Adobe Inc.
Group Welfare Plan

Summary Plan Description

Amended and Restated Effective January 1, 2025

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1. Introduction

This wraparound summary plan description ("SPD") describes the health and welfare benefit plans sponsored by and made available to eligible employees of Adobe Inc. (the "Company") through the Adobe Inc. Group Welfare Plan (the "Plan").

The Company maintains the Plan to provide benefits for the exclusive use of its eligible employees and their eligible dependents and beneficiaries. When the term "eligible employee" is used in this SPD, it refers to an individual who meets the eligibility requirements in Section 2. When the term "family member" or "dependent" is used in this SPD, it generally refers to spouses, domestic partners, and children who are related to an eligible employee as described in Section 2. Please read Section 2, "Eligibility Requirements" very carefully, because each benefit plan may define the term "dependent" in a slightly different way.

The benefit plan materials referenced in Appendix A, together with any updates, including any Summary of Material Modifications (SMMs) and annual enrollment materials, are incorporated by reference into this SPD. This document, including all documents incorporated by reference, is intended to meet the SPD requirements of the Employee Retirement Income Security Act of 1974 ("ERISA").

The Plan offers both insured plan (where an insurance plan is purchased from an insurance carrier) and self-insured plan (where Adobe pays for the plan benefits) options. Different laws apply depending on whether a plan is insured or self-insured. Insurance companies and health maintenance organizations (HMO's) are regulated by state law. In contrast, many of these state laws are preempted by ERISA for the self-insured plans. ERISA, a federal law, preempts any state laws that relate to employee benefit plans. The result is that self-insured plans are not required to provide many of the same state-mandated benefits as insured plans. Please refer to **Appendix B: Claim and Appeals Administration and Funding Information** to see the funding status of each benefit plan option.

Notwithstanding any other provision in this SPD, Adobe Inc. intends to operate the Plan in compliance with the transparency, surprise billing and other applicable requirements in the relevant provisions of the Consolidated Appropriations Act, 2021 ("CAA") and the Transparency-In-Coverage Regulations as they become effective, based on a good faith, reasonable interpretation of the statute, existing regulations and other official guidance.

Please share this SPD with your covered family members.

Plan Details

For detailed information, please refer to:

- Appendix A for a list of the benefit plan materials;
- Appendix B for claims and appeals administration and funding information; and
- Appendix C for Plan administration information; and
- Appendix D for Domestic Partner Coverage Policy Statement.

The Company offers the benefit plans listed below to eligible employees and family members. (Certain benefit plans may not be available to all Company employees and dependents. For example, if you do not have child or elder care expenses, you may not be eligible for the Dependent Care FSA plan):

- Medical,
- Dental,
- Vision,
- Short-term Disability (STD),
- Long-term Disability (LTD),
- Life and Accidental Death and Dismemberment Insurance (AD&D),
- 401(k), ESPP, DCP

- Employee Assistance Program (EAP),
- Expert Medical Opinion Services,
- Cancer Support Services,
- Group Legal,
- Business Travel Accident (BTA),
- Health Care Flexible Spending Account (Health Care FSA), and
- Dependent Care Flexible Spending Account (Dependent Care FSA).

Note that the Dependent Care FSA is not subject to ERISA and is not part of the Plan. However, a description of the Dependent Care FSA is included in this document for your convenience. The Company also offers a Health Savings Account (HSA) with certain medical benefit options. Although the HSA option is mentioned at times in this document it is not subject to ERISA and is not a part of the Plan.

This SPD provides no guarantee that you are eligible to participate in every benefit or plan described. *Each plan may have its own different eligibility requirements, so be sure to review your benefit plan material carefully.*

Important Note

Every effort has been made to ensure that the information in this document is complete and accurate. However, if there is a conflict or a difference between what is written here, and the related benefit plan materials, the related benefit plan materials will govern, unless otherwise provided by law and with the exception of any eligibility provisions which are determined by the Company. If there is a conflict between the benefit plan materials and this document with respect to the legal compliance requirements of ERISA and any other federal law, this document will govern.

The Company or its authorized delegate, in its sole discretion, may amend or terminate in writing any of the benefit plans or any provision of the Plan at any time. No benefit described in the Plan will be considered to "vest."

This document does not create a contract nor guarantee employment between the Company and any individual. Your employment is always on an at-will basis. The Company or you may terminate the employment relationship without notice at any time and for any reason.

No participant or beneficiary in any benefit plan will have any right to a benefit beyond that specifically described in the Plan or in the related benefit plan materials.

Keep Your Records Updated

Make sure that the Company always has your current home address and telephone number to correctly administer your benefits and to send you benefits information or any notices. You can update your address, phone number or other personal information on **Workday** – go to Inside Adobe>Tools & Process> Software & Applications. Be sure to update your permanent, mailing, and emergency contact address accordingly. If you need assistance updating your information on Workday, visit the Support Center to submit a case with the Employee Resource Center (ERC).

For questions about this SPD, provisions of the Plan, the individual benefit plans, or to receive a paper copy of this document, please contact Adobe's Benefits Support Team at 855-898-4218.

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2. Eligibility Requirements

Who is Eligible

You are generally eligible for Adobe's health and welfare benefits on your first day of work, if you are regularly scheduled to work at least 24 hours per week[1] and are on the U.S. payroll of the Company and you are not a seasonal or temporary employee, a leased or agency employee, an independent contractor, or a consultant. Interns are eligible for a limited selection of benefit options as explained below.

You may also enroll your eligible dependents in certain benefits. For such benefits, your eligible dependents include:

- Your Spouse:

  For purposes of this Plan, a "Spouse" is the individual to whom the eligible employee is lawfully married, but not legally separated;
- Your Domestic partner (as defined below);
- Your (or your Spouse's/Domestic Partner's) child(ren):
  - through the month in which they attain age 26 for medical benefits, regardless of their marital status, regardless of student status and whether or not they live with you or you provide any of their support; or
  - through any age if they have a physical or mental disability, are incapable of self-support, and dependent upon you for support *(As defined by the Internal Revenue Code and as determined by the Plan Administrator. The disability must have existed before age 26.)*; or
  - whom the Plan is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or
  - who are required to be covered by applicable state law
- Your Siblings, Parents, Parents-in-law, Grandparents, Grandparents-in-law, and Grandchildren for Teladoc Medical Experts (Expert Medical Opinion Services) benefit only

In the case of a child with a disability, you may be required to provide periodic proof of his/her disability for the child to maintain eligibility. Individuals who are not eligible for coverage are described below, under "Who is Not Eligible." Siblings, Parents, Parents-in-law, Grandparents, Grandparents-in-law, and Grandchildren of an Eligible Employee, a Spouse, or Domestic Partner are not eligible for coverage under any benefit plan other than the Teladoc Medical Experts (Expert Medical Opinion Services) benefit.

Eligibility Definitions

For the purposes of eligibility for Adobe health and welfare benefits, the following definitions apply.

"Children" is defined as:

- Your biological children
- Your stepchildren
- Your Domestic Partner's children
- Your legally adopted children, including children placed with you for adoption
- Children for whom you are responsible as a legal guardian or under the terms of a Qualified Medical Child Support Order (QMCSO).

[1] Some eligibility rules vary by benefit plan; where additional rules apply, these rules are described within the applicable benefit plan materials.

Domestic Partners are defined as individuals of the same sex or opposite sex who are in a domestic partnership, civil union or other similar formal relationship that is not a marriage under state law. Domestic Partners of eligible employees are eligible for benefits if the following criteria are met:

- You and your partner satisfy either of the two following requirements:
  - Have a committed relationship of mutual caring that has existed for at least the 12 consecutive months immediately prior to the date you are requesting coverage for your Domestic Partner; and have maintained the same principal place of residence for at least the 12 consecutive months immediately prior to the date you are requesting coverage; and are also responsible to each other for the direction and financial management of your household; **OR**
  - Your relationship has been recorded, certified and/or registered by a national, state, city or regional government authority.

For more details regarding Domestic Partner coverage, refer to Adobe's Domestic Partner Coverage Policy Statement in Appendix D.

Note: references to a "Spouse" or "child(ren)" throughout this SPD also apply to a Domestic Partner and/or a Domestic Partner's child(ren), unless otherwise noted.

Due to federal and certain state tax laws, there are significant tax implications associated with covering a Domestic Partner and/or a partner's child(ren). For more information, see ***"Domestic Partner Health Benefits and Taxes" in Section 4, "Paying for Coverage"***.

Who is Not Eligible

The following individuals who perform services for the Company are *not* eligible for coverage under any of the benefit plans, unless specifically stated as eligible elsewhere in this SPD:

- **Part-time employees:** Any employees regularly scheduled to work less than 24 hours per week.
- **Consultants or independent contractors**: Individuals with specialized knowledge or skills who are retained to provide advice or perform services for the Company, and whom are either independent contractors or employees of another entity. A consultant or independent contractor who is reclassified as an employee will not receive benefits, except those mandated by state or federal laws, even if, by the terms of the Company's benefit plans in effect at the time of reclassification, the consultant would otherwise be eligible.
- **Temporary and seasonal employees:** Individuals employed for short-term assignments (generally lasting three months or less); note, however, that individual's status will not change from temporary status to another status because the individual's assignment has been extended.
- **Agency or leased employees:** Individuals employed pursuant to a written agreement with an approved agency or other third party for a specific job assignment or project; such individuals include leased employees as defined under any plan and by section 414(n) of the Internal Revenue Code.
- **Nonresident aliens:** Individuals who are nonresident aliens and who do not receive any earned income from U.S. sources.[2]

In addition, the following family members of benefit-eligible employees are not eligible for coverage under any of the benefit plans unless otherwise noted in this SPD:

- Children past the month in which they attain age 26, unless they have a physical or mentally disability as described previously
- Grandchildren (even if the parent of such child is covered under this Plan), unless the grandparent has been appointed legal guardian of the child and is an eligible employee

[2] For the purposes of this provision, "earned income" is as defined under section 911(b) of the Internal Revenue Code, and "sources within the U.S." is as defined under section 861(a)(3) of the Code.

- Spouses or children living outside the U.S. or Canada, unless they receive medical coverage as a result of a foreign-service assignment
- Other family members, including your (or your Spouse's) parents, brothers, sisters, grandparents, etc. as well as roommates

Interns

Interns are defined as individuals who are pursuing a degree at an accredited college and/or university who are employed by the Company pursuant to a work plan on a short-term basis. An individual working under such an arrangement will be classified as an intern even if he or she does not receive academic course credit from the college or university upon completing the terms of employment.

Interns are eligible for the following benefits if regularly scheduled to work at least 24 hours per week and on the US payroll of the company.

- Medical Benefits – Aetna HealthSave Basic plan (after a 90-day waiting period)
- Employee Assistance Program – 24/7 access to crisis helpline and work-life resources
- Voluntary Disability Insurance (VDI) – California interns only

Hawaii Employees

Hawaii employees will be automatically enrolled in state approved medical coverage (HMSA) per the Hawaii Prepaid Health Care Act requirements. If you wish to waive this coverage and are eligible to do so under Hawaii state law, you must complete a HC-5 waiver form for the current calendar year and provide a signed copy to the Adobe Benefits Support Team.

Spousal Support Orders

You may be required to provide and/or pay for health coverage for a former Spouse pursuant to a spousal support or other comparable order, judgment or decree resulting from a divorce, legal separation or annulment. If the order provides that coverage is to be covered under the Plan, forward the order, judgment or decree to Adobe's Benefits Support Team, who will work with the Plan Administrator to determine whether such coverage may be provided under the terms of the Plan. Coverage under the Plan will not extend to any individual who is ineligible for benefits. To meet the requirements of the court order, judgment or decree, you may need to pay the cost of COBRA coverage.

Qualified Medical Child Support Orders

You may be required to provide health coverage for your child(ren) pursuant to a Qualified Medical Child Support Order (QMCSO).

- A QMCSO is a properly completed National Medical Support Notice or any judgment, decree or order, including a court approved settlement agreement, that is issued by: a domestic relations court or other court of competent jurisdiction, or
- an administrative process established under state law which has the force and effect of law in that state,
- assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and
- the Plan Administrator determines what is qualified under the terms of ERISA and applicable state law.

In general, only children who meet the eligibility requirements as dependents – for example, by meeting the age requirements – can be covered under a QMCSO. A QMCSO can apply to children who:

- were born out of wedlock,
- are not claimed as dependents on your federal income tax return, and

- do not live with you.

If you receive a QMCSO, you must enroll your child within 31 days of receipt by reporting a qualified change in status through the **Adobe Benefits Enrollment Site** and enrolling your child(ren) in your plan(s) in compliance with the court order. If Adobe receives a QMCSO relating to you and your child(ren), Adobe will determine if the QMCSO is qualified and whether the Company is required to extend coverage to the child. If the QMCSO is qualified, and you fail to select appropriate coverage, Adobe must make the plan selection. The cost of plan coverage required by the QMCSO will be deducted from your paycheck.

- You can get a copy of the Plan's QMCSO procedures free of charge from the Adobe's Benefits Support Team (request by opening a support case or by phone 1-855-898-4218).

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3. How to Enroll

New Employees

As a new employee, you must make your health and welfare plan elections (including an election to waive coverage) within 15 days of your hire date by accessing your enrollment through the **Adobe Benefits Enrollment Site**. Thereafter, you may make benefit elections once each year during Open Enrollment or when you experience a change in status. Once you have made your elections online, you should print a copy of your confirmation statement for your records.

If you do not complete your enrollment within the required time period, you will automatically be enrolled in default coverage, as explained below.

Default Coverage

If you are a(n):

- **Current participant**, your default coverage is generally your current benefits, i.e., your benefits, including Health Care FSA and/or Dependent Care FSA election(s) if any, will continue from one year to the next.

  You may opt to waive Adobe medical coverage with proof of other coverage.

  If you elected to waive any benefit, your waiver of that benefit will continue from one year to the next. However, Adobe will allow you to actively re-enroll during any Open Enrollment period and within the enrollment window for qualifying life events.

- **New participant**, default coverage includes the following *for you only*: [3]
  - **Medical** coverage under the Aetna HealthSave Basic. (Limited exceptions apply; for example, Hawaii employees will be defaulted to the HMSA Plan.) Adobe will not make any employer HSA contributions to the Aetna HealthSave Basic plan whether enrolled affirmatively or by default. If you have other medical coverage, you may opt to waive Adobe medical coverage with proof of other coverage.
  - **Dental** coverage under the Delta Dental plan
  - **Vision** coverage under the Basic Vision plan
  - **Employee Life** coverage of 3 times your base pay, up to $500,000
  - **Employee AD&D** coverage of 3 times your base pay, up to $500,000
  - **Short-Term Disability/State Disability Insurance** coverage equal to 100% of your base salary (or TTC for sales) for up to 10 weeks, then 66 2/3%
  - **Long-Term Disability (LTD)** coverage equal to $66^{2}/_{3}$% of base salary (or TTC for sales) up to a maximum cap.

