.

Enroll Now

Call 888-311-9487

Plan Number - 551637
Verification Number - 55163799
Rollover Services - 866-865-2660
Enrollment Website - enroll.voya.com
Participant Website - VoyaRetirementPlans.com

Pay Yourself to Save

If you decide to invest, doing so with the HelloFresh 401(k) Plan may keep more money in your pocket today. Consider the chart below showing the difference between investing with a plan versus investing outside a plan.

Ann makes $40,000 a year and decides to put aside 6% of her bi-weekly pay for the future.[1]		
	If she contributes to the 401(k) Plan	If she saves outside the 401(k) Plan
Her bi-weekly paycheck	**$1,539**	**$1,539**
6% of her bi-weekly pay contributed to the plan	**- $92**	**N/A**
Her new taxable income	**$1,447**	**$1,539**
Federal income taxes	**-$405**	**-$431**
Take-home pay	**$1,042**	**$1,108**
Money saved outside the plan	**N/A**	**-$92**
Money left in her pocket per bi-weekly paycheck	**$1,042**	**$1,016**

[1]This hypothetical illustration assumes a bi-weekly savings of $92– or six percent of pay – equal to $2,400 per year and a federal tax rate of 28 percent and is for demonstration purposes only. It is not intended to (1) serve as financial advice or as a primary basis for your investment decisions and (2) imply the performance of any specific security. Please note that distributions will be taxed as ordinary income when distributed and are subject to any tax penalties that may apply.

Compounding is a Multiplier Effect.[1]

The younger you start planning for retirement, the more you may benefit. By investing early in your career, you'll enjoy the potential benefits of tax-deferred growth and compounding of interest for decades. Consider Larry and Susan. Susan not only ends up with more money than Larry, but she also contributed significantly less money than him. This is one of the potential benefits of starting early.

	Larry	Susan
Age at which savings started	**45**	**25**
Monthly contribution	**$300**	**$100**
Total contribution by age 65	**$72,000**	**$48,000**
Total pre-tax savings at age 65	**$171,798**	**$324,180**

[1]This hypothetical illustration assumes each account earns an annual rate of return of 8 percent and is for demonstration purposes only. It is not guaranteed and not based on the rate of return of any particular investment and does not include costs incurred under a particular investment. It is also not intended to serve as financial advice or as a primary basis for your investment decisions. Systematic investing does not ensure a profit nor guarantee against loss. Investors should consider their financial ability to continue their purchases through periods of low price levels. Taxes are generally due upon withdrawal.

Traditional vs. Roth

The HelloFresh 401(k) Plan offers an additional contribution option called the Roth after-tax. It offers you the opportunity to take tax-free distributions when you retire (as long as you meet certain qualifications) – in exchange for paying taxes on your contributions upfront. Whether Roth after-tax is right for you depends on a variety of factors. You may want to consider this option if you can answer yes to any of the following questions.

- Are you looking for tax-free growth and tax-free retirement income?
- Are you interested in minimizing taxes on your Social Security benefits in retirement?
- Are you early in your career, anticipate pay raises in the future, and want to pay taxes now rather than in retirement when your tax rate could be higher?
- Are you simply unsure what tax rates will be in the future, and you want to essentially "lock in" today's tax rates?
- Do you want to diversify your tax strategy and divide your contributions between before-tax and after-tax providing two different tax treatments on your retirement savings?

Take the following example. Stan makes $40,000 a year and wants to save six percent of his bi-weekly salary for the future. For Stan, receiving potentially tax-free retirement income means a difference of as little as $14 in his bi-weekly pay.

	Stan makes before-tax contributions to the plan:	Stan makes Roth after-tax contributions to the plan:	Stan contributes both types:
Gross bi-weekly pay	$1,538	$1,538	$1,538
Contribution percentage	6% before tax	6% after-tax	3% before tax. 3% after tax
Contribution amount	$92	$92	$92
Tax on contributions	$0	$14	$7
Total taken from pay	$92	$106	$99

Note: This hypothetical illustration assumes a bi-weekly savings of $92 – or six percent of $40,000 – and a federal tax rate of 15 percent and is for demonstration purposes only. It is not intended to (1) serve as financial advice or as a primary basis for your investment decisions and (2) imply the performance of any specific security. The introduction of the Roth after-tax option does not increase your total contribution limit to the plan. Your contributions, whether Roth after-tax or before-tax, or a combination of both in total, are subject to the Internal Revenue Code contribution limits. Taxes are generally due upon withdrawals of the tax-deferred assets and early withdrawal penalties may apply to withdrawals taken before age 59 1/2. You should consult with an advisor when you consider your options or make tax-related decisions. Legal and tax advice are not offered by Voya and its representatives.

