Helen of Troy

Elevate Your Well-being, Enhance Your Life: Enroll in Your Benefits

2025 Benefits

My Total Well-being:

Health Benefits Guide





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Table of Contents

In this Guide, we use the term Company to refer to Helen of Troy. This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the Company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, the Plan Documents and/or Summary Plan Descriptions (SPD) that govern each plan's operation contain full plan details. Whenever an interpretation of a plan benefit is necessary, we will use the actual plan documents.

Our Benefits Philosophy

We are committed to elevating the lives of our associates by creating and maintaining a common culture of care – striving for total health and supporting financial well-being.

- Foster a culture care across the Helen of Troy community with thoughtfully designed programs, support and guidance
- Improve the health, well-being, and vitality of our associates and their families
- Drive associate engagement and personal health management accountability and awareness
- Being an employer of choice through benefits offerings that drive a competitive advantage in recruiting, retention, and developing talent
- Sustainably manage health expenditures
- Activate the linkage between care for customers and care for our associates

Plain Language

We strive to write all program material in plain language to make it easy to understand. Here are some examples:

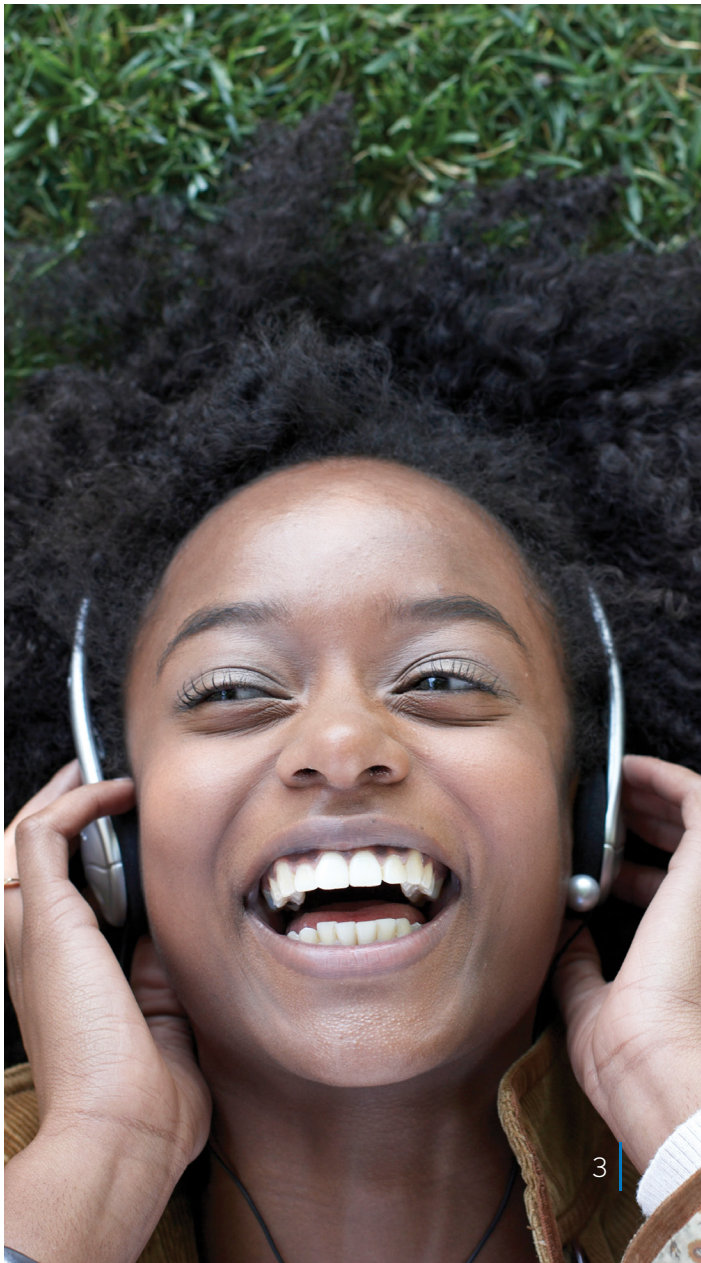
- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member.
- We limit acronyms to ones you know. For example, CDHP is the Consumer-Driven Health Plan.
- Our Benefits Guide and program material have the same format and similar descriptions to help you compare plans.
- Access to our "In Touch" site – Throughout this document, we refer you to additional information found on our "In Touch" internal communications and associate engagement platform.

Have a Smartphone?

We have equipped this Benefits Guide with mobile-friendly barcodes. These barcodes are more commonly referred to as “Quick Response” codes, or QR codes. Scanning these codes will take you to a separate site on your phone, allowing you to see new content. They might show you a website, video or article. They can take you anywhere – you just have to scan them first.

So How Do I Scan Them?

Download a QR code app or use your camera on your smartphone. When you scan the QR code, you can instantly go to more content.



Helen of Troy My Total Well-Being Team is Here to Help

Visit the My Total Well-being page of the In Touch or access the Benefits Guide on Workday as additional resources to help you navigate through your benefits.

- Provides an overview of each benefit
- Access the carrier contact information to get information about your plan coverage and claims information
- Links to access the carrier website and the online registration

Have additional questions or need assistance?

Contact the My Total Well-being Team

- Eligibility Questions
- Open Enrollment Support
- Carrier Escalations

1. Email us at:	**gethealthy@helenoftroy.com**
2. Workday Help Case:	**Log into Workday** • **Click View all apps** • **Click on "Help" and create a case**
3. Call us at:	**833-211-2200 or extension 2200** **M-F 7am to 5am MDT**

Eligibility & Enrollment

You and your family have unique needs, which is why our benefits program offers a variety of benefit plans from which you may choose. Consider your spouse's benefits through his or her place of employment and your dependents' eligibility when weighing each option.

Eligibility

If you are a full-time associate of Helen of Troy who is regularly scheduled to work at least 30 hours a week, you are eligible to participate in the available plans.

When Does Coverage Begin?

The elections you make are effective immediately. For some benefits, due to IRS regulations, once you have made your choices, you won't be able to change your benefits until the next annual open enrollment period – unless you experience a Qualifying Life Event.

Eligible Dependents

Dependents eligible for coverage in our benefits plans include:

- Your legal spouse/domestic partner (or common-law spouse in states that recognize common-law marriages). In addition, relative to the medical plan, your legal spouse who does not work for an employer that offers medical coverage.
- Children up to age 26 (includes biological children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom you or your spouse/domestic partner have been awarded legal guardianship).
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your Medical Plan to continue coverage past age 26.

You must provide verification of dependent eligibility upon enrollment. You must satisfy verification requirements before enrolling your dependents.

Things to Consider During Open Enrollment

Take the following situations into account before you enroll to make sure you have the right coverage.

- Does your spouse/domestic partner have benefits coverage available through another employer?
- Did you get married, divorced, or have a baby recently? If so, do you need to add or remove any dependent(s) and/or update your beneficiary designation?
- Did any of your covered children reach their 26th birthday this year? If so, they are no longer eligible for benefits unless they meet specific criteria. You can find additional details in the Eligible Dependents section of this Guide.

Curious about Qualifying Life Events and how they may affect your coverage?

How to Enroll

You can learn more details about your benefits programs on the "In Touch" site. To begin your enrollment process, log on to Workday or call the My Total Well-Being at 833-211-2200 to enroll in, or decline, benefits.

Here are a few key points to remember:

- As a full-time associate, you are required to either enroll in, or decline the offered benefits. If you decline benefits, you are required to record a beneficiary for the Company-paid basic life insurance.
- You must complete your enrollment or decline benefits within 30 days of your first work day as a full-time associate.
- If you enroll your spouse or child(ren), you must provide required dependent verification documents) within 30 days of your first day as a full-time associate.
- Benefits become effective immediately upon hire, provided that you enroll within 30 days of your first day.
- If you do NOT enroll, your next opportunity is annual enrollment – unless you have a qualifying change in status such as a marriage, birth, divorce or losing coverage under your spouse's medical plan.

As an eligible participant in the Company benefits plans, you are entitled to be furnished certain documents required by ERISA (the Employee Retirement Income Security Act of 1974). The Company intends to provide the following documents to you by electronic delivery:

- The Summary Plan Descriptions (SPD) and any required Summaries of Material Modifications (SMM)
- Plan Certificates
- Regulatory Notices

Please review the Compliance Notices Requirements policy on the "In Touch" site for additional information.

Qualifying Life Events

When one of the following events occurs, you have 30 days from the date of the event to update your benefits record or notify the My Total Well-Being Center. The list below is not an exhaustive list. For a comprehensive list, refer to the Flexible Benefits Plan and Summary Plan Description.

- Change in your legal marital status (marriage, termination of domestic partnership, divorce or legal separation)
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Change in your spouse/domestic partner's employment status (resulting in a loss or gain of coverage)
- Change in your employment status from full-time to part-time, or part-time to full-time, resulting in a gain or loss of coverage
- Entitlement to Medicare or Medicaid
- Eligibility for coverage through the marketplace
- Change in your address or location that may affect the coverage for which you are eligible

Your change in coverage must be consistent with your change in status. Please direct questions regarding specific life events and your ability to request changes to the My Total Well-Being Center.

Preparing to Enroll

Helen of Troy provides you with the best coverage possible. As a committed partner in your health, Helen of Troy will absorb a significant amount of the costs. If applicable, we deduct your share of the contributions for certain benefits on a pre-tax basis (e.g., medical, dental, vision, flexible spending account, etc.) to lesson your tax liability.

Please note that associate contributions for Medical and Dental coverage vary depending on your annual base pay (known as salary brackets). Review the cost rates for a breakdown.

Keep in mind that you may select any combination of Medical, Dental, and/or Vision plan coverage. For example, you could select Medical coverage for you and your entire family, but select Dental and Vision coverage only for yourself. The only requirement is that you, as an eligible Helen of Troy associate, must elect coverage for yourself in order to elect any dependent coverage. You have the option to select coverage from the following categories:

- Associate Only
- Associate + Spouse or Domestic Partner
- Associate + Child(ren)*
- Associate + Family*

**Includes Child(ren) of either the Associate and/or Domestic Partner*

Be sure to have the Social Security numbers and birthdates for any eligible dependent(s) that you plan to enroll. You cannot enroll your dependent(s) without this information.

Healthcare Tips

Preventing Medical Mistakes

An influential 2013 report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own healthcare, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.
   - Ask questions and make sure you understand the answers.
   - Choose a doctor with whom you feel comfortable talking.
   - Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all medicines you take.
   - Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
   - Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
   - Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
   - Make sure your medicine is what the doctor ordered. Ask the pharmacist about the medication if it looks different than you expected.
   - Read the label and patient package insert when you get your medicine, including all warnings and instructions.
   - Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

3. Get the results of any test or procedure.
   - Ask when and how you will get the results of tests or procedures.
   - Don't assume the results are fine if you do not get them when expected; be in person, by phone, or by mail.
   - Call your doctor and ask for results.
   - Ask what results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.
   - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the healthcare you need.
   - Be sure you understand the instructions you get about the follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.
   - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
   - Ask your doctor, "Who will manage my care when I am in the hospital?"
   - Ask your surgeon:
   - "Exactly what will you be doing?"
     - "About how long will it take?"
     - "What will happen after my surgery?"
     - "How can I expect to feel during recovery?"
   - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia and any medications or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer – The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety, but also to help choose quality healthcare providers and improve the quality of care you receive.
- https://www.ihi.org/Topics/PatientSafety/Pages/default.aspx – Institute for Healthcare Improvement has information on how to ensure safer healthcare for you and your family.
- www.bemedwise.org – The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicine.
- www.leapfroggroup.org – The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org – The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Never Events

When you enter the hospital for treatments of one medical problem, you don't expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complaints may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

Aetna has a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a "Never Event" occurs, neither your benefits plan nor you will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions for inpatient services needed to correct "Never Events," if you use Aetna preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

Program Facts

No Pre-Existing Condition Limitation

Our benefits program will not refuse to cover the treatment of a condition you had before you enrolled in this plan solely because you had the condition before you enrolled.

Minimum Essential Coverage (MEC)

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Acts (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-individual-shared-responsibility-provision for more information on the individual requirement for MEC.

Minimum Value Standard (MVS)

Our health coverage meets the minimum value standard of 60% that the ACA established. This means that we provide benefits to cover at least 60% of total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this Benefits Guide.

Where can you get information about enrolling in the our benefits program

See the "In Touch" site for enrollment information as well as:

- Information on our benefits program and plans available to you
- A health plan comparison tool
- Information on – and links to – other electronic enrollment systems
- When you may change your enrollment
- How you can cover your family members
- What happens when your enrollment ends
- When the next open enrollment begins

Aetna doesn't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from the Human Resources Benefits Group. For information on your premium deductions, you must also contact the My Total Well-being Center.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms look a lot like the urgent care centers you are likely used to, but the costs and services can be drastically different. In general, consider an urgent care center as an extension of your primary care physician, while you should use freestanding emergency rooms for health conditions that require a high level of care. Research the options in your area and determine which ones your carrier plan's network covers; note that balance billing may apply. Choosing an urgent care center for everyday health concerns could save you hundreds of dollars.

Healthcare

Medical Benefits

Our Medical coverage helps you maintain your well-being through preventive care and access to an extensive network of providers. Aetna is our administrator for our Medical benefits. It is up to you to choose the Plan that best matches your needs. Please keep in mind that the option you elect will remain in place for the plan year unless you have a Qualifying Life Event.

Medical Premiums

We will deduct premium contributions for Medical from your paycheck on a pre-tax basis. Your plan of choice and salary bracket will determine your premium cost-sharing.

Medical Plan Summary

The chart in the subsequent pages provides a summary of the Medical coverage. All covered services are subject to Medical necessity as determined by the Plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

How to Find a Provider

To see a current list of Aetna network providers online, go to www.aetna.com or call Aetna Customer Care at 888-416-2277 for assistance.

$ Click here to view my cost-share rate for this benefit.

	PPO		CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible				
Individual	$2,000	$4,000	$1,750	$3,500
Family	$4,000	$8,000	$3,500	$7,000
Coinsurance (Associate Pays)	20%*	40%*	20%*	40%*
Calendar Year Out-of-Pocket Maximum (Maximum Includes Deductible)				
Individual	$6,000	$12,000	$5,250	$10,500
Family	$12,000	$24,000	$10,500	$21,000
Lifetime Maximum	Unlimited		Unlimited	
Copays/Coinsurance				
Office Visits	$25 copay	40%*	20%*	40%*
Specialist Visits	$45 copay	40%*	20%*	40%*
Preventive Care	100% covered	40%*	100% covered	40%*
Urgent Care	$45 copay	40%*	20%*	40%*
Emergency Room	20%*	20%*	20%*	20%*

*After Deductible

Each member enrolled under your PPO medical plan must satisfy the individual deductible amount. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will be applied toward the "per family" deductible amount. When you reach the family deductible amount, you will not have to satisfy further individual deductibles for the remainder of that calendar year. No member may contribute more than the individual deductible amount to the "per family" deductible amount.

Under the Consumer-Driven Health Plan (CDHP) the deductible is based on an aggregate deductible, meaning that the medical plan doesn't begin paying for the healthcare expenses of anyone in the family until the entire family deductible has been met. As each member of the family uses and pays for healthcare services, the amount paid for those services is credited toward the family's aggregate deductible. There is no individual deductible limit. Once the aggregate family deductible has been met, the medical plan will kick in for the entire family.

Healthcare Cost Transparency

CDHPs and tools such as Health Savings Accounts have helped put the power of health-care spending in consumers' hands. This means you have control over how your health-care dollars are spent. But with the cost of services varying widely even within the same network and geographic area, how can you be sure you're getting the most bang for your health-care buck? Use the Aetna Medical Payment Estimator tool. This online tool allows consumers to compare costs. For more information, visit www.aetna.com.

TIP

Save Money by Seeing In-Network Physicians and Taking Advantage of Preventive Care Services Your Plan Offers.

Pharmacy Benefits

Prescription Drug Coverage for Medical Plans

We determine your cost by the tier assigned to the prescription drug product. All products on the list are assigned as Generic, Preventive Generic, Preferred Brand, or Non Preferred Brand.

CVS Health is our administrator for our Pharmacy benefits. CVS Health has a large number of pharmacies in the network. The CVS Health Customer Service is available to assist you with your pharmacy questions 7 days a week 24 hours a day at 1-888-792-3862.

CVS Health will answer questions such as:

- Is my pharmacy in the network?
- Is my drug covered and what will it cost?
- Can you assist me with my claim questions?
- Are there lower cost alternatives?
- Can you help me transition my mail order prescription?

Things you can do to help:

- Watch for your new ID card and the materials on the pharmacy plan.
- Make sure you show your ID card the first time you fill your prescription.
- Call CVS Health if you have questions or need help.

