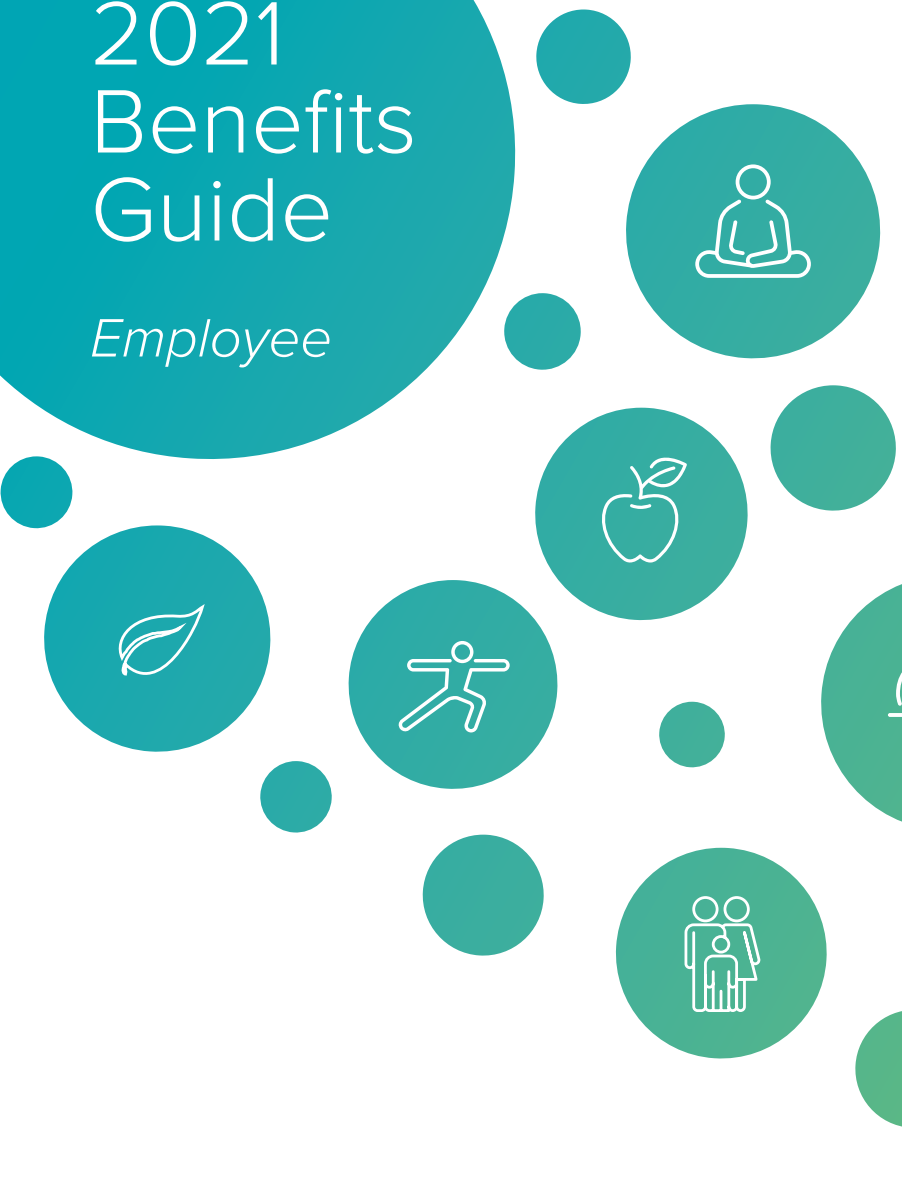
2021 Benefits Guide

Employee



O'Melveny

Your O'Melveny Benefits

Our attorneys and staff are our most valued assets. O'Melveny takes pride in providing a comprehensive and competitive benefits package from quality health care, 100% paid basic life, accident and disability coverage as well as a portfolio of additional benefits designed to meet your individual needs.

In our US office, we call our benefits package "Signature Benefits" because it can be customized to meet your personal needs and is as unique as your individual signature.

Your Benefits Include:

- Health care coverage, including medical, dental and vision benefits for you and your eligible dependents
- Life and accidental death and dismemberment insurance for you and your eligible dependents
- Long-term disability coverage
- Healthcare (HCFSA) and dependent care (DCFSA) flexible spending accounts
- Health Savings Account (HSA)
- 401(k) plan
- Employee assistance program through CCA@YourService
- Additional benefits to enhance your life

This Benefit Guide is one of the tools you can use to put your benefits to work for you. Whether you are enrolling for the first time or are a current participant, this guide outlines your benefits plans and options, walks you through enrollment, and can help you make your benefits decisions. For more details about your benefits, refer to the O'Melveny & Myers LLP Summary Plan Description (SPD).

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. For further information, visit medicare.gov.

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Who Is Eligible for Signature Benefits

O'Melveny attorneys and staff are eligible for Signature Benefits so long as you are classified as a common-law full-time employees. Some part-time employees may also be eligible for benefits (see hours requirement below).

Hours Requirements:
- 21 hours per week in New York
- 22.5 hours per week in all other US locations

An "attorney," for benefits purposes, is any one of the following: associate, visiting associate, counsel, or staff attorney. This includes attorneys on reduced schedules, but does not include summer associates, law clerks and part-time attorneys who do not meet the hours requirement above.

Individuals who are not classified as common-law employees, at the firm's discretion, including but not limited to independent contractors, non-employee consultants and employees of any entity other than O'Melveny, are not eligible for Signature Benefits. This is true even if this classification is determined to be erroneous or is retroactively revised.

All references to "employees" in this guide include attorneys and staff employees unless otherwise noted.

Dependent Eligibility

You may also enroll your eligible dependents in many of the Signature Benefits plans. Your eligible dependents are:
- Your legal spouse or domestic partner
- Your dependent children until age 26
- Your unmarried children of any age who are totally disabled and dependent upon you for support

A domestic partner is a person of either gender with whom you have a committed relationship, similar to a marriage. If you would like to enroll a domestic partner, please contact the Benefits Team for details regarding eligibility requirements and a domestic partner affidavit.

You will be required to submit medical certification of disability to continue coverage past your child's 26th birthday. Additionally, you may be required to provide a certificate of tax dependency. You will also be required to submit Social Security numbers for all dependents.

When Benefits Begin

Coverage begins on date of hire for all eligible employees.