GLOSSARY OF TERMS

DEDUCTIBLE: A deductible is the amount of money you must meet before your plan begins paying for services covered by coinsurance. Some services, such as office visits, that require copays do not apply to the deductible. For example, if your plan's deductible is $1,500, you'll pay 100 percent of eligible healthcare expenses until you have met the $1,500 deductible. After that, you share the cost with your plan by paying coinsurance.

COPAYMENT: A copayment (copay) is the fixed dollar amount you pay for certain in-network services on a Traditional plan. In some cases, you may be responsible for coinsurance after a copay is made.

COINSURANCE: Your share of the costs of a healthcare service, usually figured as a percentage of the amount charged for services. You start paying coinsurance after you've met the deductible. Your plan pays a certain percentage of the total bill, and you pay the remaining percentage.

OUT-OF-POCKET MAXIMUM: This is the most you must pay for covered services in a plan year. After you spend this amount on deductibles and coinsurance, your health plan pays 100 percent of the costs of covered benefits. However, you must pay for certain out-of-network charges above reasonable and customary amounts.

FORMULARY: A list of prescription drugs covered by the plan. Also called a drug list.

IN-NETWORK: A group of doctors, clinics, hospitals and other healthcare providers that have an agreement with your medical plan provider. You pay a negotiated rate for services when you use in-network providers.

OUT-OF-NETWORK: Care received from a doctor, hospital or other provider that is not part of the plan agreement. You'll pay more when you use out-of-network providers since they don't have a negotiated rate with your plan provider. You may also be billed the difference between what the out-of-network provider charges for services and what the plan provider pays for those services.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP): This is a type of medical plan that requires the member to reach a deductible prior to having services covered by coinsurance. All expenses paid by the member count toward the deductible and out-of-pocket maximum.

GUARANTEED ISSUE: The amount of coverage that you can receive without having to answer health questions (Evidence of Insurability). The guaranteed issue applies to the voluntary life plan and buy-up long term disability.

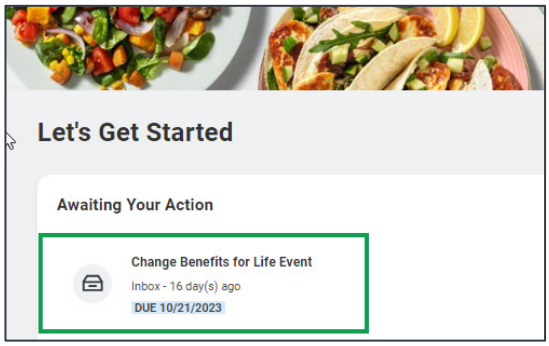
EVIDENCE OF INSURABILITY: Evidence of Insurability (EOI) is an application with medical questions that you complete in order to be considered for certain types of insurance coverage. Evidence of Insurability applies to the voluntary life and buy-up long-term disability plans.

BENEFITS ENROLLMENT FOR NEW HIRES

Enroll in Benefits

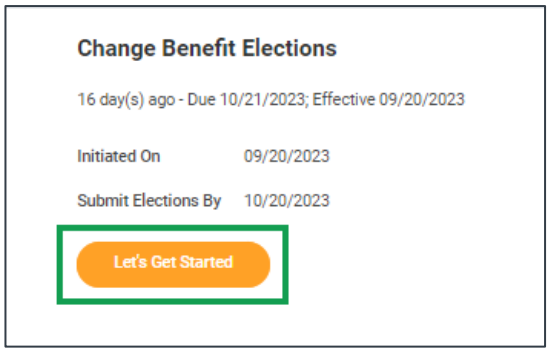
From the Workday Home Page (https://wd3.myworkday.com/hellofresh):