	PPO		CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
RETAIL RX (30-DAY SUPPLY) - Associate Pays				
	Associate Pays	Associate Pays	Associate Pays	Associate Pays
GENERIC	$10 copay	40% after $10 copay	20%*	40%*
PREVENTIVE GENERIC	$10 copay	40% after $10 copay	$10 copay	40%*
PREFERRED BRAND	$35 copay	40% after $35 copay	20%*	40%*
NON-PREFERRED BRAND	$50 copay	40% after $50 copay	20%*	40%*
MAIL ORDER RX (90-DAY SUPPLY) FILLED THROUGH CAREMARK CVS OR CVS HEALTH PHARMACY - Associate Pays				
	Associate Pays	Associate Pays	Associate Pays	Associate Pays
Generic	$20 copay	Not covered	20%*	Not covered
Preventive Generic	$20 copay	Not covered	$20 copay	Not covered
Preferred Brand	$70 copay	Not covered	20%*	Not covered
Non-Preferred Brand	$100 copay	Not covered	20%*	Not covered

*After Deductible

PrudentRx

The PrudentRx Copay Program allows members in the PPO plan to get any covered specialty medications that are on the Plan's exclusive specialty list for $0 out of pocket when filled via CVS Specialty.

PrudentRx works with drug manufacturers to get copay card assistance and will manage enrollment and renewals for those copay cards on your behalf. Once enrolled in the copay program, you will have a $0 out-of-pocket cost, regardless if their specialty therapy has a manufacturer copay card program.

If you do not enroll or choose to opt-out of the program, you will be responsible for 30% of the cost of your specialty medication(s).

Enrollment

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter from PrudentRx with instructions in how to enroll.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx at 1-800-578-4403 to register.

Q & A:

Generic Drugs

What is a generic drug?

When a new, FDA-approved drug goes on the market, it may have patent or exclusivity protection that enables the manufacturer to sell the drug exclusively for a period of time. When those expire or no longer serve as a barrier to approval, other companies can make it in generic form.

Are generic drugs as effective as brand-name drugs?

Yes. A generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used. The FDA requires generic drugs have the same high quality, strength, purity, and stability as brand-name drugs.

Are generic drugs as safe as brand-name drugs?

Yes. The FDA must approve the generic drug before it can be marketed.

Are generic drugs that much cheaper than brand-name medications?

Yes. On average, the cost of a generic drug is 80% to 85% lower than the brand-name equivalent.

Is there a generic equivalent for my brand-name drug?

To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov to view a catalog of FDA-approved drug products, as well as drug labeling information.

Requirement to Have Maintenance Medications Filled in 90-Day Supplies

What is the requirement to have maintenance medications filled in 90-day supplies?

Plan participants who take a maintenance medication must fill those prescriptions in a 90-day supply either through Caremark CVS mail order pharmacy or at a CVS pharmacy at the current, more affordable copay/coinsurance amount.

What is a maintenance medication?

Maintenance drugs are medications prescribed for chronic, long-term conditions and are taken on a regular, recurring basis. Examples of chronic conditions that may require maintenance drugs are high blood pressure, high cholesterol, and diabetes.

Why have this requirement?

It is less expensive to produce one 90-day supply prescription (pharmacy services, packaging, invoicing, unit cost, etc.) than to produce three 30-day supplies, so the medical plan pays less and you pay less. Since these medications are taken continuously and are available both through retail and mail-order pharmacies, it is one way to contain rising expenses without causing additional costs or effort to the patient.

The option to fill a 90-day supply at a CVS pharmacy offers identical cost savings relative to the mail order benefit and provides the convenience of retail. The benefit of this program to you is that the cost to you for a 90-day mail order at CVS Pharmacy will be the same as your mail order benefit – two times the cost of a 30-day supply under the PPO Plan and 20 percent coinsurance after satisfying the calendar year deductible under the CDHP.

How will I know if I need to obtain a 90-day supply?

Your pharmacist will inform you when the plan requires you to purchase your maintenance medication in 90-day increments.

How much will a 90-day supply cost?

Under the PPO Plan, co-pays for 90-day maintenance prescriptions for the Medical PPO Plan is $20 for generic, $70 for brand-name and $100 for non-formulary drugs. Under the CDHP, your coinsurance is 20 percent after satisfying the calendar year deductible. You can obtain a 90-day supply at either a CVS Pharmacy® Retail location or through the CVS mail order.

What if I don't do the 90-day refills for my maintenance medications?

You will incur the full cost of your medication following your first two fills. Your copay under the PPO plan will not apply, or, if you're enrolled in the CDHP and have satisfied the calendar year deductible, there will be no shared coinsurance. To avoid the additional cost, you must fill your 90-day prescription at a local CVS Pharmacy® or by mail with CVS Caremark® Mail Service Pharmacy.

What should I do to receive a 90-day medication fill?

To start receiving a 90-day supply of medication at CVS pharmacies, you will need to:

- Ask your physician to write your prescription for a 90-day supply with the appropriate number of refills. Often times, your doctor will call in the prescription directly to your pharmacy, so be sure to have the phone number of your pharmacy ready when you call your doctor.
- Either take your prescription to CVS Pharmacy or use the mail-order services through Caremark CVS mail order to receive your prescriptions.

Is there a list of maintenance medications or somewhere online participants can input the drug name to see if it falls into this category?

No, there is not a list; however, your pharmacist will be able to tell you if each is considered a maintenance medication when the prescription is run through the claims system. In general, maintenance medications are taken on a long-term basis for chronic or long-term conditions such as high blood pressure, cholesterol, and diabetes. They do not include medications, such as antibiotics, taken for acute illnesses.

Consumer-Driven Health Plan Overview

Consumer-Driven Health Plan (CDHP) Option

Our CDHP option provides traditional healthcare coverage and tax-advantaged way to help build savings for future medical expenses. The plan gives you greater control over how you use your healthcare benefits.

When you enroll in this CDHP, you will have the option to set up a Health Savings Account (HSA). Once you have completed the process, Helen of Troy will contribute to your HSA upon your eligibility.

With this plan, we cover in-network preventive care. As you receive other non-preventive medical care, you must meet the plans deductible before we pay benefits according to the benefits described in the Summary of Benefits and Coverage (SBC). You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This CDHP includes five key components:

1) In-Network Medical and Dental Preventive Care

The plan covers preventive care services, such as periodic health evaluations (e.g., routine physicals), screening services (e.g., routine mammograms), well-child care, routine child and adult immunizations. We cover these services at 100% if you use a network provider. The services are described in the SBC.

2) Traditional Medical Coverage Subject to the Deductible

After you have paid the plans deductible, the plan pays benefits under traditional medical coverage described in the SBC at the corresponding out-of-pocket limits.

3) Savings

Health Savings Accounts (HSAs) provide a means to help you pay out-of-pocket expenses (refer to section on HSA features).

4) Health Savings Account (HSAs)

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received Veterans Affairs (VA) and/or Indian Health Services (IHS) benefits within the last three months, or do not have other health insurance coverage other than another high deductible health plan.

Helen of Troy makes a contribution to your HSA (refer to the HSA overview). In addition to our contribution, you have the option to make the additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law. You own your HSA, so the funds can go with you if you change plans or employment.

If you enroll in the Consumer Driven Health Plan (CDHP), you are eligible to receive the company's HSA contributions. Helen of Troy will request that the carrier open an HSA under your name to deposit the company contributions. As federally mandated, under the Customer Identification Process (CIP), the carrier will send you a letter requesting documentation needed to confirm your identity to open the HSA. This process is referred to as the account vetting process. If you fail to timely complete the vetting process, you will lose any retrospective company contributions and any of your own contributions will be returned to you on a post-tax basis. If at a later date, you complete the vetting process the company will resume contribution on a prospective basis.

Federal Tax Tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your federal tax return. By fully funding your HSA early in the year, you have flexibility of paying qualified medical expenses from tax-free HSA dollars or (after tax out-of-pocket dollars). If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- Health Equity, provides a debit card and record-keeping services. Health Equity is the custodian for the HSA accounts.
- Your contributions to the HSA are tax deductible.
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits.
- Your HSA earns a tax-free interest or any investment gains through a choice of voluntary investment options.
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents. (See IRS publication 502 for a complete list of eligible expense) .
- Your unused HSA funds and interest accumulate year to year.
- It's portable – the HSA is owned by you and is yours to keep, even when you leave Helen of Troy employment.
- When you need it, funds up to the actual HSA balance are available.

Important consideration if you want to participate in a Healthcare Flexible Spending Account (HCFSA): if you are enrolled in this CDHP you are not eligible to enroll in a General Purpose HCFSA; however, you may enroll in the Limited Use HCFSA.

5) Catastrophic Protection for Out-of-Pocket Expenses

When you use network providers, your annual maximum for our-of-pockets expenses (deductibles, coinsurance and copayments) for covered services is limited to $5,250 for associate only or $10,500 for associate and family enrollment. If you use non-network providers, your out-of-pocket maximum is $10,500 for associate only or $21,000 for associate and family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the plans allowable amount or benefit maximum.)

Health Education Resources and Account Management Tools

The section on special features describes the health education resources and account management tools available to you to help you manage your healthcare and your healthcare dollars.

Connect to www.aetna.com for access to Aetna navigator, a secure and personalized member site offering you a single source for health and benefits information. Use it to:

- Perform self-service functions, like checking your deductible balance or the status of a claim.
- Gather health-related information from Aetna's InteliHealth website, one of the most comprehensive health sites available today.

Aetna Navigator gives you direct access to:

- Cost of care tools that compare in-network and out-of-network provider fees, and the costs for service such as routine physicals, emergency room visits, lab tests, X-rays, MRIs, etc.
- Medical payment Estimator that provides real-time, out-of-pocket estimates for medical expenses based on your Aetna health plan. You can compare the cost of doctors and facilities before you make an appointment, helping you budget for and manage healthcare expenses.
- A hospital comparison tool that allows you to see how hospitals in your area rank on measures important to your care.
- DocFind online provider directory.
- Online customer service that allows you to request member ID cards, send secure messages to Member Services and more. You may also print ID cards directly from the Aetna Navigator or pull up your ID Card directly from the Aetna mobile app.
- Healthwise Knowledgebase where you get information on thousands of health-related topics to help you make better decisions about your healthcare and treatment options.

$ Click here to view my cost-share rate for this benefit.

Dental Benefits

Routine preventive care such as regular Dental check-ups can help lower your risk of stroke and heart disease. Helen of Troy's Dental coverage will provide you and your family affordable options for overall health. Coverage is available from Aetna.

Network Dentists

Your Plan's in-network dentists have agreed to charge lower fees, which helps keep money in your pocket. If you choose to use a dentist who doesn't participate in your Plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit Aetna at www.aetna.com.

Dental Premiums

We will deduct premium contributions for Dental from your paycheck on a pre-tax basis. Your tier of coverage will determine your premium cost-sharing.

Dental Plan Summary

Dental Plan benefits are available to you on a voluntary basis. The chart below gives a summary of the Dental coverage that Aetna provides. All out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	DENTAL PPO	
	In-Network	Out-of-Network
Calendar Year deductible		
Individual	$50	$50
Family	$150	$150
Calendar Year maximum		
Per Person	$1,250	$1,250
COVERED SERVICES		
Preventive Services Oral Exams, Routine Cleanings, Bitewing X-rays, Fluoride Applications, Sealants, Space Maintainers, Full Mouth X-rays, Panoramic X-rays	100%	100%
Basic Services Fillings, Oral Surgery, Simple Extractions, Endodontic, Periodontic	80%*	80%*
Major Services Oral Surgery, Complex Extractions, Root Canal Therapy, Crowns, Dentures, Bridges	50%*	50%*
Orthodontics Dependent Child(ren) Only	50%	50%
Orthodontic Lifetime Maximum	$1,500	

*After Deductible

Vision Benefits

If you wear glasses or contacts, chances are you already have a steady appointment with an eye doctor. But even those with perfect eyesight should have their Vision checked on a regular basis. To ensure that you and your family have access to quality Vision care, Helen of Troy offers a comprehensive Vision benefit through Superior Vision (or through VSP for certain Osprey locations).

Vision Plan Summary

Vision Plan benefits are available to you on a voluntary basis. The chart below gives a summary of the Vision coverage provided by Superior Vision. All out-of-network services are subject to Reasonable and Customary (R&C) limitations. Superior Vision will pay in-network copayments directly to the provider and reimburse out-of-network services up to the scheduled amounts below.

So often we look at Vision Care as a way to get glasses or contacts. In reality, true vision care goes so much further.

Important reasons (click on the QR code for details)

Reason 1

Regular eye exams are not only important for your vision but also vital for disease prevention and the detection of serious medical conditions. Learn more about the five ways an eye exam can potentially save your life.

Reason 2

A visit to an eye care professional may reveal some early signs of various forms of dementia, including Alzheimer's disease. Read more about the eye-brain connection.

Reason 3

Approximately 45 million Americans wear contact lenses. Not caring for them properly can lead to infections and damage to your eyes. Learn more about the importance of properly wearing and caring for contact lenses.

TIP

According to the Centers for Disease Control and Prevention, approximately 14 million Americans 12 and older have self-reported visual impairment (defined as 20/50 or worse).

$ Click here to view my cost-share rate for this benefit.

	VISION	
	In-Network	Out-of-Network
Covered Materials		
Lenses		
Single Vision Lenses	$10 copay	Up to $26 reimbursement
Bifocal Lenses	$10 copay	Up to $34 reimbursement
Trifocal Lenses	$10 copay	Up to $50 reimbursement
Frames		
Retail Frame Equivalent	$130	Up to $52 reimbursement
Contact Lenses		
Necessary	Paid In-full	Up to $210 reimbursement
Elective	$130 allowance	Up to $100 reimbursement
Copays		
Examination	$10 copay	Up to $37 reimbursement
Materials	$10 copay	Schedule of reimbursement
Benefit Frequency		
Examination	Once per calendar year	
Lenses	Once per calendar year	
Frames	Once per calendar year	
Contacts (in lieu of Lenses and Frames)	Once per calendar year	

Telemedicine

It's all about the relationship

One of the most important elements of healthcare is the relationships members have with their doctor.

With Aetna Virtual Primary Care®, we elevate that relationship and make it even better by improving access and creating a connected, data-powered experience how and where you want it.

Telemedicine through Teladoc is an additional benefit available to associates and their dependents. With Teladoc, you have on-demand access to board-certified doctors and pediatricians by online video, phone, or secure email.

With Teladoc, you can be treated for various general health and general pediatric care issues without leaving the comfort of your home. You can use this service for after-hours non-emergency care, when your primary care physician is not available, to make requests for prescriptions or refills, or if you are traveling and need general medical care.

For Virtual Primary Care (VPC):

Zero copay for the PPO plan (annual $145 initial visit fee, and $65 for subsequent visits until deductible is met under the CDHP)

How is this solution different?

VPC comprehensive virtual primary care plan offering access to a dedicated virtual provider and care team

- Provides access to wide network of specialists and doctors when in-person care is preferred
- Member-selected, dedicated, virtual care provider from first 30-45-minute visit to every visit thereafter
- Coordination of in-person care, loca healthcare services, including labs, tests, and more
- Dedicated care team access 24/7 via in-app SMS or phone for pre-, during, and post-visit support

For other healthcare specialties:

Copay of $10 for the PPO plan ($49 for the CDHP) per consultation

Mental healthcare

$85 or less / therapist visit

$190 or less / psychiatrist first visit

$95 or less / psychiatrist ongoing visit

Talk to a therapist 7 days a week (7 a.m. to 9 p.m. local time)

Dermatology

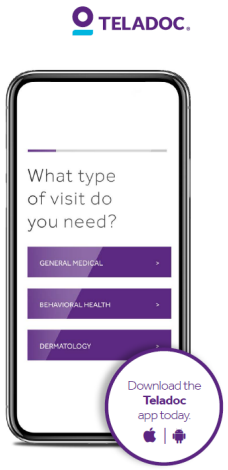
$75 or less / consult

Upload images of a skin issue online and get a custom treatment plan within two days

Examples of items that can be treated include allergies, asthma, headache, pink eye, respiratory infections, ear infections, and much more. Please note that some states do not allow physicians to prescribe medications via telemedicine. For more information, visit www.teladoc.com.

When should you use Teladoc?

- Teladoc: Use Teladoc anytime, anywhere for non-emergency conditions like the flu, bronchitis, stress, psoriasis, and more.
- Family Doctor: Your primary care physician (PCP) is ideal for annual exams and ongoing medical conditions needing regular monitoring.
- Urgent Care: Use an urgent care clinic when you need an in-person visit for conditions like earaches, sprains, or minor cuts.
- ER: Go to the ER if you need emergency medical care for severe conditions like chest pain, burns, or broken bones.