    Your dependents will not receive any coverage.

- **Intern,** eligibility for medical coverage begins after a 90-day waiting period. If eligible, you will receive an email on your 91st day of employment with instructions on how to enroll. At that time, you may enroll yourself and your eligible dependents in the Aetna HeathSave Basic medical plan. If you do not enroll in medical within your election period, you will be deemed to have waived medical coverage.

[3] If you die or are hospitalized during the time period allowed for initial enrollment before you are able to complete your enrollment, Adobe will automatically enroll you in the default coverage.

If You and Your Spouse Both Work for Adobe

The following rules will apply if both you and your Spouse are employed by Adobe:

- Each of you must enroll or waive individually in the desired health and welfare benefits.
- You may each enroll for coverage as employees, or one may enroll as an employee and cover the other as a dependent. However, you may not be covered simultaneously as an employee and a dependent. (For more information refer to *Section 12, "Coordination of Health Care Benefits."*)
- You and your Spouse may not cover the same child as a dependent for any benefit.
- You may *not* elect dependent life insurance coverage for your Spouse; similarly, *only one of you* may elect life insurance for your child(ren).

If you and your Spouse have only one child who qualifies as an eligible dependent under the Dependent Care Flexible Spending Account, only one of you will be eligible to receive the Company gift contribution. For more information, refer to the Flexible Spending Account benefit plan materials listed in Appendix A.

Annual Enrollment

Employees may enroll for coverage, change coverage levels or waive coverage during the annual enrollment period, which will be announced each year. Annual enrollment elections will be effective as of the first of the following Plan year. If you do not change your elections during annual enrollment, your coverage levels will continue from the previous year, including contributions to the Flexible Spending Accounts and Health Savings Accounts (unless you elected customized HSA contributions).

Evidence of Insurability (Good Health)

Note that certain benefits, such as life insurance, may require evidence of insurability (proof of good health) if you or your spouse/domestic partner do not enroll when initially eligible and wish to enroll or if you wish to increase coverage at a later date.

COBRA qualified beneficiaries are eligible to participate in the annual enrollment process if their maximum COBRA period has not expired. (See *Section 11, "Continuation of Health Care Coverage."*)

Enrolling or Changing Coverage at Other Times

In general, you cannot enroll, drop coverage or change your or your dependents' coverage under the Plan except during annual Open Enrollment. However, you may be able to drop or add coverage for yourself or a dependent in a benefit plan during the Plan year if you experience an event triggering a HIPAA special enrollment right or you experience certain change in status life events. The rules for changing your elections are described in *Section 9, "Making Changes to Your Elections."*

When Coverage Begins

Participation generally begins on the date you and your dependents become eligible for benefits, provided that you timely enroll, if required. (For more details, see *Section 3, "How to Enroll."*)

You should be aware of the following rules regarding when coverage begins, subject to any enrollment requirement:

- You may be required to be actively at work for non-health benefits to become effective. In such cases, if you are not actively at work when your coverage would otherwise take effect, it will not go into effect until you return to your regular schedule for one full day.

- Your dependents' (spouse/partner and children) health care coverage will go into effect when yours does as long as the individual is an eligible dependent; however, special rules may apply to dependent life insurance. See the disability benefit material listed in Appendix A for more information.
- Your dependents may be required to submit "evidence of insurability" (proof of good health) before certain life insurance coverage amounts (for your Spouse and/your dependent child(ren)) will become effective. See the life insurance benefit material listed in Appendix A for more information.

When Coverage Ends

Coverage for you and/or your dependents under the Plan ends when one or more of the following occurs, whichever occurs earliest:

- Your employment ends, except medical, dental, vision and EAP coverage ends at the end of the month in which you terminated employment.
- You or your dependents no longer meet the eligibility requirements described in *Section 2, Eligibility Requirements* or any new eligibility requirements the Company establishes. (Coverage for children generally terminates at the end of the month in which they turn 26.)
- You stop making any required contributions for coverage.
- The Company terminates a particular benefit, policy, or the Plan.

The exact date on when coverage under a particular benefit plan ends varies according to the benefit plan. You should refer to the applicable benefit plan descriptions that are part of this SPD more information. You may be eligible to continue certain benefits after your coverage ends as described in *Section 11, "Continuation of Health Care Coverage."*

Health coverage for employees' Spouse, Domestic Partner or enrolled child ends as above unless coverage ends sooner as a result of a status event. See *Section 9, "Making Changes to Your Elections"* for more information.

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4. Paying for Coverage

You and the Company share the cost of coverage under certain benefit plans, as described in your enrollment materials. Your portion of the cost varies according to the benefits and coverage levels (i.e., single, family, etc.) you elect. The cost of coverage does not include your costs for any applicable deductibles, copays, out-of-network charges or non-covered items.

Contributions for Health Benefits

Pre-Tax Payroll Contributions

Active employees generally pay their contributions for health benefits on a "pre-tax" basis; that is, before federal income and employment taxes are deducted from their paychecks. In addition, contributions to the Health Care FSA and the Dependent Care FSA are paid on a pre-tax basis.

Paying for benefits on a pre-tax basis means that Social Security taxes will not be deducted for the pre-tax contribution. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these payments. This could result in a small reduction in the Social Security benefit you receive at retirement. Contact your tax advisor for questions on how your elections may affect your Social Security benefit and any other tax consequences.

If you enroll under the ***Aetna HealthSave medical plan*** with a Health Savings Account***,*** the Company will consider you eligible to contribute to a HSA and will make contributions toward your Health Savings Account and allow you to make pre-tax contributions towards a Health Savings Account through the Company's Section 125 plan. Please note you must take the necessary steps to open a Health Savings Account within 90 days of enrolling in the ***Aetna HealthSave medical plan*** in order for the Company to make contributions toward your Health Savings Account. If you do not open a Health Savings Account within this time period, you will forfeit any Company contribution for the entire Plan year.

If you are not eligible to contribute to a Health Savings Account because you have other disqualifying health plan coverage (that is not Medicare or TRICARE), you may not enroll in the Aetna HealthSave medical plan. **If you are not eligible to contribute to a Health Savings Account because you are enrolled in Medicare or TRICARE and indicate it on the Adobe Benefits Enrollment Site**, you may still enroll in the Aetna HealthSave medical plan but without a Health Savings Account and the Company will consider you ineligible to contribute to a HSA and will not make contributions towards your Health Savings Account.

If you enroll under the ***Aetna HealthSave Basic medical plan*** either affirmatively or by default, the Company will consider you eligible to contribute to an HSA and allow you to make pre-tax contributions towards a Health Savings Account through the Company's Section 125 plan. If you are not eligible to contribute to an HSA, you can elect the Aetna HealthSave Basic medical plan but you must not make any HSA contributions.

Interns are not eligible to open an Adobe Health Savings Account (HSA).

Contributions to the Health Savings Account (HSA) are also made on a pre-tax basis. Note: Some states, including California and New Jersey, will apply state income taxes to your HSA contributions. **You are responsible for determining whether you are eligible to contribute to a Health Savings Account. If you are not eligible, you may be subject to adverse tax consequences. Consult your tax advisor to determine your eligibility.** Individuals will be responsible for reconciling any tax issues arising from HSA contributions they made or that were made by the Company on their behalf for periods during which they were not HSA-eligible under IRC Sec. 223. See IRS Publication 969 for information about Health Savings Accounts, including eligibility. The Company also has discretion to make a contribution to your Health Savings Account if you are enrolled in certain medical plan options. Please see the most recent enrollment materials for information about the Company's contributions, if any, to an HSA account.

Contributions for Other Benefits

Employee contributions for life insurance, disability, and other optional benefits are paid on an after-tax basis.

Domestic Partner Health Benefits and Taxes

Because of federal and certain state tax laws, health coverage for Domestic Partners and their children is generally deducted from paychecks on an "after-tax" basis. Also, the value of Company-provided coverage (minus contributions you pay on an after-tax basis) will result in "imputed income." Imputed income is treated as taxable wages* and may substantially increase your tax liability. In limited circumstances where your Domestic Partner or his or her children are your tax dependents, health benefits for your Domestic Partner and his or her children may be eligible for tax-favored coverage under the Internal Revenue Code (IRC). See IRS Publication 502 for a discussion of the federal definition of a tax dependent. The publication is available at http://www.irs.gov/publications/p502/index.html.

**Depending on state tax laws that apply to you, you may not be subject to state income tax on the Company's contributions toward your Domestic Partner's medical coverage (for example, in California, if you enroll your "registered domestic partner," as defined under California law).*

Important: Benefits provided to Domestic Partners frequently do not satisfy the federal and state rules for tax-favored health benefits. Please contact your personal tax advisor for more information on the tax consequences of Domestic Partner coverage.

Unpaid Leave of Absence

Depending on the type of unpaid leave of absence, employees may have benefits continued through COBRA provided the employee actively elects to continue coverage, or they may have the option to pay for their health benefit coverage on a pre or post tax basis. For more information on leaves of absence, refer to the "Time Off" section on benefits.adobe.com > Resources > Policies and Plan Documents.

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5. Health Benefit Information

The Plan includes health (medical, prescription drug, dental, vision, EAP and Health Care FSA) benefits. For eligibility information for these plans, refer to Section 2.

Benefit Plan Materials

The benefit plan materials for the health plans in which you are eligible to enroll generally will be provided to you automatically by email or hard copy. If you don't receive these materials, contact Adobe's Benefits Support Team at the numbers listed in Appendix B.

The benefit plan materials, listed with hyperlinks in Appendix A, describe the covered benefits including, but not limited to:

- coverage of drugs, emergency care, preventive care, medical tests and procedures and durable medical equipment,
- eligibility to receive services,
- exclusions, limitations and terms for obtaining coverage (such as, but not limited to, rules regarding preauthorization and utilization review, reimbursement and subrogation rights of the Plan, and coordination of benefits),
- cost sharing (including deductibles and copayment amounts),
- annual and lifetime maximums and other caps or limits,
- circumstances under which coverage may be denied, reduced or forfeited,
- procedures to be followed in obtaining services, and
- procedures available for the review of denied claims.

Please refer to Appendix A to find the benefit plan materials. You may also obtain a copy of the benefit plan material for the health plan in which you are enrolled by contacting the plan directly at the address or phone number listed in Appendix B. Information about your health plan may also be available on-line at the carriers' Web sites (see Appendix B).

Provider Networks

If you are enrolled in a health plan that provides benefits through provider networks, a list of providers will be provided without charge after your coverage takes effect. If you do not receive a provider directory from your health plan, please contact the health plan at the address, phone number, or Web site listed in Appendix B. Provider directories are also generally available online. If you are enrolled in a plan that offers coverage through provider networks but also offers out-of-network coverage, generally provider lists are not provided, but you can access a list of providers on-line at the carriers' Web sites (see Appendix B). If you require a list of providers, please contact the health plan to make your request.

Refer to the benefit plan material for your health plan for a description of:

- how to use network providers,
- the composition of the network,
- the circumstances under which coverage will be provided for out-of-network services, and
- any conditions or limits on the selection of primary care providers or specialty medical providers that may apply.

Generally, if you participate in a health plan that provides benefits through a network of providers, benefits will be paid only if your provider participates in or is associated with a network that your health plan uses. In addition, some health plans, such as an HMO, may require a referral from a primary care physician before a patient can be treated by a specialty provider.

For plans that require the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available. For children, you may designate a pediatrician as a primary care provider. You do not need prior authorization from a primary care provider or any other person in order to obtain access to obstetrical or gynecological care from a healthcare professional in the network who specializes in obstetrics or gynecology.

Maternity Hospital Stays (Newborns' and Mothers' Health Protection Act)

Federal law protects the benefit rights of mothers and newborns related to any hospital stay in connection with childbirth. In general, group health plans and health insurance issuers may not:

- restrict benefits for the length of hospital stay for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).
- require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay of up to 48 hours (or 96 hours).

For details on any state maternity laws that may apply to your medical plan, please refer to the benefit plan material for the medical plan in which you are enrolled.

Benefits for Mastectomy-Related Services (Women's Health and Cancer Rights Act)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). 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, and
- prostheses; and
- treatment of physical complications of all stages of the mastectomy, including lymphedemas.

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

For information on WHCRA benefits or details about any mastectomy-related state laws that may apply to your medical plan, please refer to the benefit plan material for the medical plan in which you are enrolled.

Mental Health Parity

Except in limited circumstances, Federal law requires that any mental health care coverage provided by a group health plan generally be comparable to the coverage available for other types of illness or disease. In particular:

- The financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to mental health and substance abuse benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits;
- Mental health benefits and substance abuse benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to such benefits;
- Out-of-network mental health and substance abuse benefits must generally be made available to covered persons if out-of-network medical/surgical benefits are available;
- Standards for medical-necessity determinations and reasons for any denial of benefits relating to mental health benefits and substance abuse benefits must be made available upon request to plan participants; and
- Annual and lifetime dollar limits may be no lower for mental health and substance abuse benefits than for medical and surgical benefits.

Health Information Privacy Rights

HIPAA includes provisions relating to the privacy practices of group health plans, such as those offered through the Plan. These provisions specify how your protected health information will be handled. For more details, see Adobe's *"HIPAA Notice of Privacy Practices."*

Nondiscrimination

HIPAA prohibits the Plan and the insurance companies from discriminating on the basis of health factors. Neither the Plan nor the insurance companies may impose evidence of insurability or underwriting requirements or otherwise determine eligibility for health coverage on the basis of an individual's health status. HIPAA prohibits discrimination among similarly situated Plan participants and their dependents (including late enrollees) based on health status or health claims experience.