1. Click the **Change Benefits for Life Event** task from **Awaiting Your Action**.

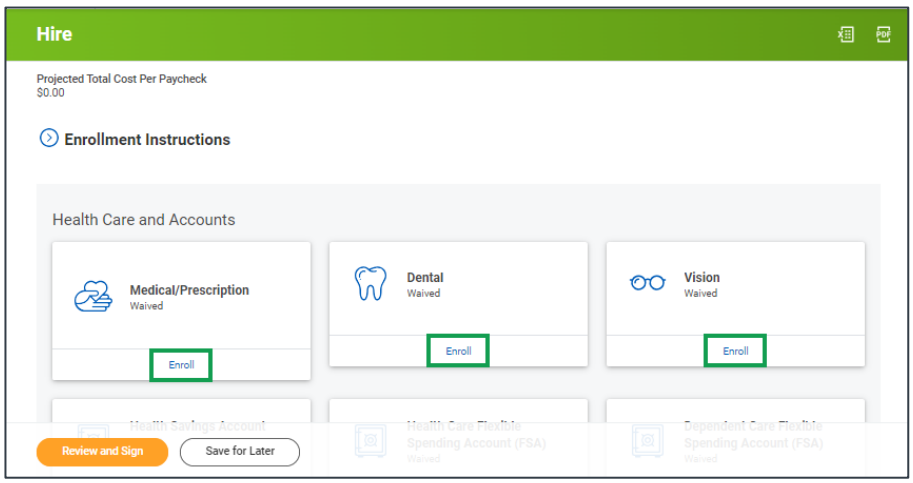


> **Note:**
> If you are unable to locate this action item, please go to your inbox to locate it.

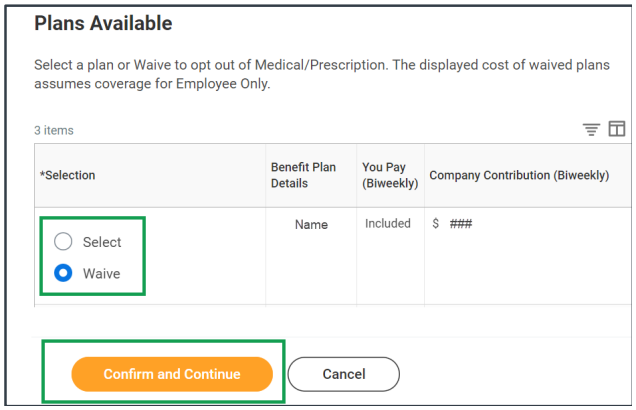
2. Your Inbox will open. Click **Let's Get Started**.