Health advice is just a video chat away

Set up your account

Set up your Teladoc account

Complete medical history

Doctor will review information about past conditions, medications, allergies, and your family's medical history

Request a visit

Request a visit with the next available doctor OR schedule a time that fits your needs

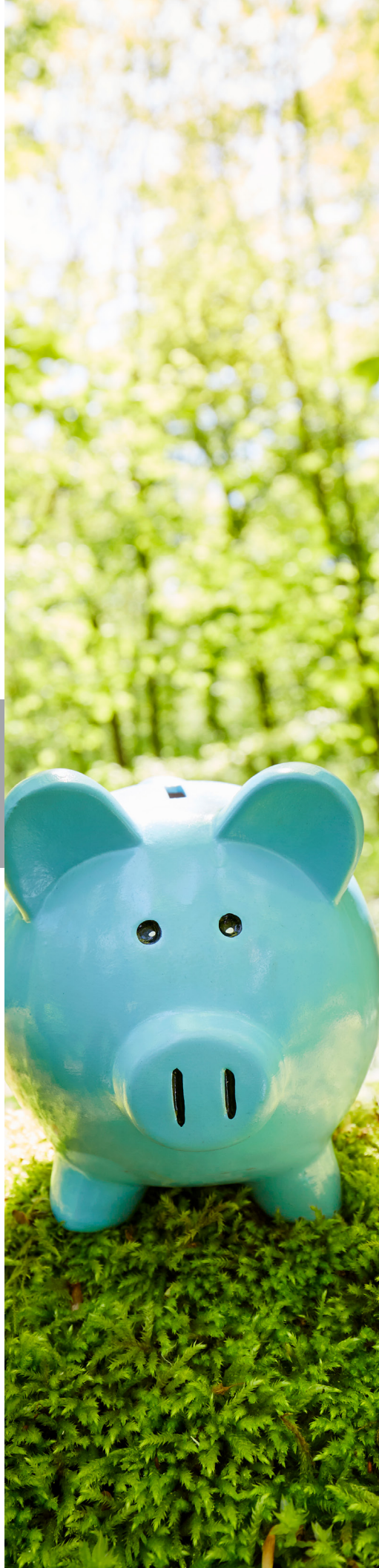
Talk to a doctor

Talk to a doctor 24/7 by phone or video (app or online)

Get resolution

If medically necessary, the doctor will send a prescription to the pharmacy of your choice

Healthcare Savings Plan



Health Savings Account (HSA)

The HSA helps you meet the deductible and pay your share of qualified medical expenses. Helen of Troy contributes to your HSA, and you may contribute as well. Use the account for eligible expenses, or let it grow for future expenses – even those in retirement. You'll save on taxes, too. Contributions and earned interest are tax-free, and you are not taxed on withdrawals to pay qualified expenses.

Here are eight important facts that you should know about the HSA:

FACT 1: You must actively enroll into the CDHP to make your own HSA contributions.

FACT 2: You do not need to contribute to the HSA to receive the Helen of Troy contribution.

FACT 3: If you did not set up your HSA during the annual enrollment process, you may still do this at any time.

FACT 4: To receive the Helen of Troy contribution, you must enroll in the CDHP.

FACT 5: You cannot enroll in a General Purpose Flexible Spending Account and be eligible for the HSA.

FACT 6: Helen of Troy starts you off with a tax-free, front-load contribution in early January[1].

FACT 7: You can help build your account through payroll deductions or additional deposits, up to the IRS limit.

FACT 8: You may change your payroll deduction amount at any time.

2025 HSA IRS Funding Limits[2]	
Individual	$4,300
Family	$8,550
Catch-Up Contribution (Ages 55+)	$1,000
2025 Helen of Troy HSA Contribution[1]	
Associate Only	Front Load $750
Associate + Spouse or Domestic Partner or Child(ren)*	Front Load $750 Plus Additional $250 During 2025[3]
Associate + Family*	Front Load $1,000 Plus Additional $500 During 2025[3]

[1]If your HSA effective date is after January 1st, Helen of Troy's contribution will be prorated. This contribution will be made as soon as administratively possible in the month after the change or for new hires, after your hire date.
[2]Limited up to the IRS annual dollar limit.
[3]Additional HOT contribution paid proportionately per pay period within the calendar year. If your HSA effective date is after January 1st, HOT's contribution will be prorated. This contribution will be made as soon as administratively possible in the month after the change or for new hires, after your hire date.
*Includes Child(ren) of either the Associate and/or Domestic Partner

Here's how the plan works

Visit your doctor or get other healthcare services. Show your ID card.

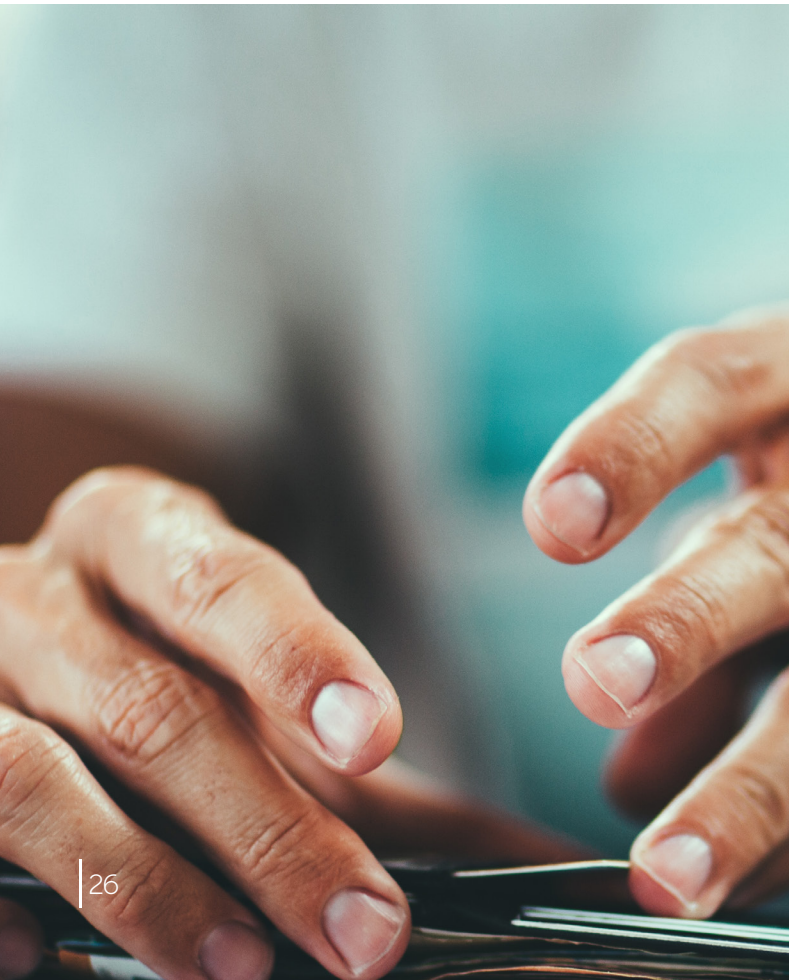
It usually costs less if you stay in the network. To look up network doctors, log in to www.aetna.com and click "Find a doctor, dentist or facility" in the "I want to…" menu.

Get a bill and pay your doctor directly. Use your HSA funds if you like.

In the beginning of the year, your share of the cost will be 100 percent, until you meet the deductible. After that, the plan generally pays the larger share. Your doctor will bill you for your share after the claim is processed.

Once you reach your out-of-pocket limit, you pay nothing for covered in-network services for the rest of the year.

If you have family coverage, once the family out-of-pocket limit is met, all family members will be considered as having met their out-of-pocket limit, and the plan pays 100% of the costs for the remainder of the calendar year. There is no individual out-of-pocket limit to satisfy within the family out-of-pocket limit.



How to pay with your HSA:

Whether you're picking up a prescription, paying for a doctor's visit, or dealing with a bill after the fact, using your HSA to pay for qualified medical expenses is easy. Choose your preferred method.

1. **Use your HSA debit card**
   If you have an HSA debit card, ensure the provider has your current medical coverage, then use your HSA debit card to pay.
2. **Pay online through the HealthEquity portal**
   You can choose to pay your invoice for billed services directly through the HealthEquity Member Portal. Log in at my.HealthEquity.com to get started.
3. **Reimburse yourself**
   Pay out-of-pocket for qualified medical expenses including office visits, medical, dental, vision, and prescription costs, then reimburse yourself. You can request reimbursement by check or direct deposit.
4. **Download the HealthEquity mobile app**
   With the HealthEquity mobile app, you can use your device to pay claims or reimburse yourself, upload receipts, and manage your account – all on the go.

Checking your HSA balance is a snap

Log in to **my.HealthEquity.com** to monitor your activity or check your balance.

View a list of eligible HSA expenses at HealthEquity.com/HSA-QME.

Questions?

Log in to your HealthEquity Member Portal to chat with the HealthEquity Member Services team.

Health Savings Account Features

Fees

There is no HSA set-up fee.

Helen of Troy pays the administration fee under the Consumer-Driven Health Plan (CDHP).

If you are no longer employed by Helen of Troy, there is a $2.95 monthly administrative fee that will be deducted from your HSA every month.

Eligibility

You must:

- Enroll in the Consumer-Driven Health Plan (CDHP)
- Have no other health insurance coverage (does not apply to another CDHP plan, specific injury, accident, disability, dental, vision or long-term care coverage)
- Not to be enrolled in Medicare
- Not to be claimed as a dependent on someone else's tax return
- Not have received VA and/or Indian Health services benefit in the last three months
- Complete and return all banking paperwork

Funding

If you are eligible for HSA contributions, Helen of Troy will contribute to your HSA.

In addition, you may contribute pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits.

You may contribute to your HSA by setting up an electronic funds transfer from your checking or savings account up to the maximum allowed.

Associate and Family Enrollment

Front-Load and Per Pay Period Contribution:

	Front Load	Annual Amount Funded Proportionately Per Pay Period
Associate Only	$750	$0
Associate + Spouse or Domestic Partner Or Child(ren)*	$750	$250
Associate + Family*	$1,000	$500

Contributions subject to proration if enrolled after January 1st.

*Includes Child(ren) of either the Associate and/or Domestic Partner

Contributions/credits	The maximum that you can contribute to your HSA is an annual combination of the CDHP contribution made by Helen of Troy and enrollee contribution funds, which when combined, do not exceed the annual statutory dollar maximum. If you are age 55 or older, the IRS allows you to contribute up to $1,000 in catch up contributions. If you enroll during open enrollment, you are eligible to fund your account up to the maximum contribution limit set by the IRS. You are eligible to fund your account up to the maximum contribution limit set by the IRS, even if you have partial year coverage as long as you maintain your CDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the plan will contribute to your account for the year. If you do not meet the 12-month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death and disability. You may rollover funds you have in other HSAs to this CDHP HSA (rollover funds do not affect your annual maximum contribution under this CDHP). You are able to make a one-time, tax-free, irrevocable, trustee-to-trustee rollover from your IRA to your HSA. Any amount you rollover from an IRA will count towards your annual HSA contribution limit for the year in which the rollover was made. Any amount you rollover from an IRA will count toward your annual HSA contribution limit so you will need to make sure that the amount you transfer from your IRA combined with your other HSA contributions for the year do not exceed the annual HSA Contribution Limit. HSAs earn tax-free interest (does not affect your annual maximum contribution).
Access Funds	You can access your HSA by the following methods: • Debit card – the debit card must be activated in order to have access to HSA funds, customer service, and online information. • The online portal. • Direct Deposit for HSA reimbursement - Reimbursements can be sent electronically to personal or checking savings accounts. You can access this feature from the associate portal.
Distributions/withdrawals	
Medical	You can pay the out-of-pocket expenses yourself, your spouse/domestic partner, or your dependents (even if they are not covered by the CDHP). Your HSA is established the first of the month following the effective date of your enrollment in this CDHP. If the CDHP is effective on a date other than the first of the month, the earliest date medical expenses will be allowable is the first of the next month. If you incur a medical expense between your CDHP effective date but before your HSA is effective, you will not be able to use your HSA to reimburse yourself for those expenses. Note: Plan contributions are typically deposited around the middle of each month. See IRS publication 502, which can you can access on the "In Touch" site, for a list of qualified eligible medical expenses.
Non-Medical	If you are under the age 65, withdrawal of funds for non-medical expenses will create 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, you can use distributions for any reason without being subject to the 20% penalty. However, they will be subject to ordinary income tax.

Availability of Funds	Funds are not available for withdrawal until all of the following steps are completed: • Your enrollment in this CDHP is effective. • The CDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. • The fiduciary send you an HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you. After the plan administrator receives enrollment and contributions from HOT and your HSA has been created by Health Equity, and funded, the enrollee can withdraw funds up to the amount contributed for any expenses incurred on or after the date the HSA was initially established.
Account Owner	HAHB enrollee
Annual Rollover	Yes, accumulates without a maximum cap.

Fee Description	Fee (not all inclusive)
Monthly Account Maintenance	No Charge
Returned Deposit Check	$20.00 per returned deposit check
Checks Returned for non-sufficient funds	$20.00 per returned check
Stop payment of check	$20.00 per stopped check
Returned EFT* Deposit	$20.00 per EFT deposit return
Replacement of Lost/Stolen HSA debit card	Up to 3 free, additional or replacement cards/$5 per card
Paper Statement	$1.00 – eStatements available online at no charge

*Electronic Funds Transfer (EFT)

Calculate your tax savings from an HSA.

Healthcare Flexible Spending Accounts (FSAs)

FSAs allow you to set aside pre-tax payroll deductions to pay for out-of-pocket healthcare expenses such as deductibles, copays, and coinsurance, as well as dependent care expenses.

General Use Healthcare Flexible Spending Account

You can contribute up to $3,200 (for 2024) for qualified Medical expenses with pre-tax dollars, which will reduce the amount of your taxable income and increase your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them, allowing you to avoid waiting for reimbursement.

Please note: Over-the-counter (OTC) drugs are not eligible for reimbursement through an FSA without a doctor's prescription. Also, this benefit is not available when enrolled in the CDHP.

Limited Use Flexible Spending Account

Designed to complement a Health Savings Account, a Limited Use Flexible Spending Account (LUFSA) allows for reimbursement of eligible Dental and Vision expenses. You must decide how much to set aside for this account. You may contribute up to $3,200 (for 2024) in the LUFSA.

How to Use the Account

You may use your FSA debit card at locations such as doctor and dentist offices, pharmacies, and Vision service providers. You cannot use the card at locations that do not offer services under the Plan, unless the provider has also complied with IRS regulations. Should you attempt to use the card at an ineligible location, the transaction will be denied.

Once you incur an eligible expense, submit a claim form along with the required documentation. If you have a question about a reimbursement, contact Health Equity. Should you need to submit a receipt, you will receive an email or be mailed a receipt notification from Health Equity. You should always retain a receipt for your records.

General Rules and Restrictions

In exchange for the tax advantages that FSAs offer, the IRS has imposed the following rules and restrictions for the Healthcare FSA:

- Your expenses must be incurred during the plan year.
- You cannot transfer your dollars from one FSA to another.
- You must "use it or lose it"- any unused funds will be forfeited.
- You cannot change your FSA election in the middle of the plan year unless you experience a Qualifying Life Event like marriage, divorce or birth of a child.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. This means that you must always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. Failure to provide proof that an expense was valid can result in your card being turned off and your expense being deemed taxable.

2½-Month Grace Period

- FSA participants have an additional 2½-month grace period of time to incur expenses after the Plan Year ends (December 31st).
- If during the current plan year an expense is incurred between December 31st and March 15th of the subsequent calendar year, AND received for reimbursement on or before April 30th (run-out period), it will be eligible under the grace period.

Limited-Purpose Flexible Spending Account FAQs

What is a limited-purpose flexible spending account?

A limited-purpose health flexible spending account (referred to as a limited-purpose FSA) is much like a typical, general-purpose health FSA. However, under a limited-purpose FSA, eligible expenses are limited to qualifying dental and vision expenses for you, your spouse, and your eligible dependents.

Here's how a limited-purpose FSA works. Money is set aside from your paycheck before taxes are taken out. You can then use your pre-tax FSA dollars to pay for eligible vision or dental expenses throughout the plan year. You save money on expenses you're already paying for, like dental checkups, vision exams, eyeglasses, and much more.

Why is it a good idea to have a limited-purpose FSA?

IRS rules do not allow you to contribute to a health savings account (HSA) if you are covered by a general-purpose health FSA. By limiting FSA reimbursements to dental and vision care expenses, you (or your spouse/domestic partner) remain eligible to participate in both a limited-purpose FSA and an HSA. Participating in both plans allows you to maximize your savings and tax benefits.

What is an HSA and who is eligible to participate?

