STITCH FIX

Your life.

Your style.

Choose the benefits that meet your unique needs for next year.

What's new for 2024?

Critical Illness, Accident and Hospital Indemnity insurance — helping you cover necessary expenses • Pages 24 & 25

Find your fit

See how personas can help you decide • Page 2

Your life. Your style.

Your life and your style aren't like anyone else's. That's why you have the opportunity each year to choose the benefits that best meet your unique needs. Read through this guide and then it's time to go shopping for your 2024 benefits!

What's new for 2024?

We are introducing Critical Illness, Accident and Hospital Indemnity benefits, which can help cover unexpected costs related to a serious health event and can pay you for preventative care. Pages 24 & 25.

In this guide

Find your fit

No matter where you are in life's journey, you can shop for and purchase the benefits that best meet your needs for 2024. Do you see yourself in any of these descriptions? Look for these personas throughout this guide to help find your right fit.

Discovery

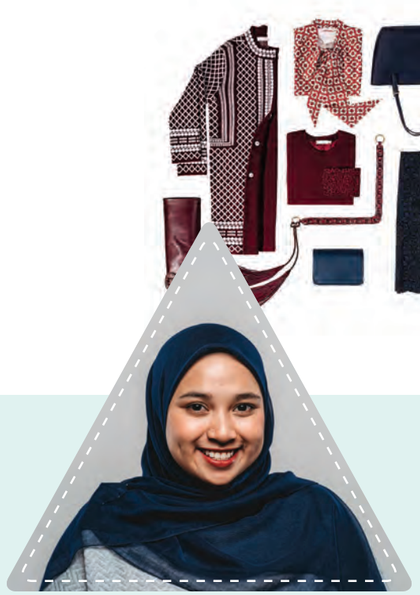
- Are you in your early career?
- Are you new to healthcare or transitioning off your parents' insurance?

The Discovery persona typically needs minimal care and wants to save more per paycheck, but still wants an annual wellness exam and the option to see a doctor occasionally.

Growth

- Are you mid-career?
- Are you thinking about starting a family or do you already have young children?
- Do you understand the basics of healthcare, but still find it confusing?

The Growth persona typically needs more ongoing care and is willing to invest in care to get the most out of their benefits.



Stability

- Are you mid-to-late career?
- Are you caring for kids and parents?
- Do you understand the basics of healthcare and typically choose the same plan year after year?

The Stability persona typically knows the level of care they need each year and have regular prescriptions, etc. They are willing to invest in care, but are also thinking about retirement.

Legacy

- Are you late-career?
- Are you thinking about retirement or transitioning to Medicare in the next 5-10 years?

The Legacy persona is typically stable, but additional care needs may be increasing. Controlling costs is becoming more important.

Eligibility and enrollment

Who can shop for benefits?

You are eligible for benefits if you are a full-time employee working 30 or more hours per week.*

You may also enroll other family members in your benefits coverage. When covering dependents, you must choose the same plans for your dependents as you select for yourself.

Eligible dependents include:

- Your legal spouse or qualified domestic partner.**
- Children under the age of 26; there are no limitations or prerequisites such as student or marital status.
- Children may continue coverage past age 26 if they are fully dependent on you for support due to a mental or physical disability, as indicated as such on your federal tax return.

The cost to you for dependent coverage will vary depending on the number of dependents you enroll in the plan and the particular plan you choose.

Returns not allowed (with a few exceptions)

Once you elect your benefits, they remain in effect for the entire plan year — January 1 through December 31, 2024.

You may change coverage during the plan year only if you experience a qualifying life event (QLE) and must take action in Workday within 30 days of the event date.

Qualifying life events include:

- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse or dependent child
- Adoption of or placement for adoption of your child
- Dependent gains or loses coverage through another source
- A significant change in your or your spouse's health coverage due to your spouse's employment
- Change of employment status by you or your spouse
- Qualification by the Plan Administrator of a Medical Child Support Order
- Loss of coverage under your parent's plan

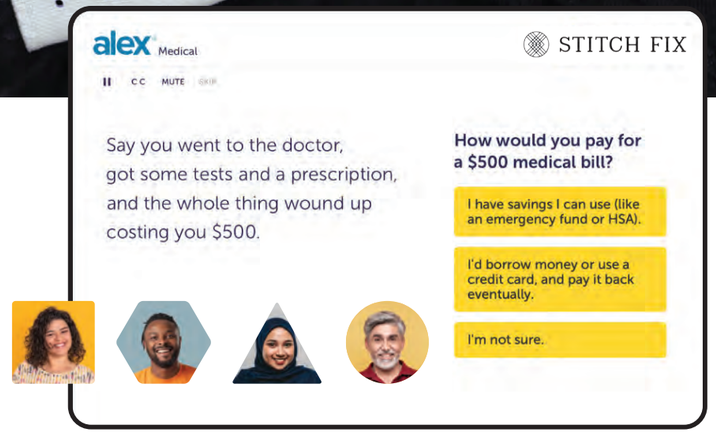
*Part-time employees working 20 or more hours per week are eligible for Carrot and Modern Health.

**If you elect to cover a domestic partner, you will pay income and Social Security tax on the portion of the insurance premium Stitch Fix contributes to your partner's coverage.

Choosing the right medical plan

When deciding which medical plan is the best fit for you and your family, it's important to consider the total cost of coverage. This includes what you pay in premiums, out of your paycheck, and what you pay for services.

While each medical plan covers in-network preventive screenings in full, the medical plans vary on annual deductibles, copays, and levels of coinsurance. This means you may pay more out-of-pocket costs with one plan versus another.



Scan or visit ALEX at start.myalex.com/stitchfix

Ask ALEX

ALEX®, the official Stitch Fix benefits counselor, helps you find the plan that fits you and your family the best, with easy-to-understand explanations for any questions you might have along the way.

You'll receive personalized, confidential benefits guidance, which you can access on any computer, tablet, or smartphone. Before you make your enrollment decisions, let ALEX help you find the plans that make the most sense for you.

Note: You must make changes in Workday to update your benefits. ALEX is a guide to help you make choices; it does not enroll for you.

Saves you time — Most users spend about 7 minutes with ALEX, but it really just depends on how much guidance you'd like. And ALEX can save your place, so you can leave and then pick up right where you left off.

Accessible — Use ALEX on your phone, tablet, or any device you've got.

Confidential — Your ALEX experience is totally private. It doesn't maintain personal info or submit it back to your employer (or anyone else), so it's completely anonymous.

Easy to get started — ALEX will ask you to estimate what type of medical care you might need this year (doctor visits, surgeries, ER visits, prescriptions, etc.), so you may want to tally those up and talk to your family about their needs, but ALEX can also help you come up with some estimates.

Making the best choice — ALEX takes the amount each plan would cost you out of your paycheck (your premium) and adds that to the amount it would cost for the services you said you might use. **Then Alex recommends the best plan for your needs**.

Make a list

Any good shopper knows a list can keep you on track – now and throughout the year. That's why we've started a list of to-dos for Open Enrollment and another for to-dos to keep in mind throughout the year. Feel free to add your own items to these lists.

For Open Enrollment

- Read through this guide and understand all of your options for 2024.
- Consider how you used your benefits in 2023 and whether you expect anything to change for next year.
- Ask ALEX for help understanding which medical plan might be the best choice for you. See page on the left for details.
- Contact the Benefits Concierge Team at 888-246-6680 or schedule a one-on-one appointment at employeeconnects.com/stitchfix.
- Watch for the personas throughout this guide to see if they offer insight into making good choices.
- Enroll for your 2024 benefits before the Open Enrollment deadline.
- Review your benefits in Workday to make sure your 2024 benefits are correct.
- Update your dependent's information, including social security, date of birth and address.