3. The Hire enrollment page displays. Click **Enroll** on each desired tile to elect the benefit.

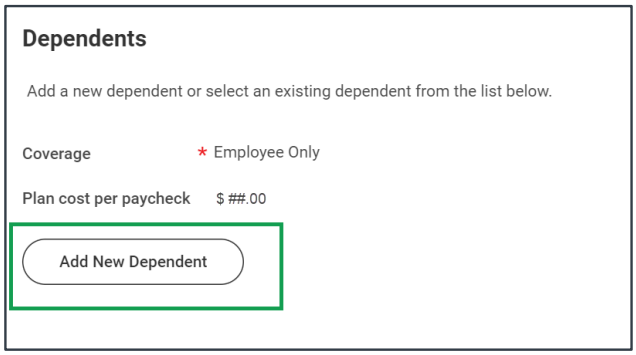


4. For the selected plan, use the radio buttons to choose **Select** or **Waive**. Then click **Confirm and Continue**.

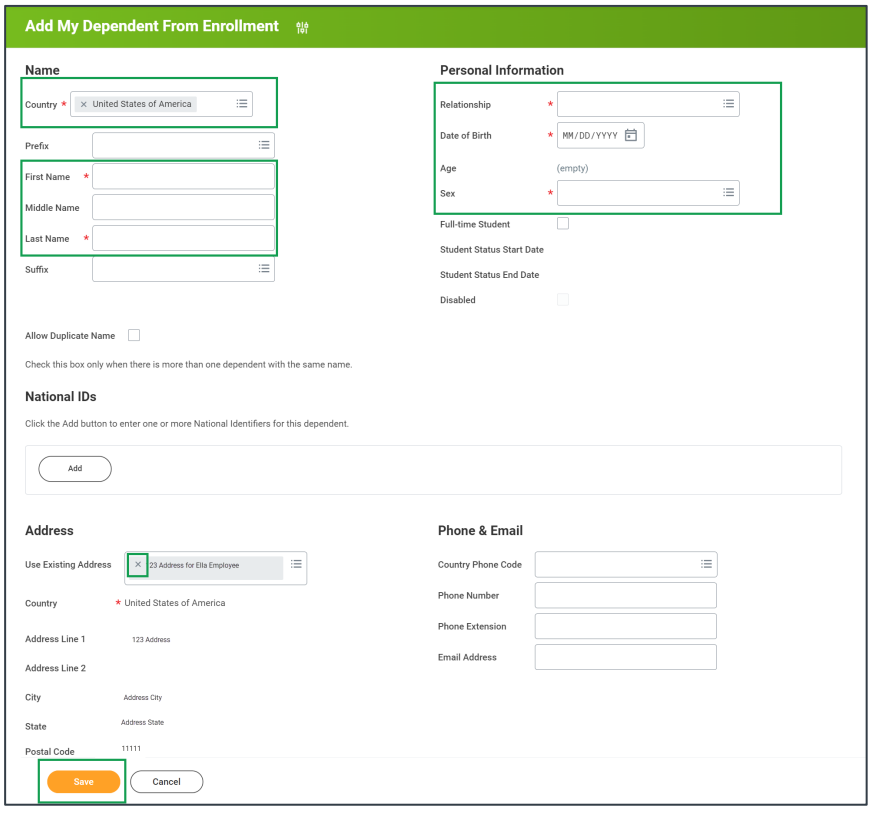


> **Note:**
>
> Accounts will default to waive.

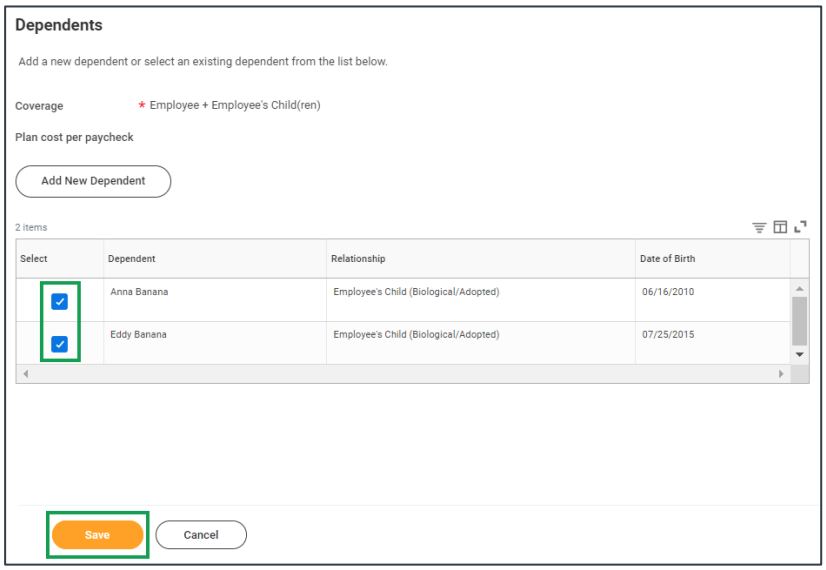
5. If the selected plan allows dependents, you may click **Add New Dependent**, then click **OK**.



6. Enter the dependent's **Country, First Name, Last Name, Relationship, Date of Birth,** and **Sex**. Your existing address will be used by default. Click X in the **Use Existing Address** prompt to add a different one. Click **Save** to return to your plan selection.



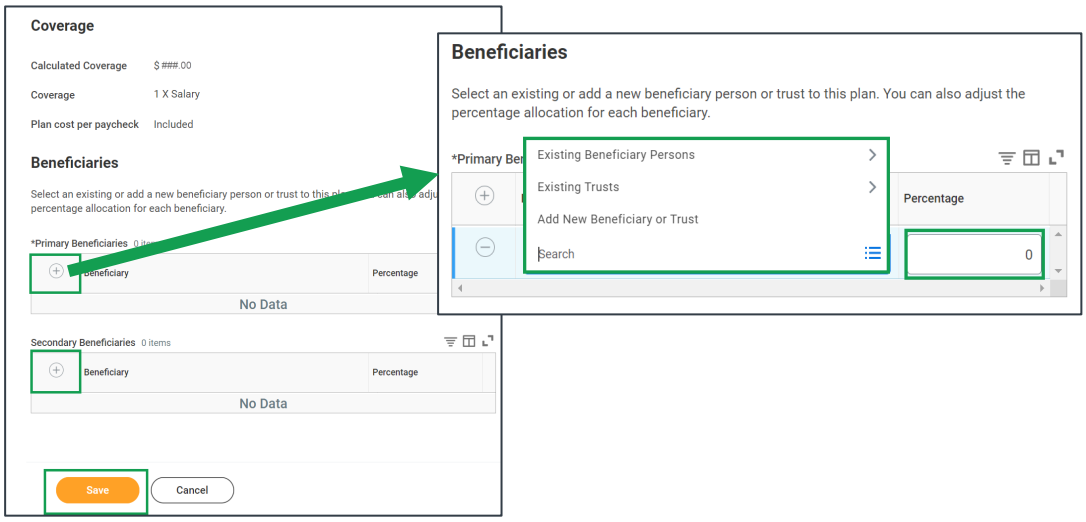
7. Be sure that the check mark appears next to the dependent(s) added, then click Save.