An HSA is a healthcare account and savings account in one. The main purpose of this account is to offset the cost of a qualifying Consumer-Driven Health Plan (CDHP) or also known as a High Deductible Health Plan (HDHP) and provide savings for your out-of-pocket eligible healthcare expenses – those you and your tax dependents may have now and in the future.

Health Equity administers the HSA, and HSA account holders must agree to the terms of the custodial or trust agreement. This is a "portable" account, which means if you have an HSA, you own it! HSAs may be included in your associate benefits package, but after you set up your account, it's yours to keep, even if you change jobs or retire.

IRS guidelines govern HSA eligibility, and not everyone can set up an HSA. You must meet all of the following requirements before you can open an HSA and contribute to it each month:

- You are covered under a qualifying high deductible health plan (HDHP) as defined by IRS rules.
- You are not covered under another health plan that is not a qualified HDHP, such as coverage under a spouse's non-HDHP, a general-purpose health FSA, or a general-purpose health reimbursement arrangement (HRA).
- You are not entitled to Medicare.
- You are not eligible to be claimed as a dependent on another person's tax return.

You continue to maintain your HSA eligibility each month that you meet the conditions listed above on the first day of the month. Plus, it's up to you to decide if you meet these eligibility requirements. This is also important to know when making HSA contributions.

What expenses are eligible under a limited-purpose FSA?

A limited-purpose FSA covers qualified out-of-pocket expenses for dental or vision care provided to you, your spouse, or dependents. Typical eligible expenses include:

Qualified Dental Expenses

- Cleaning
- Fillings
- Crowns
- Braces

Qualified Vision Expenses

- Contact lenses
- Eyeglasses
- Eye exams
- Vision correction procedures

Here are some other IRS rules you should know about:

- **No double-dipping** – Expenses reimbursed under your limited-purpose FSA cannot be reimbursed under any other plan or program – including an HSA. Only your eligible out-of-pocket expenses may be reimbursed. Plus, expenses reimbursed under this FSA may not be deducted when you file your tax return.
- **Timing is everything** – FSAs have a start date and an end date, and the time in between is called the plan year. Expenses must be incurred during the FSA plan year. As noted in IRS guidelines, expenses are incurred when you (or your spouse or dependents) are provided with the vision or dental care that gives rise to the eligible expenses, and not when you are formally billed, charged for, or pay for the services. This means the date of service must be within the current plan year and not when you pay for the service.

What expenses are not covered under a limited-purpose FSA?

Expenses that are not approved are called "ineligible expenses." Ineligible limited-purpose FSA expenses include:

- Insurance premiums
- Medical expenses, including deductibles, co-insurance, and copays
- Alcohol and drug rehab expenses
- Prescription medicines
- Over-the-counter medicines and items
- Medical equipment
- Contraceptives
- Cosmetic procedures
- Expenses for services incurred after the coverage period ends
- Expenses reimbursed by an insurance provider or other health plan
- Personal use items, such as toothpaste, razors, and shampoo
- Dental whitening procedures and kits

These are only a few of the examples of expenses that aren't covered by a limited-purpose FSA.

What if an expense is eligible for reimbursement under both my FSA and HSA?

You may not use funds from both your limited-purpose FSA and your HSA to cover the same eligible expense. Since there's no double-dipping allowed, you must choose which account will reimburse your expense.

Is there a limit to how much I can contribute to my limited-purpose FSA?

Yes. As a result of the Affordable Care Act, associate contributions have been capped for limited-purpose FSA plans. The annual limit is $3,050 (for 2023), and you cannot contribute more than this amount.

What happens if I have funds left in my limited-purpose FSA at the end of the plan year?

Grace period extension – gives you extra time to incur eligible expenses and use funds remaining in your account after the plan year ends. The grace period begins on the first day of the following plan year and lasts two months and 15 days.

What is a run-out period?

It's a set number of days after the plan year ends that allows you to submit claims for eligible expenses incurred during the plan year.

Some people get a run-out period confused with a grace period extension, so here's an example that shows the difference. Let's say your plan year begins on January 1st and ends on December 31st.

The **run-out period gives you extra time to submit reimbursement request** for eligible expenses incurred during the plan year. If you have a dental checkup in December (the last month of the plan year), you may submit a reimbursement request for that expense during the run-out period. You will be reimbursed from the funds left in your limited-purpose FSA from the previous year. The run-out period last 4 months, so in this example, the run-out end on April 30th.

A **grace period extension gives you extra time to spend funds** left in your account from the previous year. If you buy eyeglasses in January (the month after the plan year ends), you may use the remaining funds from the previous year to cover that expense. The grace period lasts two months and 15 days, so in this example, the grace period ends on March 15th.

What is the "use-it-or-lose-it" rule?

The IRS created this rule, which states that all money left in your FSA is forfeited after the plan year ends, or if applicable, after the run-out period.

The unused portion of your limited-purpose FSA cannot be paid to you in cash or other benefits, and you can't transfer money between FSAs. To reduce your risk of losing money at the end of the plan year, carefully estimate your expenses when choosing your annual election amount.

Flexible Spending Account and Health Savings Account: Which is Right for You?

Flexible Spending Accounts (FSAs) and Heath Savings Accounts (HSAs) are two ways to save pre-tax money to pay for your eligible healthcare costs. But how do you know which one is right for you? The chart below explains the main differences between FSAs and HSAs to help you make the right choice for you and your family.

	FSA	HSA
Ownership	Your employer owns the FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	The HSA is an account that you own. It is a savings account in your name and you always have access to the funds, even if you leave your employer.
Eligibility & Enrollment	The employer determines eligibility for an FSA. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event.	You must enroll in a Qualified High Deductible Health Plan to be eligible to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or enrolled in Medicare or TRICARE. You can change your contribution at any time during the plan year.
Taxation	Contributions are tax-free via payroll deduction.	The money in the account is "triple tax-free," meaning: 1. Contributions are tax-free. 2. The account grows tax-free. 3. Funds are spent tax-free (if used for qualified expenses).
Contributions	Both you and your employer can contribute to the account according to IRS limits. The contribution limit for 2024 is $3,200. This amount does not have to include the employer contribution.	Both you and the company can contribute to the account according to IRS limits. The contribution limit for 2025 is $4,300 for individuals and $8,550 for families. This amount includes the employer contribution. If you are 55 or older, you may make a "catch-up" contribution of $1,000 per year.
Payment	Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and get reimbursed from the account. You must submit your receipts for reimbursement.	Many HSAs include a debit card, ATM withdrawal or checkbook. You may use the debit card to pay for qualified expenses directly. You could also use online bill payment services from the HSA financial bank to pay for qualified expenses. You decide when and if you should use the money in your HSA to pay for qualified expenses, or if you want to use another account to pay for services and save the money in your HSA for future qualified expenses or retirement.
Roll Over or Grace Period	You must use the money in the account by end of Plan Year. The plan includes a 2.5-month grace period after the end of the plan year for any extra expenses to be incurred and reimbursed. Any unclaimed funds at the end of the run out are lost and returned to your employer.	The money in the account rolls over from year to year. Funds are always yours, and you may use them for future qualified expenses.
Qualified Expenses	Physician services, hospital services, prescriptions, dental care and vision care. A full listing of eligible expenses is available at www.irs.gov.	Physician services, hospital services, prescriptions, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full listing of eligible expenses is available at www.irs.gov.
Other Types	Other types of FSAs include: · Dependent Care FSA – Allows you to set aside pre-tax dollars for elder or child dependent care and covers expenses such as baby-sitting, day care and before- and after-school care. · Limited Use FSA – Some employers offer a Limited Use FSA that only covers Dental and Vision expenses. Limited Use FSAs are typically offered in conjunction with an HSA as the IRS does not allow someone to have a Health FSA and an HSA.	There is only one type of HSA.

Please refer to your Summary Plan Description or plan certificate for your plan's specific FSA or HSA benefits.

Disability

$ Click here to view my cost-share rate for this benefit.

Income Protection

Helen of Troy offers disability coverage to protect you against a debilitating sickness or injury. This insurance protects a portion of your income until you can return to work, or until you reach retirement age.

Short-Term Disability (STD) Insurance

STD insurance protects a portion of your income if you become partially or totally disabled for a short period of time. Helen of Troy provides a 70% benefit. You will have the option to purchase an extra 10% or 20% buy-up on top of the 70%. You must be sick or disabled for at least seven days (immediately for surgery or in-patient hospital confinement) before you can receive a benefit payment. Payments may last up to 13 weeks. Certain exclusions may apply. Please refer to your Summary Plan Description or plan certificate for details or contact My Total Well-Being Center for specific benefits.

Long-Term Disability (LTD) Insurance

LTD insurance protects a portion of your income if you become partially or totally disabled for an extended period of time. This insurance replaces 60% of your income, up to a maximum of $25,000 per month, depending on your current annual earnings. You must be sick or disabled for at least 90 days before you can receive a benefit payment. Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner. Certain exclusions, along with any pre-existing condition limitations, may apply. Please refer to your Summary Plan Description or plan certificate for details or contact My Total Well-Being Center for specific benefits.

Life Insurance

Survivor Benefits

Discussing what might happen to your family if you were not around to provide for them isn't always the easiest conversation, but it is necessary. Survivor benefits provide financial assistance in an absence, and can help you plan for the unexpected. If you have Life insurance now, chances are you can take comfort in knowing that those who depend on you will be provided for.

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Life and AD&D benefits are essential to the financial security of you and your family. As such, it is important to understand how your Plan works and what benefits you will receive.

Basic Life and AD&D benefits are provided to you as a part of your basic coverage. Helen of Troy provides associates with Basic Life and AD&D insurance through Prudential, which guarantees that loved ones, such as a spouse or other designated survivor(s), continue to receive part of an associate's benefits after death.

Your Basic Life and AD&D insurance benefit is One times your base annual earnings, up to $750,000 (Two times your annual earnings for officers). If you are a full-time associate, you automatically receive Life and AD&D insurance even if you elect to waive other coverage.

Beneficiary Designation

A beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life that Helen of Troy offers. Benefits payable for a dependent's death under the Prudential insurance are payable to you.

It is important that your beneficiary designation is clear so there is no question as to your intentions. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies), please indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in percentages.

For example:

PRIMARY	CONTINGENT
Mary J. Doe, Wife (34%) Jane Doe, Daughter (33%) John Doe, Son (33%)	**Joseph W. Doe, Son (50%) Jane Doe, Daughter (50%) OR Estate of the Insured (100%)**

$ Click here to view my cost-share rate for this benefit.

Life and AD&D Insurance

Eligible associates may purchase Voluntary Life and AD&D insurance for themselves and their families. You pay premiums through post-tax payroll deductions.

BASIC LIFE/AD&D	
Coverage Amount	1 times your base annual earnings (2 times for Officers)
Who Pays	Helen of Troy
Benefits Payable	Upon death or dismemberment
Maximum Benefit	$750,000
Evidence of Insurability (EOI) Required	No
VOLUNTARY ASSOCIATE LIFE	
Coverage Amount	1, 2, or 3 times your base annual earnings
Who Pays	Associate
Benefits Payable	Upon death
Maximum Benefit	$500,000
Evidence of Insurability (EOI) Required	If you elect coverage over $200,000 or if you change your election
Age Based Reduction	Life insurance Benefits for an Associate age 65 and over will reduce to 65% of the Life Insurance Benefits at age 65 and to 50% of the Life Insurance Benefit at age 70.
VOLUNTARY DEPENDENT LIFE	
Coverage Amount	Spouse or Domestic Partner: $5,000 increments limited to 50% of Associate's Voluntary Life amount; Child(ren): $1,000 increments
Who Pays	Associate
Benefits Payable	Upon death
Maximum Benefit	Spouse or Domestic Partner Child(ren)*: $10,000
Evidence of Insurability (EOI) Required	Spouse or Domestic Partner: Amounts over $25,000 or you change your election
Age Based Reduction	Life Insurance Benefit Age Based Reduction for Spouse is based on the Associates age. See Age Based Reduction under the Voluntary Associate Life above.
VOLUNTARY ASSOCIATE AD&D	
Coverage Amount	Associate: 1, 2, or 3 times base annual earnings; Spouse or Domestic Partner: $5,000 increments limited to 50% of Associate's Voluntary AD&D amount; Child(ren)*: $1,000 increments
Who Pays	Associate
Benefits Payable	Upon death or dismemberment
Maximum Benefit	Associate: $500,000; Spouse or Domestic Partner: $250,000; Child(ren)*: $10,000
Evidence of Insurability (EOI) Required	No

*Includes Child(ren) of either the Associate and/or Domestic Partner

Additional Coverage

$ Click here to view my cost-share rate for this benefit.

Critical Illness Insurance

Why is having Critical Illness Insurance so important?

Your family's expenses will continue if – and when – a critical illness occurs.

Studies show that some families spend as much as $14,444 or more during a time of critical illness and recovery. And while financial experts recommend having three to nine months of living expenses set aside to help in an emergency situation like undergoing a serious illness, with today's economy, most families don't have that kind of money in reserve.

Quality health and disability insurance plans aren't always enough. There may still be coverage gaps. Disability income plans cover a portion of your income while health insurance may leave you with some expenses to pay including:

- Health plan deductibles
- Prescription copays
- Out-of-network treatments
- Alternative treatments

Critical illnesses can happen at any age and more often than you may think.

The odds of you or a family member suffering a critical illness are actually quite surprising. Studies have shown:

- The average age for onset of a critical illness is 43.
- Every year about 715,000 Americans have a heart attack.
- One out of every two men will be diagnosed with cancer at some point in their lives.
- One out of every three women will be diagnosed with cancer at some point in their lives.

Critical Illness Insurance can help safeguard your finances by providing you with a lump-sum payment when your family needs it most. The payment you receive is yours to spend as you see fit and in addition to any other insurance you may have.

How can having MetLife Critical Illness Insurance benefit you and your loved ones?

MetLife Critical Illness Insurance provides a lump-sum payment of $5,000 or $10,000 if you or a covered family member is diagnosed with one of the following medical conditions and meets the policy and certificate requirements: full benefit cancer, partial benefit cancer, heart attack, stroke, coronary artery bypass graft, kidney failure, alzheimer's disease, major organ transplant, and the 22 listed conditions. Your plan pays a recurrence benefit for the following covered conditions: heart attack, stroke, coronary artery bypass graft, full benefit cancer and partial benefit cancer. A recurrence benefit is only available if an initial benefit has been paid for the covered condition.

There is a benefit suspension period between recurrences.

MetLife will make payments directly to you, not to the doctors, hospitals or other healthcare providers. You will receive a check mailed directly to your home. The payment you receive is yours to spend as you see fit and may be used to cover ongoing household bills like:

- Groceries
- Mortgage and car payments
- Child care
- Or any other way you want; the choice is yours

$ Click here to view my cost-share rate for this benefit.

Accident Insurance

Why is having accident insurance so important?

Even the best medical plans may leave you with extra expenses to pay out of your own pocket.

As good as the healthcare is that you receive today, an accident can require a variety of treatments, tests, therapies and other care and services to assist in recovery. Each of these services usually means extra out-of-pocket costs for you to pay, beyond what your medical plan may cover, including:

- Medical plan deductibles
- Copayments for doctor visits and specialist care, as well as prescription drugs
- Extra costs for out-of-network care and treatment

Other household expenses may be harder to cover due to lost or reduced income – like your mortgage, car payment, child care or household upkeep – while you recover.

Accident insurance can help you be better prepared by providing you with a payment to use as you see fit if you experience a covered event. There are no waiting periods for coverage to begin and payment will be in addition to any other insurance you may have.

This payment can help you focus more on getting back on track and less on the extra expenses an accident may bring.

This plan provides a lump-sum payment for over 150 different covered events, such as these:

- Fractures – $50 to $3,000
- Concussions – $200
- Dislocations – $50 to $3,000
- Cuts/lacerations – $25 to $200
- Second and third degree burns – $50 to $5,000
- Eye injuries – $200
- Skin grafts
- Coma – $5,000
- Torn knee cartilage – $100 to $800
- Broken teeth – $25 to $100
- Ruptured disc – $500

This plan provides a lump-sum payment for over 150 different covered events, such as these:

- Ambulance – $200 to $750
- Physician follow-up visits – $50
- Emergency care – $25 to $50
- Transportation – $200
- Inpatient surgery – $100 to $1,000
- Home modifications
- Outpatient surgery – $150
- Therapy services including: – $15
- Physical and occupational therapy
- Medical testing benefits – $100, including:
  - X-rays
  - MRIs
  - CT scans

$ Click here to view my cost-share rate for this benefit.

Legal Protection

LegalShield provides the legal protection you and your family need and deserve.

Direct Access to a Dedicated Provider Law Firm

You will receive unlimited legal consultation and advice on personal legal matters. 100% of matters are covered in-network and your provider firm is even available for emergency situations.

Fast Response

An attorney will respond to your legal matter within four business hours or less.