The Genetic Information Nondiscrimination Act of 2008 ("GINA") supplements HIPAA's nondiscrimination requirements to regulate the use of genetic information about Plan participants and their dependents and other family members (as defined by GINA). GINA will preclude the Plan and any insurance companies or HMOs underwriting its benefits from setting premiums or contributions levels based on genetic information, requiring mandatory genetic testing, or requesting, requiring, or purchasing genetic information for underwriting purposes. Under GINA, "genetic information" refers to any information about an individual's genetic tests, any genetic tests of the individual's family members and relatives, and any manifestation of a disease or disorder in the individual's family members but does not include gender or age. A "genetic test" includes any analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes. Tests that do not detect abnormalities and those that are directly related to manifested disease or disorder or pathological conditions that could reasonably be detected by a health care professional with appropriate training and expertise are not encompassed within this definition. GINA defines "underwriting purposes" to mean rules for eligibility for coverage, computation of premiums or contribution amounts, application of pre-existing condition limitations, and other activities relating to the creation, renewal, or replacement of an insurance contract or health benefits.

Please refer to the applicable certificates of coverage and other documentation relating to the component benefits for additional information.

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6. Survivor Benefits

Benefit Plan Material

The benefit plan materials for the plan in which you are enrolled generally will be provided to you automatically by email or hard copy. If you don't receive these materials, contact Adobe's Benefits Support Team at the numbers listed in Appendix B.

The benefit plan materials listed in Appendix A describe the nature of covered services including, but not limited to:

- eligibility to receive coverage;
- exclusions, limitations, and terms for obtaining coverage;
- cost sharing;
- annual and lifetime maximums and other caps or limits;
- circumstances under which coverage may be denied, reduced, or forfeited;
- procedures to be followed in obtaining coverage; and
- procedures available for the review of denied claims.

You may also obtain a copy of the benefit plan material for the plan in which you are enrolled by contacting the plan directly at the address or phone number listed in Appendix B.

Life, Disability and Accident Benefits

Employees of the Company are eligible for life, accidental death and dismemberment insurance (AD&D), short-term disability (STD), long-term disability (LTD), and business travel accident (BTA) benefits if they meet the requirements described in Section 2.

Eligible employees may elect to cover their eligible dependents in life insurance. **Note: If both you and your Spouse are employed by Adobe you may not elect life insurance for your Spouse. In addition, only one of you may elect life insurance for your child(ren).**

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7. Other Benefits

Benefit Plan Material

The benefit plan materials for the plan in which you are enrolled generally will be provided to you automatically by email or hard copy. If you don't receive these materials, contact Adobe's Benefits Support Team at the numbers listed in Appendix B.

- The benefit plan materials listed in Appendix A describe the nature of covered services including, but not limited to exclusions, limitations, and terms for obtaining coverage;
- cost;
- annual and lifetime maximums for health care services that are not considered essential health benefits and other caps or limits;
- circumstances under which coverage may be denied, reduced, or forfeited;
- procedures to be followed in obtaining coverage; and
- procedures available for the review of denied claims.

You may also obtain a copy of the benefit plan material for the plan in which you are enrolled by contacting the plan directly at the address or phone number listed in Appendix B.

Group Legal Insurance

For an after-tax premium, participants receive the benefits of the legal plan by either visiting an attorney in person or via telephone. Employees of the Company are eligible to elect this plan if they meet the requirements described in Section 2.

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8. Flexible Spending Accounts

Health Care Flexible Spending Accounts (Health Care FSA)

A Health Care FSA allows you to set aside money on a pre-tax basis to help pay for certain health care expenses. This means you pay no taxes on the amount you contribute to a Health Care FSA. You may draw on a Health Care FSA to reimburse yourself for eligible health care expenses. The Health Care FSA is a "use or lose" benefit. Employees have until March 31st to submit claims incurred during the immediately preceding plan year. Any funds left in the Health Care FSA after March 31st will be forfeited.

Important note: employees enrolled in an Adobe High Deductible Health Plan (e.g., the Aetna HealthSave Basic plan, the Aetna HealthSave plan) are not eligible to open an Adobe Health Care FSA even if they don't participate in or contribute to the Adobe-sponsored HSA plan.

Interns are not eligible to open an Adobe Health Care FSA.

For additional information on the benefits and rules for the Health Care FSAs, please refer to the Flexible Spending Account benefit plan materials listed in Appendix A.

Dependent Care Flexible Spending Account (Dependent Care FSA)

The Dependent Care FSA allows you to set aside money on a pre-tax basis to help pay for certain dependent care necessary to allow you and your Spouse, if any, to work or look for work. This means you pay no taxes on the amount you contribute to your Dependent Care FSA. The Dependent Care FSA is a "use or lose" benefit. Employees have until March 31st to submit claims incurred during the immediately preceding plan year. Any funds left in the Dependent Care FSA after March 31st will be forfeited.

You may draw on the Dependent Care FSA to reimburse yourself for eligible dependent care expenses you incur for your eligible dependents such as your child under age 13, a Spouse or other dependent of any age who is physically or mentally unable to care for him or herself and satisfies certain other requirements.

For additional information on the benefits and rules for the Dependent Care FSA, please refer to the Flexible Spending Account benefit plan materials listed in Appendix A.

Interns are not eligible to open an Adobe Dependent Care FSA.

Important Note

In addition to the Dependent Care FSA, another method of tax savings for dependent care expenses is the Federal Tax Credit. Depending on your personal situation, you may be able to participate in the Dependent Care FSA for certain expenses and still take a Federal Tax Credit for certain remaining eligible expenses. However, you may not take both the Federal Tax Credit *and* receive reimbursement from the Dependent Care FSA for the same expenses. You may want to consult IRS Publication 503 and/or a tax advisor to help you decide whether the federal tax credit *and*/or Dependent Care FSA will result in better tax savings for you.

Making Changes to Your Flexible Spending Account Plan Elections

Status Events

Once you make your elections for participation in the Flexible Spending Accounts you generally cannot change your elections until the next annual enrollment period. However, certain changes are permitted if they are made due to certain status events as described *Section 9, "Making Changes to Your Elections."* Furthermore, your elections in the Flexible Spending Accounts will continue from one year to the next year unless you change your election during an annual enrollment period or following the occurrence of certain status events.

For additional information on the benefits and terms under the Flexible Spending Accounts, please refer to the Flexible Spending Account benefit plan materials listed in Appendix A.

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9. Making Changes to Your Elections

If you experience a life event and you want to make a change in your benefit elections, you must submit an election change request within 31 days starting on the date of the qualifying event unless otherwise specified herein. **New employees must enroll within 15 days of their hire date. Interns must enroll within 15 days of becoming eligible to participate in the plan.** Otherwise, your next opportunity to make benefit changes is the next annual Open Enrollment period or the date you have another life event, whichever occurs first. This section explains the Plan's rules for making or changing your elections.

Status Event: Life Events

Subject to applicable law, you will be eligible to make a change to your benefit elections during the Plan Year (as long as you meet the consistency requirements below) in the event of any of the following life events:

- **Legal marital status.** An event that changes your legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment.
- **Domestic Partner status.** An event that changes the status of your Domestic Partnership, including establishment or termination of a Domestic Partnership or death of your Domestic Partner.
- **Number of dependents.** An event that changes your number of children, including birth, death, adoption and placement for adoption.
- **Employment status.** An event that changes your, your Spouse or your child's employment status, resulting in a gain or loss of eligibility for coverage. Examples include:
  - Beginning or terminating employment
  - A strike or lockout
  - Starting or returning from an unpaid leave of absence
  - Changing from part-time to full-time employment or vice versa
  - A change in worksite
- **Dependent status.** An event that causes your children to become eligible or ineligible for coverage because of age, student status, or similar circumstances
- **Residence.** A change in your, your Spouse, or child's home address if the change results in your or your eligible dependents living outside your medical or dental plan's network service area.
- **HIPAA Special Enrollment Events.** Events such as the loss of other coverage that qualify as special enrollment events under Health Insurance Portability and Accountability Act (HIPAA)
- **FMLA leave.** Beginning or returning from an unpaid FMLA leave
- **Reduction in hours of service.** You and your dependents may drop your group health plan coverage under the Plan, even if you remain eligible for such coverage, if:
  - You were reasonably expected to work 30 hours per week and you experience a change in employment, after which you are reasonably expected to work less than 30 hours per week, and
  - You intend to enroll yourself and any dependents dropping coverage in another health plan (satisfying the Affordable Care Act's definition of minimum essential coverage) effective no later than the first day of the 2nd month after you drop Adobe coverage; however,
  - You are not permitted to change your Health Care Flexible Spending Account elections because of a reduction in hours of service;
- **Enrollment in a health plan offered through the public Marketplace**
  - If you are eligible for a special enrollment period to enroll in public Marketplace coverage, or you want to enroll in public Marketplace coverage during the public Marketplace's annual open enrollment period, you

may drop group health plan coverage under this Plan (including for any dependents, if applicable), even if you remain eligible for coverage under this Plan.

  - If your enrolled dependent(s) become(s) eligible for a special enrollment period to enroll in public Marketplace coverage, or they want to enroll during the public Marketplace's annual open enrollment period, you may drop group health plan coverage for them under this Plan. However, you can retain enrolment for you and any covered dependents who do not intend to move to the Marketplace.
  - Any individual whose coverage is dropped at this time) must intend to enroll in public Marketplace coverage that is effective no later than the day immediately following the last day coverage under this Plan is dropped.

- For action steps to take when you experience a life event, refer to a list of action steps by life event on benefits.adobe.com > Enrollment & changes > Life Events.

Consistency Requirements

Except for election changes due to a HIPAA special enrollment, according to federal law, the change you make to your benefit elections must be "due to and consistent with" your life event. To satisfy the "consistency rule," your life event and corresponding change in election must meet both of the following requirements:

- **Effect on eligibility.** Except for the Dependent Care FSA, the life event must have an effect on eligibility for coverage under a Company plan or under a plan sponsored by the employer of your Spouse or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage or if the status event results in an increase or decrease in the number of your dependents who may benefit from coverage under the plan.

For the Dependent Care FSA, the life event must affect the amount of dependent care expenses eligible for reimbursement. (For example, your child reaches age 13, and dependent care expenses are no longer eligible for reimbursement.)

- **Corresponding election change.** The election change must correspond with the life event. For example, if your dependent loses eligibility for coverage under the terms of a medical plan, you may cancel medical coverage only for that dependent. For insurance and disability insurance coverages, an election to increase or decrease coverage in response to a life event is considered to correspond with the event.

Status Event: Coverage and Cost Events

In some instances, you can make changes due to events that affect your cost or coverage, as described below. The coverage and cost event rules do not apply to the Health Care FSA.

Coverage Events

If the Company adds or eliminates a plan option in the middle of the Plan Year (January 1 to December 31), or if Company coverage is significantly limited or ends, you can elect different available coverage for yourself and/or eligible dependents in accordance with IRC regulations (if the other plan option permits). Coverage events may also include election opportunities allowed under other Company plans. Here are some examples:

- If there is a reduction under a plan option that reduces coverage to participants overall, in general, participants enrolled in that plan option may revoke their election and elect coverage under another option providing similar coverage.
- If the Company adds another plan option mid-year, participants can drop their existing coverage and enroll in the new plan option. You may also enroll yourself and/or eligible dependents in the new plan option even if not previously enrolled for coverage at all (if that plan option permits).
- If another employer's plan allows you, your Spouse or child to make an election change during that plan's annual Open Enrollment period, you may make a corresponding mid-year election change.
- If another employer's plan (for example, your Spouse's employer) allows you, your Spouse partner, or child to change his or her health plan elections in accordance with IRS regulations, you may make a corresponding mid-year election change to your coverage.

Cost Events

If your cost for coverage increases or decreases significantly during the Plan year, you may make a corresponding election change. For example, you may elect another plan option with similar coverage (if that plan option permits), or drop coverage if no coverage is available. In addition, if there is a significant decrease in the cost of a plan option during the year, you may enroll in that plan option, even if you declined to enroll in that plan option earlier. Any change in the cost of your plan option that is not significant will result in an automatic increase or decrease, as applicable, in your share of the total cost.

For example, if you change your dependent care provider mid-year, you may change your Dependent Care FSA contributions to correspond with the new provider's charges. If your dependent care provider (other than a provider who is your relative) raises or lowers its rates mid-year, you may increase or decrease your contributions. Additionally, if your dependent care provider reduces or increases the number of hours that it provides care, you may make a corresponding change to your Dependent Care FSA election.

The Plan Administrator may from time to time establish and communicate a maximum number of changes that can be made to Dependent Care FSA elections in a particular Plan Year.

Special Enrollment Rights for Medical Coverage

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 ensures certain individuals have access to health care coverage. Consequently, you and your dependents may be eligible to enroll in an Adobe medical plan during the Plan Year, even if you previously declined coverage.

Loss of Coverage/New Dependents Special Enrollment Rights

You will be eligible to enroll yourself (and *any* eligible dependents) in an Adobe medical plan if:

- Your or your dependents' COBRA coverage under another plan ends involuntarily.
- You or your dependents have lost coverage under another plan because:
- employer contributions to the plan stopped (this will apply even if the covered individual continues receiving coverage under the prior plan by paying the amount previously paid by the employer)
- the plan was terminated
- there was a loss of eligibility due to divorce, legal separation, death, termination of employment, a reduction in hours to part-time status that affected benefits eligibility, the covered individual no longer lives or works in an HMO service area and no other benefit option is available, or the plan no longer offers benefits to a class of individuals that includes the previously covered individual
- the covered individual incurs a claim that would exceed any lifetime limit on all benefits.
- As a covered employee, a court has ordered you to provide coverage for a dependent.
- Your child loses coverage under either Medicaid or a state Children's Health Insurance Program (CHIP).
- Your child becomes eligible for premium assistance subsidy under CHIP.

In addition, if you gain a new dependent during the year (through birth, legal adoption or placement for adoption, or marriage), you may enroll that dependent, as well as yourself and any other eligible dependents, in your medical plan – again, even if you previously declined medical coverage – or change your medical elections.

This special enrollment right…

- Will be extended to you only if you submit your new enrollment elections on the Adobe Benefits Enrollment Site **within 31 days** starting on the date of the qualifying event unless otherwise specified herein. However, for Medicaid or CHIP events you have **60 days** to submit your election changes.
- Applies to *medical coverage only.* If you declined any other coverages, you must either wait until Open Enrollment to elect such coverage, unless you experience another status life event that enables you to change your elections as described above

CHIP/Medicaid/State Premium Assistance Special Enrollment Rights. Employees and/or their dependents who are eligible for but not enrolled in a Company medical plan, may request enrollment in a Company medical plan if they lose coverage under Medicaid or CHIP because they are no longer eligible. In addition, they may *enroll* in a Company medical plan if they become eligible for state premium assistance under Medicaid or CHIP. Specific restrictions may apply. Employees have *60 days* from the date of one of these events to request enrollment in a Company health plan. Employees may also change health plans at this time.