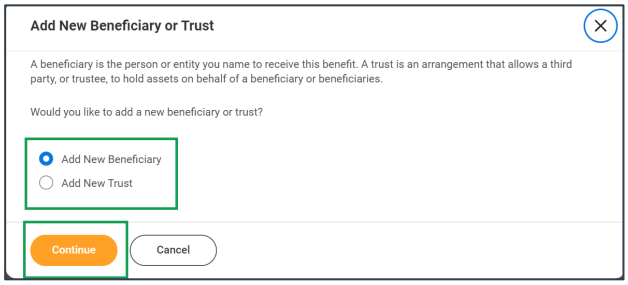
Note:

After each plan election you will get a pop up stating your benefit changes are updated but are not submitted until you click Review and Sign on the Hire enrollment page.

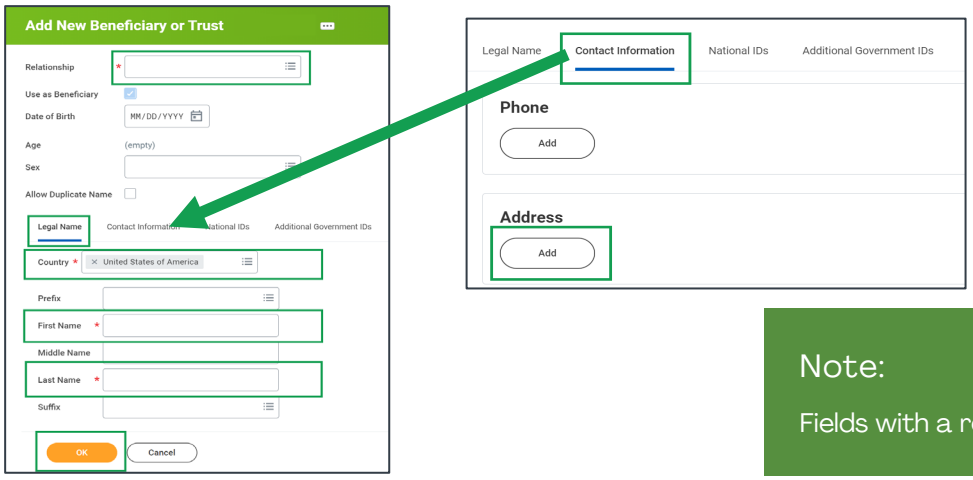
8. Life and AD&D plans require a beneficiary. To add a beneficiary, click + then add a new beneficiary or trust. Once your beneficiary is entered, select a Percentage. The Primary Beneficiary's total must add up to 100%. Secondary beneficiaries are optional. Click Save.



9. Using the radio buttons select **Add New Beneficiary or Trust** then click **Continue**.



10. Enter the beneficiary's **Relationship** and the required fields from the **Legal Name** tab. Enter their **Address** on the **Contact Information** tab. Click **OK** to save.



Note:

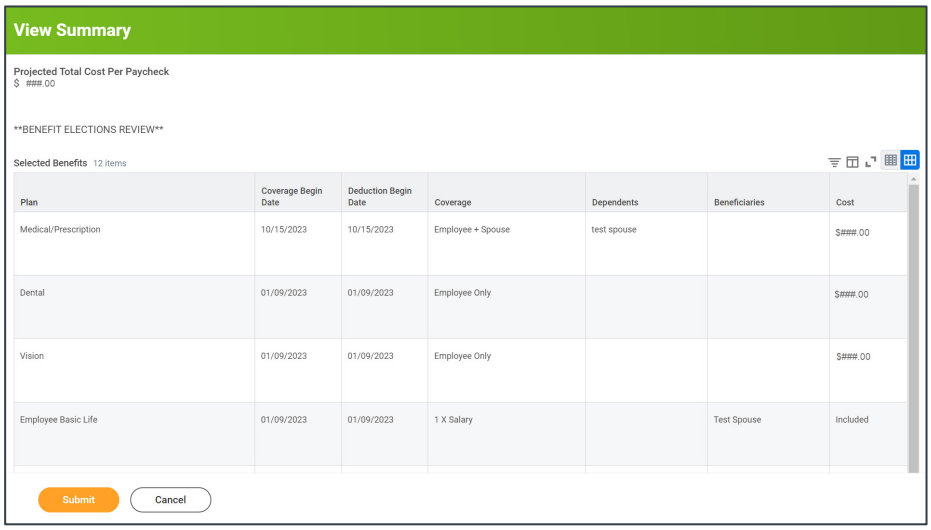
Fields with a red asterisk are required.