Document Review and Preparation

An attorney can help you review and prepare common legal documents for wills, trusts, and more.

Court Representation

You will receive representation for legal matters such as traffic tickets and even house closings.

Letters and Phone Calls

Letters and phone calls can be made on your behalf to resolve legal matters such as warranty disputes or a dispute with a creditor.

Speeding Ticket Assistance

Your provider law firm will review your speeding ticket and even attend court on your behalf if required. You can easily upload your ticket using the LegalShield mobile app.

Mobile App

The LegalShield mobile app allows you to call your provider law firm directly and makes it easy to upload and prepare documents for fast legal review.

$ Click here to view my cost-share rate for this benefit.

Allstate Identity Protection

Product features

Comprehensive monitoring and alerts

Proactive monitoring helps you stop fraud at its earliest sign and enables quick restoration for minimal damage and stress.

Enhanced identity monitoring

Our proprietary monitoring platform detects high-risk activity to provide rapid alerts at the first sign of fraud.

Dark web monitoring

In-depth monitoring goes beyond just looking out for a participant's Social Security number. Bots and human intelligence scour closed hacker forums for compromised credentials and other personal information. Then we immediately alert participants who have been compromised.

Lost wallet protection

Easily store, access, and replace wallet contents. Our secure vault conveniently holds important information from credit cards, credentials, and documents.

Solicitation reduction

We aid you in opting in or out of the National Do Not Call Registry, credit offers, and junk mail.

High-risk transaction monitoring

We send alerts for non-credit-based transactions like student loan activity and medical billing.

Digital exposure reports

You can see and identify where your personal information is publicly available on the internet.

Account activity

You're alerted when unusual activity on your personal banking accounts could be a sign of account takeover.

Financial activity monitoring

Alerts triggered from sources such as bank accounts, thresholds, credit and debit cards, 401(k)s, and other investment accounts help you take control of your finances.

Social media monitoring

We keep tabs on social accounts for everyone in the family, watching for vulgarity, threats, explicit content, violence, and cyberbullying.

Credit monitoring and alerts

We alert for transactions like new inquiries, accounts in collections, new accounts, and bankruptcy filings.

Data breach notifications

We send alerts every time there's a data breach affecting you directly so you can take action immediately.

Credit assistance

Our in-house experts will help you freeze your credit files with the major credit bureaus. You can even dispute credit report items from your portal.

Sex offender notifications

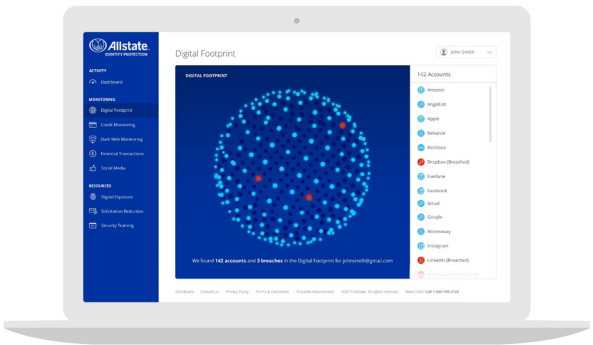
Our monitoring system notifies you if a sex offender is registered in a nearby area.

Full-service case management and resolution

We fully manage your restoration case, helping you save time, money, and stress.

Mobile app

Access the entire Allstate Identity Protection portal on the go! Available for iOS and Android.



Protect the entire family

We have a generous definition of family, covering those who live in the participant's household and those they take care of financially – everyone that's "under roof and wallet." If they are dependent on you financially or live under your roof, they're covered.

Best-in-class customer care

Should fraud or identity theft occur, highly trained in-house experts are available 24/7 to fully restore compromised identities, even if the fraud or identity theft occurred prior to enrollment. And with a $1 million identity theft insurance policy, you can rest assured that you're protected.

Highly trained and certified support team

Our in-house experts are trained and certified to handle and remediate every type of identity fraud case. When resolving complex cases of identity theft, our satisfaction score is an industry-leading 100%.

24/7 U.S.-based customer care center

We believe customer care is an essential part of our team. Our support center is located directly in our corporate headquarters, and our customer care team is available 24/7.

$1 million identity theft insurance

If you fall victim to fraud, we will reimburse your out-of-pocket costs.

Retirement, Stock & Discount Programs

Associate Stock Purchase Plan and 401(k) Retirement Savings and Investing Plan

Associate Stock Purchase Plan

A Share in the Helen of Troy Limited through the Stock Purchase Plan

The Helen of Troy Limited makes available to associates an opportunity to purchase common stock through the Helen of Troy Limited Associate Stock Purchase Plan. This benefit plan differs from a retirement plan in that associates can easily – and without IRS penalty – purchase Helen of Troy Limited stock at a discount. The stock purchase price will be 85% of the fair market value on the beginning date of the option period or the ending date; whichever date has the lower price. The total annual shares are limited to a maximum fair market value of $25,000. Additionally, this stock purchase plan gives associates the opportunity to share in the success of Helen of Troy Limited.

401(k) Retirement Savings and Investing Plan

Administered by Fidelity Management Trust Company, the Helen of Troy 401(k) Plan offers an excellent way to build savings for the future. You can save up to 60% of eligible pay on a pre- and/or after tax basis under the Plan.

Here's how it works. You may select any amount between 1 and 60 percent of your eligible pay to contribute to your 401(k) – up to the annual IRS dollar limit.

Effective 1/1/2025, the matching formula will increase to 100% on the first 4%, and 50% on the next 2%.

To maximize the employer match contributions, you'll want to save at least enough to get the full employer match, but you might also need to pace your contributions so you don't hit the IRS deferral limit too early in the year and miss out on employer matches in the later months.

Essentially, there's an optimal range in terms of 401(k) contribution percentage, where (depending on your salary) you are not exceeding the annual IRS contribution limit before the end of the calendar year, which will also allow you to nab the full employer match. Since the plan does not have a true-up feature, it would benefit you to ascertain this optimal range.

For assistance in calculating your contributions and maximize the employer match, we recommend you discuss your options with your personal retirement advisor or contacting the company sponsored retirement planning and investment advice service with Captrust.

Once you have established your account, you will be able to choose investment options. You can spread your investments among several options to take advantage of what each has to offer and help balance different types of risk. Reviewing this information can help you understand and compare your options.

If you are age 50 or over and have reached the annual IRS limit or Plan's maximum contribution limit for the year, you may make additional salary deferrals. It's important to remember that the IRS regulated limit may change each calendar year.

Under the plan's rules, you are entitled to 100% of your account balance in your:

- Associate pre-tax account
- Employer matching contribution account
- Rollover account
- After-tax account

And any other earnings.

Retirement Planning and Investment Advice Services

Financial independence and your blueprint journey for success. Pack your bags and buckle up as you navigate your financial journey.

Helen of Troy believes in helping you make the most of your benefits in order to help you build a solid financial future. That's why we've hired CAPTRUST as a resource for investment advice and to help you define your retirement goals. CAPTRUST can provide recommendations to ensure you are able to retire comfortably and predictably.

When it comes to money, do you think about your future, where you're going, and how to get to each of those stops along the way?

Is retirement one of those stops?

Retirement may feel far away; however, the sooner you get started, the more prepared for the future you will be.

What is your destination?

CAPTRUST has a variety of services to help you create a Blueprint to guide your financial success planning.

CAPTRUST services include:

- Enrollment assistance
  - Assist participants in establishing and accessing account information
- Retirement Blueprint® preparation
  - Determine proper savings level/deferral rates
  - Investment recommendations based on your investment risk tolerance
  - Retirement progress report
- Distribution option counseling
  - Counseling around taking money out of your retirement plan during retirement
- Pre-retiree consulting/counseling
  - Assess financially how prepared you are to retire and education on Social Security options
- Access to online tools
  - Webinars, newsletters, videos, and calculators
- Access to Advice Desk 800 number
  - Free dial number to receive investment advice
- On-site financial wellness workshops

Schedule an appointment online

Learn more on www.captrustadvice.com

Welcome to Your Discount Program!

What is the **Helen of Troy Savings & Discount Program?**

Your Savings & Discount Program is a one-stop-shop for thousands of exclusive discounts in more than 25 different categories. That means there's something for everyone!

How to Navigate Your Discount Program

Local Offers

Located in the Quick Links section, Local Offers allow you to use your location to see all of the discounts near you, wherever you are! Discounts can be filtered by category and distance.

Interests

Let us know what you're interested in so we can ensure you're seeing the perks you'll most enjoy, front and center on your Discount Program Home Page.

Brands

Looking for something specific? The Brands tab, found in the Quick Links section, is an easy and quick way to search for all the discounts available to you.

Suggest a Business

Don't see what you're looking for? Head to the Suggest a Business page, found in the upper right-hand corner of your Home Page, to suggest your favorite brands and local spots be added to your Discount Program.

Need Some Help? Reach Out To Us!

PerkSpot's customer service team works tirelessly to help you access your Discount Program and redeem deals easily. Below are some important details regarding customer service availability.

Hours
Monday - Friday
9am - 6pm

Phone Number
866-606-6057

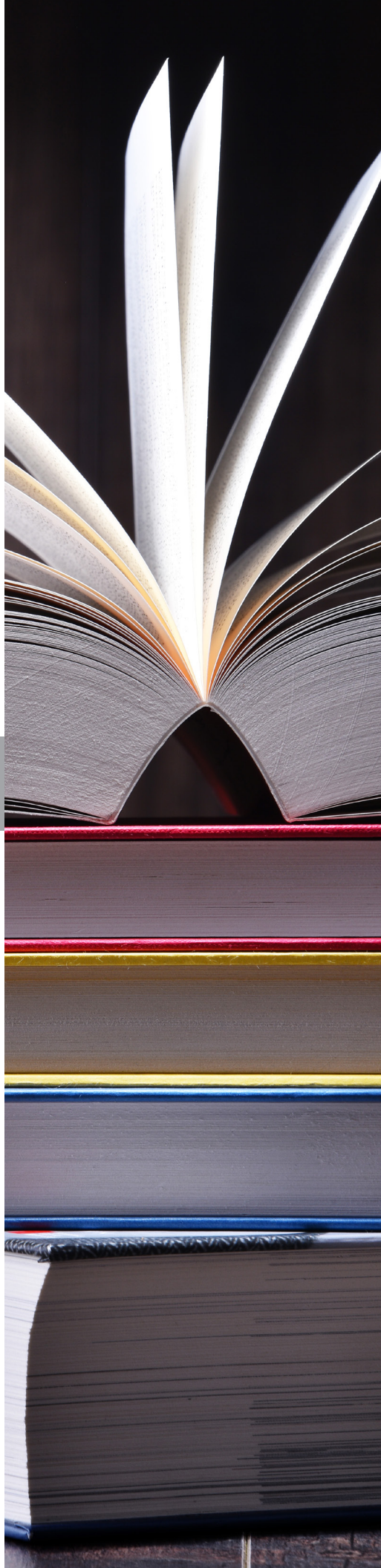
Email
cs@perkspot.com

Support*
support.perkspot.com

**If you've still got some questions, visit support.perkspot.com to submit a request. Our bilingual Customer Service team will reach out and can answer any questions in both English and Spanish.*

Ready to save? Head to HelenofTroy.perkspot.com to get started!

Development



Supporting Talent With an Educational Assistance Program

This program has been designed to enhance associate work-life experience by encouraging and supporting an associate's decision to continue their education or engage in professional development opportunities.

Under this program, eligible associates who enroll in a degree or certification program may be reimbursed up to $5,250 each calendar year for tuition, school fees, and lab expenses. Just get your course approved by your manager before you enroll, pass the course with a grade of C or better if it's an undergraduate course, or a grade of B or better if it's a graduate course.

Eligible associates will be required to complete an application, obtain department signatures, and submit the application to the benefits department. Additional details can be found on the My Total Well-being page of the In Touch. If you have any questions about this program, please send an email to gethealthy@helenoftroy.com.

Important Things to Keep In Mind

- Must be a Helen of Troy full-time associate for 90+ consecutive days
- Have good performance standing
- Complete Individual Development Plan in Workday
- Receive manager's approval
- Complete the application with four weeks in advance of start of course (pre-approval required)
- Earn a "C" or better
- Submit for reimbursement within 30 days of course / semester end date
- Approval is based on available funding and provided on a first-come, first-served basis. If you do not obtain prior approval, cost for any courses taken may not be approved or reimbursed

Ready to Apply?

1. Initiate your application through Workday
2. Be ready to upload your supporting documentation
3. The Workday process flow will collect the required approvals
4. Set to start!

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Family-Friendly Benefits

Dependent Care Flexible Spending Account

Dependent Care Flexible Spending Account allows you to set aside pre-tax payroll deductions for dependent care expenses.

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA as well – whether or not you elect any other benefits.

The Dependent Care FSA allows you to set aside pre-tax funds to help pay for expenses associated with caring for elder or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that you deposit in your account at that time.

- With the Dependent Care FSA, you are allowed to set aside up to $5,000 (for 2024) to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children younger than the age of 13 and dependents of any age who are incapable of caring for themselves.
- Expenses are reimbursable as long as the provider is not anyone considered your dependent for income tax purposes.
- In order to be reimbursed, you must provide the tax identification number or Social Security number of the party providing care.

This account covers dependent day-care expenses that are necessary for you and your spouse to work or attend school full time. The dependent must be a child younger than the age of 13 and claimed as a dependent on your federal income tax return or a disabled dependent who spends at least eight hours a day in your home.

Examples of eligible dependent care expenses include:

- In-Home babysitting services (not by an individual you claim as a dependent)
- Care of a preschool child by a Licensed Nursery or Day Care Provider
- Before- and after-school care
- Day camp
- In-House dependent day care

Due to federal regulations, you cannot reimburse expenses for your domestic partner and your domestic partner's children under the Flexible Spending Account programs. Please check with your tax advisor to determine if any exceptions apply to you.

General Rules and Restrictions

In exchange for the tax advantages that FSAs offer, the IRS has imposed the following rules and restrictions for both Healthcare and Dependent Care FSAs:

- Your expenses must be incurred during the plan year.
- You cannot transfer your dollars from one FSA to another.
- You cannot participate in Dependent Care FSA and claim a dependent care tax deduction at the same time.
- You must "use it or lose it" – any unused funds will be forfeited.
- You cannot change your FSA election in the middle of the plan year unless you experience a Qualifying Life Event like marriage, divorce or birth of a child.

2½-Month Grace Period

- FSA participants have an additional 2½-month grace period of time to incur expenses after the Plan Year ends (December 31st).
- If during the current plan year an expense is incurred between December 31st and March 15th of the subsequent calendar year, AND received for reimbursement on or before April 30th (run-out period), it will be eligible under the grace period.

Fertility and Family-Building Benefits

There are many different fertility and family-building journeys, whether you are looking to start your family today or preserve your options for the future. Kindbody provides end-to-end fertility services with a dedicated Care Navigation Team to guide you through your journey and coordinate the full spectrum of benefits available to you and your covered family members.

Benefits include:

- Up to two (2) full KindCycles per lifetime with fertility medication through Kindbody Rx*
- Reimbursement for eligible adoption, donor, or surrogacy expenses up to $10,000 per lifetime
- Up to five (5) Holistic Health and coaching sessions, including foster to adopt support
- Access to Kindbody's full suite of services and network of partner clinics
- White-glove guidance for care path, including a dedicated phone line for Helen of Troy employees
- A personalized patient portal

*If covered under the Helen of Troy Aetna plan, medical plan cost share applies to medical and pharmacy benefits. For those who have waived medical coverage under Helen of Troy, medical and pharmacy benefits are subject to a fertility services calendar year deductible of $1,750 (employee only) or $3,500 (employer/partner) as well as a coinsurance of 80/20 and a OPX of $5,250 per individual / $10,500 per family.

Get Started With Kindbody:

1. Head to kindbody.com/activate-kindbody-benefit
2. Create your Kindbody account using any email address
3. Confirm eligibility by using your Unique ID (your Associate ID) AND Access Code (case sensitive)
   - If you elected Helen of Troy's medical plan through Aetna, use code **KINDHELEN1**
   - If you waived medical coverage through Helen of Troy, use code **KINDHELEN2**

   [Spouses/partners use the Unique ID of the employee+S]

Pet insurance

from Nationwide®

Fetch the best health coverage for your pet through your voluntary benefits package. With two budget-friendly plans plus a $500 wellness benefit option[1], there's never been a better time to sign up for My Pet Protection®, available only through your workplace benefits program.

- Get cash back on eligible vet bills: Choose 50% or 70% reimbursement[2]
- Easy to use: Base plans have a $250 annual deductible and $7,500 in annual benefits
- Just for employees: Preferred pricing offered only through your company
- Use any vet, anywhere: No networks, no pre-approvals

Did you know? Nationwide is the first provider with coverage plans for birds and exotic pets.