Your Contributions

The firm pays a significant portion of your cost for medical, dental, vision, long-term disability, life and AD&D coverage. You pay a greater share of the cost of dependent health care coverage with the firm. You pay the full cost of all voluntary benefits.

Your covered salary will determine the amount O'Melveny pays for your benefits.

Your covered salary is your base annual salary on your date of hire or on September 1 of the current plan year for Open Enrollment.

Premiums for health care coverage for you and your spouse and/or your dependent children will be deducted from your pay before income taxes are withheld.

Your cost for medical, dental and vision coverage will be based on the coverage level you select. Signature Benefits offers five levels of coverage from which to choose:
- Employee only
- Employee plus spouse or domestic partner
- Employee plus child or children
- Employee plus family
- Waive health care coverage

Premiums for domestic partner coverage will be withheld on an after-tax basis. The value of the health care coverage provided to your domestic partner is treated by the IRS as taxable income, and will be imputed in your income, resulting in additional tax withholding.

Individual contribution amounts for these plans may be found in Workday.

Waiving Coverage
You may waive health care coverage.

If you waive coverage and then lose your current coverage or acquire a new dependent through marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents in the firm's plans. See "Special Enrollment Rights" on page 4 for details.

Although there is no longer a federal individual mandate, you may be subjected to an individual mandate in certain municipalities (including: CA,RI, D.C., NJ, MA, VT).

Enrolling in Signature Benefits

Newly Eligible Employees
When you join the firm or become benefits eligible, one of the first things you will be asked to do is complete your benefits enrollment online in Workday, the firm's global HR system.

Follow these steps:
- Review your enrollment materials, including this guide, for valuable information
- Complete your enrollment within 31 days of your date of hire

Be sure to include any additional forms or documentation required. The benefits you elect when you first enroll remain in effect until December 31. You may not make changes during the year unless you experience a qualified change in status, outlined on this page.

Default Coverage
If you do not make your benefit selections in Workday within 31 days of becoming eligible, you will only be enrolled into the following plans:
- Basic Life insurance equal to one times your covered salary
- Basic AD&D coverage equal to one times your covered salary
- The 50% Long-Term Disability Plan

Your dependents, if any, will not have medical, dental or vision coverage and you will not be allowed to change your enrollment until the next Open Enrollment (unless you have a qualified change in status as defined on this page).

Open Enrollment
Each year during Open Enrollment, you should review and, if necessary, make changes to your Signature Benefits. If you do not review and confirm your benefits, they will automatically rollover with the exception of any Health Savings Account (HSA) or Flexible Spending Account (FSA). During Open Enrollment you may:
- Change your medical and dental plan elections
- Add or remove dependents
- Enroll in, increase or decrease contributions to the health care or dependent care flexible spending accounts (FSA)
- Enroll in a Health Savings Account (HSA)
- Apply for additional life and accidental death insurance for yourself and your eligible dependents or decrease your coverage; and
- Change your long-term disability plan election

Any changes you make during Open Enrollment will take effect January 1 and remain in effect until December 31 of that same plan year.

Changing Your Benefits During the Year

Qualified Change in Status
The benefits and coverage levels you elect when you first enroll, and during subsequent Open Enrollments, remain in effect throughout the plan year (January 1 to December 31). You may not make changes to your enrollment unless you experience a "qualified change in status" as defined by the IRS, and notify the Benefits Team within 31 days of the change. Such changes include:
- Marriage
- Divorce or legal separation
- Birth, adoption, or placement for adoption of a child
- Death of a spouse, or domestic partner or child
- A child reaches the maximum age for coverage
- Any change in the employment status of you or your spouse or domestic partner that results in a change in benefits eligibility, such as start or end of employment, a change in number of hours worked, or start or end of an unpaid leave of absence
- Moving outside your medical plan service area
- You, your spouse or domestic partner or dependent children become entitled to Medicare or Medicaid.

If you have a qualified change in status and want to change your benefits election, you must notify the Benefits Team and submit allowable changes within 31 days of the qualifying event. Thereafter, you may not make changes to your benefits election until the next Open Enrollment period. Any changes you make must be consistent with your change in status. For example, if you and your spouse have a baby, you may add your child to your medical plan, but you may not drop your spouse from the plan.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because you have other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

When Coverage Ends

Your coverage under Signature Benefits ends the last day of the month in which you are no longer eligible, with the exception of disability, HCFSA, and DCFSA; which terminate on the date you are no longer eligible. Additionally, dependent coverage ends on the last day of the month in which a dependent ceases to meet the eligibility requirements outlined on page 2.

You may elect to continue medical, dental and vision coverage for yourself and/or your spouse or dependent children under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) for up to 18 months, depending on the situation.

You or your spouse or dependent children may be able to elect COBRA if group health care coverage is lost due to:

- A reduction in your hours or your termination of employment (for reasons other than gross misconduct)
- Divorce or legal separation
- A dependent child no longer meeting the eligibility requirements for coverage as outlined on page 2
- Your death

The Benefits Team will provide you with the relevant information if you become eligible for COBRA.

Medical Plan Options

The firm recognizes the importance of quality, flexibility and choice when it comes to your medical care. You may select one of three medical plan options to best meet your needs.

This section of the Benefits Guide provides an overview of your medical plan choices. You may choose from:

- EPO HD Choice – High Deductible EPO with Health Savings Account (in-network coverage only)
- PPO HD Choice Plus – High Deductible PPO with Health Savings Account
- PPO Traditional Choice Plus – Traditional PPO

All three plans, provided by UnitedHealthcare, are available in all firm locations, nationwide.

Each of the medical plan options provides comprehensive coverage for most medically necessary health care needs, including preventive and routine care, as well as hospitalization, maternity, emergency and prescription drug coverage. There are, however, differences in coverage limits, coinsurance and deductibles. Be sure to review your choices carefully. Each plan is outlined on page 7.

EPO HD Choice – High Deductible Health Plan with HSA*

UnitedHealthcare "Choice" Network

This is an in-network only plan; there are no out-of-network benefits. You do not need to select a Primary Care Physician (PCP) or obtain a referral to see a specialist, in most cases. After you satisfy the annual calendar year deductible, the plan will cover expenses at 90%, if you see an in-network provider. If you have enrolled dependents, you must meet the family deductible before the plan will begin paying benefits.

PPO HD Choice Plus – High Deductible Health Plan with HSA*

UnitedHealthcare "Choice Plus" Network

This plan gives you the flexibility to choose in-network doctors and facilities for maximum benefit or to see out-of-network providers at a higher cost. You are not required to select a PCP and do not need a referral to see a specialist, in most cases.