11. When you have finished enrolling in your benefits, click **Review and Sign**.

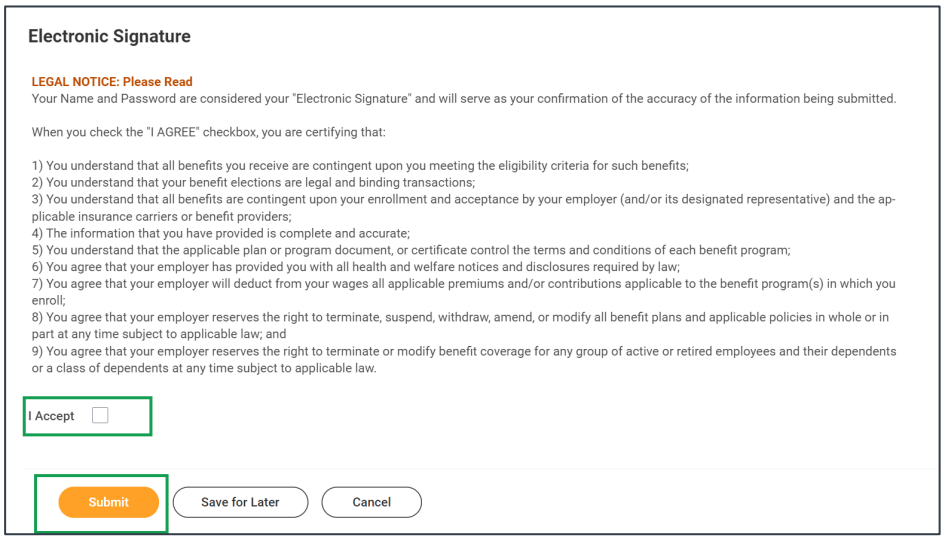
Note:

You have an option to select Existing Address for beneficiary

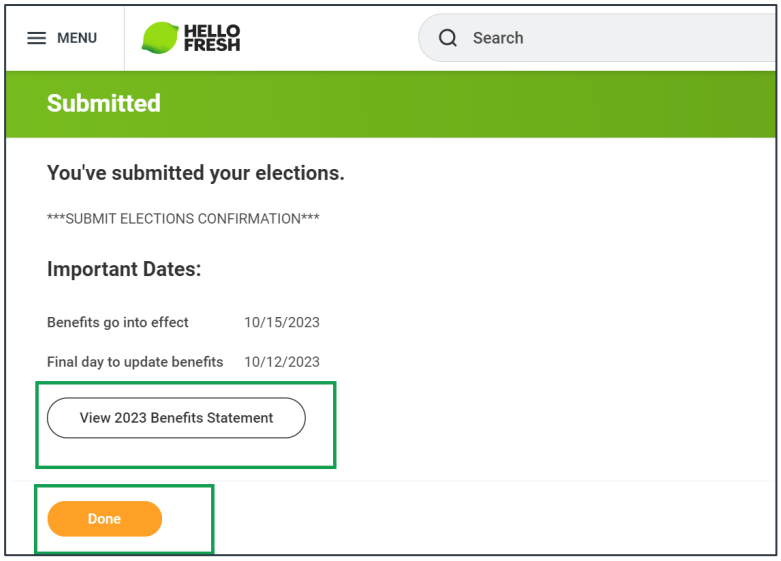
12. Review your benefit elections on the View Summary page