For 2024

- Check your first payroll stub of the year to ensure the correct amount has been deducted from your paycheck for your new benefits.
- Make appointments for your annual well checkup and physical exams for your children. Be sure you're up to date on vaccinations and cancer screenings.
- Make appointments for two dental cleanings during the year for all family members.
- Be sure your life insurance beneficiaries are up to date.
- Revisit the amount you're contributing to the 401(k) plan. If you can, increase that amount so you're saving for a more secure future.
- Be sure you designate a beneficiary for your 401(k) plan too!

Your medical plan options

Shop for the right plan to meet your needs, and you'll leave with something invaluable — the first step to living a healthy life.

HDHP

High deductible health plan (HDHP) with health savings account (HSA)

SEE PAGE 9

PPO

Preferred provider organization (PPO) plan

May be used with a Flexible Spending Account (FSA)

SEE PAGE 10

EPO

Exclusive provider organization (EPO) plan

May be used with a Flexible Spending Account (FSA)

SEE PAGE 11

Not available in all areas

LOCALPLUS

Cigna LocalPlus plan

May be used with a Flexible Spending Account (FSA)

SEE PAGE 12

Available in CA and GA only

HMO

Health maintenance organization (HMO) plan

May be used with a Flexible Spending Account (FSA)

SEE PAGE 13

Cigna

HDHP

High deductible health plan (HDHP) with health savings account (HSA)

The HDHP plan is a great option if your need for care is low. Per paycheck, the HDHP plan is the least expensive (FREE for employee-only coverage!), AND Stitch Fix contributes a generous amount to your HSA!

The HDHP may not be a the right fit if you visit the doctor frequently and don't have money set aside in a health savings account (HSA).

- ✅ Lower per-paycheck costs
- ✅ Free money from Stitch Fix into your HSA
- ✅ Larger networks for both in- and out-of-network coverage
- ⚠️ You have to pay the deductible before the plan begins to pay
- ⚠️ Though this plan is cheaper overall, it can feel unpredictable

	In-network	Out-of-network
Deductible		
Individual	$1,750	$3,000
Individual within family plan	$3,200	$4,500
Family	$3,500	$6,000
Out-of-pocket (OOP) maximum		
Individual	$3,200	$6,000
Individual within family plan	$3,200	$6,000
Family	$6,400	$12,000
Lifetime maximum	Unlimited	
Deductible counted toward OOP?	Yes	
Coinsurance / copays		
Preventive care	No charge	30%*
Primary care physician	10%*	30%*
Specialist	10%*	30%*
Diagnostics X-ray and lab	10%*	30%*
Urgent care	10%*	30%*
Emergency room	10%*	
Inpatient hospital care	10%*	30%*
Outpatient surgery	10%*	30%*
Pharmacy		
Retail Rx — up to 30-day supply		
Generic	$10*	Not covered
Preferred brand	$40*	
Non-preferred brand	$60*	
Specialty drugs	30% to a max of $100*	
Retail and Home Delivery Rx — up to a 90-day supply		
Generic	$20*	Not covered
Preferred brand	$80*	
Non-preferred brand	$120*	

*After deductible

Note: Female contraceptives and preventive medications are covered 100% in-network. All covered services are subject to medical necessity as determined by the plan. All out-of-network services are subject to Reasonable and Customary (R&C) limitations. This means you are responsible for all charges over this allowance.

This plan could be a good fit for:

Discovery

Stability

Your bi-weekly payroll deductions for this plan:

Employee only
$0.00

Employee + spouse/ domestic partner**
$118.70

Employee + child(ren)
$105.64

Employee + family
$168.11

** If you elect to cover a domestic partner, you will pay income and Social Security tax on the portion of the insurance premium Stitch Fix contributes to your partner's coverage.

PPO

Preferred provider organization (PPO) plan*

The PPO plan is the most predictable, but also the most expensive. It has fixed copays, like $20 when you see your primary care doctor. For things like MRIs or X-rays, you pay a percentage of the cost (coinsurance), until you meet your deductible.

This plan work well for anyone who may need a higher level of care, is having a baby or if you don't mind paying more each pay period for a broader network with predictable costs. Keep in mind that the most expensive option does not necessarily mean the best coverage for you.

- ✅ Better for those who have more medical expenses and who require regular treatment for health conditions
- ✅ More of your expenses are covered by insurance
- ✅ Choose any doctor or hospital
- ⚠️ Per-paycheck cost is the highest of all the plans

	In-network	Out-of-network
Deductible		
Individual	$500	$500
Family	$1,000	$1,000
Out-of-pocket (OOP) maximum		
Individual	$2,000	$3,000
Family	$4,000	$6,000
Lifetime maximum	Unlimited	
Coinsurance / copays		
Preventive care	No charge	30%**
Primary care physician	$20 copay	30%**
Specialist	$20 copay	30%**
Diagnostics X-ray and lab	10%**	30%**
Urgent care	$25 copay	30%**
Emergency room	10% after $100 copay	10% after $100 copay
Inpatient hospital care	10%**	30%**
Outpatient surgery	10%**	30%**
Pharmacy		
Retail Rx — up to 30-day supply		
Generic	$15	Not covered
Preferred brand	$30	
Non-preferred brand	$60	
Specialty drugs	30% to a max of $100	
Retail and Home Delivery Rx — up to a 90-day supply		
Generic	$30	Not covered
Preferred brand	$60	
Non-preferred brand	$120	

*Note: For Utah employees, the Cigna PPO utilizes the PPO network, and not the Open Access Plus (OAP) network.
**After deductible
All covered services are subject to medical necessity as determined by the plan. All out-of-network services are subject to Reasonable and Customary (R&C) limitations. This means you are responsible for all charges over this allowance.

This plan could be a good fit for:

Growth

Legacy

Your bi-weekly payroll deductions for this plan:

Employee only
$102.55

Employee + spouse/ domestic partner**
$300.07

Employee + child(ren)
$267.05

Employee + family
$424.99

** If you elect to cover a domestic partner, you will pay income and Social Security tax on the portion of the insurance premium Stitch Fix contributes to your partner's coverage.

EPO

Exclusive provider organization (EPO) plan

An EPO plan has all the benefits of a PPO like predictable costs and regular copays, but uses Cigna's national network of healthcare providers to choose from which means your per-paycheck cost is lower. This plan does not offer an out-of-network option, but uses a national network of providers. Take the time to ensure all of your providers and hospitals are in Cigna's Open Access Plus network.

- ✅ Premiums are less than a PPO, and you get all the benefits of simply copays/ easy-to-understand costs
- ✅ No deductible
- ✅ Finding new providers in-network is easy on the Cigna App
- ⚠️ Some of your existing providers may not be in the network
- ⚠️ Surgeries, diagnostic care, and hospital stays may require extra work on your part to ensure all of the providers are in-network

	In-network only
Deductible	
Individual	None
Family	
Out-of-pocket (OOP) maximum	
Individual	$1,500
Family	$3,000
Lifetime maximum	Unlimited
Coinsurance / copays	
Preventive care	No charge
Primary care physician	$20 copay
Specialist	$20 copay
Diagnostics X-ray and lab	No charge
Urgent care	$25 copay
Emergency room	$100 copay
Inpatient hospital care	No charge
Outpatient surgery	No charge
Pharmacy	
Retail Rx — up to 30-day supply	
Generic	$15
Preferred brand	$30
Non-preferred brand	$50
Specialty drugs	30% to a max of $100
Retail and Home Delivery Rx — up to a 90-day supply	
Generic	$30
Preferred brand	$60
Non-preferred brand	$100

All covered services are subject to medical necessity as determined by the plan.

This plan could be a good fit for:

Discovery

Stability

Legacy

Your bi-weekly payroll deductions for this plan:

Employee only
$40.85

Employee + spouse/domestic partner**
$170.74

Employee + child(ren)
$151.96

Employee + family
$241.82

**If you elect to cover a domestic partner, you will pay income and Social Security tax on the portion of the insurance premium Stitch Fix contributes to your partner's coverage.