The plan pays a higher percentage of covered costs when you use in-network providers and facilities.

After you satisfy the annual calendar year deductible, the plan will cover expenses at 85% if you see an in-network provider. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual deductible amount. The plan will cover 60% of reasonable and customary (R&C charges) if you see a out-of-network provider.

* For detailed information about the HSA, see page 14.

PPO Traditional Choice Plus

UnitedHealthcare "Choice Plus" Network

This plan gives you the flexibility to receive care from both in-network doctors and facilities for maximum benefits or to see out-of-network providers at a higher cost. For in-network doctor visits and for prescriptions, you will not need to satisfy the annual deductible, you will simply pay a copay. All other care will require you to meet the deductible before you start paying a co-insurance.

Under the plan, you are not required to select a PCP and you do not need a referral to see a specialist, in most cases.

This plan has the lowest deductible of all of our plans, and is not HSA eligible. It also has the highest monthly contributions.

Prescription Drug Coverage

The Signature Benefits medical plans provide coverage for prescription drugs.

- Generic preventive prescription drugs are covered at 100%
- All other prescriptions are subject to the deductible and coinsurance, except for prescriptions on the PPO Traditional Choice Plan

Specialty Pharmacy Prescriptions must be obtained through UnitedHealthcare's Specialty Pharmacy program. This program ensures a better use of benefits and provides 24/7 access to specially trained pharmacists.

UHC Clinical Management Programs

The medical plans include a number of programs that can provide support to you and your family when you experience an illness. You can access these programs by calling UHC.

These programs can provide assistance as you navigate the health care system, including clinical support with a diagnosis and determining the best treatment options for you.

These programs include services for:

- Back pain
- Congenital heart disease
- Healthy pregnancy
- Neonatal support post delivery
- Kidney disease
- Reproductive services

Cancer Support Program

UHC members who are preparing for cancer treatment or have already started, a nurse can help you navigate treatment options and help you find a network provider from a high-quality Centers of Excellence (COE) facility. Here's more of what you can expect:

- Connect with a nurse specially trained in oncology for support — and throughout your treatment journey
- Get help exploring your options, finding answers to questions and managing symptoms and side effects
- Receive support working with your doctors, so you feel informed to make decisions for your health

Get started by calling 1-866-936-6002, Monday through Friday, 7 a.m. to 7 p.m. CT or visit myuhc.phs.com/cancerprograms.

Other Provisions Affecting Coverage

Health Insurance Marketplace

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you are eligible for depends on your household income.

IMPORTANT: If you receive financial assistance in a Health Insurance Marketplace and are not entitled to it, the IRS may ask you to repay the financial assistance you received.

Women's Health and Cancer Rights Act

In accordance with Federal law, the O'Melveny medical plan options provide coverage for the following services in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The plan in which you are enrolled will determine coverage in consultation with you and your physician. Coverage for breast reconstruction and related services will be subject to deductibles, coinsurance and plan maximums that are consistent with those that apply to other benefits under the plan.

MEDICAL PLAN OPTIONS

Health Plan Feature	EPO HD Choice	PPO HD Choice Plus		PPO Traditional Choice Plus	
	In Network	In Network	Out-of-Network	In Network	Out-of-Network
Annual Deductible (Individual)	$1,500	$3,000	$5,000	$1,000	$2,000
Annual Deductible (Family)	$3,000	$6,000	$10,000	$2,000	$4,000
Annual Out-of-Pocket Max (Individual)	$3,000	$5,000	$7,000	$4,000	$8,000
Annual Out-of-Pocket Max (Family)	$6,000	$10,000	$14,000	$8,000	$16,000
Doctor Visits	**You Pay**	**You Pay**		**You Pay**	
Preventive care services	$0 deductible does not apply	$0 deductible does not apply	Not Covered	$0 deductible does not apply	40% after deductible
Primary care office visit	10% after deductible	15% after deductible	40% after deductible	$30	40% after deductible
Specialists office visits	10% after deductible	15% after deductible	40% after deductible	$40	40% after deductible
Urgent Care Visit	10% after deductible	15% after deductible	40% after deductible	$50	40% after deductible
Emergency Room Visit	10% after deductible	15% after deductible	15% after deductible	$150	$150
Services	**You Pay**	**You Pay**		**You Pay**	
Hospital Inpatient and Outpatient Services	10% after deductible	15% after deductible	40% after deductible	20% after deductible	40% after deductible
Lab, X-Ray, and Major Diagnostics – Outpatient	10% after deductible	15% after deductible	40% after deductible	20% after deductible	40% after deductible
Reproductive Resource Services – Infertility – $25,000 lifetime max	10% after deductible	15% after deductible	Not Covered	20% after deductible	Not Covered
Mental Health / Substance Abuse Office Visits	10% after deductible	15% after deductible	40% after deductible	$30	40% after deductible
Mental Health / Substance Abuse Services	10% after deductible	15% after deductible	40% after deductible	20% after deductible	40% after deductible
Durable Medical Equipment (DME)	10% after deductible	15% after deductible	40% after deductible	20% after deductible	40% after deductible
Acupuncture – $500 limit per year	10% after deductible	15% after deductible	40% after deductible	$30	40% after deductible
Rehabilitation Services	10% after deductible	15% after deductible	40% after deductible	$30	40% after deductible
Prescription Benefits	**You Pay**	**You Pay**		**You Pay**	
Prescription Drug Benefit – 31-day supply	10% after deductible	15% after deductible	15% after deductible	Tier 1: $10 Tier 2: $30 Tier 3 $50	Tier 1: $10 Tier 2: $30 Tier 3 $50
Mail-Order Rx – 90-day supply	10% after deductible	15% after deductible	Not Covered	Tier 1: $25 Tier 2: $75 Tier 3 $125	Not Covered
Preventive Care Rx	$0 deductible does not apply	$0 deductible does not apply	Not Covered	$0 deductible does not apply	Not Covered

Note: Plan percentage for out-of-network coverage is based on reasonable and customary charges. Pre-service notification is required for certain services.

Balance billing occurs if you visit an out-of-network provider. The provider can bill you for the difference between what your health insurance chooses to reimburse and what the provider chooses to charge. To receive the highest level of coverage, always visit in-network providers.