How to use your pet insurance plan

1 Visit any vet, anywhere.

2 Submit claim.

3 Get reimbursed for eligible expenses.

To enroll, visit: https://benefits.petinsurance.com/helenoftroy

[1] Starting on 9/1/23 new members can select the My Pet Protection® Wellness500 coverage option, with the earliest effective date of 10/1/23 and forward. Existing members can add My Pet Protection® Wellness500 during their respective renewal period only.

[2] Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions.

Nationwide®

Nationwide®

My Pet Protection®

PLAN SUMMARY

Nationwide pet insurance helps you cover veterinary expenses so you can provide your pets with the best care possible—without worrying about the cost.

My Pet Protection coverage highlights

My Pet Protection is available in two reimbursement options (50% and 70%) with an optional $500 wellness benefit so you can find coverage that fits your budget.[1] Base plans have a $250 annual deductible and $7,500 annual benefit.

Coverage includes[2]:

- Accidents
- Illnesses
- Hereditary and congenital conditions
- Cancer
- Behavioral treatments
- Rx therapeutic diets and supplements
- Wellness[1] and more

My Pet Protection includes these additional benefits for cats and dogs:

- Lost pet advertising and reward expense
- Emergency boarding
- Loss due to theft
- Mortality benefit

What makes My Pet Protection different?

My Pet Protection is available through your employer's voluntary benefit plan, which includes preferred pricing and is guaranteed issuance.[3] It also includes additional benefits like lost pet advertising, emergency boarding and more.

It's no surprise that My Pet Protection is the most paw-pular coverage plan from America's #1 pet insurer.[4]

Did you know? Nationwide is the first provider with coverage plans for birds and exotic pets.

Nationwide offers more than great coverage

vethelpline®

- 24/7 access to veterinary experts
- Available via phone, chat and email
- Unlimited help for everything from general pet questions to identifying urgent care needs

Nationwide PetRx*Express*℠

- Save time and money by filling pet prescriptions at participating in-store retail pharmacies across the U.S.
- Pharmacy submits claims directly to Nationwide
- More than 4,700 pharmacy locations

To enroll, visit: https://benefits.petinsurance.com/helenoftroy

[1] Starting on 9/1/23 new members can select the My Pet Protection® Wellness500 coverage option, with the earliest effective date of 10/1/23 and forward. Existing members can add My Pet Protection® Wellness500 during their respective renewal period only. [2] These are examples of general coverage; please review plan document for specific coverages. Some exclusions may apply. Certain coverages may be excluded due to pre-existing conditions. See policy documents for a complete list of exclusions. [3] Guaranteed issuance does not mean guaranteed coverage since certain exclusions could apply. [4] State of the Industry Report 2022, North American Pet Health Insurance Association.

Nationwide®

Wellness

Health & Wellness Program

Get Started on a Healthier Lifestyle

Achieving and Maintaining Good Health and Well-being

The Helen of Troy Benefit Plan has designed a wellness program to encourage healthy lifestyles. We encourage you to take ownership of your well-being in all its dimensions, which involves:

- Living Secure
- Living Healthy
- Living Connected
- Living Engaged
- Living Happy

These dimensions include financial security, being engaged in your job, living healthy, being happy, and having a positive relationship at work, home, and in the community. All associates can participate in the wellness program.

We have partnered with Personify Health (formally Virgin Pulse) to offer you an award-winning wellness program that includes a robust digital platform with integrated live coaching services and more.

Through this program, you can earn points by participating in an abundance of health and well-being activities. You can redeem these points for cash.

Find the Healthy Action That's Right for You

Our wellness program makes these tools available at no cost to you.

Biometric Screening

A Biometric Screening includes measurements of physical characteristics such as height, weight, body mass index, blood pressure, blood cholesterol, and blood glucose. It serves as a benchmark or a baseline that can be used to evaluate risk for a variety of health issues, many of which can be prevented through early detection and lifestyle changes. For this reason, we strongly recommend you participate in a company-sponsored biometric screening offered at no cost to you. Onsite Biometric Screening Events are held at most Helen of Troy offices annualy.

Health Check Survey

A Health Check Survey is like an interview you take online. It is not that much different from the questions your doctor would ask during an annual check-up. You share information about your health habits and history. Then, you get a personalized health summary that can help you understand your health needs.

Live Coaching Services

Condition Management Coaching

Whether you've been recently diagnosed with a chronic condition or have lived with one for some time, with Chronic Condition Management, you'll have access to a dedicated Partner in Health. Chronic Condition Management covers a range of conditions and Personify Health offers resources to help motivate you to reach your health goals.

Lifestyle Coaching

You are set up with a one-on-one health coach to help you meet your health and well-being goals. Your health coach will provide support, guidance, and resources as you work toward your goals. You can talk to your health coach about tobacco use, weight control, exercise plans, nutrition questions, stress management, and more.

Transform

Transform is a 12-month structured coaching program focused on condition prevention and management in three areas: Weight Management, Blood Pressure, and Pre Diabetes. Transform offers you:

- One-on-one support from a personal health coach
- A specialized plan to educate, inspire and support your goals
- A connected health device to motivate and help you and your coach easily track progress

Health Actions

An example of a Healthy Action is obtaining a routine preventive exam or participating Company-sponsored wellness challenges, health educational sessions, and more.

Fitness Tracking

The Centers for Disease Control and Prevention recommends that adults get at least 150 minutes per week of moderate – intense exercise. If you don't have a regular daily routine, tracking your daily fitness allows you to see exactly how much you have done each week so you can plan on how to meet your goal for the week.

Noel Geoffroy
Helen of Troy CEO

"At Helen of Troy, we empower our associates to be healthy and well by ensuring that they have access to exceptional preventive care. When we take control of our health, we're investing in ourselves."

Other Resources

My Care Checklist

My Care Checklist is a handy, personal healthcare tracker that is right at your fingertips. It assists you in managing your health by keeping track of health checkups, all in one place.

Nutrition Guide

Choose what you'd like to work on, like cutting out sweets or portion control. Then get tips to help you achieve your goals.

Sleep Guide

What's your sleep like? Decide what you need to work on, like getting to bed earlier or quieting down. Then get information to help you rest.

Daily Cards

Every day, we'll send you two new tips to help you live well. Plus, we'll make sure they're about the areas that interest you the most.

Recipes

Get ideas for healthy meals, build a shopping list, and make a weekly meal plan. Healthy eating is easier when you have the help of an app!

Social Groups

Getting healthier and learning something new is easier with friends. Join a group to stay motivated, chat with others, and achieve goals together.

Journeys® Digital Coaching

Want to exercise more? Better manage a health issue? Now you can use our digital coaching tool, Journeys®, to make simple changes to your health, one small step at a time.

We Want to Help You Become Healthier - Starting Right Now

We want to help you be at your healthiest. And we want to help you to embrace total well-being. With our wellness program, you can change your life. It's time your health and well-being became a priority. Are you ready to take advantage of your benefits? Start on the pathway to change today - and discover how your health and wellness benefits can really make a difference. It's easy to get started.

Visit www.join.virginpulse.com/HelenOfTroy to learn more about the well-being benefits, programs, and incentives available to you. Well-being isn't far away!

Tobacco Cessation Program

Tobacco use is the leading cause of preventable illness and death in the United States. It causes many different cancers as well as chronic lung diseases such as emphysema and bronchitis, heart diseases, and many other serious health problems.

Helen of Troy provides a tobacco-free premium incentive. This incentive will be available to all associates enrolled in a Helen of Troy group medical plan (excludes dental or vision) who, during the Annual Open Enrollment, certify that in the immediate prior six months, either:

Option 1: They have been tobacco-free, or
Option 2: Successfully completed the Helen of Troy-approved tobacco cessation program

Note: If an associate's spouse/domestic partner is enrolled in a Helen of Troy group medical plan, the associate must certify that the spouse meets either Option 1 or Option 2 above in order to receive the associate incentive.

Associates and/or Spouses/Domestic Partners that have not previously certified their tobacco-free status and subsequently meet the tobacco-free requirements should submit an affidavit by the listed deadlines to begin receiving premium incentives. New associates or associates enrolling for the first time in the medical plan that are not eligible for the tobacco-free incentive immediately upon enrollment may recertify during any of the indicated deadline dates. If after meeting the requirements for the incentive and recertification is completed within the first 90 days of enrollment in the medical plan, we will provide a retroactive 90-day credit against the share of the medical plan premium.

Deadline To Complete Option 1 Or Option 2	Date Of Qualifying Premium Incentive
January 1st	March 1st
April 1st	June 1st
July 1st	September 1st
October 1st	January 1st

Helen of Troy's tobacco cessation program – called the Freedom From Smoking Lung Helpline – applies to associates and, if applicable, spouses enrolled in our benefits plan. The American Lung Association offers the program. The course is eight weeks and is available via telephone.

Read additional details regarding the incentive requirement in the tobacco-free premium incentive FAQ found on the "In Touch" site.

Tobacco-Free Premium Incentive FAQs

The Tobacco Cessation Program is a comprehensive program that promotes positive behavior change with the goal of improving health. This program includes an incentive that reduces your cost share of the medical premium.

General Questions

To whom does the premium incentive apply?

This incentive will be available to all associates enrolled in a Helen of Troy group medical plan (excludes dental or vision) who, certify that in the immediate prior six months, either:

Option 1: Have been tobacco-free or

Option 2: Successfully completed the Helen of Troy-approved tobacco cessation program

(Note: If an associate's spouse/domestic partner is enrolled in a Helen of Troy group medical plan, the associate must certify that the spouse/domestic partner meets either Option 1 or Option 2 above in order to receive the associate incentive).

If the associate fails to satisfy one of the options above during enrollment, the associate will have additional opportunities throughout the year to qualify for the incentive using the indicated deadline dates below.

Associates and/or spouses and domestic partners that have not previously certified their tobacco-free status and subsequently meet the tobacco-free requirements are encouraged to submit an affidavit by the listed deadlines to begin receiving premium incentives. New associates or associates enrolling for the first time in the medical plan that are not eligible for the tobacco-free incentive immediately upon enrollment may recertify during any of the indicated deadline dates. If after meeting the requirements for the incentive and recertification is completed within the first 90 days of enrollment in the medical plan, we will provide a retroactive 90-day credit against the share of the medical plan premium.

Deadline to Complete Option 1 or Option 2	Date of qualifying premium incentive
January 1st	March 1st
April 1st	June 1st
July 1st	September 1st
October 1st	January 1st

What is the reduced amount of the annual premium incentive?

It is approximately $600 less than the standard medical premium rate.

How will the premium incentive be administered?

Your medical premium will continue to be deducted from your pay; however, your standard medical premium rate will be reduced by the Tobacco-Free Premium Incentive.

Why did Helen of Troy implement the Tobacco-Free Premium Incentive?

Studies show that a tobacco user's annual medical costs are on average $1,700 higher than the costs of a non-tobacco user. The premium incentive is an attempt to reward associates who are making good health choices and create a financial incentive for others to do the same.

How does Helen of Troy define a "tobacco user?"

A tobacco user is a person who has used tobacco in the past six months. Tobacco includes any form of tobacco products which includes: cigarettes, cigars, chewing tobacco, pipe tobacco, snuff, dip, e-cigarettes, or any similar tobacco-related product.

I use the nicotine patch; does that count as tobacco use?

No. Nicotine replacement therapy, such as the nicotine patch or nicotine gum, does not count as tobacco use.

Are electronic cigarettes recognized as nicotine replacement therapy?

No. According to the U.S. Food and Drug Administration (FDA), "e-Cigarettes may contain ingredients that are known to be toxic to humans." One of the chemicals detected in the FDA's analysis was Diethylene glycol, which is an ingredient used in antifreeze. Several FDA-approved smoking cessation aids are available for tobacco users, depending on their dependence on nicotine. These include nicotine gum, nicotine trans-dermal patches, nicotine lozenges, nicotine inhalation products, nicotine nasal sprays, and several prescription medications.

Why does the premium incentive only apply to tobacco-free?

According to the National Institute on Drug Abuse:

- Smoking harms nearly every organ in the body. It's been linked to cataracts and pneumonia, and it accounts for about one-third of all cancer deaths. The overall rates of death from cancer are twice as high among smokers as among nonsmokers
- Smoking has been linked to about 90 percent of all cases of lung cancer and is associated with many other cancers and lung diseases. It's also been well documented that smoking substantially increases the risk of heart disease, including stroke, heart attack, vascular disease, and aneurysms
- All tobacco, including smokeless tobacco, contains nicotine, which is addictive. The amount of nicotine absorbed from smokeless tobacco is 3-4 times greater than that delivered by a cigarette, and while nicotine is absorbed more slowly from smokeless tobacco, more nicotine per dose is absorbed and stays in the bloodstream longer

How can Helen of Troy charge me more for being a tobacco user?

The wellness program exemption from HIPAA's nondiscrimination rules allows employers to offer health plan-related financial incentives to discourage tobacco use if the total reward is limited, promotes good health or prevents disease, and is available to all similarly situated individuals.

Is this kind of premium incentive (charging tobacco-users more) illegal?

No. Many employers have enacted similar policies, and they have survived numerous legal challenges. In fact, charging tobacco users higher rates is required by state law in Texas for associates covered by the state's health plan.

Isn't this just another way to shift costs to associates?

No. This is a benefit change designed to persuade associates into getting healthier by offering financial incentives.

Will other health-related premium incentives be considered in the future for things like obesity, alcohol use, and so forth?

Helen of Troy will continue to evaluate medical research regarding other health factors as we develop plan design recommendations for future plan years. Our goal is to build a culture of health and wellness in which associates choose to become healthier.

The affidavit we sign mentions that we "may be subject to testing for nicotine." How will Helen of Troy determine who gets tested and when?

Helen of Troy does not have plans to randomly test associates for nicotine. Testing would only be required if there is reasonable suspicion (not merely rumors or gossip) that an associate who attested to being tobacco-free was actually using tobacco and falsely obtaining the Tobacco-Free Premium Incentive.

When and how often do I need to certify my tobacco user status to qualify for the Tobacco-Free Premium Incentive?

You (and, if applicable, your enrolled spouse) must declare your tobacco status annually during the Healthcare Annual Open Enrollment.

What if I don't certify my tobacco user status during enrollment?

You will not receive the Tobacco-Free Premium Incentive.

What if associates certify that they are not tobacco users when, in fact, they are?

When you certify your tobacco-user status, you attest that you are telling the truth. If it is later discovered that you made a false statement, you will be subject to disciplinary action, up to – and including – discharge, retroactive collection of the difference between the standard healthcare premium rate and the premium incentive rate, and cancellation of your healthcare coverage.

If I complete six months as a non-tobacco user any time after enrollment, can I receive the Tobacco-Free Premium Incentive at that time?

Yes. When you have been a non-tobacco user for at least six months, you should certify your non-tobacco user status. If you complete six months as a non-tobacco user by one of the dates below, your tobacco-free premium incentive will be applied on the indicated incentive date:

Deadline to Complete Option 1 or 2	Date of qualifying premium incentive
January 1st	March 1st
April 1st	June 1st
July 1st	September 1st
October 1st	January 1st

If I'm a new hire or I'm a first-time enrollee into one of the Helen of Troy Group Medical Plans, and I declare myself a tobacco-user, how can I participate and take advantage of the Tobacco-Free Premium Incentive?

New associates or associates enrolling for the first time in the medical plan that are not eligible for the tobacco-free incentive immediately upon enrollment may recertify during any of the indicated deadline dates. If after meeting the requirements for the incentive and recertification is completed within the first 90 days of enrollment in the medical plan, a retroactive 90-day credit against the share of the medical plan premium will be provided.

Enrollment into the program is simple and participation is free to Helen of Troy associates and qualified spouses.

Follow these simple steps:

- Download the application from the "In Touch" site
- Complete and sign the enrollment form
- Email the completed form to Get Healthy inbox at gethealthy@helenoftroy.com
- Review Enrollment and Participation guide
- Prepare for a call from a representative from the American Lung Association (ALA)

How do I complete an approved tobacco cessation program?

Our eight-week telephonic program is designed to assist you be successful in completing the program. The program is composed of eight weekly-calls with an ALA counselor.

The calls are planned around your schedule and your availability, you'll let ALA know what the best time is to reach you! ALA will make three attempts to reach you to plan the weekly calls, once scheduled they will send you text reminders the day before your call. At the end of the eight-week program, ALA will provide you with a certificate of completion, you'll need to email the certificate along with the Tobacco Affidavit, to gethealth@helenoftroy.com to apply for the Tobacco-Free Incentive program.

If I complete an approved tobacco cessation program during the current Plan Year, will Helen of Troy refund the tobacco-user additional premium that's already been taken from my pay?

No. Some of your future additional premium will be waived, but you will not receive a refund of any amount that has already been deducted.