Other Status Life Events

Medicare or Medicaid Entitlement. You may change an election for medical coverage mid-year if you, your Spouse or your child becomes entitled to coverage under Medicare or Medicaid. However, you are limited to reducing your medical coverage only for the person who becomes entitled to or loses eligibility for Medicare or Medicaid, and to adding medical coverage only for the person who loses eligibility for Medicare or Medicaid.

Judgment, Decree, or Order. You may revoke an election for health coverage mid-year and make a new election if a judgment, decree or order requires health coverage for your child, including a foster child. The order must have resulted from a divorce, legal separation, annulment or change in legal custody, and must meet the requirements of a qualified medical child support order (QMCSO).

You may change your health plan election to provide coverage for the eligible child if the order requires coverage to be provided under the Plan. You may also cancel coverage for the child if the order requires your Spouse, former Spouse, or other individual to provide coverage for the child; but only if coverage for the child is actually provided. Proof of that other coverage may be required.

If you are enrolled in the Aetna HealthSave medical plan and you experience a status event, your Health Savings Account allotment may be adjusted. This adjustment only applies if you add a dependent to your plan and your coverage level changes from employee only to family coverage. For example: If you have a baby, your HSA allotment may be changed. Employees who remove a dependent will not have their HSA allotment adjusted. In such cases, if you have elected to make additional contributions to your HSA you may need to modify your election amount to comply with HSA contribution limits. The HSA proration schedule can be found in the Rewards Guide PDF on benefits.adobe.com > HSA contributions.

Confirming Election Changes

If you experience a status event and want to change in your benefit elections, you must access the **Adobe Benefits Enrollment Site** **to make the change. You must** change your election **within 31 days** of the event starting from the event date (60 days for CHIP/Medicaid events). Be sure to print a copy of your Confirmation Statement for your records.

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10. Claims and Appeals Procedures

Important Note

The claims procedures outlined below are representative of the claims procedures followed by the claims administrators of benefit plans that are subject to ERISA and offered under the Plan. See the applicable benefit plan material listed in Appendix A for the specific process the claims administrator for your health plan will follow, unless no such materials are available, in which case the claims procedures outlined below will apply.

Any request for a specific benefit shall be made in accordance with the applicable insurance policy or administrative agreement directly to the claims administrator for that specific benefit. See Appendix B for claims administrator contact information.

A claim for benefits must be filed within twelve (12) months from the date the claim was incurred or as provided in the applicable insurance policy or administrative agreement. In some cases you must exhaust the applicable Plan claims and appeal procedures before seeking external review of the Plan's decision or filing a lawsuit about the decision. An action may not be brought if more than twelve (12) months have passed since the date the claims administrator rendered its final decision upon appeal or as provided in the applicable insurance policy or administrative agreement.

The claims procedures for each specific benefit plan will be provided automatically to you without charge as a part of the applicable benefit plan material. If you do not receive the plan material, contact Adobe's Benefits Support Team.

Filing an Initial Claim

You must follow the specific claims and appeals rules established by the various benefit arrangements in order to maximize your benefits under the Plan. Unless otherwise stated, the rules apply to all benefit arrangements, including medical, dental and vision. In the case of medical plans, certain special rules apply, as noted. If you are required to file an initial claim for benefits, you must do so within the time specified by the benefit plan and in accordance with the plan's established claim procedures. See the applicable benefit plan material listed in Appendix A for details on filing claims. See Appendix B for a list of claim administrators. If you do not receive the claim procedures, contact your claims administrator directly.

Overview of Claims and Appeal Procedures

To the extent not otherwise provided under the evidence of coverage booklets or other documentation for a component benefit available under the Plan, the following claims and appeals procedures shall be applicable:

Health claims are divided into four categories: urgent care claims, pre-service claims, post-service claims and concurrent care decisions. Different rules and timeframes apply to each type of claim, as described below.

Claim-Related Definitions

Claim

"Claim" is any request for plan benefits made in accordance with the plan's claims-filing procedures, including any request for a service that must be pre-approved. Claims must be submitted in writing to the appropriate claims administrator listed in Appendix B.

The Plan recognizes four categories of health benefit claims:

1. *Urgent Care Claims*

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum

function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. The Plan must defer to an attending provider to determine if a claim for Medical benefits is urgent.

2. Pre-service Claims

"Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

3. Post-Service Claims

"Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided. *Note: Claims for Health Care FSA benefits are always considered post-service claims.*

4. Concurrent Care Claims

"Concurrent care claims" are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim," or "post-service claim," depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

Adverse Benefit Determination

If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision.

An adverse benefit determination for disability claims or Medical benefit claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time. However, if the plan retroactively cancels coverage for failure to pay required contributions, that is not an adverse benefit determination.

- **Adverse Decision or Adverse Appeal Decision.** A denial, reduction, termination of or failure to provide or make payment (in whole or in part) for a benefit. An adverse decision includes a decision to deny benefits based on: (i) an individual's ineligibility to participate in the plan; (ii) utilization review; (iii) a service being characterized as experimental or investigational or not medically necessary or appropriate; (iv) a concurrent care decision and (v) certain retroactive terminations of medical coverage – called rescissions – regardless of whether a medical claim has been filed.
- **Final Adverse Decision.** An adverse decision of a medical claim that has been upheld by the appropriate claims administrator at the end of the internal appeals process, or an adverse decision for which the internal appeals process has been exhausted under the "deemed exhaustion" rules described below.
- **Authorized Representative.** An individual authorized to act on your behalf in pursuing a claim or appeal in accordance with procedures established by the plan. For urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative. (A health care professional is a physician or other health care professional who is licensed, accredited or certified to perform specified health

services consistent with state law.) For information about appointing an authorized representative, contact the claims administrator listed in Appendix B.

Initial Claim Determination

For each of the Plan benefits, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator listed in Appendix B for the benefit at issue. The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan's review procedures and the time limits applicable to such procedures; and
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

In the event of an adverse benefit determination for a claim under health benefits, the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request, and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

In the event of an adverse benefit determination for a disability claim, the notice will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - the views of medical or vocational experts obtained by the plan, without regard to whether the advice was relied upon for the adverse benefit determination; and
  - any Social Security Administration disability determination regarding the claimant presented to the Plan;

- Either the specific rule, guideline, protocol, standards, or other similar criteria relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and

- A statement that reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits are available free of charge, upon request.

For Medical claims, the notice will also include information sufficient to identify the claim involved. This includes:

- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;

- A description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;

- In addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and

- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

Time Frames for Initial Claims Decisions

Time frames generally start when the Plan receives a claim. (See the special rule for "concurrent care" decisions to limit previously-approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to "days" means calendar days. Health Care Flexible Spending Account claims are considered non-urgent "post-service" claims.

	Medical, Dental, Vision, Employee Assistance Plan, & Health Care Flexible Spending Account Plan				Short-Term & Long-Term Disability	Life, AD&D, Business Travel,& Legal
	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits		
Time frame for Providing Notice	Notice of determination (*whether adverse or not*) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours. If you request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours of receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.	Notice of determination (*whether adverse or not*) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days.	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.	Notice of adverse determination must be provided by the Plan enough in advance to give you an opportunity to appeal and obtain decision before the benefit at issue is reduced or terminated.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 45 days.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 90 days.

	Medical, Dental, Vision, Employee Assistance Plan, & Health Care Flexible Spending Account Plan				Short-Term & Long-Term Disability	Life, AD&D, Business Travel,& Legal
	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits		
Extensions	If your claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the Plan's receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination.	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before initial 15-day period ends.*	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.*	N/A	The Plan has up to 30 days, if necessary due to matters beyond the Plan's control. A second 30-day extension may also be permitted. The Plan must provide the extension notice before the period(s) ends.*	The Plan has up to 90 days for special circumstances and must provide the extension notice before the period ends.
Period for Claimant to Complete Claim	You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information).	You have at least 45 days to provide any missing information.	You have at least 45 days to provide any missing information.	N/A	You have at least 45 days to provide any missing information.	No rule.
Other Related Notices	Notice that your claim is improperly filed or that information is missing must be provided by the Plan as soon as possible (no later than 24 hours after receipt of the claim by the Plan).	Notice that your claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days after receipt of the claim by the Plan).	N/A	N/A	N/A	N/A

*15- or 30-day extension period (whichever is applicable) is measured from the time that the claimant responds to the notice from the Plan that the claim is missing information.

Appealing a Claim

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an authorized representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing, except for urgent care claims which you may file orally or in writing and should be filed with the appropriate Claims Administrator. For a list of claims administrators, see Appendix B. If you don't appeal on time, you lose your right to later object to the decision, as you will not have exhausted your internal administrative appeal rights (which is generally a requirement before you can sue in state or federal court and, for medical plan claims, seek external review of the Plan's decision).

Medical coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

For disability claims and for Medical claims, the Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

For disability claims and for Medical claims, prior to making a benefit determination on review, the Claims Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the Medical claim. This evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

If the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your Medical benefit claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review, and you may ask the Plan to explain why the error is minor and why it meets this exception.

For a disability claim, if the Plan fails to strictly adhere to all the requirements of the disability claims and appeals process with respect to your disability benefit claim, you are deemed to have exhausted the internal claims and

appeals process. In this case, you may pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. If a court rejects your demand for immediate review based on the exceptions above, your claim will be considered as refiled on appeal upon receipt of the court's decision, and the plan will notify you of the resubmission.

Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment under the Medical benefit plan, you may begin an expedited external review before the Plan's internal appeals process has been completed.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described in the *Time Frames for Appeals Process* section of this SPD. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review; and
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

For adverse benefit determinations under a health benefit under the Plan, the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

For Medical claim adverse benefit determinations, the notice will also include:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);
- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- A description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;

- In addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and

- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

For adverse benefit determinations on disability claims, the notice will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

  - the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

  - the views of medical or vocational experts obtained by the plan, without regard to whether the advice was relied upon for the adverse benefit determination; and

  - any Social Security Administration disability determination regarding the claimant presented to the Plan;

- A description of any applicable contractual limitations period, including the date on which the claim expires;

- Either the specific rule, guideline, protocol, standards, or other similar criteria relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and

- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the following chart.

Unless the right to an external review applies under the Medical benefit plan, all decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

External Review of the Plan's Decision – Medical Plans Only

In addition to the above internal Plan claims and appeals opportunities, there is an opportunity for external review of medical plan decisions involving a coverage rescission or medical judgment. External review is available for any claim that involves a medical judgment as provided in the final rules implementing the Affordable Care Act and for rescissions of coverage. For example, external review is available to a claim that is denied on the basis of medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; a determination that a treatment, service or supply is experimental or investigational; a determination whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; or a determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of The Mental Health Parity and Addiction Equity Act of 2008 as codified in Internal Revenue Code Section 9812 and Treasury Regulations Section 54.9812, which generally require, parity in the application of medical management techniques. A denial,

reduction, termination, or a failure to provide payment for a benefit based on a determination that participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan is not eligible for external review.

Definitions

- **Deemed Exhaustion.** The Plan considers your claim or appeal to have completed all levels of internal review if the claims administrator fails to follow the Plan's claim decision and appeal requirements (unless the error was (1) minor; (2) non-prejudicial; (3) attributable to good cause or matters beyond the claims administrator's control; (4) part of an ongoing good-faith exchange of information; and (5) not reflective of a pattern of noncompliance).
- **External Review.** Review of an adverse decision or final adverse decision by an Independent Review Organization/External Review Organization (ERO).
- **Final External Review Decision.** A determination by an ERO at the conclusion of an external review.

Requesting External Review

You must complete all of the levels of appeal described above before you can request external review for a medical plan claim, other than in a case of "deemed exhaustion." Your valid authorized representative may act on your behalf in filing and pursuing this voluntary appeal.

The notice of adverse decision or final adverse decision that you receive from the claims administrator will describe the process to follow if you wish to pursue an external review. You must submit the request for external review to the claims administrator within four months of the date you received the adverse decision or final adverse decision notice.

Filing an external review request will have no effect on your rights to any other benefits under the Plan. An external review request is voluntary; you are not required to undertake it before pursuing legal action.

Preliminary Review

The claims administrator will conduct a preliminary review to determine that you were covered by the Plan at the time the service was requested or provided, your request does not relate to an eligibility matter, you have exhausted the internal appeals process (unless deemed exhaustion applies), and you have provided all paperwork necessary to complete the external review.

The claims administrator will inform you if your request is complete but not eligible for external review, including the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If your request is not complete, the claims administrator will describe the information or materials needed to make the request complete and allow you to perfect your external review request within the four-month filing deadline or within the 48-hour period following the receipt of the notice, whichever is later.

Referral to External Review Organization (ERO)

An External Review Organization (ERO) will be assigned to conduct the external review. The assigned ERO will timely notify you in writing whether the request is eligible for and has been accepted for external review. The notice will provide an opportunity for you to submit in writing, within ten business days following the date of receipt, additional information for the ERO to consider when conducting the external review. Within one business day after making its decision, the ERO must notify you, the claims administrator and the Plan.

The ERO will review all of the information and documents timely received. In reaching a decision, it will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The assigned ERO will provide its written notice of the final external review decision within 45 days after the ERO receives the request for the external review. The ERO will deliver the notice of final external review decision to you, the claims administrator and the Plan.

Upon receipt of a notice of a final external review decision reversing the adverse decision or final adverse decision, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

The Plan will allow you to request an expedited external review at the time you receive:

- An adverse decision if it involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; and

- A final adverse benefit decision, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final adverse decision concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the claims administrator will determine whether your request meets the reviewability requirements set forth above for standard external review and notify you of its determination.

Referral of Expedited Review to ERO

Upon a determination that a request is eligible for external review following preliminary review, the claims administrator will assign an ERO. The ERO will render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the ERO will provide written confirmation of the decision to you, the claims administrator and the Plan.

Time Frames for Appeals Process

The claim appeals procedures for a specific benefit are set forth in the Benefit Booklets for that benefit. Please consult the Benefit Booklet for the specific benefit involved. Where not otherwise covered by the Benefit Booklets, the following procedures will apply. The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the Plan's procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to "days" mean calendar days. The Plan can require two levels of mandatory appeal review.

	Medical, Dental, Vision, Employee Assistance Plan, & Health Care Flexible Spending Account Plan			Short-Term & Long-Term Disability	Life, AD&D, Business Travel, & Legal
	Urgent Care Claims*	Non-Urgent Care Pre-Service Claims*	Non-Urgent Care Post-Service Claims*		
Period for Filing Appeal	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 60 days.