Medical Concierge Services

2nd MD

2nd MD is a service available to help you when you and/or your enrolled dependents are faced with an important medical decision. 2nd MD works with leading medical specialists to review your and/or your enrolled dependents' specific situation, and then provides feedback on your and/or your enrolled dependents' diagnosis and treatment plan. 2nd MD can help you possibly avoid unnecessary procedures, spot misdiagnoses and improve existing treatment plans. Sometimes the second opinion might confirm your current course of action; other times it might provide a different viewpoint.

2nd MD could be used when you or your enrolled dependent:

- Are facing a new medical diagnosis
- Have questions about your treatment plan or medications
- Are considering possible surgery
- Are managing ongoing medical conditions

With your permission, the 2nd MD team will collect and analyze all your relevant medical records and then connect you with a specialist, via phone or video, to discuss your case and conduct a full review of your diagnosis and treatment plan.

To get started, contact a 2nd.MD nurse through any of these methods:

- 2nd.md/omm
- 1.866.269.3534
- From the 2nd.MD mobile app

One Medical Group

Eligible members experience a unique approach to doctor visits, designed around their needs. With quality care, comprehensive services and efficient use of technology, One Medical offers high-touch customer service in a warm, stress-free office setting. Benefits of membership include:

- Longer, same-day appointments that start on time
- Comprehensively trained primary care doctors
- Email access to your doctor, online scheduling and prescription renewals.
- Locations within close proximity to most O'Melveny offices

NFP Benefits Concierge and Claims Advocate

O'Melveny employees have access a dedicated Benefits Concierge representative as well as access to their Claims Advocacy Services. They are your personal advocates and can help you navigate and understand the O'Melveny Signature Benefits as well as work directly with the insurance companies to make sure your claims from O'Melveny Signature Benefits are paid accurately and in a timely manner.

Some of the areas the Dedicated Benefits Concierge can help with are:

- Benefit Plan Design Questions
- ID Card Issues
- Provider Network Issues
- COBRA Questions

Some areas the Claims Advocacy Services can help with are:

- Claims Questions
- Review of Explanations of Benefits
- Questions Regarding Bills / Claims Resolution
- Prescription Issues
- Appeals

You can reach a Benefits Concierge representative at 877-835-1361 or e-mail DBbenadmin@nfp.com Business Hours for Benefits Concierge are 9 am to 6 pm EST / 6 am to 3 pm PST. The Claims Advocacy team can be reached at CSclaims@nfp.com.

Vision Plan

The firm automatically provides vision coverage through Vision Service Plan (VSP) to all employees and dependents enrolled in a Signature Benefits medical plan.

VSP is a leading provider of eye care services with an extensive network of eye doctors throughout the country. The plan allows you to obtain vision care from VSP Signature network providers or to seek care from any licensed professional.

How VSP Works

Before benefits are paid, each covered individual is responsible for the first $25 of covered services whether for an eye exam or for materials, regardless of whether a VSP network provider is used or not. The plan covers one exam and lenses or contact lenses every 12 months. Frames are covered every 24 months. VSP providers may charge extra for cosmetic items such as blended lenses and designer frames. Vision benefits are covered as outlined in the table below.

VSP also provides discounts for additional pairs of glasses and contact lenses when purchased from the VSP network provider.

Non-VSP Providers

When you see a non-VSP provider, you must pay the entire cost of services when they are received and submit a claim for reimbursement. You will be reimbursed up to the maximum amount the plan will pay, less your applicable copayment, which may be less than your actual cost.

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Provider			
WellVision Exam	Focuses on your eyes and overall wellness	$25 for exam and glasses	Every 12 months
Prescription Glasses			
Frame	• $120 allowance for a wide selection of frames • $140 allowance for featured frame brands • 20% savings on the amount over your allowance	Combined with exam	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Combined with exam	Every 12 months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35 – 40% on other lens enhancements	$0 $80 – $90 $120 – $160	Every 12 months
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Diabetic Eyecare Plus Program	Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	***Glasses and Sunglasses*** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam. ***Retinal Screening*** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam ***Laser Vision Correction*** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		

Dental Plan Options

Healthy teeth and gums are an important part of your overall well-being. To help you maintain your dental health, the firm offers you a choice between two dental plans to best meet your needs.

Both plans cover a broad range of dental services, from preventive and basic care to major care and orthodontia. In all locations, you may choose between:

- Cigna Dental Preferred Provider Organization (PPO) plan
- The Cigna Dental Maintenance Organization (DMO) plan

You may also waive dental coverage.

Cigna Dental PPO Advantage

The Dental PPO plan does not restrict your access to dentists; you may use any PPO (in-network) dentist or any out-of-network dentist. There is no annual deductible. Two annual cleanings and exams are covered at 100% with no deductible requirement. The plan will pay a percentage of covered expenses, as outlined in the table on the next page.

Cigna Dental Care DMO

Designed much like a medical HMO, you choose a participating dentist or dental facility, called your primary dentist, to provide all your care. There is no deductible to meet or claim forms to file. The plan covers two annual cleanings and exams at 100%. You will pay a pre-determined copayment for all other covered services as outlined in the table below.

Comparison of Dental Options

Cigna Dental DMO (Copayment Schedule)

Annual Deductible **Calendar Year Maximum**	None None
Preventive & Diagnostic Care Oral Exams (Two per year) Routine Cleanings (Two per year) X-rays	 $0 $0 $0
Basic Restorative Care Fillings, Extractions, Oral Surgery	 $0 to $75 based on service
Major Restorative Care Crowns, Dentures, Bridges	 $0 to $340 based on service
Orthodontia Children to age 19 Adults	 $1,800 $2,400
Other Services	Refer to Patient Charge Schedule

Comparison of Dental Options

Cigna Dental PPO (Co-Insurance Schedule)