Cigna

LocalPlus

Cigna LocalPlus

The LocalPlus plan is similar to the EPO plan — predictable costs, regular copays — but uses a smaller network of healthcare providers in your local area. It's the least expensive per paycheck of the plans. This plan does not offer an out-of-network option.

The LocalPlus plan is a great option if you are in the Discovery, Stability, or Legacy categories, because you can keep costs low if you stay in the network. Take the time to ensure all of your providers and hospitals are in Cigna's LocalPlus network.

- ✅ Per-paycheck cost is the least expensive plan with copays
- ✅ There is no deductible
- ✅ Finding new providers in-network is easy on the Cigna App
- ⚠️ Some of your existing providers may not be in the network
- ⚠️ If you are traveling out of your local area, your coverage is limited to emergency care
- ⚠️ Surgeries, diagnostic care, and hospital stays may require extra work on your part to ensure all of the providers are in-network

	In-network only
Deductible	
Individual	None
Family	
Out-of-pocket (OOP) maximum	
Individual	$1,500
Family	$3,000
Lifetime maximum	Unlimited
Coinsurance / copays	
Preventive care	No charge
Primary care physician	$20 copay
Specialist	$20 copay
Diagnostics X-ray and lab	No charge
Urgent care	$25 copay
Emergency room	$100 copay
Inpatient hospital care	No charge
Outpatient surgery	No charge
Pharmacy	
Retail Rx — up to 30-day supply	
Generic	$15
Preferred brand	$30
Non-preferred brand	$50
Specialty drugs	30% to a max of $100
Retail and Home Delivery Rx — up to a 90-day supply	
Generic	$30
Preferred brand	$60
Non-preferred brand	$100

All covered services are subject to medical necessity as determined by the plan.

This plan could be a good fit for:

Discovery

Stability

Legacy

Your bi-weekly payroll deductions for this plan:

Employee only
$31.30

Employee + spouse/domestic partner**
$130.85

Employee + child(ren)
$116.45

Employee + family
$185.32

**If you elect to cover a domestic partner, you will pay income and Social Security tax on the portion of the insurance premium Stitch Fix contributes to your partner's coverage.

KAISER PERMANENTE

HMO

Health maintenance organization (HMO) plan

Only available if you live in California or Georgia, the HMO covers procedures based on the particular laws in those states. You select your primary care physician, who coordinates your healthcare needs, including referrals and specialists. This plan does not offer an out-of-network option and relies on Kaiser providers in your local area.

- ✅ Per-paycheck costs are reasonable
- ✅ No deductible to meet!
- ✅ Your PCP takes care of referrals to specialists
- ⚠️ Plans are only available in California or Georgia
- ⚠️ State laws may govern your access to care
- ⚠️ If you are traveling out of your local area, your coverage is limited to urgent and emergency care

	In-network only
Deductible	
Individual	None
Family	
Out-of-pocket (OOP) maximum	
Individual	$1,500
Family	$3,000
Lifetime maximum	Unlimited
Coinsurance / copays	
Preventive care	No charge
Primary care physician	$20 copay
Specialist	$20 copay
Diagnostics X-ray and lab	No charge
Urgent care	$20 copay
Emergency room	$100 copay
Inpatient hospital care	No charge
Outpatient surgery	$20 copay
Pharmacy	
Retail Rx — up to 30-day supply	
Generic	$15
Preferred brand	$30
Non-preferred brand	$30
Specialty drugs	$30
Retail and Home Delivery Rx — up to a 90-day supply (Kaiser GA)/up to 100-day supply (Kaiser CA)	
Generic	$30
Preferred brand	$60
Non-preferred brand	$100

All covered services are subject to medical necessity as determined by the plan.

This plan could be a good fit for:

Discovery

Growth

Stability

Legacy

Your bi-weekly payroll deductions for this plan: California	**Your bi-weekly payroll deductions for this plan:** Georgia
Employee only $34.72	**Employee only** $31.02
Employee + spouse/domestic partner** $152.77	**Employee + spouse/domestic partner**** $136.46
Employee + child(ren) $138.88	**Employee + child(ren)** $124.05
Employee + family $208.32	**Employee + family** $186.09

**If you elect to cover a domestic partner, you will pay income and Social Security tax on the portion of the insurance premium Stitch Fix contributes to your partner's coverage.

Check out these amazing medical plan accessories

Resources for Cigna plan participants

Transgender benefits

Cigna understands the challenges that transgender or gender nonconforming people face. That's why they have placed extra emphasis on training their teams and creating programs to meet your unique needs.

my.cigna.com

Take control of your health

Cigna offers free monthly seminars on eating disorders, substance abuse, and behavioral health awareness for children and families.

my.cigna.com

Cigna One Guide

Your Cigna One Guide® team is ready to answer all your health plan questions, and so much more.

800-CIGNA24
cigna.com/guideme

MDLIVE virtual visits

Get minor medical care, schedule mental health appointments, and have prescriptions sent directly to your local pharmacy.

my.cigna.com

Our whole-person approach

Behavioral experts are standing by to help address the challenges of autism spectrum disorder, child/adolescent mood and anxiety disorders, eating disorders, substance use, and more.

my.cigna.com

Conception benefits

All employees and their spouses or partners are eligible to access services including lab and radiology tests, artificial insemination, in vitro fertilization (IVF), and more.

my.cigna.com

Virtual care for chronic conditions

Lose weight, manage diabetes, and lower blood pressure with Omada Health— a personalized, one-on-one coaching program.

omadahealth.com/stitchfix

Resources for Kaiser plan participants

Virtual visits

The next time you schedule an appointment at Kaiser Permanente, you may be offered a video visit with your doctor, which can save you time and travel expenses.

kp.org/mydoctor/videovisits

Calm

Calm uses meditation and mindfulness to help lower stress, reduce anxiety, and improve sleep quality. Listen to guided meditations taught by world-renowned experts, sleep stories narrated by celebrities, mindful movement videos, and more.

kp.org/selfcareapps

Healthy lifestyle programs

Take an active role in your health with customized online programs designed to help you live healthier. Take a total health assessment and you'll get a customized plan to help you make healthy lifestyle changes. The programs take 20 minutes to complete, and you can do so at your own pace. (Also available in Spanish.)

kp.org/healthylifestyles

Get emotional support 24/7

Kaiser is collaborating with Ginger to help you cope with some of life's most common challenges like managing stress and relationships. Ginger's highly trained emotional support coaches are there when you need it.

ginger.com

Medical care while you're away from home

If something unexpected happens while you're away from home, it's easier than ever to get medical advice 24/7, access care by phone or video, and email non-urgent questions to your doctor's office.

Away from Home Travel Line:
951-268-3900 (TTY 711)

kp.org/travel

When it's time to check out

For those enrolled in the HDHP medical plan:

Use a health savings account (HSA) to pay for eligible expenses. HSAs and HDHP plans go hand in hand. Stitch Fix will automatically enroll you in a health savings account with Health Equity if you select the HDHP medical plan and put money in the account for you to keep and spend on eligible medical expenses! An HSA makes it easy to pay for current medical, dental, and vision costs and save for future needs now or into retirement.

The benefits of an HSA

HSAs give you a triple tax advantage:

1. Set aside tax-free* money.
2. Pay for eligible expenses tax-free.*
3. Unused funds roll over year-to-year, and any amount over $1,000 can be invested. All earnings are tax-free.*

The funds in your HSA are yours to keep, even if you leave the company.

How it works:

In 2024, you can contribute up to:
- Employee only: $3,400
- Employee + dependents: $6,800

Stitch Fix will automatically contribute:
- Employee only: $750
- Employee + dependents: $1,500

Your max contributions for 2024:
- Employee only: $4,150
- Employee + dependents: $8,300

Age 55+ catch-up contribution:
- Additional $1,000

It's easy to spend your HSA funds!
HealthEquity will send you an HSA debit card to pay for eligible expenses.