However, new associates or associates enrolling for the first time in the medical plan that are not eligible for the tobacco-free incentive immediately upon enrollment may recertify during any of the indicated deadline dates. If after meeting the requirements for the incentive and recertification is completed within the first 90 days of enrollment in the medical plan, a retroactive 90-day credit against the share of the medical plan premium will be provided.

How much will I pay to participate in the approved tobacco cessation program?

We provide the tobacco cessation program to you at no charge.

How often can one complete the approved tobacco cessation program to qualify for the Tobacco-Free Premium Incentive?

The approved tobacco cessation program can only be taken once annually for the purposes of qualifying for the incentive.

What does it mean to have successfully completed the Helen of Troy-approved tobacco cessation program?

To successfully complete the program, the associate must comply with the requirements of the Freedom From Smoking Lung Helpline program and attach your certificate of completion from the ALA to your affidavit.

Emotional & Mental Health Benefits

Just like your physical health, your mental and emotional health is an essential part of your overall wellness, deserving of your ongoing attention and care. Helen of Troy is committed to promoting and supporting the health and well-being of our associates by providing emotional and mental health resources and fostering a healthy workplace culture.

RethinkCare

Available to all regardless of enrollment in the medical plan

RethinkCare is an activity-based learning system, a training platform for mindfulness, resilience, and mental and emotional wellbeing. The mission is to help people live healthier, happier, and more engaged lives.

In just five minutes a day, you'll learn to reduce stress, while improving emotional intelligence, happiness, and physical health.

Topics Include:

Mindfulness and Wellbeing Training

Be Happier

- Balance Your Emotions*
- Cope with Grief and Loss*
- Boost Happiness*
- Tap Into Joy
- Be Positive (4 weeks)
- Transform Emotions
- Understand Your Emotions*
- Emotions and Music
- Anger Management*
- Shift Difficult Feelings

7 Trainers, 140 sessions & articles

Boost Physical Health

- Connect with Your Body*
- Manage Chronic Pain*
- Connect with Nature
- Work with Pain*
- Relax in Nature
- Yoga for Athletes
- Resillence in Illness (4 weeks)
- Be Body Positive*
- Healthy Eating*
- Practice Outside
- Parents: Resilience in Illness (4 weeks)
- Athletic Mind Training*
- Healing Injury and Illness

9 trainers, 235 sessions & articles

Learn to Meditate

- Mindfulness Basic Training
- Basic Training with Pascal
- Basic Training with Kelly
- Learn the Basics with Mark
- Extend Mindfulness
- Unlock Your Potential
- Mindfulness 101*
- Practice in Silence

4 trainers, 86 sessions & articles

Reduce Stress and Anxiety

- Be Fluid and Non-Reactive*
- Calm Flyer Kit
- Calm Anxiety*
- Overcome Conflict*
- Reduce Daily Stress*
- Accepting and Letting Go*
- Shifting Stress
- Focus and Be Calm*

5 trainers, 94 sessions & articles

Practice Yoga

- Boost Balance
- De-Stress Your Body
- Desk Yoga
- Power Moves
- Relieve Muscle Tension
- Sculpt and Stretch
- Restorative
- Yoga for Moms
- Stretch the Inflexible
- Yoga for Beginners
- Simple Yoga
- Yoga Basics
- Breathe and Stretch
- Detox and Twist
- Energize Your Body
- Improve Stability
- Isolate and Focus
- Improve Your Posture
- Inversion Fundamentals
- Loosen Hips
- Strengthen and Energize
- Morning Moves
- Restore and Renew
- 7 Day Practice
- Align Your Body
- Unwind

3 trainers, 133 sessions & articles

Performance and Relationships Training

Build Emotional Intelligence

- Live Fully Every Day
- Staying Present
- Empathy and Compassion
- Motivation
- Turning Difficulties Around
- Influencing with Goodness
- Mindfulness Tips
- Being in the Now
- Communication with Insight
- Become Self Aware*
- The Power of Breath*
- Self-Awareness
- Leading with Compassion
- Compassionate Strength
- Resilience
- Experience Peace of Mind*
- Positive Neuroplasticity
- Self-Management
- Develop Self-Awareness
- Clear Your Mind*
- Understanding the Brain
- Connect with your Senses*
- Thriving Together

15 trainers, 293 sessions & articles

Access RethinkCare in these easy steps:

1. Log in or create an account at http://app.member.virginpulse.com/ on your desktop or mobile device.
2. Click into the RethinkCare tile through the Benefits Page. If you're on a desktop, this will open a new RethinkCare tab. If on your mobile device, you will be prompted to download the RethinkCare app.
3. Start training via Desktop, Android, or iOS app. Don't forget to set daily reminders on your mobile app to remember to come back and train each day. Anytime, anywhere.

*Team Guide Available

Sleep Guide

Available to all regardless of enrollment in the medical plan.

Sleep is incredibly important to your health. It strengthens your memory, can prevent disease, and makes you happier.

We spend about a third of our lives asleep. Sleep is essential – It is as important to our bodies as eating, drinking, and breathing, and is vital for maintaining good mental and physical health. Sleeping helps us to recover from mental as well as physical exertion.

Sleep and health are strongly related - poor sleep can increase the risk of having poor health, and poor health can make it harder to sleep. Sleep disturbances can be one of the first signs of distress.

That's why we offer a Sleep Guide to help.

Use it to track your bedtime routine, nightly sleep – and get more Zzzs for good.

Get started:

Go to http://app.member.virginpulse.com/

Once you've signed in, click "Programs" from the main menu. Then choose the Sleep Guide.

Live Services Coaching

Available to all regardless of enrollment in the medical plan

It can be tough to manage your health goals all by yourself. That's why we offer free access to dedicated health coaches who can talk to you on the phone and help you make a plan for getting healthier.

Whether you're looking for help on managing your health issue like reducing stress, sleep well, or anxiety or depression, the health coaches are there for you. And they're only a phone call away.

Schedule a call to:

- Talk to a health and wellbeing expert.
- Get confidential, one-on-one sessions to discuss your goals.
- Discover new motivation and get personal guidance - all at no cost to you

During a one-on-one confidential session, the coaches can help you. Your coach is a health expert. The kind of expert everyone wishes they could talk to, and who is 100% focused on you. Have a health concern that's new to you or impacts your daily wellbeing? Coaches are experienced in helping people manage:

- Reduce stress
- Anxiety
- Depression
- Insomnia
- Alcohol misuse
- Opioid misuse
- And much more

Get started:

Go to http://app.member.virginpulse.com/

Choose the Health tab and from the drop-down menu, choose coaching.

You'll see programs that are recommended for you based on your health assessment results, click on the "Navigate Health Situations" option, click on the program of interest.

Find a date with available times on the calendar and choose the time that fits your schedule.

AETNA Resources for Living

Available to all regardless of enrollment in the medical plan

AETNA Resources for Living services are available to you – all members of your household and your adult children up to the age of 26. Service is confidential and is available 24 hours a day, seven days a week.

Counseling and relationship support includes:

- Unlimited, toll-free telephonic access to EAP dedicated staff, 24 hours per day
- Telephonic access to licensed behavioral health professionals
- Support, consultations, and resources for stress, family relationship issues, anger management, substance abuse, and helping you balance work and home life
- Direct access to a full range of Web-based tools and resources, such as easy-to-find information, self-assessments, and more, on a variety of relevant topics
- Eight face-to-face counseling sessions with licensed network professionals – at no cost to you

Get started:

Call 800-955-6422 or online at www.resourcesforliving.com.

Teladoc

Available when enrolled in the Helen of Troy Group Medical Plan

Mental Health, support for stress, anxiety, depression and more.

With Teladoc 24/7 access to doctors by phone or video, it's easier than ever before to seek mental healthcare.

Take care of yourself by connecting with mental healthcare professionals during a virtual therapy session with Teladoc.

While life is stressful enough under normal circumstances, with additional challenges brought our way by the COVID-19 pandemic, many people – from parents balancing working from home and helping their children with remote learning to older adjust who may feel isolated or lonely during this time – have found themselves struggling emotionally. When and if you find yourself in this position, it's important to know that there's never a wrong time to seek treatment for your mental health and overall wellness.

Scheduling an appointment with a Teladoc provider is hassle-free. Review the provider profiles and select a doctor or specialist of your choice, then make your appointment (it can be scheduled within minutes, hours, or days).

Therapist, Psychologist $85 or less/session, Psychiatrist (ongoing session) $190 or less/evaluation and $95 or less/session

Get started:

www.teladoc.com

1. Simply register for the service online or through the Teladoc app and complete your medical history
2. Within your registration page, click on the Mental Health option
3. Follow the prompts in finding the best provider for your needs
4. Make your appointment

AETNA - myStrength

Available to all regardless of enrollment in the medical plan

The health club for your mind.

Many things affect our moods, big life changes, past experiences, random events, and sometimes it feels like our moods are controlling us. We struggle to get out of bed. We feel stressed during the day or anxious at night.

Find hope with myStrength.

Like a virtual gym for the mind, myStrength offers a range of proven self-help resources empowering you with tools and inspiration to manage life's challenges and strengthen overall wellbeing. Each time you come to myStrength, you'll find new and unique personalized applications. Like motivational resources and e-learning programs to help you manage anxious or depressive thoughts or feelings. You will also find tailored wellness tools just for you to help you build a strong mind, body, and spirit.

Register today and find videos, articles, and learning activities on myStrength.

Get started:

www.resourcesforliving.com

1. Username: Helen of Troy/ Password: eap
2. Got to services > myStrength
3. Click "Visit myStrength website"
4. Enter your company access code – Helen of Troy
5. Follow the instructions to create your own personal account

Give the mobile app a try too.

Get inspired on the go. With the myStrength mobile app.

You can:

- Get custom inspiration right on your smartphone
- Track your mood over time
- Upload your own inspiring photos and videos
- Opt to receive check-in reminders

AETNA - MindCheck

Available to all regardless of enrollment in the medical plan

We all have good days and bad days, good moments, and bad ones. MindCheck online tools help you manage your emotional health and focus on the positive. And with practice, you can start feeling better overall.

Take control of your emotional health

"How are you doing?"

It's a standard greeting. And you might offer a quick "Fine, thanks," in response. But when you know how you feel, you can improve your emotional health. So how are you doing? MindCheck® online tools help you find the answer.

Your emotional health contributes to your overall health.

Part of being healthy involves taking care of your feelings. For example, positive thinking is linked to health benefits that include:

- Faster recovery
- Better sleep
- Fewer colds
- Greater sense of happiness
- Longer lifespan
- Strong mind, body, and spirit

Find out where you stand

How do you feel? How do you want to feel? You can't plan a route to where you want to go until you know where you are.

The MindCheck online tool asks you four simple questions so you can be aware of how you're feeling. You'll be matched to a color and level to provide insight into your emotional health. And the MindCheck site tracks your history, so you can see how your results change over time.

Take care of your health

MindCheck online tools makes it easy to improve your emotional well-being. Measure your mindset and get immediate feedback and resources to maintain a positive outlook. You'll also find tips, articles, and videos on a variety of topics that include:

- Relationships
- Depression
- Fitness and nutrition
- Stress
- Substance use and more

Now, it's easy to take control of your emotional health. Remember to check back often. The more you know about taking care of your emotional well-being, the healthier and happier you can be.

So the next time someone asks how you're doing, you can say "I'm doing well." And you'll mean it.

Get started: www.mindchecktoday.com. Register using your own password.

Talkspace

Available to all regardless of enrollment in the medical plan

In collaboration with our Employee Assistance Program, AETNA Resources For Living, we offer messaging-based emotional health counseling and support for everyday emotional wellness needs like relationship issues and workplace stress. It also assists with diagnosed conditions such as: **Depression, Anxiety, PTSD, and Substance use disorders.**

With this feature, you can message dedicated therapist by text, audio, or video through a proprietary app. You can message as often as you wish, anytime of the day or night, seven days a week. The therapist engages daily, five days per week and chooses the days based on their schedule, not simply Monday through Friday.

Message-based counseling is not appointment-based. Communications and scheduling are flexible. This eliminates a significant barrier that prevents people from accessing behavioral care: scheduling and commuting to a recurring therapy appointment. This is an ideal behavioral solution for associates commuting across the country, internationally, and across time zones.

How message-based counseling works

You take a brief automated online assessment (less than two minutes). A matching algorithm considers state licensure requirements, provider availability and area of expertise and provides three potential therapists. You determine who you want to work with by reviewing the provider profile. This includes:

- Therapist video
- Licensure/credentials
- Reviews from other members
- Availability/schedule
- Education/experience
- Background
- History on Talkspace

After selecting a therapist, the app creates a private and secure digital therapy room for you and therapist. Only both can access the room and the therapy transcript (except for emergency situations). A 10-minute introductory video is included to build the therapeutic relationship and to address any user or technical questions directly.

Generally, you may begin your therapy journey the same day both decide it may be beneficial. A weeks' worth of chat equals one face to face visit. Based on your needs, goals, objectives, and methods for achieving those goals, you and therapist develop a treatment plan known as the "therapy journey."

Network

The network includes over 5,000 licensed, credentialed providers throughout the U.S. with training on how to effectively communicate in a messaging-based environment. Each holds a masters-level or higher certification, and is experienced, licensed and insured. Ongoing quality review of de-identified data ensures quality care.

The app is completely confidential, HIPAA compliant, secure and clinically proven. You can access the app on your smartphone, computer or tablet. **Get started:** talkspace.com/rfl

1. Provide basic demographic and Employer information
2. Complete brief intake to view best therapist matches
3. Select a therapist and schedule an (optional) complimentary 10-minute introductory video session to learn more about the provider and therapy
4. Create a Talkspace account and download the app for easy future access

Occupational Coverage

Business Travel Accident & Foreign Voluntary WC

Your safety and security are very important to us, especially while you are traveling on Company business. With that in mind, we are pleased to provide coverage for Business Travel Accident (BTA) and Foreign Voluntary Workers Compensation.

As part of these coverages, you are also provided with travel assistance services from AIG Travel. Services available to you include:

- **Travel Security Assistance**
- **Travel Medical Assistance**
- **Concierge Services**

Benefit Highlights

This is a summary of benefits. It is not a legal document and does not imply a guarantee of benefits. While this summary may answer most of your questions, the insurance policy contains full coverage details. Whenever an interpretation of a benefit coverage is necessary, we will use the actual insurance policy.

Multi-National Business Travel Accident (BTA)

BTA insurance coverage can be utilized in the event you experience any travel inconveniences, security issues, or medical emergencies incurred outside of the course of employment while traveling anywhere in the world. Key Business Travel Insurance Policy Benefits (not all inclusive):

- **Accidental Death & Dismemberment** - including paralysis benefits
- **Emergency Medical Evacuation**
  - Benefit to bring one person (chosen by the insured) to and from the hospital or other medical facility where the Insured Person is confined if the Insured Person is alone. (Limit is cost of one round-trip economy airfare ticket) and must be at least 50 miles from home).
  - Benefit to pay for the return of children who were accompanying the associate (limit is cost of a single one-way economy airfare ticket).
- **Repatriation of Remains**
  - Pays covered expenses up to policy maximum to return the insured's body home if life is lost due to injury or emergency sickness while at least 50 miles from home.
- **Security Evacuation with Natural Disaster**
  - Pays eligible expenses up to the policy maximum to take the insured person to the nearest place of safety (determined by a designated security consultant).
- **Out-of-Country Medical**
  - Helps pay covered medical services incurred by the insured person during the course of any trip outside their country of permanent residence and while traveling on business. Trip length must be less than 180 days.
  - Hospital Admission Guarantee Charge/Medical Expense Guarantee Charge - $10,000 limit.

Who is covered under this policy?

- Coverage is provided to all associates, while travelling on business for Helen of Troy.
- Spouse and Dependent Children are covered while traveling with the associate at the direction and expense of Helen of Troy.

When are you covered?

- When traveling on business including 14 days (before or after) of personal deviation / sojourn travel both domestic and international
- 24-hour protection in the event of an injury or illness during the course of a trip
- Coverage as the result of declared or undeclared war – excluding the United States or the persons country of permanent residence (Travel to Iraq & Afghanistan must be reported prior).
- Dependents are covered when traveling as part of a Family relocations trip or a trip paid for by Helen of Troy.

Restrictions and limitations

- This insurance coverage acts as a backstop to the local policies and can, in some cases, cover claims not covered locally when:
  - Local policy limits have been exhausted (differences in limits "DIL")
  - Claim not covered by local policy terms & conditions (Difference in Conditions "DIC")
- Benefits payable by the insurance carrier for medical-related claims under this policy are typically paid directly to the healthcare provider; however, in certain circumstances, it is possible that claim payment will be processed on a reimbursement arrangement to the claimant. Under these circumstances, payment by the insurance company will be made to Helen of Troy U.S. and in return reimbursed to the claimant. The reimbursement will be reduced by the required tax. This is also a requirement for any death-benefit proceeds.