Time frame for Providing Notice of Benefit Determination on Review	As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review.	Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 15 days of each appeal.	Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal.	Within a reasonable period of time, but not later than 45 days after receipt of request for review.	Within a reasonable period, but not later than 60 days from receipt of request for review.
Extensions	None.	None.	None.	Additional 45 days if special circumstances require extension (with period "tolled" until you respond to any information request from the Plan).	Additional 60 days if special circumstances require extension.

* An appeal of a concurrent care decision to reduce or terminate previously-approved benefits may be an urgent care, pre-service, or post-service claim, depending on the facts.

Your Right to Information

Upon request to the applicable claims administrator listed in Appendix B, and free of charge, you have a right to reasonable access to and copies of all documentation, records, and other information relevant to the claims administrator's denial of a claim or appeal. Information is "relevant" if it:

- was relied upon in making the decision on your claim or appeal,
- was submitted to, considered or generated by the claims administrator in considering your claim or appeal, or
- demonstrates compliance with the claims administrator's administrative processes for making claim decisions.

You are also entitled access to, and a copy of, any internal rule, guideline, protocol or other similar criteria used as a basis for a decision on your denied claim upon request, free of charge. Similarly, if your claim is denied based on a determination involving a medical judgment, you are entitled to an explanation of the scientific or clinical reasons for that determination free of charge upon request. (A medical judgment includes whether a treatment, drug or other item is experimental, investigational or not medically necessary or appropriate.) In addition, if voluntary appeals or alternative dispute resolution options are available under the plan, you are entitled to receive information about the procedures for using these alternatives. *Section 14, "Your Rights and Privileges Under ERISA,"* in this SPD provides additional information on legal action you can take if you feel your right to a benefit has been improperly denied.

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11. Continuation of Health Care Coverage

Coverage During Leaves of Absence

Approved Leaves of Absence

As required under the Family and Medical Leave Act of 1993 ("FMLA leave"), the Washington State Family Leave Act (WFLA), the California Family Rights Act (CFRA), California Pregnancy Disability Leave Law (PDL), Hawaii Prepaid Health Care Act, or any other state or federal law, that mandates benefits continuation during a leave of absence, the Company will continue your group health coverage on the same terms that apply to active employees. If you are receiving Company wages while on these leaves of absence, the employee's portion of the premium will generally continue to be deducted from wages on a pretax basis. If these leaves are not paid through Company wages, employees may be required to pay their portion of the premium during leave on a post-tax basis. Adobe may also waive the employee portion of the premium for the period during which these leaves are unpaid.

For other leaves of absence, including Personal Leave, employees may have benefits continuation through the Company or through COBRA. You may also discontinue your coverage during an unpaid leave of absence. In either case, when you return to work after the leave, your benefits may be reinstated, with the exception of Dependent Care FSA and Health Care FSA. For more information on leaves of absence, refer to Leaves of absence on the benefits website.

For information about reinstatement in the Health Care Flexible Spending Account, see the Flexible Spending Account benefit plan material listed in Appendix A. For additional information on leaves of absence, such as how to request a leave, your rights and obligations, and the impact on Plan benefits, contact **Lincoln Financial Group**, the leave administrator, directly at **1-888-873-5476**. If you need further assistance, submit a case to the ERC via the Support Center.

Military Leaves of Absence (USERRA)

If you take a military leave of absence that qualifies as a leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you may continue health coverage for up to 24 months as long as you give the Company advanced notice (with certain exceptions) of the leave.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the portion you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire cost of the coverage. You can continue medical coverage for the lesser of 24 months, beginning on the date the absence begins, or the length of the leave.

If you take a military leave, but your health coverage is terminated, for instance, because you do not elect the extended coverage, upon reemployment you will be treated as if you had not taken a military leave when determining whether an exclusion or waiting period applies upon your reinstatement into the applicable plan.

Generally, no exclusions or waiting periods may be imposed upon reinstatement, except exclusions or waiting periods that would normally apply if you had not lost coverage due to your military leave.

Under circumstances in which COBRA continuation coverage rights also apply (see Federal COBRA Continuation Coverage" below), an election for continuation coverage will be an election to take concurrent COBRA/USERRA medical coverage. The payment procedures and deadlines applicable to COBRA continuation coverage also apply to USERRA coverage.

For additional information on military leave, such as how to request a leave, your rights and obligations, and the impact on Plan benefits, please contact **Lincoln Financial Group**, the leave administrator, directly at **1-888-873-5476**. If you need further assistance, call 1-408-536-4357 and follow the prompts or submit a case to the ERC via the Support Center.

Other Leaves of Absence

For questions regarding disability, workers' compensation and other leaves, please contact **Lincoln Financial Group**, the leave administrator, directly at **1-888-873-5476**. If you need further assistance, submit a case to the ERC via the Support Center.

Federal COBRA Continuation Coverage

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act, or COBRA, Company employees and/or their dependents may be eligible to continue health plan coverage (called "COBRA coverage") at group rates. Health plan coverage includes medical, prescription drug, dental, vision, employee assistance plan and the Health Care Flexible Spending Accounts (Health Care FSAs). **Note:** Adobe is not required to and will not make HSA contributions to COBRA participants.

COBRA coverage is available in certain instances, called "qualifying events," where coverage under the Plan would otherwise end. You may elect to continue coverage at your own expense on an after-tax basis when the coverage that you have through the Plan ends. The coverage described below may change as permitted or required by changes in any applicable law.

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of COBRA. In some states, state law provisions may also apply to the insurers and HMOs offering benefits under the Plan. **For more information, contact the COBRA Administrator listed in Appendix B.**

There may be other coverage options for you and your family through the Health Insurance Marketplaces created as part of the Patient Protection and Affordable Care Act. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov. In a Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a Spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days of when your group coverage ends. Otherwise, you will generally have to wait until Marketplaces hold open enrollment.

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[4] 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.

[4] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

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.

Cost of COBRA Coverage

You will be required to pay up to 102% of the cost of coverage. If your coverage is extended from 18 months to 29 months for disability, you will be required to pay up to 150% of the cost of coverage beginning with the 19th month of coverage.

The cost of group health plan coverage periodically changes. If you elect COBRA coverage, the COBRA administrator will notify you of any changes in the cost. Premiums are established in a 12-month determination period and will increase during that period if the Plan has been charging less than the maximum permissible amount, if the qualified beneficiary changes coverage level, or in the case of a disability extension.

The initial payment for COBRA coverage is due 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis. You have a grace period of 30 days.

Contacting the COBRA Administrator

If you have any questions about COBRA coverage or the application of the law, contact the COBRA administrator, bswift, at (855) 898-4218. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at www.dol.gov/ebsa.

Notification Requirements

The Company must inform you of your rights to continued coverage under COBRA following:

- The end of your employment.
- Another qualifying event that affects your (and as a result, your dependents') coverage.

You or your dependent must notify the Company if coverage for a dependent ends as a result of a divorce or legal separation, dissolution of domestic partnership or a child losing his or her dependent status. The Company must receive this notification within 60 days of the qualifying event in order for the dependent to have COBRA continuation rights. *If you or the dependent fail to notify the Company within this time frame, COBRA coverage will not be made available to you.*

To provide notification of a COBRA-qualifying event, you must access the **Adobe Benefits Enrollment Site** within 60 days of the qualifying event. If for any reason you are unable to submit your COBRA-qualifying event through the Adobe Benefits Enrollment Site, you must provide written notice to Adobe's Benefits Support Team – a verbal notification, either in person or by telephone, is not acceptable. Written notice must be sent to Adobe at the address listed in **Appendix B.** If you need assistance, contact Adobe's Benefits Support Team by email or by phone at (855) 898-4218.

Your notice must be postmarked no later than the last day of the required notice period. Your notice must include both the:

- Name and address of the employee covered under the Plan.
- Name(s) and address(es) of the qualified beneficiary(ies).

After you (or your dependent) have notified the Company, the Company (or the administrator) will then send you a COBRA election form within the time allotted. All notices and other communications regarding COBRA coverage and your health plans should be directed to the COBRA Administrator. See Appendix B for contact information for the COBRA administrator.

Who is Eligible for COBRA?

If you're covered by the Plan on the day before a qualifying event, you have the right to choose COBRA coverage if you lose coverage under the terms of the Plan because of a reduction in your hours of employment or the termination of your employment (unless you're terminated because of your gross misconduct) or you take a Personal Leave of Absence that exceeds 30 calendar days or a military leave of absence that exceeds 12 months.

If you're enrolled in the Plan and don't return to work following a leave of absence under the Family and Medical Leave Act (FMLA), the event that will trigger COBRA coverage is the date that you indicate you won't be returning to work following the leave or the last day of the FMLA leave period, whichever is earlier.

If you're the Spouse of an employee and you're covered by the Plan on the day before the qualifying event, you're considered a qualified beneficiary. That means you have the right to choose COBRA coverage for yourself if you lose group health coverage under the terms of the Plan for any of the following reasons:

- your Spouse dies;
- your Spouse's employment is terminated (for reasons other than gross misconduct) or your Spouse's hours of employment are reduced;
- your Spouse takes a Personal Leave of Absence that exceed 30 calendar days (health care coverage terminates on the 31st day) or a military leave of absence that exceeds 12 months (health care coverage terminates the day after the one year "leave anniversary";
- you divorce or legally separate from your Spouse (this includes a divorce or legal separation that occurs after the employee drops you from coverage, if the employee acted in anticipation of the divorce or legal separation); or
- your Spouse becomes entitled to (i.e., enrolled in) Medicare (Part A, Part B, or both).

If you're a child of an employee and you're covered under the Plan on the day before the qualifying event, you're also considered a qualified beneficiary. This means you have the right to COBRA coverage if you lose coverage under the terms of the Plan for any of the following reasons:

- the employee dies;
- the employee's employment is terminated (for reasons other than the employee's gross misconduct) or the employee's hours of employment are reduced;
- the employee takes a Personal Leave of Absence that exceed 30 calendar days (health care coverage terminates on the 31st day) or a military leave of absence that exceeds 12 months (health care coverage terminates the day after the one year "leave anniversary";
- the employee becomes entitled to (i.e., enrolled in) Medicare (Part A, Part B or both); or
- you cease to be an eligible child under the Plan.

If the covered employee elects continuation coverage and then has a child (either by birth, adoption or placement for adoption) during that period of COBRA coverage, the new child is a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing a written notice to the COBRA Administrator of the new child's birth, adoption or placement for adoption at the address provided in **Appendix B**. This written notice should include information about the new child who will be receiving COBRA coverage. The COBRA Administrator may ask for documentation supporting the birth, adoption or placement for adoption of the new child.

If a qualified beneficiary fails to notify the COBRA Administrator about a new child within 31 days of the birth, adoption or placement for adoption COBRA coverage cannot be elected for the new child. Notify the COBRA Administrator within 31 days starting on the date of the qualifying event if you acquire a child and want to enroll them in COBRA coverage. Newly acquired eligible dependents (such as a Spouse) won't be considered qualified beneficiaries, but may be added as dependents. Notify the COBRA Administrator within 31 days starting on the date of the qualifying event if you acquire a new Spouse and want to enroll them in COBRA coverage.

COBRA-like Continuation Coverage for Domestic Partners

Although domestic partners are not qualified beneficiaries under federal COBRA, the Company currently provides COBRA-like continuation coverage to domestic partners and their children who were covered under the health plans when group coverage would otherwise have been lost.

In the description of federal COBRA above, whenever the term:

- "Spouse" is used and wherever "qualified beneficiary" when referring to a Spouse is used, the term "domestic partner" as defined by the Plan also generally applies.
- Wherever the terms "child" or "children" are used, or wherever "qualified beneficiary(ies)" when referring to a child or children is used, the child/children of a Domestic Partner also generally applies.
- Wherever the term "divorce" is used, termination of domestic partnership also generally applies.
- Wherever the term "COBRA continuation coverage" is used, COBRA-like continuation coverage also generally applies.

Your Duties

You must inform Adobe of a divorce, legal separation, or child's loss of dependent status under the Plan, if you wish to preserve your right to elect COBRA coverage. You must provide notice within 60 days from the latest of (1) the date of the divorce, legal separation or loss of dependent status or (2) the date coverage is lost because of the event.

Notice must be provided to Adobe through the **Adobe Benefits Enrollment Site.** If for any reason you are unable to submit your COBRA-qualifying event through the Adobe Benefits Enrollment Site, you must provide written notice to Adobe**.** The contact information for the Adobe's Benefits Support Team and the COBRA Administrator can be found in **Appendix B.**

The notice must identify the employee or qualified beneficiary requesting COBRA coverage and the qualifying event that gave rise to the individual's right to COBRA coverage. In addition, the employee or qualified beneficiary may be required to provide the COBRA Administrator with documentation supporting the occurrence of the qualifying event.

If you fail to notify Adobe within this 60-day period, the right to elect COBRA coverage will be lost.

When Adobe is notified that one of these events has happened, the COBRA Administrator will in turn notify you about your right to choose COBRA coverage.

The COBRA Administrator's Duties

Qualified beneficiaries will be notified of the right to elect COBRA coverage if they lose coverage under the terms of the Plan because of any of the following events:

- the employee dies;
- the employee's employment is terminated (for reasons other than the employee's gross misconduct) or the employee's hours of employment are reduced; or
- the employee takes a Personal Leave of Absence that exceed 30 calendar days (health care coverage terminates on the 31st day) or a military leave of absence that exceeds 12 months (health care coverage terminates the day after the one year "leave anniversary"; or
- the employee becomes covered by Medicare (Part A, Part B, or both).

Electing COBRA

To elect or inquire about COBRA coverage, contact the COBRA Administrator. Under the law, you have 60 days to elect COBRA coverage measured from the date you would lose your active coverage because of one of the events described earlier, or, if later, 60 days after you receive notice of your right to elect COBRA coverage. An employee or family member who doesn't choose COBRA coverage within the time period described above loses the right to elect

COBRA coverage. The employee and family members will be required to reimburse the Plan for any claims mistakenly paid after the date coverage would normally have ended.

If you choose COBRA coverage, your coverage will be the same coverage you had immediately before the event and the same coverage that is being provided to similarly situated beneficiaries. “Similarly situated” generally refers to a current employee or dependent who hasn’t had a qualifying event.

You’ll have the same opportunity to change coverage as similarly situated active employees have, e.g., at Open Enrollment or if you gain a new dependent. This also means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified.