Learn more at healthequity.com

HSA contributions

When you open an HSA, Stitch Fix will automatically contribute to your HSA. Company contributions are disbursed quarterly and are prorated based on your effective date.

Keep in mind, there are a few important rules you need to follow. If you use your HSA funds for expenses the IRS considers eligible, the money remains tax-free.* If you use funds for ineligible expenses, you will pay applicable taxes and an excise tax penalty (currently 20%).

The fine print
- You must be enrolled in a qualified high deductible health plan (HDHP).
- Funds in your HSA are available to spend after they have been deposited to your account through Payroll or Stitch Fix contributions.
- You cannot be covered under another non-qualified health plan, including your spouse's Healthcare Flexible Spending Account (FSA).
- You cannot be enrolled in Medicare or TRICARE.
- You cannot be claimed as a dependent on someone else's tax return.
- Refer to IRS Publication 969 for complete rules.

*State taxes may still apply in California and New Jersey. For detailed tax implications of an HSA, please contact your professional tax advisor.

For those who would like tax-advantaged accounts:

Use Flexible Spending Accounts (FSAs).

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax dollars to pay for eligible health and dependent care expenses.

There are three types of FSAs:

1. **Healthcare FSA**
   For those enrolled in the PPO, EPO, LocalPlus, or HMO plans.
2. **Dependent Care FSA**
   Available to anyone and their spouse if working full-time.
3. **Limited Purpose FSA**
   Only for those enrolled in the HDHP medical plan.

The fine print:
- Healthcare and Limited Purpose FSA funds are available to spend the first day of the plan year or after new hire enrollment. Funds are repaid throughout the year through payroll deductions.
- Dependent Care FSA funds are available to spend after they have been deposited to your account through Payroll contributions.
- All expenses for the Healthcare and Dependent Care Flexible Spending Accounts must be incurred during January 1 through December 31, and you have 90 days after the plan year ends to submit claims.
- At the end of the calendar year, participants can roll over up to $640 of unused FSA funds to the following year. Any remaining funds above this amount will be forfeited. Rollover is not available to participants in the Dependent Care FSA.
- Once you enroll in the FSA, you can only change your contribution amount if you experience a qualifying life event.
- You cannot transfer funds from one FSA to another.

How it works:

You estimate how much you'll spend on eligible expenses in the coming year and elect to have that amount deducted from your pay on a pre-tax basis. Each year, you must elect the annual amount you want to contribute to each account.

In 2024, you can contribute up to:
- Healthcare FSA: $3,200
- Dependent Care FSA: $5,000
- Limited Purpose FSA: $3,200

Navia will send you an FSA debit card to pay for eligible expenses.

Manage your FSA at naviabenefits.com

Eligible expenses

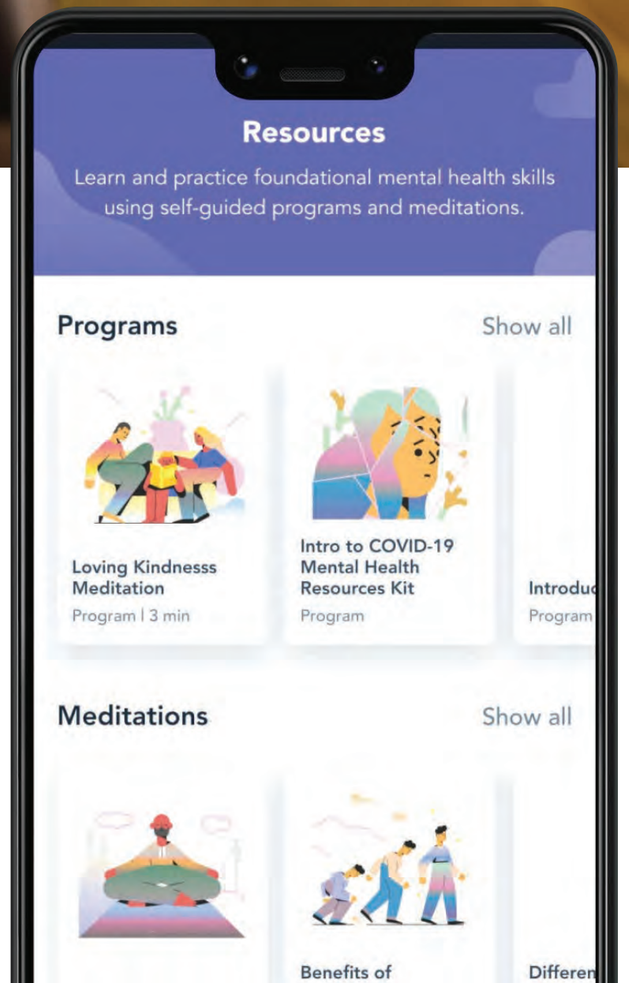
Healthcare FSA
- Healthcare expenses, such as deductibles, copays, and prescriptions
- Eyeglasses or contact lenses
- LASIK surgery
- Orthodontia

Dependent Care FSA
- Dependent care expenses for a child under 13
- Private day care providers and nannies
- Licensed care for disabled dependents
- Care for an elderly parent who is dependent on you

Limited Purpose FSA
- Eyeglasses or contact lenses
- Dental or vision copays
- Orthodontia

For a complete list of eligible expenses, visit irs.gov/publications and find Publication 969.

Mental health, tailored to you.



Welcome to your resource for mental health and wellbeing! The Modern Health platform connects you to all kinds of resources to help you with all kinds of stressors.

You and your eligible dependents can take advantage of:

8 private coaching sessions through in-app video calls and unlimited texting with your selected coaches

8 therapy sessions in person or virtual, as needed

24/7 access to a digital library of programs and guided meditations

Learn more at modernhealth.com

EAP/Work-Life Services

Everyone needs a little help from time to time. You may be surprised to learn that Modern Health will support you in a wide range of personal issues or services, including the following:

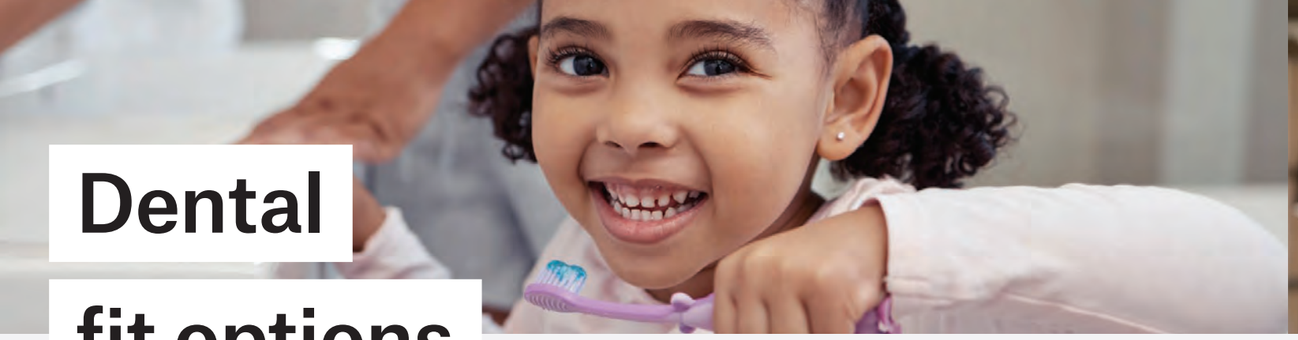
Daily living services
Need help with household repairs? Planning an event or vacation? Modern Health will confirm availability, services, and prices for businesses/consultants so you can make an easy informed decision.

Child care, tutoring, and elder care assistance
Finding the right resources for a child or an older adult can be a challenge. Modern Health will help you find what kind of help you need caring for children or elders in your life by giving you names and numbers of providers in your area.