Download the AIG Travel App to access coverage during your business travel.

AIG Travel App Download Instructions:

- Install the AIG Travel Assistance App from the Apple App Store or Android Play Store from your smartphone.
- Tap on "Register" and when you reach "Country where coverage was purchased," select "United States – Accident and Health."
- Input the required fields and Helen of Troy's master policy number 9156968. For the username (email address), we recommend using your Helen of Troy email address.

After completing registration you may also access the full website at www.aig.com/us/travelguardassistance and utilize existing login credentials.

Here also is a link to the app video tutorial, AIG Travel Assistance Mobile App video tutorial.

http://s7d2.scene7.com/is/content/aigassets/travelguard/america-canada/us-worldwide/videos/aig-travel-assistance-app-demo-v2-video-autox432-800k.mp4

Requesting a Visa Letter

Some countries require proof of travel medical insurance to cover any expenses that may arise; some may even require certain benefit limit requirements. While only certain countries require travel insurance for entry, we would recommend that you take a visa letter for all business travel outside of your home country. This would avoid having to unexpectedly purchase coverage.

Request a visa letter by emailing us the following information at gethealthy@helenoftroy.com:

- Passport number, destination, travel start date, and travel end date.

Foreign Voluntary Workers Compensation (FVWC)

FVWC provides coverage due to bodily injury by accident/disease, arising out of and in the course of employment incurred outside of the associate's home country.

When are you covered?

Here are the most common situations where FVWC may apply:

- Short-term business travel for covered associates.
- Long-term assignment outside the United States for covered associates.
- Travel outside the country of origin (the US or another country) for covered employees.

Who is covered under this policy?

All associates are covered for injuries occurring during the course of work, including:

- **U.S. hires:** Individuals who travel outside the U.S. for business or who are assigned to work in another country. Foreign-based associates are sometimes referred to as “expats” or U.S. nationals.
- **Local nationals:** Associates who are hired and assigned to work in their home country (country of origin) are referred to as local nationals. For example, a citizen of the United Kingdom who is hired and assigned to work in the United Kingdom is considered a local national.
- **Third-country nationals:** Associates who are hired in their country of origin and assigned to work outside their home country are called third-country nationals (TCN). One example of a TCN is an associate hired in Australia and assigned to work in The Netherlands.
- **Expatriate (Ex-pats):** An individual temporarily or permanently residing in a country other than their native country.

Helen of Troy

2025 Rate Sheet

Medical, dental, and vision benefits for domestic partnership (Domestic Partner and/or Domestic Partner Child(ren)) are provided on an after-tax basis and subject to imputed tax liability unless proof of tax dependency or step-child status is provided using the Domestic Partner Tax Certification form.

Medical Premiums

BI WEEKLY CONTRIBUTIONS - NON-TOBACCO USER	PPO			CDHP		
	Annual Salary Under $25,000	Annual Salary $25,000 - $79,999	Annual Salary $80,000+	Annual Salary Under $25,000	Annual Salary $25,000 - $79,999	Annual Salary $80,000+
Associate Only	$40.94	$83.26	$92.94	$30.27	$61.57	$68.71
Associate + Spouse or Domestic Partner	$199.91	$249.90	$279.18	$147.82	$184.79	$206.44
Associate + Child(ren)**	$158.58	$193.39	$215.80	$117.26	$143.01	$159.57
Associate + Family**	$242.22	$281.26	$306.83	$182.69	$207.33	$226.16

BI WEEKLY CONTRIBUTIONS - TOBACCO USER	PPO			CDHP		
	Annual Salary Under $25,000	Annual Salary $25,000 - $79,999	Annual Salary $80,000+	Annual Salary Under $25,000	Annual Salary $25,000 - $79,999	Annual Salary $80,000+
Associate Only	$64.02	$106.34	$116.01	$53.35	$84.65	$91.79
Associate + Spouse or Domestic Partner	$222.98	$272.98	$302.26	$170.89	$207.87	$229.51
Associate + Child(ren)**	$181.65	$216.47	$238.87	$140.34	$166.09	$182.64
Associate + Family**	$265.30	$304.34	$329.91	$205.77	$230.40	$249.24

Dental Premiums

BI WEEKLY CONTRIBUTIONS	DENTAL PPO		
	Annual Salary Under $25,000	Annual Salary $25,000 - $79,999	Annual Salary $80,000+
Associate Only	$7.10	$9.19	$9.60
Associate + Spouse or Domestic Partner	$20.40	$25.89	$27.01
Associate + Child(ren)**	$18.37	$23.30	$24.32
Associate + Family**	$30.07	$37.27	$38.90

Vision Premiums (Superior Vision)

BI WEEKLY CONTRIBUTIONS	VISION
Associate Only	$3.67
Associate + Spouse or Domestic Partner	$6.98
Associate + Child(ren)**	$6.60
Associate + Family**	$11.02

Vision Premiums (VSP for Osprey)

BI WEEKLY CONTRIBUTIONS	VISION
Associate Only	$3.67
Associate + Spouse or Domestic Partner	$5.88
Associate + Child(ren)**	$6.00
Associate + Family**	$9.67

Life and AD&D Insurance

VOLUNTARY LIFE INSURANCE

Rates/$1,000 (monthly)

Age (As of January 1, 2025)	Associate	Age (As of January 1, 2025)	*Spouse or Domestic Partner
Under 29	$0.085	Under 29	$0.085
30-34	$0.094	30-34	$0.094
35-39	$0.122	35-39	$0.122
40-44	$0.188	40-44	$0.188
45-49	$0.329	45-49	$0.329
50-54	$0.536	50-54	$0.536
55-59	$0.846	55-59	$0.846
60-64	$0.978	60-64	$0.978
65-69	$2.369	65-69	$2.369
70+	$4.249	70+	$4.249

VOLUNTARY AD&D INSURANCE

Premium Rates – $1,000 (monthly)

Associate, Spouse/ Domestic Partner or Child(ren)**	$0.03

VOLUNTARY CHILD LIFE INSURANCE

Premium Rates – $1,000 (monthly)

Child(ren)**	$0.122

* Spouse or Domestic Partner rate is based on the associate's age for life and AD&D insurance

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:

$ _____ ÷ 1,000 = $ _____ x Age Based Rate = $ _____ x 12÷26 = $ _____

Benefit Elected — Monthly Premium — Biweekly Premium

**Includes Child(ren) of either the Associate and/or Domestic Partner

Helen of Troy 2025 Rate Sheet (continued)

Supplemental Accident Insurance

BI WEEKLY CONTRIBUTIONS	ACCIDENT INSURANCE
Associate Only	$3.11
Associate + Spouse or Domestic Partner	$4.80
Associate + Child(ren)**	$5.57
Associate + Family**	$7.42

Supplemental Critical Illness Insurance

	$5,000 LUMP SUM OF CRITICAL ILLNESS INSURANCE					
BI WEEKLY CONTRIBUTIONS	<29	30-39	40-49	50-59	60-69	70+
Associate Only	$0.72	$1.22	$2.70	$5.65	$11.98	$21.85
Associate + Spouse or Domestic Partner	$1.25	$2.01	$4.25	$8.82	$18.55	$33.62
Associate + Child(ren)**	$1.27	$1.78	$3.25	$6.21	$12.53	$22.41
Associate + Family**	$1.80	$2.56	$4.80	$9.37	$19.11	$34.18

	$10,000 LUMP SUM OF CRITICAL ILLNESS INSURANCE					
BI WEEKLY CONTRIBUTIONS	<29	30-39	40-49	50-59	60-69	70+
Associate Only	$1.43	$2.45	$5.40	$11.31	$23.95	$43.71
Associate + Spouse or Domestic Partner	$2.49	$4.02	$8.49	$17.63	$37.11	$67.25
Associate + Child(ren)**	$2.54	$3.55	$6.51	$12.42	$25.06	$44.82
Associate + Family**	$3.60	$5.12	$9.60	$18.74	$38.22	$68.35

Short-Term Disability Buy-Up Rates

SHORT-TERM DISABILITY BUY-UP COVERAGE
10% Buy-Up Premium Rate - $0.0334 (per $10 Of Weekly Pay)
20% Buy-Up Premium Rate - $0.0668 (per $10 Of Weekly Pay)

10% BUY-UP: TO CALCULATE HOW MUCH YOUR 10% STD BUY-UP COVERAGE WILL COST

$	÷ 52 =	$	÷ 10 =	$	x $0.0334 =	$	x 12÷26 =	$	
Annual Salary		Weekly Salary				Monthly Premium		Biweekly Premium	

Note: To obtain the Bi weekly cost, multiply the monthly premium cost by 12 and divide by 26.

20% BUY-UP: TO CALCULATE HOW MUCH YOUR 20% STD BUY-UP COVERAGE WILL COST

$	÷ 52 =	$	÷ 10 =	$	x $0.0668 =	$	x 12÷26 =	$	
Annual Salary		Weekly Salary				Monthly Premium		Biweekly Premium	

**Includes Child(ren) of either the Associate and/or Domestic Partner

Helen of Troy 2025 Rate Sheet (continued)

LegalShield Pre-paid Legal

BI WEEKLY CONTRIBUTIONS	PRE-PAID LEGAL
Associate Only	$7.27

Identity Protection

BI WEEKLY CONTRIBUTIONS	IDENTITY PROTECTION PRO	IDENTITY PROTECTION PRO PLUS
Associate Only	$3.67	$4.59
Associate + Spouse or Domestic Partner	$6.44	$8.28
Associate + Child(ren)**	$6.44	$8.28
Associate + Family**	$6.44	$8.28

**Includes Child(ren) of either the Associate and/or Domestic Partner

Glossary

Associate Contribution – The monthly amount you pay for your coverage.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service, typically after you meet your deductible. For instance, if your plan's allowed amount for an office visit is $100 and you've met your deductible (but haven't yet met your out-of-pocket maximum), your coinsurance payment of 20% would be $20. Your plan sponsor or employer would pay the rest of the allowed amount.

Consumer-Driven Health Plan (CDHP) – Plan option that provides choice, flexibility and control when it comes to spending money on healthcare. Preventive care is covered at 100% with in network providers, there are no copays, and all qualified associate-paid Medical expenses count toward your deductible and your out-of-pocket maximum.

Copay – The fixed amount, as determined by your plan, you pay for healthcare services received.

Deductible – The amount you owe for healthcare services before your health plan sponsor (employer) begins to pay its portion. For example, if your deductible is $1,750, your plan does not pay anything until you've met your $1,750 deductible for covered healthcare services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement sent by your plan carrier that explains which procedures and services were provided, how much they cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision. These statements are also posted on the carrier's website for your review.

Flexible Spending Accounts (FSAs) – An option that allows participants to set aside pre-tax dollars to pay for certain qualified expenses during a specific time period (usually a 12-month period). There are two types of FSAs: the Healthcare FSA and the Dependent Care FSA.

- **Healthcare FSA –** With the Healthcare FSA, participants can use their accounts to cover eligible Medical expenses such as copays, eye exams, prescriptions and more. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code. Please note that over-the-counter medications are not eligible for reimbursement without a doctor's prescription with the Healthcare FSA.
- **Dependent Care FSA –** A Dependent Care FSA helps to reimburse participants for eligible expenses associated with caring for a qualified dependent, such as a dependent younger than age 13 or another dependent that may be incapable of self-care. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Both accounts are "use it or lose it," meaning that funds not used by the end of the plan year will be lost. Some plans allow for a Grace Period or a rollover into the next plan year.

Health-Care Cost Transparency – Also known as Market Transparency or Medical Transparency. healthcare provider costs can vary widely, even within the same geographic area. To make it easier for you to get the most cost-effective healthcare products and services, online cost transparency tools, which are typically available through health insurance carriers, allow you to search an extensive national database
to compare costs for everything from prescription drugs and office visits to MRIs and major surgeries.

In-Network – In-network providers are doctors, hospitals and other providers that contract with your plan carrier to provide healthcare services at discounted rates.

Out-of-Network – Out-of-network providers are doctors, hospitals and other providers that are not contracted with your plan carrier. If you choose an out-of-network doctor, services will not be provided at a discounted rate.

Out-of-Pocket Maximum – The most you pay during a policy period (usually a 12-month period) before your health plan begins to pay 100% of the allowed amount. This limit does not include your premium, charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your health plan carrier to confirm what payments apply to the out-of-pocket maximum.

Over-the-Counter (OTC) Medications – Medications typically made available without a prescription.

Prescription Medications – Medications prescribed to you by a doctor. Cost of these medications is determined by their assigned tier: Generic, Preventive Generic, Preferred Brand or Non-Preferred Brand.

- Generic Drugs – Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding Preventive Generic or Preferred Brand versions. The color or flavor of a Generic medicine may be different, but the active ingredient is the same. Generic drugs are usually the most cost-effective version of any medication.
- Preventive Generic Drugs – Brand-name drugs on your provider's list of approved drugs. You can check online with your provider to see this list.
- Preferred Brand Drugs – Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- Non-Preferred Brand Drugs – Prescription medications used to treat complex, chronic and often costly conditions such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia. Because of the high cost of these specialty drugs, many insurers require that specific criteria be met before a drug is covered. These requirements often include:
- Performing a prior authorization to request coverage of the medication
- Having a specific disease that the drug is FDA-approved to treat
- Having a history of trying and failing cheaper medications
- Creating high out-of-pocket costs when purchasing medication
- Restricting what pharmacy can dispense these medications

Reasonable and Customary Allowance (R&C) – Also known as an eligible expense or the Usual and Customary (U&C). The amount your plan carrier will pay for a Medical service in a geographic region based on what providers in the area usually charge for the same or similar Medical service.

Step Therapy – The goal of a Step Therapy Program is to steer associates to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before a non-preferred brand medication is eligible for coverage without prior authorization.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, your plan carrier or plan sponsor will provide you with a clear and easy to follow summary of your benefits and plan coverage.

Important Contacts

Coverage	Contact
Medical	Aetna 888-416-2277 www.aetna.com Group #: 870588
CVS Health	888-792-3862 www.aetna.com
Dental	Aetna 888-416-2277 www.aetna.com Group #: 870588
Vision	Superior Vision 800-507-3800 www.superiorvision.com
Health Savings Account	Health Equity 866-346-5800 www.HealthEquity.com
Flexible Spending Accounts	Health Equity 855-428-0447 www.wageworks.com
Life and AD&D	Prudential Waiver of Premium & Life Claims Phone: 800-524-0542 Fax: 888-227-6764 grouplifeclaims@prudential.com Life Conversion Phone: 877-889-2070 Fax: 888-634-1118 Life Portability Phone: 800-778-3827 www.prudential.com/mybenefits Policy #: 72248
Disability	Prudential Disability Claims Phone: 800-842-1718 Fax: 877-889-4885 Disability Tax Questions Phone: 866-648-2225 www.prudential.com/mybenefits Policy #: 72248
Employee Assistance Program	Aetna Resources for Living 800-955-6422 www.resourcesforliving.com Username = helen of troy Password = eap
Travel Assistance	Cigna Secure Travel 888-226-4567 www.europassistance-usa.com
Voluntary Critical Illness and Voluntary Accident Insurance	MetLife 800-438-6388 www.metlife.com

Coverage	Contact
Telemedicine	Teladoc 800-835-2362 www.teladoc.com
Helen of Troy My Total Well-Being Center	1 Helen of Troy Plaza El Paso, TX 79912 833-211-2200 or extension 2200
Legal	LegalShield 888-807-0407 Email: membersupport@ legalshieldcorp.com Website: https://benefits.legalshield.com/ helenoftroy Group #: 302475
Identity Protection	Allstate 800-789-2720 www.myaip.com Client ID: 6200
Pet Insurance	Nationwide For Quotes & to Enroll, visit: https://benefits.petinsurance.com/ helenoftroy or Call: 877-738-7874 Associate Policy or Claim Questions Member Care: 800-540-2016
Fertility and Family Building Concierge	KindBody https://kindbody.com/activate- kindbody-benefit/ Access code: KINDHELEN
Retirement Planning and Investment Advice Services	Advice Services Captrust 800-967-9948 www.captrustadvice.com
Foreign Voluntary Workers Compensation	Policy Number: WS11007104 Toll-Free/Free Phone (within the U.S. or Canada), call 800-401-2678 Collect/Reverse Charge (outside the U.S.): + 1 (817) 826-7008 or within the U.S.
Multi-National Business Travel Accident	Policy Number: 9156968 Toll-Free/Free Phone (within the U.S.): 800-533-0699 Collect/Reverse Charge (outside the U.S.): + 1 (817) 826-7051
Discount Program	Perkspot 1-866-606-6057 helenoftroy.perkspot.com

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