13. Scroll to the bottom and select the I accept **checkbox**, then click **Submit**.



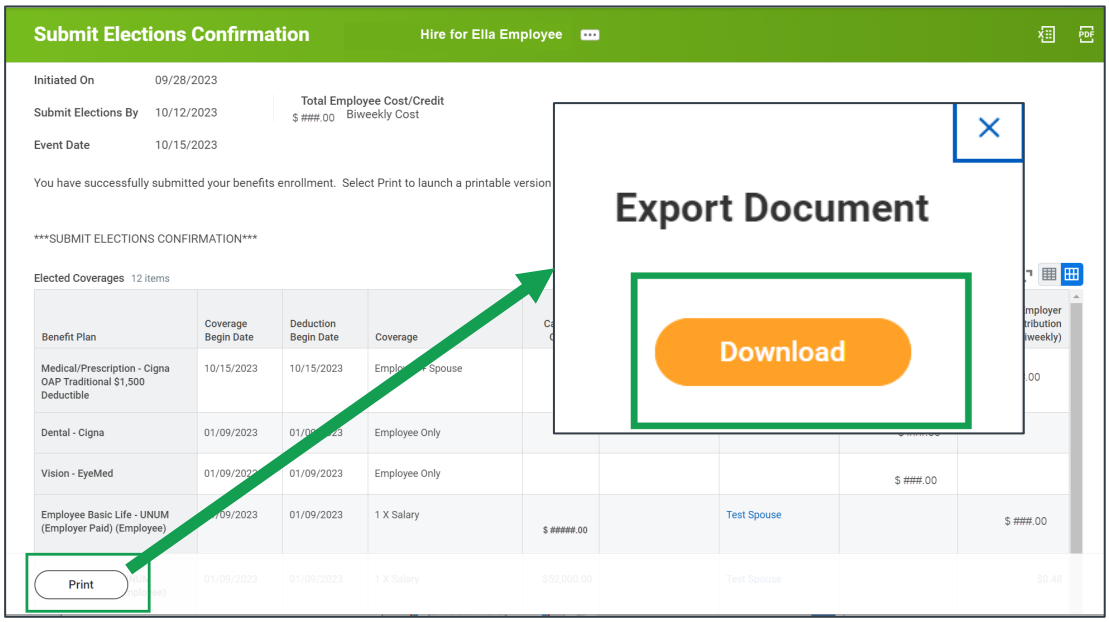
14. Click the **View Benefits Statement** button to review and print.



Note:

Please review and ensure the benefits and dependents you selected are correctly assigned to each plan.

15. Click the **Print** button at the bottom of the Submit Elections Confirmation Page. Select **Download** from the Export Document pop up. The PDF containing your Benefit Elections will download to your device. Open your download folder to view/print/save the document.



If you have questions or need assistance with your enrollment, please contact the Hello Fresh Benefits and Payroll Connect Center at 877-431-7867 (1-877- HF1STOP)

HEALTH PLAN NOTICES

TABLE OF CONTENTS

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Hello Fresh About Your Prescription Drug Coverage and Medicare."

IMPORTANT NOTICE FROM HELLOFRESH ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Hello Fresh and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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

2. HelloFresh has determined that the prescription drug coverage offered by the HelloFresh Employee Healthcare Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to wait to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. However, there are some important exceptions to the late enrollment penalty.

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the Hello Fresh Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Hello Fresh Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Hello Fresh Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Hello Fresh prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information.
NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Hello Fresh changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: January 1, 2024
Name of Entity/Sender: Bernie Lipman
Contact—Position/Office: Director of Benefits
Address: 28 Liberty Street
New York, NY 10005

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HELLOFRESH

IMPORTANT NOTICE

COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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.

This notice is provided to you on behalf of:

HelloFresh Health and Welfare Benefit Plan*

* This notice pertains only to healthcare coverage provided under the plan.

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Hello Fresh that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- Uses and Disclosures Relating to Treatment, Payment, or Healthcare Operations.
- **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other healthcare professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
- **Payment**: Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one healthcare plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
- **Healthcare Operations:** The Plan may use and disclose your PHI in the course of its "healthcare operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.
- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
- **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as HelloFresh) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.
- **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
- **Required by Law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
- **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
- **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
- **To Avert Threat to Health or Safety**: In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- To Request Restrictions on Uses and Disclosures: You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- To Choose How the Plan Contacts You: You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- To Inspect and Copy Your PHI: Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- To Request Amendment of Your PHI: If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- To Find Out What Disclosures Have Been Made: You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or healthcare operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, or breach notification process, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Bernie Lipman
Director of Benefits

Effective Date
The effective date of this notice is: January 1, 2024.

HELLOFRESH **EMPLOYEE HEALTHCARE PLAN**

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within 31 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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

To request special enrollment or obtain more information, contact:

Bernie Lipman
Director of Benefits

* This notice is relevant for healthcare coverages subject to the HIPAA portability rules.

GENERAL COBRA NOTICE

Re: CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction
What is COBRA continuation coverage

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.
- If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
  - The parent-employee dies;
  - The parent-employee's hours of employment are reduced;
  - The parent-employee's employment ends for any reason other than his or her gross misconduct;
  - The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
  - The parents become divorced or legally separated; or
  - The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment,
- Death of the employee,
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both_.