Legal services
Talk to a professional over the phone or face-to-face about civil, consumer, and criminal law; personal and family law, including adoption, divorce, and custody issues; real estate; and estate planning.

Financial services
Talk to an advisor about budgeting, credit and financial questions (investment advice, loans, etc.), and retirement planning.

Identity theft recovery services
Modern Health will give you information on ID theft prevention. If your identity is stolen, you will be connected to a fraud resolution specialist who can help.



Dental fit options

Add dental coverage to your list of essential must-haves since dental care is an important part of your overall health. Our dental plans help keep your smile healthy through regular preventive dental care and offers coverage to fix problems as soon as they occur. Review your dental plan options to determine which plan is best for you and your family.

PPO dental plan

With the PPO dental plan, you may visit any dentist of your choice. Keep in mind, you'll get the best price and receive the highest coverage when you use an in-network provider. If you visit an out-of-network provider, you will not benefit from discounted rates and will pay more out-of-pocket for services.

	PPO basic plan		PPO enhanced plan	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Deductible				
Individual	$100	$200	$50	
Family	$300	$600	$150	
Annual maximum	$1,500	$1,500	$2,500	
Diagnostic and preventive care (e.g., cleanings, fluoride treatments, sealants, and X-rays)	0%		0%	
Basic services (e.g., fillings, periodontics, scaling and root planing, and oral surgery)	20% after deductible	40% after deductible	10% after deductible	20% after deductible
Major services (e.g., crowns, bridges, and full and partial dentures)	50% after deductible		40% after deductible	50% after deductible
Orthodontia				
Coverage	Child(ren) up to age 19 only; **no adult coverage**		Adult(s) and child(ren)	
	50%		50%	
Lifetime maximum	$1,500		$2,500	

For services provided by an out-of-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 90th percentile of all provider-allowed amounts in the geographic area. The dentist may balance bill up to their usual fees.

Your bi-weekly payroll deductions for this plan:	**PPO basic**	**PPO enhanced**
Employee only	$1.65	$6.36
Employee + spouse/domestic partner**	$6.60	$21.18
Employee + child(ren)	$7.42	$23.83
Employee + family	$10.72	$34.42

**If you elect to cover a domestic partner, you will pay income and Social Security tax on the portion of the insurance premium Stitch Fix contributes to your partner's coverage.

Dental and vision plans do not issue physical ID cards.
Your provider can verify your eligibility using your name and personal information such as Social Security number or date of birth and our group number.

Vision fit options

The eyes have it! Keep your vision clear and your eyes in good health with regular eye exams. To help you manage your health, we offer vision coverage through VSP. Under this plan, you may use the eye care professional of your choice. However, when you use a participating VSP provider, you get the best price, receive higher levels of coverage, and enjoy the best discount on your fashionable eyewear.

	VSP Choice network — basic plan	VSP Choice network — enhanced plan
Copays	**In-network**	**In-network**
Vision exam	$0 copay	$0 copay
Vision materials	$25 copay	$0 copay
Benefit frequency		
Exams	Once per 12 months	Once per 12 months
Lenses	Once per 24 months	Once per 12 months
Frames	Once per 24 months	Once per 12 months
Contacts	0%	0%
Covered services		
Frames	$150 allowance for a wide selection of frames; 20% savings on the amount over your allowance	$200 allowance for a wide selection of frames; 20% savings on the amount over your allowance
Lenses (single vision, lined bifocal, and lined trifocal)	Included in prescription glasses Anti-reflective coating $30 copay	Included in prescription glasses Anti-reflective coating $30 copay
Contacts (instead of glasses)	$150 allowance Up to $60 copay fitting and evaluation	$200 allowance Up to $60 copay fitting and evaluation
Contacts (medically necessary)	$25 copay	$0 copay

Your bi-weekly payroll deductions for this plan:	**VSP basic**	**VSP enhanced**
Employee only	$0.42	$0.52
Employee + spouse/domestic partner**	$1.43	$1.87
Employee + child(ren)	$1.46	$1.91
Employee + family	$2.35	$3.08

**If you elect to cover a domestic partner, you will pay income and Social Security tax on the portion of the insurance premium Stitch Fix contributes to your partner's coverage.

LightCare members without a need for prescription eyewear can use their LightCare benefit to purchase ready-made, non-prescription, blue light-filtering glasses or ready-made, non-prescription sunglasses. When selecting this option, both the frame and lens benefits will be exhausted.

Walmart and Sam's Club special pricing and discounts: In addition to other retail chain partners like Costco or Visionworks, Walmart and Sam's Club will now be available. Please inquire directly at your local Walmart or Sam's Club for more details.

Standard progressive: All standard progressive lenses ("K" category progressives) will be covered in full. Additionally, Ethos, a new digital progressive lens that leverages new technology for better precision and a faster adjustment period, will also be included.

Plan for the unexpected

Monthly expenses such as mortgage payments, food costs, and utilities continue even if you are unable to work. **That's why Stitch Fix automatically enrolls you in disability coverage and at NO COST to you!**

If you experience an injury or illness that prevents you from working, disability coverage provides partial income replacement to assist you financially. Start by learning more about leaves and the programs that will assist you financially.

LeaveLogic is a confidential leave planning tool that makes it easier for you to plan, take, and return from a leave of absence. Start planning your leave of absence at stitchfix.leavelogic.com.

Need extended time away?

Consider a leave of absence.

Start planning your leave with LeaveLogic and find all the information you need in an easy, confidential LeavePlan just for you. With LeaveLogic, you can navigate your leave benefits, plan a full leave scenario, and get step-by-step guidance for what's next.

Whether you're planning time off or looking to understand your options, start your leave journey now with personalized support and confidential answers to your biggest leave questions.

Short-Term Disability (STD)

Stitch Fix provides **FREE** income replacement when you need it the most! Short-Term Disability (STD) provides you with a portion of your income if you are unable to work due to a non-occupational illness or injury. STD benefits may be offset by benefits you receive from state-mandated disability plans in California, Connecticut, Massachusetts, New Jersey, New York, Rhode Island, or the Commonwealth of Puerto Rico.

STD percent of earnings	66 2/3%
Weekly maximum	$3,500
Elimination period	7 days
Maximum duration	12 weeks

Long-Term Disability (LTD)

For extended injuries and illnesses beyond the period of short-term disability, Stitch Fix still provides **FREE** income replacement. Long-Term Disability pays you a portion of your earnings if you cannot work for an extended time due to a disabling illness or injury.

LTD percent of earnings	66 2/3%
Monthly maximum	$15,000
Elimination period	90 days
Maximum duration	To age 65

Plan your future fit

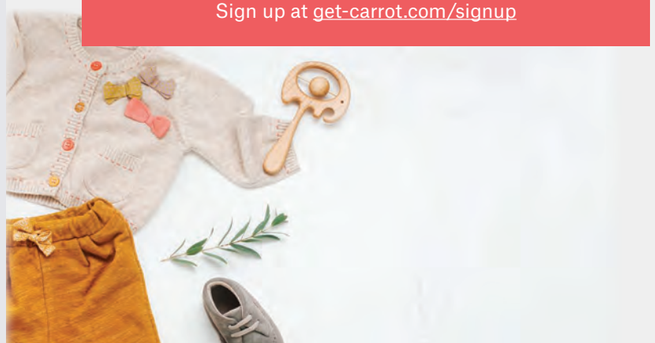
Every family is different, so your family-forming benefits should be unique to you as well. Whether you need adoption services, surrogacy, freezing and storage of eggs or embryos, or just an expert to walk you through your options and processes, Carrot is your resource.

Carrot provides:

- Educational content to help you understand your options.
- Video tutorials for common procedures like injections
- Help locating the right clinic for you
- Access to Carrot experts who can answer your questions
- And much more

You also have access to Carrot Pregnancy, which offers virtual access to doctors, doulas, and midwives, and emotional wellbeing experts to help you stay healthy throughout pregnancy and prepare for labor and delivery.