Network – Total Cigna DPPO	Cigna DPPO Advantage		Cigna DPPO		Out-of-Network†	
Calendar Year Maximum (Class I, II and III expenses)	$2,000		$1,500		$1,500	
Annual Deductible Individual Family	 $0 per person $0 per family		 $50 per person $150 per family		 $50 per person $150 per family	
Reimbursement Levels	Based on Reduced Contracted Fees		Based on Fee Schedule or Discount Schedule		80th percentile of Reasonable and Customary Allowances†	
Dental Plan Feature	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
Class I – Preventive & Diagnostic Care Routine Cleanings Bitewing X-rays Panoramic X-ray Fluoride Application Sealants Space Maintainers Palliative (Emergency) Care to Relieve Pain Exams	100%	No Charge	100%	No Charge	100%	No Charge†
Class II – Basic Restorative Care Fillings Root Canal Therapy/Endodontics Osseous Surgery Periodontal Scaling and Root Planing Denture Adjustments and Repairs Oral Surgery – Simple Extractions Oral Surgery – All Except Simple Extractions Anesthetics Surgical Extractions of Impacted Teeth Repairs to Bridges, Crowns and Inlays	80%	20%	80%*	20%*	80%*	20%**
Class III – Major Restorative Care Crowns Dentures Bridges Inlays/Onlays Prosthesis Over Implant	50%	50%	50%*	50%*	50%*	50%**
Class IV – Orthodontia Lifetime Maximum	50% $2,000 Covered for Children & Adults	50%	50%* $2,000 Covered for Children & Adults	50%*	50%* $2,000 Covered for Children & Adults	50%**

* Subject to annual deductible

† Balance billing occurs if you visit an out-of-network provider. The provider can bill you for the difference between what your insurance reimburses and what the provider chooses to charge. To receive the highest level of coverage, always visit in-network providers.

Your Life Insurance and AD&D Choices

The firm provides basic life and accidental death and dismemberment (AD&D) insurance at no cost to you. You may purchase additional coverage for yourself, your spouse or domestic partner and your children. Life insurance pays a benefit if the covered individual dies. In addition, AD&D insurance pays a benefit if you die or lose a limb or sight in a covered accident.

Employee Basic Life and AD&D Insurance

You automatically receive life and AD&D insurance coverage for yourself equal to one times your covered salary. If you choose, you may reduce either of these benefits to $10,000. You cannot waive basic life or AD&D coverage. The value of your basic life insurance coverage that exceeds $50,000 will be imputed as taxable income.

Employee Supplemental Life and AD&D Insurance

If you elect 1x salary coverage you may also elect additional life and AD&D coverage in multiples of your covered salary in the following increments:

- 1x covered salary
- 2x covered salary
- 3x covered salary
- 4x covered salary
- 5x covered salary

The total amount of supplemental life or AD&D insurance coverage cannot exceed $1,000,000.

Definition of "Covered Salary"

For life and AD&D insurance purposes, "covered salary" means your base annual salary on your date of hire or on September 1 of the current plan year for Open Enrollment.

Evidence of Insurability

If you elect more than $800,000 in supplemental life insurance, or if you want to increase your coverage by more than 1x your covered salary at any time, you must provide "proof of good health" to the insurance carrier before coverage will take effect. Please complete and return the required form to MetLife within the designated time frame (the form can be found on the ommni life insurance page). In addition, you may be required to have a physical exam at your own expense.

Dependent Life and AD&D Insurance

You may also elect life and AD&D insurance for your spouse or domestic partner and/or dependent children.

Dependent Life Insurance

Life insurance coverage is available for your spouse or domestic partner equal to 50% of your coverage amount, to a maximum of $100,000. If you elect more than $50,000 in life insurance for your spouse or domestic partner, he or she will be required to provide proof of good health before coverage will take effect.

Life insurance coverage is available for your dependent children ages 10 days to 26 years in the following increments:

- $2,500 per child
- $5,000 per child
- $7,500 per child
- $10,000 per child

Dependent AD&D Insurance

Also, you may purchase AD&D coverage for your eligible family members. If you elect 'Family' coverage, it will cover all eligible members at the below amounts:

- **Individual:** 1-5x your covered salary
- **Spouse/domestic partner:** 100% of your AD&D coverage, to a maximum of $1,000,000
- **Child(ren):** 15% of your AD&D coverage, to a maximum of $150,000 per child

How AD&D Benefits are Paid

If you...	Plan pays...
Die in a covered accident	100% of your benefit amount
Lose both feet, both hands, sight in both eyes, one hand and one foot, either one hand or one foot and sight in one eye	100% of your benefit amount
Lose either one hand, one foot or sight in one eye	50% of your benefit amount

Group Travel Accident Insurance

The firm provides $150,000 of Group Travel Accident insurance to protect you against most types of losses when you are traveling on firm business.

If you sustain a covered loss due to an accident that occurs while traveling on business, the plan will pay a benefit to you or your beneficiary. The injury must be sustained while the program is in force and the loss must occur within 365 days of the date of the accident.

Aetna World Traveler Plan

You have access to an international business travel plan that not only provides you with medical insurance and emergency assistance during your business trip — it also offers peace of mind.

The following options are available as part of your coverage:

- Urgent and emergency medical care
- Emergency medical evacuation
- Transportation after initial evacuation
- Confinement visitation
- Return of dependent children
- Repatriation of mortal remains
- Medical referrals
- Emergency medication, vaccine and blood transfers
- Legal referral assistance
- Translation services

Long-Term Disability Coverage

The Signature Benefits long-term disability (LTD) plans provide you with valuable income protection if you are injured or ill and unable to work for an extended period.

The firm offers two levels of LTD coverage from which to choose. You must elect one LTD option. You may not waive coverage.

Your LTD options are:

- **60% LTD Plan:** Pays 60% of your monthly salary to a maximum monthly benefit of $15,000 after you have been continuously disabled for 90 days. Benefits end when you reach age 65 if the disability occurs prior to age 60. For disabilities occurring later, the duration of payment varies depending on your age at the time you become disabled.
- **50% LTD Plan:** Pays 50% of your monthly salary to a maximum monthly benefit of $2,500 after you have been continuously disabled for 180 days. Benefit payments end after 5 years.

The firm will issue a credit for LTD to you each pay period to offset half the cost of LTD (based on the cost of the 60% LTD plan). The total cost of coverage will be deducted from your paycheck after taxes are withheld; therefore, any benefits you receive are generally not taxable.

Upon initial enrollment in LTD coverage, you are not required to provide proof of good health. If you elect the 50% plan and, at a future Open Enrollment period, you choose to increase coverage from the 50% plan to the 60% plan, you will not be covered for any disability caused by conditions that existed during the three months prior to your changing plans. In addition, benefits will not be payable until you have been enrolled in the 60% plan for at least 12 months.

Health Savings and Flexible Spending Accounts

Eligible employees can gain valuable tax advantages by participating in the Health Savings Account, Health Care and Dependent Care Flexible Spending Accounts available through O'Melveny. These accounts allow you to deduct money from each paycheck on a pre-tax basis and set it aside to reimburse yourself for certain eligible expenses you incur during the year.