Separate Elections

Each qualified beneficiary has the right to elect COBRA coverage. This means that a Spouse or child can elect COBRA coverage even if the covered employee chooses not to. However, a covered employee or Spouse may elect COBRA coverage on behalf of other qualified beneficiaries, and a parent or legal guardian may elect COBRA coverage on behalf of a minor child.

Length of COBRA Coverage

If elected, COBRA coverage begins on the date your active employee coverage ends. For dependents who no longer satisfy the requirements for dependent coverage, COBRA coverage begins on the first day of the payroll period following notice of the qualifying event. However, coverage won’t take effect unless COBRA coverage is elected as described above and the required premium is received.

The maximum duration of COBRA coverage depends on the reason you or your covered dependents are eligible for COBRA coverage.

If group health coverage ends because of your termination of employment or reduction in hours or due to a personal or military leave of absence, COBRA coverage may continue for you and your covered Spouse and dependents for up to 18 months.

However, if termination of employment or reduction of hours follows Medicare enrollment, the COBRA coverage period for your Spouse and children is 36 months from the Medicare enrollment date or 18 months from the subsequent termination or reduction of hours, whichever is longer.

COBRA coverage for your covered Spouse and dependents may continue for up to 36 months if coverage would otherwise end because:

- you die;
- you divorce or legally separate; or
- your child loses eligibility for coverage.

Note that COBRA coverage for the Health Care FSA ends at the end of the Plan year in which the qualifying event occurs.

Disability Extension

The 18 months of COBRA coverage may be extended to 29 months if an employee or covered family member is determined by the Social Security Administration to be disabled at any time during the first 60 days of an 18-month COBRA coverage period. This 11-month extension is available to all family members who have elected COBRA coverage due to the termination of employment or reduction in hours. It also applies to family members who aren’t disabled.

To benefit from the extension, the qualified beneficiary must provide the COBRA Administrator with the disability determination within 60 days after the later of (1) the Social Security Administration’s determination of disability, (2) the date on which a qualifying event occurs or (3) the date coverage is lost because of the qualifying event. The notice of Social Security disability must also be furnished to the COBRA Administrator before the end of the original 18-month COBRA coverage period.

During COBRA coverage, if the Social Security Administration determines that the qualified beneficiary is no longer disabled, the COBRA Administrator must be informed within 30 days. The notice can be made by providing to the COBRA Administrator a copy of the notice from the Social Security Administration, or by other written means. The notice must properly identify the qualified beneficiary who is no longer disabled and the date the notice of redetermination was received. The 11-month COBRA extension will end at the end of the month in which the redetermination notice from the Social Security Administration is received by the qualified beneficiary.

Second Qualifying Event Extensions

Your Spouse and dependents may have additional qualifying events while they are covered by COBRA. These events can extend their 18- or 29-month continuation period to 36 months, but in no event, will they have more than 36 months of COBRA measured from the first day of the month following the first qualifying event that originally allowed them to elect coverage. This extension may be available to the Spouse and any children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated or if the child stops being eligible under the Plan as a child. This only occurs if the additional event would have caused the Spouse or child to lose coverage under the Plan had the first qualifying event not occurred.

The law requires a qualified beneficiary to notify the COBRA Administrator if any of these additional qualifying events occur. This notice must be provided within 60 days from the latest of (1) the date of the second qualifying event, or (2) the date coverage would have been lost because of the event.

Notice of the additional qualifying event must be provided to the COBRA Administrator on the appropriate form, which may be obtained from the COBRA Administrator. The form should be returned to the COBRA Administrator.

The notice must include information about the qualified beneficiary requesting additional COBRA coverage and the qualifying event that gave rise to the individual's right to additional COBRA coverage. In addition, the qualified beneficiary may be required to provide the COBRA Administrator with documentation supporting the occurrence of the qualifying event.

If a qualified beneficiary (or their representative) fails to provide the appropriate notice and supporting documentation, if required, to the COBRA Administrator during the 60-day notice period, the qualified beneficiary won't be entitled to extended COBRA coverage.

Early Termination of COBRA Coverage

COBRA coverage will terminate before the expiration of the 18, 29 or 36-month period for any of the following reasons:

- the Company no longer provides group health coverage to any of its employees;
- the premium for COBRA coverage isn't paid on time (within the applicable grace period);
- the qualified beneficiary becomes covered – after the date COBRA coverage is elected – under another group health plan that doesn't contain any applicable exclusion or limitation for any pre-existing condition of the individual;
- the qualified beneficiary first becomes entitled to (i.e., enrolled in) Medicare after the date COBRA coverage is elected; or
- coverage has been extended for up to 29 months due to disability, and the Social Security Administration has made a final determination that the individual is no longer disabled.

State Continuation of Coverage Rights for Certain Insured Plans

Many states require insured medical plans and HMOs to provide extended health coverage to participants after their group coverage ends. These rights generally supplement federal COBRA or provide continuation coverage to those who are ineligible for federal COBRA coverage. Because the laws vary from state to state, you should review your health plan material and/or contact your health plan directly to learn about any rights you may have under state law. That way, you can meet any election and premium requirements necessary to take advantage of these state continuation coverage rights.

Even if you are not enrolled in an insured medical plan or HMO, please review the section below as it may impact your enrollment decisions when you initially enroll, or at annual Open Enrollment. For example, you may want to switch from a self-funded medical plan to an insured medical plan or HMO during annual Open Enrollment in order to take advantage of these rights.

Kaiser HMO and Cal-COBRA Extended Continuation Coverage. Insured medical plans and HMOs regulated in California are required to offer COBRA-qualified beneficiaries, who are enrolled in their plans and exhaust their 18 or 29 months of federal COBRA, an additional period of continuation coverage. Qualified beneficiaries must be offered up to a *total* of 36 months of combined federal and Cal-COBRA by Kaiser, starting from the date federal COBRA began. Note that Cal-COBRA does not apply to the dental or employee assistance plans.

Contact Kaiser for further information on Cal-COBRA. Kaiser will be able to supply you with further information regarding how to enroll, deadlines for enrollment, premium amounts, deadlines for submitting premiums and how Cal-COBRA might be beneficial to you.

Please examine your plan options carefully before declining this coverage. You should be aware that companies selling individual health insurance – for example, coverage sold outside the Marketplace or Exchange provided for under the Affordable Care Act, typically require a review of your medical history that could result in a higher premium than under Cal-COBRA, or you could be denied coverage.

Conversion Privileges

Conversion to Individual Coverage for Certain Insured Plans

When your coverage under an insured medical plan or HMO ends, you and your covered dependents may be eligible (depending on the State in which you live) to convert the group coverage into an individual medical policy within 31 days of your last day of coverage (including COBRA coverage). There are no conversion privileges for Aetna medical, dental, vision or Employee Assistance Program coverage. No medical examination or evidence of insurability is required. You or your dependent must generally apply for conversion to an individual policy within 31 days after group medical coverage has ended or whenever COBRA continuation benefits end.

For more information about conversion coverage, contact your insurance plan or HMO.

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12. Coordination of Health Care Benefits

The procedures and timeframes described in this section are the general coordination of benefit rules applicable to Company-sponsored health benefits.

The coordination of benefits rules, if any, that are applicable to the benefit plan in which you are enrolled will be furnished automatically to you without charge as part of your benefit plan material (see Appendix A).

If you do not receive the coordination of benefits procedures as part of your health benefit plan summary, please contact your benefit plan for a copy.

If you and your dependents are enrolled in a Company-sponsored health plan as well as another employer-sponsored plan, such as your Spouse's plan at work, the Company-sponsored plan coordinates its coverage with the other plan.

Here's how it works in general:

- When the Company-sponsored plan pays first, in other words, if the Company-sponsored plan is the "primary" plan, it pays benefits as though no other plan exists. The other plan may or may not pay benefits.
- When the Company-sponsored plan pays second, in other words, if the Company-sponsored plan is the "secondary" plan, it may or may not pay a benefit, depending on what the other plan (the "primary" plan) has paid. The most an enrolled person can receive is a combined total of 100% of eligible expenses from both plans.

Which Plan Pays First?

If you or your covered dependents are also covered under another health plan, the first of the following rules which applies determines which plan is primary:

1. A plan without a coordination of benefits provision is considered primary.
2. A plan in which you are covered as other than a dependent (for example, as an active employee) rather than as a dependent is primary. If you also are a Medicare beneficiary, and as a result of federal law, a plan covering you as an active employee is primary, Medicare is secondary, and a plan covering you as a retiree determines benefits and pays last. If you are covered as a dependent of an active employee and you are a Medicare beneficiary, the plan covering you as a dependent is primary. Medicare is secondary, and the plan covering you as a retiree (or as other than a dependent) determines benefits and pays last. *(When you are eligible for Medicare and Medicare is allowed by Federal law to be the primary payer, the coverage provided by the Plan will be reduced by the amount of benefits allowed under Medicare for the same covered services. This reduction will be made whether or not you actually receive the benefits from Medicare.)*
3. For a dependent child whose parents are married or are living together, whether or not they have ever been married, or if a court decree establishes joint custody of your child without specifying which parent is responsible to provide health coverage, the Company uses the "birthday rule" to determine which plan pays benefits first when your child is covered under both parents' plans. Under the birthday rule, the plan covering the parent whose birthday falls first in the calendar year is primary. The plan of the parent whose birthday falls later in the year is the secondary plan.

   If both parents share the same birthday, the primary plan will be the plan that has covered one parent the longest. The secondary plan will be the plan that has covered the other parent for a shorter period of time.
4. For a dependent child whose parents are divorced or separated or are not living together, whether or not they were ever married, and your children are covered under both parents' plans, the birthday rule does not apply. Instead, the Company uses the following rules to determine which plan pays benefits first:
   - first, the plan of the parent to whom the court specifically assigned financial responsibility for health care expenses (for instance, through a Qualified Medical Child Support Order),
   - then, the plan of the parent who has custody,
   - then, the plan of the spouse married to the parent who has custody,
   - then, the plan of the parent who does not have custody, and

- finally, the plan of the spouse married to the parent who does not have custody.

5. A plan in which you are enrolled as an active employee (or as that employee's dependent) rather than as a laid-off or retired employee is primary.
6. In most cases, a plan in which you are enrolled as an active employee or subscriber rather than as a COBRA participant is primary.
7. The plan covering the individual for the longest period of time is considered primary.
8. If none of the above rules determines which plan is primary, the allowable expenses shall be shared equally between the plans.

Coordination of Benefits with Medicare

If you continue to work for the Company after age 65 and are entitled to (which means that are you are both eligible for and enrolled in) Medicare, you may continue your medical coverage under a Company-sponsored plan and coordinate the plan with Medicare. In general, the Company-sponsored plan would be primary and pay benefits first for:

- Eligible employees age 65 and over with current employment status and spouses age 65 and over who participate in the Company-sponsored plan on the basis of the employee's current employment status.
- Social Security disabled individuals who are covered by the Company-sponsored plan on the basis of current employment status (their own or a family member's current employment status) and who are entitled to Medicare benefits (e.g., disabled spouses or dependents of an active employee, or Social Security disabled participants who have returned to work).
- For the first 30 months of Medicare entitlement, for certain individuals who become eligible for Medicare on the basis of having end-stage renal disease (ESRD), regardless of the reason for the employer coverage.

Note: The Medicare "working aged" rules described above only apply to legally married spouses. If you have a Domestic Partner, even if your domestic partnership is registered with the state) and your Domestic Partner is eligible for Medicare due to age, Medicare is primary to this Plan, and this Plan will pay secondary. This is true even if your Domestic Partner does not enroll in Medicare. **Domestic partners who are eligible for Medicare due to age should enroll in Part B as soon as they are eligible, even if they are covered as dependents under this Plan in order to avoid coverage gaps and late enrollment penalties. Domestic partners will not have a special enrollment period with Medicare if they delay enrollment in Part B because of coverage under their partner's plan and will pay permanently higher premiums for Part B if they delay.**

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13. General Plan Provisions

Administration of Plan

Discretionary Authority of Plan Administrator

The Plan Administrator has sole, absolute, and exclusive discretion to:

- Interpret the provisions of the Plan, control and manage the operation and administration of the Plan, and to correct errors.
- Interpret the other terms, conditions, limitations, and exclusions of the applicable benefit policy, including this SPD and any riders and amendments and any limits on benefits permissible under the Affordable Care Act.
- Make legal or factual determinations related to the Plan, benefits and eligibility requirements thereunder.

The Plan Administrator may delegate this discretionary authority and any other duties and responsibilities under the Plan as it deems appropriate, including but not limited to claims administrators, and unless the Plan Administrator expressly provides to the contrary, any such delegation will carry with it the Plan Administrator's full discretionary authority. Any interpretation or determination made by such person or entity delegated discretionary authority shall be given full force and effect. Unless otherwise required by law, decisions made in the Plan Administrator’s discretion are final.

Plan Documents

This SPD summarizes the main features of the Plan, and is not intended to amend, modify or expand the Plan provisions. In all cases, the provisions of the Plan document, master insurance contract, the Evidence of Coverage and Disclosures (EOCs), the certificates of coverage or other benefit materials incorporated by reference control the administration and operation of the Plan.

With the exception of any eligibility provisions which are determined by the Company, if a conflict exists between a statement in this SPD and the provisions of the Plan document, master insurance contract, the Evidence of Coverage and Disclosure (EOC), the certificates of coverage or other benefit materials incorporated by reference, the Plan document, master insurance contract, the Evidence of Coverage and Disclosure (EOC), the certificates of coverage or other benefit materials incorporated by reference will govern.

Administrative Services

Adobe may, in its sole discretion, arrange for various individuals or entities to provide administrative services in regard to a particular benefit plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time at our sole discretion – Adobe is not required to provide prior notice of or receive approval for any such change. It is your responsibility to cooperate with these individuals or entities in the performance of their responsibilities.

Benefits Plan Future

While the Company intends to continue these plans indefinitely, future circumstances cannot be foreseen, and the Company reserves the right, through its Board of Directors where applicable, to terminate, suspend, withdraw, amend, or modify the plans and/or policies (including altering the amount you must pay for any of these benefits) in writing, in whole or in part, at any time, without notice. Any such action is subject to the applicable provisions of the plan document; however, if a plan is terminated, it will not affect any claim made when the plan was in force.

An insurance carrier can cancel coverage by giving 31 days written notice. If the Company terminates the Plan, you may be able to convert certain group coverage(s) to an individual policy(ies); however, restrictions and limitations may apply.