Sign up at get-carrot.com/signup



Your Stitch Fix Carrot coverage

Coverage for all

All employees and their partners and spouses are eligible to use the funds regardless of sexual orientation, gender identification, marital status, race, or age, up to a lifetime benefit maximum of $5,000.

Types of covered services*

- Initial fertility consultation
- Baseline fertility screening
- Semen analysis
- Lab tests and diagnostics
- Egg harvesting/cycle
- Sperm freezing
- Egg/embryo freezing
- In-vitro fertilization (IVF)
- Intrauterine insemination (IUI)
- Donor sperm acquisition
- Donor egg acquisition
- Storage
- Shipping and transport of materials
- Adoption agency services
- Cancer and fertility
- Diabetes and fertility
- Genetic testing of embryos
- Menopause support
- Low testosterone support

*Reimbursement does not require a medical diagnosis of infertility. However, services must be provided at a reproductive endocrinology clinic. Eligible clinics can be located on the Carrot online platform.

New for 2024!

Unexpected medical expenses? We got you covered.

New for 2024, **Critical Illness, Accident and Hospital Indemnity insurance** can help cover unexpected medical and non-medical costs if you or a loved one has a serious health event. These plans are not medical insurance; rather, they supplement what your medical insurance covers by providing you a lump-sum, cash benefit in the case of a covered illness, accident, or hospitalization.

Choose one, two or all three of these plans – whatever fits you best.

Critical Illness Insurance

This insurance provides a fixed, lump-sum benefit if a critical illness strikes – including heart attack, stroke, paralysis and more. You may choose:

Employee Coverage Amounts	Choose $10,000, $20,000 or $30,000
Dependent Coverage	• Spouse: Choose $10,000, $20,000, $30,000 up to 100% of the employee amount • Children receive 50% of the employee amount
Wellness screening	$50 per calendar year

You will be paid a percentage of the amount of coverage you choose, depending on your diagnosis. For example, if you're diagnosed with cancer, heart attack, stroke, Parkinson's Disease, or major organ failure, you will receive 100% of the benefit amount. However, you would receive 5% for skin cancer or 50% for Coronary Artery disease.

These benefits are paid directly to you and can be used for any reason, including:

- Medical deductibles
- Prescriptions
- Transportation
- Childcare
- Living expenses

Your premium is based on your age and the amount of coverage you choose. Your per-paycheck amount will be shown when you enroll in Workday. For a complete listing of illnesses, benefits and premiums, see the plan document.

Accident Insurance

No one likes to think about the possibility of an accident, but the likelihood — as well as the havoc it can cause for families — is very real. Whether it's an automobile accident, sports injury or the inevitable slip-and-fall, an accident can bring about not only lifestyle challenges but tangible economic ones as well.

Here are some examples showing the benefit amount you would receive if you experience any of these things below as a result of a covered accident:

Fracture	Up to $5,000 (non-surgical)/ $10,000 (surgical repair)
Burns	$1,280-$10,240, depending on the severity
Emergency treatment	$165
Hospital admission	$1,025 per admission
ICU Hospital Admission	$1,550
Ground ambulance	$410
Physical therapy	$52.50 per session, up to 12 session
Wellness screening	$50 per calendar year

See the plan document for more details.

Your bi-weekly payroll deductions for this plan:

Employee only	$2.96
Employee + spouse/domestic partner	$5.03
Employee + child(ren)	$6.02
Employee + family	$8.12

Hospital Indemnity Insurance

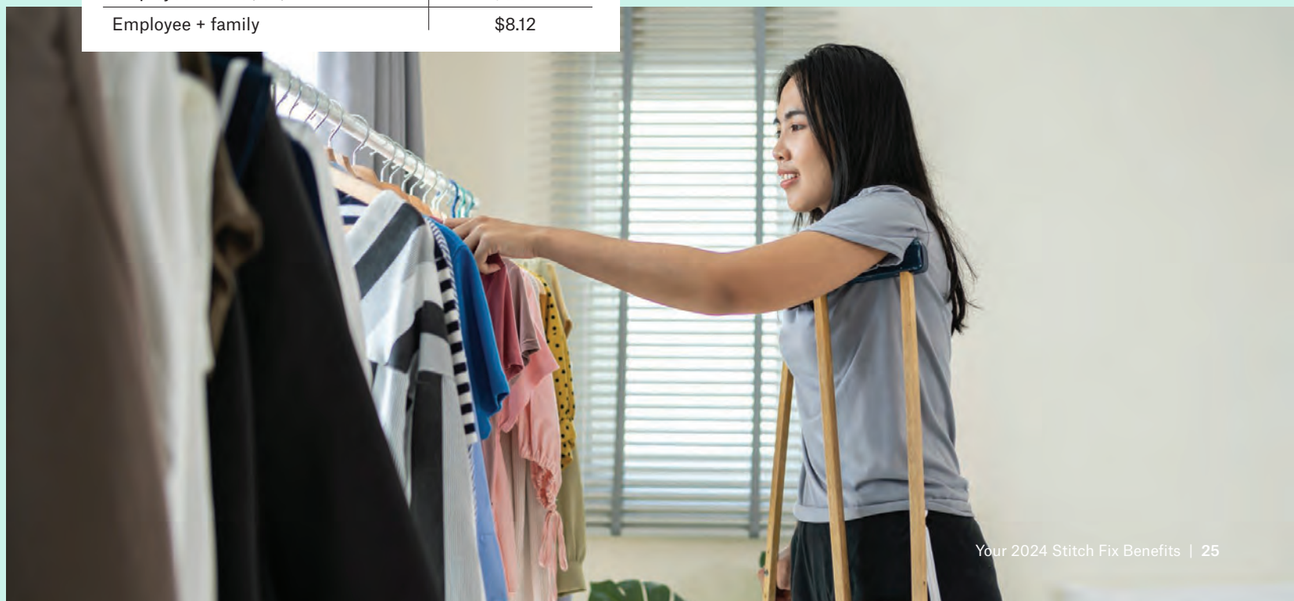
The Hospital Indemnity Plan pays a daily benefit if you have a covered stay in a hospital or critical care unit. The benefit amount is determined based on the type of facility and the number of days you stay.

Hospital admission	$1,100 per admission (4 per calendar year)
ICU admission (if in addition to hospital admission)	$2,000 per admission (1 per calendar year)
Daily hospital confinement	$110 per day, to a maximum of 365 days per calendar year
Hospital intensive care unit confinement	$210 per day, to a maximum of 365 days per calendar year
Wellness screening	$50 per calendar year

See the plan document for more details.

Your bi-weekly payroll deductions for this plan:

Employee only	$7.58
Employee + spouse/domestic partner	$12.65
Employee + child(ren)	$10.89
Employee + family	$15.84



Take it on the road

Commuter benefits

Employees can use pre-tax dollars to pay for parking or public transportation expenses while commuting to work. Participation in the commuter benefits program is voluntary and on a month-to-month basis.

Transportation or public transit

- Use for: Monthly passes, tokens, fare cards/vouchers (transit and vanpool expenses).
- Contributions: $280 monthly maximum

Parking

- Use for: Fees associated with parking at or near your place of work or parking near public transportation (parking at a bus or subway station).
- Contributions $315 monthly maximum*

Place or cancel your monthly order by the 20th of the current month for use in the following calendar month.

Please note that transit costs are not eligible for reimbursement via claim. You will need to either request a Navia debit card or request that Navia load your money directly onto your eligible transit agency card.

Enroll at naviabenefits.com

*This guide was published prior to IRS announcement. Check irs.gov for actual contribution rates.