For all 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 must notify the Plan Administrator within 0 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. 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. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives 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 on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If you believe you are eligible for this extension, contact the Plan Administrator.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

• The month after your employment ends; or

• The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If You Have Questions

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.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about 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.

Plan contact information

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Bernie Lipman
Director of Benefits

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

HelloFresh Employee Healthcare Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan issuer at 1-844-375-4194
For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from HelloFresh Employee Healthcare Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare 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. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the HelloFresh Employee Healthcare Plan at:

Bernie Lipman
Director of Benefits

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

HelloFresh Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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.

The HelloFresh Employee Healthcare Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

Cigna Medical Traditional OAP Plan $1,500	In-Network	Out-of-Network
Individual Deductible	$1,500	$3,000
Family Deductible	$3,750	$7,500
Coinsurance	20%	40%

Cigna Medical Traditional OAP Plan $4,000	In-Network	Out-of-Network
Individual Deductible	$4,000	$8,000
Family Deductible	$8,000	$16,000
Coinsurance	30%	50%

Cigna Medical HDHP Plan $1,600	In-Network	Out-of-Network
Individual Deductible	$1,600	$4,000
Family Deductible	$3,200	$8,000
Coinsurance	10%	30%

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator.

MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Bernie Lipman, Director of Benefits.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

CALIFORNIA Medicaid

Website:
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

ALASKA Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

ARKANSAS Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

FLORIDA Medicaid

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

MASSACHUSETTS Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

INDIANA Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline)
or 1-855-618-5488 (LaHIPP)

MAINE Medicaid

Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

NEW JERSEY Medicaid and CHIP

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

NEW YORK Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

MINNESOTA Medicaid

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI Medicaid

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

MONTANA Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE Medicaid

Website:
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

SOUTH DAKOTA Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

NORTH DAKOTA Medicaid	VERMONT Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: Health Insurance Premium Payment (HIPP) Program |Department of Vermont Health Access Phone: 1-800-250-8427
OKLAHOMA Medicaid and CHIP	**VIRGINIA Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
OREGON Medicaid	**WASHINGTON Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA Medicaid	**WEST VIRGINIA Medicaid**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND Medicaid and CHIP	**WISCONSIN Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA Medicaid	**WYOMING Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

CONTACTS

Medical/Rx Plan: Cigna

Group Number	3345209
Member Services	877.501.7990
Website	cigna.com

Health Savings Account: HSA Bank through Cigna

Member Services	877.501.7990
Website	myCigna.com

Dental Plan: Cigna

Group Number	3345209
Member Services	877.501.7990
Website	cigna.com

Vision Plan: EyeMed

Group Number	1029949
Member Services	866.800.5457
Website	eyemed.com

Life & Disability: UNUM

Member Services	800.421.0344
Claims	Life/AD&D 800.445.0402
	STD/LTD 866.868.6737
Group Number	STD/LTD/Life and AD&D: 652467
	LTD Buy-Up (EE paid): 878328
	Voluntary Life/AD&D: 690158
Website	Life and AD&D: unum.com
	Life and Disability: portal.unum.com

FSA and Commuter : Flores

Group Number	1000278614
Member Services	800.532.3327
Website	flores247.com

HelloFresh Benefits Website

Website	myhellofreshbenefits.com

Voluntary Accident and Hospital Indemnity: Unum

Member Services	800.635.5597
Website	unum.com

401(k) Plan: Voya

Group Number	551637
Verification Number	55163799
Enrollment Services	888.311.9487
Member Services	800.584.6001
Rollover Services	866.865.2660
Participant Website	VoyaRetirementPlans.com
Enrollment Website	enroll.voya.com

COBRA: Flores

Member Services	800.532.3327
Website	flores247.com

Employee Assistance Program: UNUM

Member Services	800.854.1446
Website	unum.com/lifebalance

Medical Bill Saver: HealthAdvocate/UNUM

Member Services	866.799.2655

Travel Assistance Program: Assist America/UNUM

Within the U.S.	800.872.1414
Outside the U.S.	609.986.1234
Email Address	medservices@assistamerica.com

Bright Horizons Back-up Care

Member Services	877.242.2737
Website	clients.brighthorizons.com/hellofresh

Support Line

Benefits and Payroll Connect Service Center
877.431.7867 (Mon-Fri 8am - 5pm CST for phone and appointments, 8am - 7pm CST web chat)

Workday Portal
wd3.myworkday.com

The contents of this guide are not all-inclusive, nor is the guide intended to be a legal document.

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