You have three plan options:

- **The Health Savings Account**, offered in conjunction with the High Deductible health plans, pays for eligible health care expenses not covered by insurance. HSA funds roll over from year to year, so you can save your contributions over time to fund more costly procedures.
- **The Health Care Flexible Spending Account** pays for eligible health care expenses not covered by insurance (for Traditional PPO and "waive medical" participants only).
- **The Dependent Care Flexible Spending Account** pays for eligible day care expenses incurred so you (and your spouse, if you are married) can work or look for work.

These accounts are governed by certain IRS rules. When you enroll in the HSA, you can change your contributions on a monthly basis. With the Health Care and Dependent Care FSAs you may not change your election unless you experience a qualified change in status during the plan year.

You must enroll in the HSA or FSA each year. Your election from the prior year will not automatically renew.

Your contributions are deducted from each paycheck in equal installments throughout the year, before Federal, Social Security, and (in most cases) state income taxes are withheld. They are deposited in the appropriate account and held there until you request reimbursement for eligible expenses.

Health Savings Account (HSA)

Generally, if you want to establish an HSA, federal law requires that your only medical coverage be a compatible high deductible medical program.

The annual contribution is subject to change based on IRS limits. For the 2021 plan year, the firm will contribute $1,000/individual and $2,000/family in the HSA account for all employees who are enrolled in either high deductible medical plan. This contribution counts toward the limit allowed by the IRS. If you were hired in 2021, this contribution is prorated based on your date of hire.

The IRS limits for 2021 are:

- $3,600 for individuals ($2,600 employee + $1,000 firm contribution for non-partners)
- $7,200 for families ($5,200 employee + $2,000 firm contribution for non-partners)
- Individuals that are 55+ may contribute up to an additional $1,000.

For more details, see the plan documents and the comparison chart.

Health Care Flexible Spending Account (HCFSA)

If you and your dependents expect to have out-of-pocket medical, dental and vision expenses (such as deductibles, coinsurance and copayments), and are currently waiving O'Melveny coverage or enrolled in the Traditional PPO Plan, you may want to consider enrolling in the Health Care FSA. The IRS has not yet announced the 2021 annual maximum amount. We will provide it via email as soon as it is announced. For your reference, the 2020 maximum was $2750. Your contributions will be deducted in equal amounts from your paycheck beginning with the first pay period of the calendar year following Open Enrollment. For midyear or new-hire enrollment, deductions will begin with the first pay period following your election.

You can use your HCFSA to pay for health care expenses incurred by you or anyone who is your eligible tax dependent- even if they are not covered under the firm's health care plans. Unless your domestic partner or your domestic partner's children are your dependents for federal tax purposes, their expenses are not eligible for reimbursement.

Eligible Health Care Expenses

A partial list of eligible expenses follows. For a more complete listing, refer to IRS Publication 502, available from your local IRS office or on the web at irs.gov.

Eligible Expenses

- Acupuncture
- Ambulance
- Artificial limbs
- Car controls for the handicapped
- Chiropractors' fees
- Christian Science practitioners' fees
- Coinsurance
- Contact lenses and supplies
- Copayments
- Deductibles
- Dentures
- Hearing devices and batteries
- Insulin

Dependent Care Flexible Spending Account (DCFSA)

Consider opening a DCFSA if your dependents require care while you (and your spouse, if you are married) work or look for work. Your contributions will be deducted in equal amounts from your paycheck beginning with the first pay period of the calendar year following Open Enrollment. For mid-year changes or new-hire enrollment, deductions will begin with the first pay period following your election.

Special Eligibility Rules for the DCFSA

To qualify for the DCFSA, you must meet the eligibility provisions, have an eligible dependent who requires day care, and be:

- Single, or
- Married and your spouse:
  - is a student and attends classes outside the home at least five months a year, or
  - is disabled and cannot care for eligible dependents
  - is employed

To receive reimbursement for dependent care expenses, your dependent must be:

- A child under age 13, or
- A person of any age who is severely physically or mentally disabled

Your dependent must live in your home at least eight hours a day and be incapable of self-care. Generally, you must also claim the individual as a dependent on your tax return. Special rules apply for children of divorced or separated parents. You can find complete details about the rules relating to children of divorced or separated parents in IRS Publication 503, available from your local IRS office or on the web at irs.gov.

Unless you can claim your domestic partner or your domestic partner's children on your income tax return, their expenses are not eligible for reimbursement.

Contribution Limits

If you decide to participate in the DCFSA, you may be able to contribute up to $5,000 a year, depending on your marital and income tax filing status, as shown in the following chart. Your contributions may be reduced, suspended, or refunded following results of required annual plan testing.

If you are	You may contribute:
Single	The lower of $5,000 or your earned income
Married and file a joint tax return	The lowest of $5,000, your earned income or your spouse's earned income If your spouse has access to a FSA, your combined contributions may not exceed the maximum outlined above
Married and you and your spouse's tax returns	The lowest of $2,500, your earned income or your spouse's earned income Your spouse may also contribute up to $2,500 to a separate Dependent Care FSA, subject to the maximum outlined above
Married, file a joint tax return and your spouse is a full-time student severely disabled	Up to $2,400 (for one dependent) or $4,800 (for two or more or dependents)

Eligible and Ineligible Dependent Care Expenses
A partial list of eligible expenses follows. For a more complete listing, refer to IRS Publication 503, available from your local IRS office or on the web at irs.gov.

Eligible Expenses
In general, you may request reimbursement for expenses that would qualify for the dependent care tax credit on your Federal income tax return, as outlined below:

- In-home services provided by a baby-sitter, nursing aide or attendant
- Services provided by a housekeeper or maid if that person is responsible for the care of an eligible dependent while you work
- Practical nursing care for an adult, in or outside the home.
- Services provided by a day care facility for children or adults (the facility must be licensed if it provides care for more than six individuals who do not normally reside there)
- Care provided outside your home (if the eligible dependent is over age 13, he or she must be disabled and spend at least eight hours per day in your home)
- Any taxes you pay as the employer of a dependent care provider

You may not claim a tax credit and receive reimbursement for the same expenses.

Ineligible Expenses

- Clothing, food or education (unless the charges are related to, and cannot be separated from, charges for care of the qualified dependent)
- Payments made to a person whom you could claim as a dependent on your income tax return, or care provided by your child whom you do not claim as a dependent, but who would be under age 19 at the end of the current tax year
- Services outside your home at a camp where your child, disabled spouse or dependent stays overnight
- Transportation to and from the place where care is provided.
- Travel and education expenses for your day care provider
- Tuition expenses for dependent children in kindergarten or above
- Services provided before January 1 or after December 31 of the current plan year (or your enrollment or termination date).