Business travel benefits

AIG Business Travel Accident (BTA)
The AIG Business Travel Accident (BTA) plan is **paid 100% by Stitch Fix**. For both domestic and international business travel, the BTA plan provides:

- Accident coverage
- 24/7 Lost/stolen baggage assistance
- 24/7 Lost passport/travel documents assistance
- 24/7 Identity theft assistance
- 24/7 Security assistance

Keep track of your 401(k)
Charles Schwab phone:
800-724-7526
Website:
workplace.schwab.com

Smart splurges for the future

401(k) retirement plan

Preparing for retirement is a part of smart financial planning. Stitch Fix provides a 401(k) plan through Charles Schwab to help you start saving now. Charles Schwab offers a variety of investment options to grow your earnings.

Eligibility
If you are 21 years of age or over, you are eligible to participate in the 401(k) plan on your date of hire and are eligible for the company match after one year of employment and 1,000 hours worked within your 12-month anniversary period.

When eligible, you may enroll in the 401(k) plan, designate beneficiaries, and allocate your asset distribution at any time. You do not need to wait for annual enrollment to make changes.

Personal contributions to your 401(k) are pre-tax and are added to your account conveniently through payroll deductions.

Advantages of a Roth 401(k)
Traditional 401(k) contributions are pre-tax, so you don't pay taxes until you withdraw the money in retirement.

Roth 401(k) distributions are post-tax, so you pay taxes during the year when you make contributions, but you don't pay taxes when you withdraw the funds in retirement. Funds grow tax-free in a Roth account.

While you may elect to make contributions to both a traditional 401(k) and a Roth 401(k), you may only contribute a combined total of $23,000 per year.

If you're age 50 or older, you can make "catch up" contributions up to $7,500 per year. You don't need to make a separate election to contribute additional "catch up" funds. Your contributions will simply continue until you meet the annual "catch up" limit.

Save for retirement like a pro

- Start saving as soon as possible.
- Begin with small contributions and increase contributions over time.
- Take advantage of the company match.
- Understand investment returns may fluctuate.
- Let it sit. Avoid penalties by leaving funds in your 401(k) until retirement.
- If you change jobs, you can roll over your retirement account.

Stitch Fix Matching
After one year of employment and 1,000 hours worked within 12 months, Stitch Fix will match 100% of your salary, up to 4%. Matching contributions are funded on a per-pay-period basis, vested immediately, and based on earnings each pay period.

Other perks

Find child care

All employees using Navia have a free resource called Kinside to assist with finding child care. Kinside is free for all Navia members and can be accessed both through your Navia account and on Kinside at kinside.com/navia — both using the Navia login.

- National database: National database can be filtered by program type, availability, area code, and more.
- Safety and quality: Access to full licensing and inspection reports for everyday care and preschool for maximum transparency.
- Online tuition payments: Easy payment portal enables you to pay the entirety of tuition online.
- Savings: Savings can include discounts of 5-20% on tuition, and waived application fees at thousands of centers across the U.S.

Discounts

Stitch Fix is happy to offer PerkSpot, a one-stop shop for exclusive discounts at many of your favorite national and local merchants!

PerkSpot is completely free!
Enjoy access to thousands of discounts in dozens of categories, updated daily.

Visit stitchfix.perkspot.com

Find the right protection, too

Stitch Fix provides FREE Life and AD&D insurance for the unexpected rainy day. With this important coverage, your loved ones can depend on you for financial security during the storm.

Life and Accidental Death and Dismemberment (AD&D) insurance

Life and Accidental Death and Dismemberment (AD&D) insurance provides financial security to you and your family if you pass away or become seriously injured.

Basic Life and AD&D insurance

Stitch Fix provides Basic Life and Basic AD&D insurance for FREE! You receive both Basic Life and Basic AD&D insurance equal to two times your annual earnings (rounded to the next higher $1,000) up to a maximum of $1,000,000.

When coverage exceeds $50,000, the value (as determined by the IRS) must be included as income and will be subject to Social Security and Medicare taxes, which may be reflected in your paycheck.

Supplemental Life and AD&D insurance

You may purchase Supplemental Life and AD&D coverage at discounted group rates. You must elect coverage for yourself in order to elect coverage for your spouse/domestic partner or child(ren).

How much Supplemental Life and AD&D insurance do I need? Consider this:

1. How much will your dependents need to pay debts, such as a mortgage, car loan, or credit card balances?
2. How much do your dependents need to maintain their current standard of living?
3. What kind of future would you like to provide for your dependents or others who depend on you for financial support?

Supplemental Life and AD&D options*

	Employee	Spouse/ domestic partner	Dependent child(ren) (live birth to age 26)
Coverage options	1, 2, or 3 times your annual salary	Increments of $5,000	Increments of $2,000
Maximum	$1,000,00	$600,000 (cannot exceed 50% of employee coverage)	$10,000
Guaranteed issue amount	$400,000	$20,000	
Guaranteed issue period	Within 30 days of benefits eligibility or a qualifying life event		

* Evidence of Insurability (EOI) may be required.

Supplemental Life and AD&D insurance premiums

Employee and spouse/domestic partner		Child(ren)
Cost per $1,000 of coverage		
Under age 24	$0.050	$0.1768
25–29	$0.045	
30–34	$0.071	
35–39	$0.090	
40–44	$0.100	
45–49	$0.150	
50–54	$0.230	
55–59	$0.345	
60–64	$0.586	
65–69	$0.908	
70–74	$1.674	
75 and older	$2.060	

AD&D premium	
Cost per $1,000 of coverage	
Employee	$0.021

Check out with the right price

To keep healthcare coverage affordable, Stitch Fix pays the majority of the medical, dental, and vision premiums for you and your dependents. Your bi-weekly payroll deductions for medical, dental, and vision coverage are shown below, taken from 26 pay periods:

Receipt

Choose your medical contributions	Cigna HDHP (w/HSA)	Cigna LocalPlus*	Cigna EPO	Cigna PPO	Kaiser HMO (CA only)	Kaiser HMO (GA only)
Employee only	$0.00	$31.30	$40.85	$102.55	$34.72	$31.02
Employee + spouse/domestic partner**	$118.70	$130.85	$170.74	$300.07	$152.77	$136.46
Employee + child(ren)	$105.64	$116.45	$151.96	$267.05	$138.88	$124.05
Employee + family	$168.11	$185.32	$241.82	$424.99	$208.32	$186.09

*LocalPlus is only available in select locations. Confirm availability in your area prior to enrolling.

Choose your dental contributions	PPO basic	PPO enhanced
Employee only	$1.65	$6.36
Employee + spouse/domestic partner**	$6.60	$21.18
Employee + child(ren)	$7.42	$23.83
Employee + family	$10.72	$34.42

Choose your vision contributions	VSP basic	VSP enhanced
Employee only	$0.42	$0.52
Employee + spouse/domestic partner**	$1.43	$1.87
Employee + child(ren)	$1.46	$1.91
Employee + family	$2.35	$3.08

Note: Contributions are per-pay-period (bi-weekly). Medical, dental, and vision contributions are deducted on a pre-tax basis.
**If you elect to cover a domestic partner, you will pay income and Social Security tax on the portion of the insurance premium Stitch Fix contributes to your partner's coverage.

Extras	
HSA, FSA, Dependent care, etc.	Your choice
Supplemental life & AD&D insurance	Your choice
401(k) contributions	Your choice
Critical Illness, Accident, or Hospital Indemnity insurance	Your choice
STD & LTD disability coverage	FREE!
Basic life and AD&D insurance	FREE!
Modern Health mental healthcare	FREE!
PerkSpot	FREE!

What's your total?

$ _____ (per pay period)

Have a question about your fit?

Stitch Fix Benefits Team

We're here to help you understand how your benefits work for you and/or your family. A benefits professional can answer questions about your medical, dental, vision, life/AD&D, disability benefits, critical illness, accident and hospital indemnity benefits, as well as claims and coverage questions.

Contact your Stitch Fix Benefits Team at
askbenefits@askus.stitchfix.com

You can also contact the benefits concierge at 888-246-6680 or schedule a 1:1 appointment at employeeconnects.com/stitchfix.