Any provision of a Plan which, on its effective date, conflicts with the requirements of Federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered), is hereby amended and interpreted to conform to the minimum requirements of such statutes and regulations.

Plan Amendment and Termination

The Company or its authorized delegate reserves the right in its sole discretion to amend in writing the Plan, or any benefit plan, in whole or in part, and/or to completely discontinue the Plan or any benefit plan at any time. The Company's decision to amend or terminate in writing is not a fiduciary decision. It is a business decision that can be made solely in the Company's interest.

The Company or its authorized delegate may in writing terminate or partially terminate the Plan, or discontinue contributions at any time in its sole discretion. In addition, the Company reserves the right to amend or terminate in writing covered expenses, benefit co-payments, lifetime maximums, and reserves the right to amend in writing the plans to require or increase participant contributions in its sole discretion. The Company also, in its sole discretion, reserves the right to amend in writing the plans to implement any cost control measures that it may deem advisable.

Insured Benefits

Certain benefits under this Plan are fully insured. See Appendix B to learn which benefits are insured.

With respect to insured benefits, claims for benefits are sent to the insurance company. In this case, the insurance company is responsible for paying claims, not the Company.

The insurance company is responsible for and has full discretionary authority for:

- determining eligibility for and the amount of any benefits payable under the applicable benefit program.
- prescribing claims and appeal procedures to be followed and the claims and appeal forms to be used by plan participants pursuant to the applicable type of benefit.

The insurance company also has the authority to require plan participants to furnish it with such information as it determines necessary for the proper administration of the applicable benefit.

With respect to insured benefits, you (or, in the case of your death, your beneficiary as that term is defined in the applicable insurance policy or contract) will be entitled to receive only the insured benefit for which provision is actually made under the insurance policy or contract.

The Company does not assume liability or responsibility for any insured benefit and you will be able to look only to the insurance contracts for payment or any benefits. You will not have any claim for insured benefits against the Company, the Plan Administrator or any employee, officer, or director of the Company.

Contributions and Premiums

The Company's Contributions

The Company may fund benefits provided under the Plan in whole or in part. Contributions made by the Company will be made at the times and in the manner determined by the Company. No assets will be set aside for the purpose of providing benefits under the Plan. The Company will pay benefits (including any insurance premiums necessary for the purchase of benefits) required under the Plan out of the general assets of the Company. In no event shall the Company have any obligation to fund self-funded benefits provided under the Plan in advance of the date that such benefits are payable or pre-pay the premiums or other fees required in order to provide insured benefits under the Plan. The Company contribution, if any, may be paid directly to the insurance company or other provider under the Plan. Such payment shall constitute a complete discharge of the liability of the Plan.

Self-Funded Benefits

The Company's general assets are the sole source of self-funded benefits under the Plan. The Company assumes no liability or responsibility for payment of such benefits beyond that which is provided in the self-funded benefit plans.

No Right to Assets

No participant, dependent, or beneficiary shall have any right to, interests in or claim for any particular assets of the Company, the Plan, any benefit plan or any underlying contract, trust or other funding vehicle.

Responsibility for Benefit Plans

Please note that:

- All service providers are independent contractors of the applicable plan; the Company is not responsible for their actions.
- Neither the Plan Administrator nor the Company is responsible for the fiscal viability of benefit providers or for the continuing participation of doctors, hospitals, and others in their networks.
- Neither the Plan Administrator nor the Company can warrant or guarantee the quality or the length of service of providers.

No Guarantee of Employment

By adopting and maintaining the Plan and these benefit plans, the Company has not entered into an employment contract with any person. Nothing in the Plan documents gives any employee the right to be employed by the Company or to interfere with the Company's right to discharge any plan participant at any time. Similarly, these plans do not give the Company the right to require any plan participant to remain employed by the Company, or to interfere with an employee's right to terminate employment with the Company at any time and for any reason.

Assignment of Benefits

Except as otherwise may be required under a qualified medical child support order (QMCSO) which assigns benefits to a child who has been designated as an alternate recipient in accordance with the Plan's QMCSO procedures; by applicable law; or as otherwise specifically provided in the Plan or benefit plan material; neither you nor your dependents nor your beneficiaries may assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any benefit or any amount payable under the Plan to you, your Spouse, dependents, or any beneficiaries on their behalf at any time under the Plan. Any attempt to so assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any such benefit or amount, whether presently or thereafter payable, will be void. If you, your Spouse, dependent, or beneficiary attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any benefit or amount payable under the Plan, or any part thereof, or if a person's bankruptcy or other event would cause amounts payable under the Plan to be subject to the person's debts or liabilities, then the Plan Administrator may direct that such benefit or amount be withheld and that the same or any part thereof be paid or applied to or for the benefit of you, your Spouse (as defined under federal law) or your dependents, or any of them in such manner and proportion as the Plan Administrator may deem proper. Such payment shall constitute a complete discharge of the liability of the benefit plan, the Company, and the Plan. Furthermore, you may not assign any right to submit a claim or appeal or any right under applicable law (including, but not limited to the right to bring any claim in court under ERISA or breach of fiduciary duty claim, or the right to request documents under ERISA). (Note: Any right to receive payment does not give rise to any assignment of any right under the Plan, including the rights to bring any claim, file an appeal or file suit.)

However, you may request and authorize the Plan Administrator or the appropriate insurance company or service provider to pay benefits directly to the hospital, physician, dentist or other person furnishing services or supplies covered under the applicable benefit plan and any such payment, if made, shall constitute a complete discharge of the liability of the benefit plan, the Company, and the Plan.

If the Plan Administrator determines that an underpayment of benefits has been made, the Plan Administrator shall take such action as it deems necessary or appropriate to remedy such situation. However, in no event shall interest be paid on the amount of any underpayment.

Company's Use of Funds

To the maximum extent permitted by applicable law, the Company shall be entitled to retain any policy dividend or refund, or portion thereof, it receives from any insurance company, administrative services organization, HMO, service plan or any other organizations or individuals.

Plan's Use of Funds

All amounts paid to and held by the Plan (or any trust established in connection with the Plan), as well as any policy dividends and/or refunds not belonging to the Company, shall be available to fund the benefits provided by any benefit plan included in the Plan and to pay the benefit plan's administrative expenses. To the maximum extent permitted by applicable law, the Plan Administrator, at its sole and unfettered discretion, may use funds accumulated under this Plan for any benefit plan (whether funds accumulated from insurance contract reserves, insurance company refunds or dividends, participant or the Company contributions, administrative fees or any other source) to reduce the level of contributions that the Company would otherwise make to the Plan for any benefit plan.

Withholding of Taxes

Withholding may be applied to amounts paid or payable pursuant to this Plan for all federal, state, local, or other taxes with respect to any amounts paid or payable under this Plan or any benefit plan.

No Estoppel of Plan

No person is entitled to any benefit under the Plan or any benefit plan except and to the extent expressly provided under the Plan or the benefit plan. The fact that payments have been made from the Plan or benefit plan in connection with any claim for benefits under the Plan or benefit plan does not (a) establish the validity of the claim, (b) provide any right to have such benefits continue for any period of time, or (c) prevent the Plan or benefit plan from recovering the benefits paid to the extent that the Plan Administrator ultimately determines that there in fact was no right to payment of the benefits under the Plan or benefit plan.

Thus, if a benefit is paid to a person under the Plan or benefit plan and it is thereafter determined by the Plan Administrator that such benefit should not have been paid (whether or not attributable to an error by such person, the Plan Administrator or any other person), then the Plan Administrator may take such action as it deems necessary or appropriate to remedy such situation, including without limitation, by deducting the amount of any such overpayment from any succeeding payments to or on behalf of such person under the Plan or benefit plan or from any amounts due or owing to such person by a participating employer or under any other plan, plan or arrangement benefiting the employees or former employees of the Company, or otherwise recovering such overpayment from whoever has benefited from it.

Refund of Overpayments

If benefits are paid under this plan for expenses incurred on account of a covered individual, that covered individual or any other individual or organization that was paid must make a refund to the plan if all or some of the:

- Expenses were not paid by the covered individual or did not legally have to be paid by the covered individual.
- Payment made under this Plan exceeded the benefits under this Plan.

The refund equals the amount of benefits paid in excess of the amount that should have been paid under this plan.

If the refund is due from another individual or organization, the covered individual agrees to help the Company obtain the refund when requested.

If the covered individual, or any other individual or organization that was paid erroneously, does not promptly refund the full amount, the plan may reduce the amount of any future benefits payable to that individual that are payable to that individual under this plan. The plan may also reduce future benefits under any other group benefits plan administered by the Claims Administrator for the Company. The reductions will equal the amount of the required refund. The plan may have other rights in addition to the right to reduce future benefits.

Subrogation and Right of Recovery

Acts of Third Parties

When you or your covered dependent (together referred to as "you") are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care (medical and dental) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- Has an equitable lien on any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and
- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the program has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses or how it is characterized.

Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury or any other equitable principle. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this SPD.
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.

- Provide all information requested by the Plan, the claims administrator or their representatives, or the Plan Administrator or its representatives.
- Execute and deliver such documents as may be required and do whatever else is needed to secure the Plan rights.

The Plan may terminate your Plan participation and/or offset your future benefits for the value of benefits advanced in the event that that the Plan does not recover, if you do not provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the subrogation provisions in these "Acts of Third Party" provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern. If the right of recovery provisions in these "Acts of Third Party" provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

All Plan rights under this section remain enforceable against the heirs and estate of any covered person.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the covered individual or made on behalf of the covered individual to any provider) from the Plan, the covered individual acknowledges that this Plan's recovery rights are a first priority claim against all responsible parties and are to be paid to the Plan before any other claim for the covered individual's damages. This Plan shall be entitled to full reimbursement on a first-dollar basis from any responsible party's payments, even if such payment to the Plan will result in a recovery to the covered individual which is insufficient to make the covered individual whole or to compensate the covered individual in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the covered individual to pursue the covered individual's damage claim. No other equitable principle shall affect the Plan's rights.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any responsible party and regardless of whether the settlement or judgment received by the covered individual identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

Cooperation

The covered individual shall fully cooperate with the Plan's efforts to recover benefits paid. It is the duty of the covered individual to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the covered individual's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the covered individual. The covered individual and his/her agents shall provide all information requested by the Plan, the claims administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights, or failure to reimburse the Plan from any settlement or recovery obtained by the covered person, may result in the termination of health benefits for the covered person or the institution of court proceedings against the covered person.

The covered individual shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The covered individual acknowledges that Adobe has the right to conduct an investigation regarding the injury, illness or condition to identify any responsible party. Adobe reserves the right to notify responsible party and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the claims administrator shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the covered individual or made on behalf of the covered individual to any provider) from the Plan, the covered individual agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the covered individual hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

Affordable Care Act Provisions

The "Affordable Care Act" means the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as in effect from time to time. In the event that the Affordable Care Act becomes no longer in effect, either in full or in part, the following provisions may no longer apply:

Pre-Existing Conditions

This Plan or any of the component major medical benefits may not exclude, limit, or deny coverage based on a pre-existing condition.

Lifetime and Annual Limits

Under the Affordable Care Act, lifetime and annual limits on the value of "essential health benefits" are prohibited under the component major medical benefits. "Essential health benefits" include ambulatory care, emergency care, hospitalization, maternity and newborn care, pediatric care (including vision and dental care), mental health and substance abuse services, prescription drugs, rehabilitation services and devices, lab services, and preventive care. For more information on the specific items and services included in these categories of Essential Health Benefits please refer to the Benefit Plan Materials referenced in Appendix A.

Other Provisions

Type of Coverage

Only non-occupational (not work-related) accidental injuries and non-occupational diseases are covered under this Plan. (Coverage for occupational injuries and diseases are covered under Workers' Compensation, which is described in "Your Workers' Compensation Benefits" in the Rewards Handbook. Benefits under the Plan do not substitute or affect any requirements for coverage under Workers' Compensation.)

Misstatement of Fact

In the event of a misstatement of any fact affecting your coverage under the Plan, the true facts will be used to determine the coverage in force, including on a retroactive basis. However, under the Affordable Care Act, health coverage may not be retroactively rescinded except for fraud or intentional misrepresentation of material fact.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to benefits. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverage or entitlement.

Oral statements made by Adobe, the claims administrators or any other individual may not amend the terms of the Plan. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control.

It is your responsibility to confirm the accuracy of statements made by the Company or its designees, including any claims administrators, in accordance with the terms of this SPD and other Plan documents.

Information and Records

At times, the Plan Administrator[5] may need additional information from you. You agree to furnish all information and proofs that may reasonably be required regarding any matters pertaining to the Plan; if you do not provide this information when requested, it may delay payment or result in a denial of benefits.

By accepting benefits under the Plan, you authorize and direct any individual or institution that has provided services to you to furnish the Plan, or its delegate, with all information or copies of records relating to the services provided to you. The Plan has the right to request this information at any reasonable time. This applies to all covered individuals, including dependents enrolled by the employee. The Plan agrees that such information and records will be considered confidential.

The Plan has the right to release any and all records concerning health care services that are necessary to implement and administer the terms of the Plan for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, the claims administrator and related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

If you would like complete listings of your medical records or billing statements, we recommend you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms. If you request medical forms or records from your health care plan, you may be charged reasonable fees to cover costs for completing the forms or providing the records.

In some cases, the claims administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as the Plan administrator.

[5] References to the Plan Administrator may also refer to the Company as applicable.

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14. Your Rights and Privileges under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). The benefit plans maintained by the Company that are governed by ERISA include those described in this SPD, except for the Dependent Care Flexible Spending Account Plan (a non-ERISA plan).

ERISA provides that all Plan participants have the right to:

Receive Information About Your Plan and Benefits

- You can examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites) all documents governing the Plan. This includes insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- By submitting a written request to the Plan Administrator, you can obtain copies of documents governing the operation of the Plan, including insurance contracts, copies of the latest annual report (Form 5500 Series), and an updated summary plan description. (The administrator can charge you a reasonable fee for the copies.)
- You should receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to provide a copy of this summary annual report to each Plan participant.