If you Leave The Firm or Stop Participating

Your accounts contributions will stop on your last day of employment or with the paycheck following your termination of participation. You will be able to file for reimbursement according to the following provisions:

- **For the DCFSA**, you have 90 days from the date you terminate or cease participation to file claims for expenses incurred from January 1, or the date your participation began through the date you cease participation or leave the firm. You may file claims up to the amount remaining in your account when you leave.
- **For the HCFSA**, you have 90 days from the date you terminate or cease participation to file claims for expenses incurred from January 1 or the date your participation began through the date you cease participation or leave the firm.
- **For the HSA**, the money in the account is yours to keep and you may continue to use it for eligible out-of-pocket expenses.

Long-Term Care Insurance

Long-Term Care insurance covers more than just nursing home care for the elderly. It protects you and your assets if you or a member of your family is incapable of self-care for an extended period of time because of illness, injury or age.

Who Can Enroll

Long-Term Care insurance is available if you are a benefits eligible employee, as defined on page 2. You may also enroll your spouse or domestic partner and eligible members of your extended family, as defined by the plan. This plan is administered by TBG West and insured by Unum Life Insurance Company of America.

Enrolling in Long-Term Insurance

You are guaranteed acceptance for benefits up to $6,000 per month if you enroll in the Long-Term Care plan within the first 30 days following your date of hire or during the first Open Enrollment following your date of hire. If you choose not to enroll during these periods, subsequently you may apply for coverage by completing an enrollment form and application. At that time, evidence of medical insurability will be required, and your application will be subject to insurance company approval.

Spouse/Domestic Partner and Extended Family
Your spouse or domestic partner and extended family members may apply for coverage by completing an enrollment form and application. Coverage is subject to medical underwriting. If your spouse/domestic partner and/or family member(s) decline to enroll at this time, they may apply during any subsequent Open Enrollment.

Cost of Coverage

Your cost of coverage is based on the benefit level and payment option you choose as well as your age at the time coverage begins.

Premiums for you and your spouse/domestic partner will be withheld from your paycheck. This benefit is optional and you pay the full cost of your own coverage and any spousal/domestic partner coverage on an after-tax basis.

Ongoing Premium Option
Under this option, you pay premiums until you become eligible for benefits. Premiums are waived while you are receiving benefits.

Accelerated Payment
This option allows you to pay your premium fully over the later of 15 years or the date you reach age 65. After your last scheduled payment has been made, your coverage will be 100% paid in full and you will not pay additional premiums at any later date.

Coverage Options

You may choose from the following options. The plan allows you to mix and match any coverage level, benefit duration and benefit maximum to best tailor your benefit to your needs.

Home Care Option
75% Total Home Care
At home or a similar location, including an assisted living facility, pays a monthly benefit equal to 75% of your monthly skilled nursing facility benefit, regardless of who provides your care and regardless of the number of days for which care is required in any location. At a skilled nursing facility, pays 100% of your monthly benefit. Your plan of care must be developed by a licensed health care practitioner.

100% Non-Family Home Care
At home, pays a daily benefit equal to 1/30th of your monthly skilled nursing facility benefit on each day for which you receive at least one hour of service from a licensed professional who is not a family member. At an assisted living facility or a skilled nursing facility, pays 100% of your monthly benefit. Your plan of care must be developed by a licensed health care practitioner.

Benefit Duration
You may choose between the following benefit durations:

- Three years, six years or lifetime (for attorneys and Managing Directors)
- Three or six years (for non-attorneys)

Benefit Amount
You may choose any monthly benefit amount between $2,000 – $9,000. This amount is known as your monthly skilled nursing facility benefit.

Assisted Living Facility Benefits

Your assisted living facility benefit is equal to your full monthly home care benefit.

When Benefits Begin

You become eligible for benefits after a 90-day elimination period as determined by the coverage option you select:

- **75% Family Home Care:** 90 consecutive days of benefit eligibility
- **100% Non-Family Home Care:** Each day on which you receive at least one hour of care counts as one day towards fulfillment of your elimination period

Becoming Eligible for Benefits

To become eligible for benefits, you must either be unable to perform two or more of the six activities of daily living (bathing, continence, dressing, eating, toileting, and transferring) without substantial assistance or have severe cognitive impairment.

A physician must also certify that you will require care for more than 90 days and provide a written plan of care.

For More Information

If you would like more information, please reach out to TBG West directly at OMM@tbgwest.com or 866-824-9378.

Other Signature Benefits

The firm provides additional benefits to help you maintain balance in your life. Coverage under the EAP is automatic; all other benefits are optional.

CCA@YourService (EAP)

CCA's Employee Assistance Program offers a new way to help you and your family balance your work and personal lives. This program offers a wide-range of services and support, such as traditional counseling for personal stress and family/relationship concerns.

However, it also provides many other services, like referrals for child and elder care – even pet care. For example, through this new program, you can obtain information to get meals delivered to your homebound elderly parent. Or you and your spouse can learn about choosing the right school for your college-bound teenager. Your family can also contact financial and legal services easily to get help with budgeting or recording your wills.

To access hundreds of articles, useful tips and Internet resources you can go to myccaonline.com and enter company code **OMM**. It is 100% confidential and available 24/7.

Voluntary Benefits Through MetLife

- **Auto & Home Insurance:** MetLife offers insurance coverage for auto, renters, condo, mobile home, motorcycle, home, boat, recreational vehicle and floods.
- **Pet Insurance:** Coverage for dogs, cats, birds, rabbits, ferrets, reptiles, and other exotic pets. Covers diagnostic tests, office visits, prescriptions, treatments, lab fees, X-rays, surgery and hospitalization. This is a direct bill benefit.
- **Hyatt Legal (MetLaw):** Assistance with common legal services such as court appearances, document review and preparation, debt collection defense, wills, family law and real estate matters.
- **Critical Illness (CI):** Provides a lump sum to use as you see fit if you experience a major medical condition.

Commuter Benefits Through WageWorks

Commuter benefits are offered to allow you to pay for public transportation, parking and van pool through automatic pretax payroll deductions. Enrollment is ongoing, so you may sign up or cancel at any time. Enrollment is completed at wageworks.com.