Please have the following available when contacting the benefits team:

- Your name and ID number listed on your insurance ID card
- Your dependent's name (if applicable)
- The date of service in question
- Your daytime phone number

Contacts

Benefit	Provider	Group/plan #	Phone	Website/email
Stitch Fix Benefits Team			415-882-7765	askbenefits@askus.stitchfix.com
Benefits Concierge Team			888-246-6680	employeeconnects.com/stitchfix
Health plan decision support	Ask ALEX	N/A		myalex.com/stitchfix/home
Medical plans	Cigna	3343874	800-244-6224	mycigna.com
	Kaiser	CA: 604866 GA: 10500	800-464-4000 888-865-5813	kp.org
Virtual visits	MDLIVE (Cigna)	3343874	888-726-3171	my.cigna.com
	Kaiser	CA: 604866	800-464-4000	kp.org/mydoctor/videovisits
Health Savings Account (HSA)	HealthEquity	N/A	866-346-5800	healthequity.com/stitchfix
Flexible Spending Accounts (FSAs)	Navia Benefit Solutions	SFX	800-669-3539	naviabenefits.com
Commuter Spending Account	Navia Benefit Solutions	SFX	800-669-3539	naviabenefits.com
Mental health	Modern Health			help@modernhealth.com
Dental plan	Cigna	3343874	800-244-6224	my.cigna.com
Vision plan	VSP	30059497	800-877-7195	vsp.com
Life and AD&D insurance	Reliance Standard	Basic: GL162732 Supplemental: GL162733	800-351-7500	rsli.com
Personalized LeavePlan	LeaveLogic			stitchfix.leavelogic.com
Disability insurance	Reliance Standard	STD: STD167860 LTD: LTD132274	877-202-0055	matrixabsence.com
Critical Illness insurance	Reliance Standard	886752	877-202-0055	matrixabsence.com
Accident insurance	Reliance Standard	886751	877-202-0055	matrixabsence.com
Hospital Indemnity insurance	Reliance Standard	886753	877-202-0055	matrixabsence.com
Family planning benefits	Carrot	N/A		support@get-carrot.com get-carrot.com/signup
401(k) plan	Charles Schwab	102826	800-724-7526	workplace.schwab.com
Corporate perks platform	PerkSpot	N/A		stitchfix.perkspot.com

This guide provides an overview of the benefits program. It is not intended to be a complete description of the benefits or official summary plan descriptions for these programs. If there is a conflict between this guide and the official plan documents, the plan documents will govern. Stitch Fix reserves the right to modify or terminate any of the described benefits at any time and for any reason. The descriptions of these benefits are not guarantees of current or future employment or benefits. For information about the specific plans available to you, please contact People & Culture.

This communication highlights some of your Stitch Fix benefit plans. Your actual rights and benefits are governed by the official plan documents.

If any discrepancy exists between this communication and the official plan documents, the plan documents will prevail. Stitch Fix reserves the right to change any benefit plan without notice. Benefits are not a guarantee of employment.

Annual notices

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

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

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

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

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

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

ALABAMA – Medicaid
Website: myalhipp.com
Phone: 1-855-692-5447

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

ARKANSAS – Medicaid
Website: myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: healthfirstcolorado.com
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): mycohibi.com
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

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

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

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: kancare.ks.gov
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

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

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

MAINE – Medicaid
Enrollment Website: mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

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

MISSOURI – Medicaid
Website: dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

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

NEBRASKA – Medicaid
Website: ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

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

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

NEW YORK – Medicaid
Website: health.ny.gov/health_care/medicaid
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: eohhs.ri.gov
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: medicaid.utah.gov
CHIP Website: health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: hca.wa.gov
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: dhhr.wv.gov/bms or mywvhipp.com
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Women's Health and Cancer Rights Act (WHCRA) Notices

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following network deductibles and coinsurance apply: Cigna – EPO No Charge, LocalPlus No Charge, HDHP 10% after deductible of $1,750 or $2,800, PPO 10% after deductible of $500 or $1,000; Kaiser No Charge.

If you would like more information on WHCRA benefits, call your Plan Administrator Stitch Fix Benefits Team at 415-882-7765.

Patient Protection Notice

Kaiser Permanente HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, Kaiser Permanente designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser Permanente at 1-800-464-4000.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or following established procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser Permanente at 1-800-464-4000.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medicare Part D — Creditable Coverage Important Notice from Stitch Fix, Inc. About Your Prescription Drug Coverage and Medicare

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For More Information About This Notice or Your Current Prescription Drug Coverage...
Contact the person listed below for further information, or call (888)-246-6680. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Stitch Fix changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

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

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

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

Date: January 1, 2024
Name of Entity/Sender: Stitch Fix Benefits Team
Address: One Montgomery Tower, Suite 1100,
San Francisco, CA 94104
Phone Number: (888)-246-6680

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

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is provided to you on behalf of:

Stitch Fix, Inc. Health Insurance Plan*

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

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

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

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

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

- Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.
  - Treatment: Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where

the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.

- Payment: Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

- Health care Operations: The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

- Other Uses and Disclosures of Your PHI Not Requiring Authorization. The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

  - To the Plan Sponsor: The Plan may disclose PHI to the employers (such as Stitch Fix) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.

  - To the Plan's Service Providers: The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.

  - Required by Law: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.

  - For Public Health Activities: The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.

  - For Health Oversight Activities: The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

  - Relating to Decedents: The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

  - For Research Purposes: In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.

  - To Avert Threat to Health or Safety: In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

  - For Specific Government Functions: The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

  - Uses and Disclosures Requiring Authorization: For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

  - Uses and Disclosures Requiring You to Have an Opportunity to Object: The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information
You have the following rights relating to your protected health information:

- To Request Restrictions on Uses and Disclosures: You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.

- To Choose How the Plan Contacts You: You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.

- To Inspect and Copy Your PHI: Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.

- To Request Amendment of Your PHI: If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

- To Find Out What Disclosures Have Been Made: You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

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

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

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

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

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

Stitch Fix Benefits Team
(888)-246-6680

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

STITCH FIX EMPLOYEE HEALTH CARE PLAN

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

Loss of eligibility includes but is not limited to:

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

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Stitch Fix Benefits Team
(888)-246-6680

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

GENERAL COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage aren't required to pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

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

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

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:
- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

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

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

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of
- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

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

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

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

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

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

Stitch Fix Benefits Team
(888)-246-6680
One Montgomery Tower, Suite 1100
San Francisco, CA 94104

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

Stitch Fix Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at (888)-246-6680.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Stitch Fix Employee Health Care Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Stitch Fix Employee Health Care Plan at: (888)-246-6680.

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

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

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

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

Cigna HDHP	In-Network	Out-of-Network
Individual Deductible	$1,750	$3,000
Family Deductible	$3,600	$6,000
Coinsurance	90%	70%

Cigna PPO	In-Network	Out-of-Network
Individual Deductible	$500	$500
Family Deductible	$1,000	$1,000
Coinsurance	90%	70%

Cigna EPO (OAP Network)	In-Network	Out-of-Network
Individual Deductible	N/A	N/A
Family Deductible	N/A	N/A
Coinsurance	100%	N/A

Cigna LocalPlus	In-Network	Out-of-Network
Individual Deductible	N/A	N/A
Family Deductible	N/A	N/A
Coinsurance	100%	N/A

Kaiser HMO (CA only)	In-Network	Out-of-Network
Individual Deductible	N/A	N/A
Family Deductible	N/A	N/A
Coinsurance	100%	N/A

Kaiser HMO (GA only)	In-Network	Out-of-Network
Individual Deductible	N/A	N/A
Family Deductible	N/A	N/A
Coinsurance	100%	100%

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at: (888)-246-6680.

MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

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

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

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

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

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

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

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact the Stitch Fix Benefits Team at (888)-246-6680.