Continue Group Health Plan Coverage

You can continue health care coverage (medical, dental, employee assistance plan, and Health Care FSA) for yourself, Spouse and/or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. For more details, review the COBRA information in this SPD, the relevant benefit plan materials, and the COBRA Notice that was mailed to your home. If you need another copy of these documents, contact the COBRA Administrator listed in Appendix B.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. These people, called "fiduciaries" of the Plan, have a duty to operate your Plan prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Company, union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right (within certain time schedules) to:

- know why this was done,
- obtain copies of documents relating to the decision without charge, and
- appeal any denial.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive your copies within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $147 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

After exhausting your appeal rights, you may file suit in a state or federal court if you have a claim for benefits which is denied or ignored, in whole or in part. After exhausting your appeal rights, you may file suit in a federal court if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order.

You may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court if:

- plan fiduciaries misuse the Plan's money, or
- you are discriminated against for asserting your rights.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210 or www.askebsa.dol.gov. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-800-444-EBSA (3272) or on the internet at www.dol.gov/ebsa.

Additional Information

Additional pertinent information is attached as follows:

Appendix A: Benefit Plan Materials

Appendix B: Claim and Appeals Administration and Funding Information

Appendix C: Plan Administration Information

Appendix D: Domestic Partner Coverage Policy Statement

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Appendix A: Benefit Plan Materials

The following supplemental benefit program materials, together with this document, constitute the summary plan description (SPD) of benefits provided for eligible employees of Adobe Inc.

Benefit Program (Policy, Group or Contract No.)	Benefit Program Material
Medical	
Aetna HealthSave Choice POS II (660819)	▪ Aetna Health Save Booklet 1/1/2025 ▪ Aetna HealthSave Choice POS II Schedule of Benefits 1/1/2025
Aetna HealthSave Basic Choice POS II (660819)	▪ Aetna HealthSave Booklet 1/1/2025 ▪ Aetna HealthSave Basic Choice POS II Schedule of Benefits 1/1/2025
Aetna HealthSelect Open Access (660819)	▪ Aetna HealthSelect Booklet 1/1/2025 ▪ Aetna HealthSelect Open Access Schedule of Benefits 1/1/2025
Aetna International Medical Plan (0299083-052-345)	▪ Aetna International Medical Plan Summary of Benefits 1/1/2025 ▪ Aetna International Booklet and Schedule of Benefits 1/1/2025
Aetna WorldTraveler Medical Plan (0299440-010-00039)	▪ Aetna WorldTraveler Medical Plan Summary ▪ Aetna WorldTraveler Medical Plan Booklet
Kaiser HMO Northern California (39163)	▪ Kaiser Northern CA Traditional Plan Evidence of Coverage 1/1/2025 ▪ Kaiser Northern CA Chiro & Acu Evidence of Coverage 1/1/2025
Kaiser HMO Southern California (233640)	▪ Kaiser Southern CA Traditional Plan Evidence of Coverage 1/1/2025 ▪ Kaiser Southern CA Chiro & Acu Evidence of Coverage 1/1/2025
Kaiser HMO Washington (1911800)	▪ Kaiser Washington Traditional Plan Evidence of Coverage 1/1/2025
HMSA (18979-1-7)	▪ HMSA CompMED Guide to Benefits (Medical Dental Vision) ▪ HMSA Prescription Drug Rider
Dental	
Delta Dental PPO (2700)	▪ US Delta Dental Plan Highlights 2025 [PDF] ▪ US Delta Dental Evidence of Coverage [PDF]
HMSA (18979-1-7)	▪ HMSA CompMED Guide to Benefits (Medical Dental Vision)
Aetna International Dental Plan (0299083-052-345)	▪ Aetna International Medical Plan Summary of Benefits 1/1/2025 ▪ Aetna International Booklet and Schedule of Benefits 1/1/2025
Vision	
HMSA (18979-1-7)	▪ HMSA CompMED Guide to Benefits (Medical Dental Vision)
Vision Service Plan (00107394)	▪ Group Vision Care Plan VSP Evidence of Coverage and Disclosure Form
Aetna International Vision Plan (0299083-052-345)	▪ Aetna International Medical Plan Summary of Benefits 1/1/2025 ▪ Aetna International Booklet and Schedule of Benefits 1/1/2025
Health Care Flexible Spending Account	

Health Care Flexible Spending Account	▪ Adobe Health Care Flexible Spending Account Benefit Summary
Dependent Care Flexible Spending Account	
Dependent Care Flexible Spending Account	▪ Adobe Dependent Care Flexible Spending Account
Short-Term Disability (STD)	
Short-Term Disability	▪ Adobe Voluntary Disability Plan ▪ Lincoln Financial STD Benefits Summary – Class 1 Certificate ▪ Lincoln Financial STD Benefits Summary – Class 2 Certificate (with Commissions)
Long-Term Disability (LTD)	
Long-Term Disability (GF3-860-038747-01)	▪ Adobe Long Term Disability Plan ▪ Lincoln Financial LTD Class 1 Certificate (Officers) ▪ Lincoln Financial LTD Class 2 Certificate
Life and Accidental Death & Dismemberment (AD&D)	
Lincoln Financial Group (SA3-860-038747-01)	▪ Lincoln Financial Life and Accidental Death and Dismemberment Summary of Benefits Class 1 Certificate ▪ Life and AD&D California Notice Class 1 & 2
Group Legal Insurance	
MetLife Group Legal (6920010)	▪ MetLife Group Legal Plan Summary
Business Travel Accident (BTA)	
Business Travel Accident (9906-44-73)	▪ Adobe Inc. Business Travel Accident

Employee Assistance Plan (EAP)	
Employee Assistance Plan	▪ Spring Health
Expert Medical Opinion	
Teladoc Medical Experts	▪ Teladoc Medical Experts Summary Plan Description
Cancer Support Services	
AccessHope	▪ AccessHope Program Description

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Appendix B: Claim and Appeals Administration and Funding Information

Please direct all claims and claim appeals to the claims administrator for the benefit program in which you are enrolled.

Benefit Programs	Claims Administrator	Funding
Medical		
Aetna HealthSave Choice POS II Aetna HealthSave Basic Choice POS II Aetna HealthSelect Open Access	Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156 Phone: (800) 872-3862 http://www.aetna.com	Self-funded
Aetna International	Aetna Global Benefits/Aetna P.O. Box 981543 El Paso, TX 79998-1543 USA Phone outside U.S. via AT&T+access: 1-800-231-7729 Phone: outside U.S. direct or collect: (813) 775-0190 Fax outside U.S.: 1-800-475-8751 Fax inside U.S.: 1-859-425-3363 Email: AGBSERVICE@AETNA.COM http://aetnainternational.com	Insured
Aetna WorldTraveler	Aetna Global Benefits P.O. Box 30258 Tampa, FL 33630-3258 USA Phone outside U.S. via AT&T+access: 1-800-231-7729 Phone: outside U.S. direct or collect: (813) 775-0190 Fax outside U.S.: 1-800-475-8751 Fax inside U.S.: 1-813-775-0625 Email: AGBSERVICE@AETNA.COM http://aetnainternational.com	Insured
Kaiser HMO, Northern California	Kaiser Foundation Health Plan, Inc. National Claims Administration P.O. Box 12923 Oakland, CA 94604-2923 Phone: (800) 464-4000 http://www.kp.org	Insured
Kaiser HMO, Southern California	Kaiser Foundation Health Plan, Inc. Claims Administration Department P.O. Box 7004 Downey, CA 90242-7004 Phone: (800) 464-4000 http://www.kp.org	Insured

Benefit Programs	Claims Administrator	Funding
Kaiser HMO, Washington	KFHPWA P.O. Box 30766 Salt Lake City, UT 84130-0766 http://www.wa.kaiserpermanete.org Claims Contact: Kaiser Foundation Health Plan of Washington P.O. Box 34585Seattle, WA 98124 -1585	Insured
HMSA	HMSA P.O. Box 860 Honolulu, HI 96808-0860 Phone: (808) 948-5555 http://www.hmsa.com	Insured
Dental		
Delta PPO Dental	Delta Dental of California P.O. Box 2105 Mechanicsburg, PA 17055-6999 Phone: (800) 932-0783 http://www.deltadentalins.com	Self-funded
Aetna International EXPAT	Aetna Global Benefits/Aetna P.O. Box 981543 El Paso, TX 79998-1543 USA Phone outside U.S. via AT&T+access: 1-800-231-7729 Phone: outside U.S. direct or collect: (813) 775-0190 Fax outside U.S.: 1-800-475-8751 Fax inside U.S.: 1-859-425-3363 Email: AGBSERVICE@AETNA.COM http://aetnainternational.com	Insured
Vision		
Vision Service Plan (VSP)	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 Phone: (800) 877-7195 Fax: (916) 463-9090 http://www.vsp.com	Self-funded

Benefit Programs	Claims Administrator	Funding
Aetna International EXPAT	Aetna Global Benefits/Aetna P.O. Box 981543 El Paso, TX 79998-1543 USA Phone outside U.S. via AT&T+access: 1-800-231-7729 Phone: outside U.S. direct or collect: (813) 775-0190 Fax outside U.S.: 1-800-475-8751 Fax inside U.S.: 1-859-425-3363 Email: AGBSERVICE@AETNA.COM http://aetnainternational.com	Insured
Flexible Spending Accounts		
HealthEquity	HealthEquity P.O. Box 14374 Lexington, KY 40512 Phone: (866)-346-5800 Fax: (801)-727-1005 http://www.healthequity.com/	Self-funded
Disability		
Short-Term Disability	Lincoln Life Assurance Company of Boston P.O. Box 8200 Dover, NH 03821-0821 Phone: (888) 873-5476 www.mylincolnportal.com Company Code: ADOBELOA	Self-funded
Long-Term Disability	Lincoln Life Assurance Company of Boston P.O. Box 8200 Dover, NH 03821-0821 Phone: (888) 873-5476 www.mylincolnportal.com Company Code: ADOBELOA	Insured
Life and AD&D		
Lincoln Life Assurance Company of Boston	Lincoln Life Assurance Company of Boston Group Life Claims P.O. Box 7212 London, KY 40742-7212 Phone: 888-787-2129 Email: GroupLifeClaims@LFG.com www.mylincolnportal.com Company Code: ADOBELOA	Insured
Group Legal Insurance		

Benefit Programs	Claims Administrator	Funding
MetLife Group Legal	MetLife Legal Plans, Inc. Director of Administration Eaton Center 1111 Superior Avenue Cleveland, Ohio 44114-2507 (For Florida plans contact MetLife Legal Plans of Florida, Inc. at the above address.)	Insured
Business Travel Accident (BTA)		
Business Travel Accident	Chubb Group of Insurance Companies 15 Mountain View Road P.O. Box 1615 Warren, New Jersey 07061-1615 Phone: (908) 903-2000 http://www.chubb.com	Insured
Employee Assistance Plan (EAP)		
Employee Assistance Plan	Spring Health NeueHouse Madison Square 110 E 25th St New York, NY 10010 https://www.springhealth.com/	Insured

OTHER CONTACTS

COBRA	
COBRA Administrator	bswift P.O. Box 617907 Chicago, IL 60661 Phone: (855) 898-4218 adobe.bswift.com
Administration	
Adobe Benefits Support Team	Benefits Support Team Phone: 855-898-4218 Adobe benefits enrollment site Send a secure message
Cancer Support Services	
AccessHope	Phone: 1-833-971-4673 connect.myaccesshope.org

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Appendix C: Plan Administration Information

Official Plan Names/Plan Numbers	Adobe Incorporated Group Welfare Plan (Plan Number 501)
Employer/Plan Sponsor	Adobe Inc. 345 Park Avenue San Jose, CA 95110-2704
Employer I.D. Number	77-0019522
Type of Plan	The benefit plans are welfare benefit plans which include medical, prescription drug, dental, vision, health care flexible spending accounts, employee assistance program, short-term disability, long-term disability, life and accidental death and dismemberment, group legal insurance and business travel accident.
Type of Administration/ Insurance Issuers	The benefit plans are provided under both self-funded and insured arrangements. Both insured (which include HMOs) and self-funded arrangements, except long-term care benefits, are provided under group contracts between the Company and the carriers or outside administrators. The long-term care benefits are provided under individual insurance policies.
Plan Funding	The insured arrangements are paid by insurance policies. The benefits and other plan costs (such as administrative costs) for the self-funded plans are paid from the general assets of Adobe Inc.
Plan Administrator	Adobe Inc. 345 Park Avenue San Jose, CA 95110-2704 1-408-536-6000
Claims Administrators	The Claims Administrators or insurance carriers – not the Company – are solely responsible for determining the amount of any benefits, if any, payable. See *Appendix B: Claim and Appeals Administration and Funding Information*
Agent for Service of Legal Process	General Counsel Adobe Inc. 345 Park Avenue San Jose, CA 95110-2704 Service of process may also be made on the Plan Administrator.
Plan Year	January 1 – December 31
Contribution Sources	Employer and participant contributions

Appendix D: Domestic Partner Coverage Policy Statement

The following coverages are available to the Domestic Partners of eligible employees who meet the Plan's eligibility requirements: medical, dental, and vision coverage and dependent life insurance plan coverage.

Taxation of Coverage: Domestic Partner and Domestic Partner dependent coverages are considered taxable benefits by the IRS and will be added to taxable income as imputed income. As such, the Adobe employee will be responsible for tax obligations.

In addition, if your Domestic Partner or Domestic Partner's child(ren) meet the dependency requirements set forth in section 152 of the Internal Revenue Code, the cost of health care coverage under the Adobe plans is payable on a pre-tax basis, and the cost of coverage will not be considered additional income to you and the imputed income requirement will not apply. Generally, section 152 of the Internal Revenue Code recognizes as dependents those individuals who live with you as a member of your household in your principal residence AND receive more than half of their support from you.

Initial Enrollment of Domestic Partner: To enroll a Domestic Partner, make the change in the Adobe Benefits Enrollment Site within 31 days of when the domestic partner relationship meets the eligibility requirements.

Termination of Domestic Partner Benefits: To remove a Domestic Partner's coverage, make the change in the Adobe Benefits Enrollment Site within 31 days of termination of the domestic partnership. COBRA equivalent coverage is available to your Domestic Partner and your partner's child(ren) at their expense for a period of time after coverage under the Adobe health care plans ends. This COBRA equivalent coverage includes medical, dental, vision and the Employee Assistance Plan.

Community Property Implications: Please be advised that some courts have recognized non-marriage relationships as the equivalent of marriage for the purpose of establishing and dividing community property. You may want to consult legal or financial counsel regarding this issue.

Fraudulent Enrollment or Failure to Update Dependent Information: As with any other coverage under the Plan, falsifying information or any failure to update the Adobe Benefits Enrollment Site due to any relevant change in the Domestic Partner relationship may subject the employee to disciplinary action up to and including termination of employment.