Bright Horizons Backup Child Care & Adult Care

To alleviate the worry working parents face when their standard method of child care and adult care is unavailable, the firm offers access to emergency backup care in your home or near each office.

Backup care is offered through Bright Horizons, an award-winning, national care organization. Learn more about the facilities and services offered by visiting BrightHorizons.com. When emergency care is needed, call your local facility. A copayment will be charged for each day of use.

In addition to backup care, Bright Horizons offers several additional services to support working families.

401(k) Plan

Your 401(k) plan, officially known as the "O'Melveny & Myers LLP 1982 Retirement Plan," can be a significant part of your retirement savings. All eligible employees, as defined by the plan, may join the 401(k) plan effective immediately as of your hire date with the firm. The 401(k) is a tax-qualified plan designed to help you save for your future. When you enroll, you set aside a portion of your earnings through tax-deferred or after-tax (Roth) payroll deductions. The 401(k) is intended for long-term savings and offers potential tax advantages; therefore, it is subject to IRS withdrawal restrictions. Be sure to read all plan documents and your enrollment and investment information thoroughly prior to joining.

Your Contributions
You will be able to contribute up to $19,500 (estimated for 2021), indexed for inflation, plus any cost-of-living adjustments established by the IRS, tax-deferred. If you are age 50 or older by December 31, 2021, you may be able to contribute up to an additional $6,500 (estimated for 2021) as a "catch-up" contribution. You may elect to contribute between 1% and 50% of your compensation on a pretax and/or Roth 401(k) basis, up to the annual IRS dollar limit each year. The IRS may limit the amount that you can contribute following the results of plan testing each year.

Vesting
You are automatically fully vested in your contributions to the plan.

Withdrawals
To enjoy the 401(k) plan's tax advantages, IRS guidelines restrict access to your account while you are an employee of the firm and prior to normal retirement. If you need access to your funds for any reason before your normal retirement, you may be able to take a loan.

Employer Contributions

Eligible non-attorney staff only

Following the completion of one year of eligible service, provided you are enrolled in the plan and an eligible employee on the last business day of the year, the firm may make a discretionary pre-tax contribution on your behalf. It is anticipated, though not guaranteed, that the firm will contribute an amount approximately equal to (a) 7.5% of your eligible pay or (b) 6% of your eligible pay, plus 5.7% of any excess pay above the Social Security wage maximum. Note, there are some Internal Revenue Service rule limitations.

Vesting
You are automatically fully vested in contributions made by the firm.

Please refer to your Fidelity enrollment package for complete details on your 401(k) plan provisions and investment options. You may access your account at 401k.com for further details or contact the Retirement Department at rdepartment@omm.com.

In Addition...

Signature Benefits is designed to reward exceptional service and help you manage your work/life responsibilities. The firm offers a variety of additional valuable programs. Benefits may vary depending on location and your classification with the firm and may change with or without notice:

- Paid time off for holidays, vacation and sick leave
- Other time off, including bereavement, jury duty, personal leave, military service and community service
- Paid maternity, disability and parental leave
- Attorney/Staff referral bonuses
- Discounts to local attractions
- On-site gym (some locations)/gym discounts
- Commuter benefits (some offices)
- Service recognition program
- Supplier discounts for automobile and computer purchases
- Wellness programs
- Private banking
- Workers' compensation
- Ergonomic consultations

Associates are also eligible for:

- Bar stipend, bar fees, clerkship bonus
- Relocation expenses
- Attorney referral bonus
- Law school matching gift program

Carrier Contact Information

CARRIER	TELEPHONE	WEB	DESCRIPTION
UHC Medical/Mental Health	800-265-2417	uhc.com or myuhc.com	Medical Program
• Care24 (Live Nurse Chat)	888-887-4114	uhc.com or myuhc.com	Have a live, personal conversation with a nurse about various health and wellness issues
• Optum Rx	855-842-6337	uhc.com or myuhc.com	Manage your prescriptions. Search for drug prices and their lower cost alternatives
• Clinical Management	800-265-2417	uhc.com or myuhc.com	Case management support for complex health issues
• Rally	800-265-2417	myuhc.com uhc.com/health-and-wellness/preventive-care	Wellness program
• Cancer Support Program	866-936-6002	myuhc.phs.com/cancerprograms	
2nd MD	866-269-3534	2nd.md/omm	Second opinion service
One Medical Group		OneMedical.com	See a doctor with same-day appointments and 24/7 access to doctors at locations convenient to O'Melveny offices
UHC Flexible Spending Accounts	877-311-7849	myuhc.com	Pre-tax dollars for out-of-pocket health and dependent care expenses
Cigna Dental	800-CIGNA24	cigna.com or mycigna.com	Dental Program
Vision Service Plan (VSP)	800-877-7195	vsp.com	Vision Insurance
UHC HSA-OptumHealth Bank	800-791-9361 866-234-8913	myuhc.com	Saving account for health expenses that rolls over from year to year
CCA@YourService EAP	800-833-8707	myccaonline.com access code: OMM	Helpful guidance, counseling, local resources or reliable professional care
MetLife Life and AD&D	800-638-6420	metlife.com	Basic/supplemental term life and accidental death and dismemberment coverage
MetLife Voluntary Benefits	800-438-6388		Voluntary home, auto and pet insurance. Critical illness (CI) coverage available to ease financial impact of a critical illness by providing lump sum benefit
Hyatt Legal (MetLaw)	800-821-6400	info.legalplans.com access code: 1500956	Affordable solutions to help with your legal needs such as court appearances, debt collection defense, document review, wills, family law and real estate matters
UNUM Disability	866-679-3054	unum.com	Income replacement in the event of a long-term illness or injury
WageWorks / HealthEquity	877-WAGEWORKS (924-3967)	wageworks.com	Pre-tax benefits for parking and public transportation expenses
Bright Horizons Backup Child and Adult Care	877-BH-Cares (242-2737)	brighthorizons.com brighthorizons.com/advantage	Provides care for your child or adult/elder relative when regular arrangements fall through
O'Melveny Benefits Team		BenefitsTeam@omm.com	
O'Melveny Benefits Portal		omelvenybenefits.com password: #OMMBenefits@1	Overview of coverages, plan features, plan costs, plan resources, contacts and important documents
NFP Benefit Concierge	877-835-1361	dbbenadmin@nfp.com	Representative can assist with O'Melveny benefit related inquiries.
NFP Claims Advocacy		csclaims@nfp.com	Claim advocate assigned to assist with billing issues, claims issues, and appeal requests.