MDM Technology USCo, LLC
Welfare Benefit Plan

Summary Plan Description

(Effective July 1, 2026)

Table of Contents

Page

About this Booklet

This is the Summary Plan Description ("SPD") for the health and welfare benefits, including the flexible spending account benefits that are provided under the MDM Technology USCo, LLC Welfare Benefit Plan ("Plan"). The Plan is provided for the benefit of eligible employees of MDM Technology USCo, LLC (the "Company").

This SPD describes the rules for eligibility, participation, enrollment, and paying for and changing benefit elections that are offered under the Plan, including under the medical, dental, vision, and flexible spending accounts benefits (each a "Benefit Program"). For detailed information about the Company's Benefit Programs, you should refer to the separate booklets that describe the Benefit Programs, except for the Flexible Spending Accounts, which are described in this document. These booklets are provided to you at particular times and can be requested, at no cost, at any time. The booklets are available on the MDM Benefits site

The rules and operation of the Plan are described in this SPD as clearly as possible with minimal use of the technical terms appearing in the legal documents. However, the official documents (including the insurance policies for the insured Benefit Programs) remain the final authority and, in the event of a conflict with this SPD, will govern in all cases. You may request a copy of the official documents from the Plan Administrator.

The Company reserves the right at any time to amend, modify, reduce, discontinue or terminate the Plan or any of its Benefit Programs.

Need Additional Information?

This SPD and the other Booklets should answer most of your questions. But what if you still need information?

You should contact NetBenefits *or call the Dun & Bradstreet Benefit Center at 1-877-362-8953.*

Plan Benefit Programs

The following Benefit Programs are part of the Plan, but you may only participate in those Benefit Programs for which you are eligible.

- Medical Plan (includes prescription drug coverage) (currently, the Cigna Open Access Plan or Cigna Open Access Health Savings Account Plan)
- Dental Plan (includes two options)
- Vision Plan
- Flexible Spending Account (FSA) Plan (includes health care and dependent care FSA benefits)
- Life Insurance (Basic, Supplemental and Dependent Life)
- Accidental Death and Dismemberment Insurance (AD&D)
- Business Travel Accident Insurance (BTA)
- Long Term Disability Insurance (LTD)
- Employee Assistance Plan (EAP)

Additional information regarding each of the Benefit Programs is provided later in this SPD and in the Enrollment Guide.

Important Information

Information About the Health Insurance Marketplaces

You can purchase health coverage for yourself and your family members through the Health Insurance Marketplace (otherwise known as an Exchange). You can enroll in this coverage only during certain months of the year unless you experience a special event that allows you to enroll midyear. If you purchase coverage through the Marketplace, you may be eligible for a premium tax credit to help pay for that coverage, but in most cases the tax credit is only available if your employer does not offer you coverage under a health plan that is "affordable" and provides "minimum value." The Company believes that the coverage provided by its Medical Plan is affordable and does provide minimum value. You will be given a notice at certain times which explains the coverage offered through Marketplace and any tax credit that may be available to you. You should review that notice carefully. You may request a copy of this notice from the Plan Administrator at any time, and one will be provided free of charge.

Eligibility

Eligible Employees

To be eligible to participate in this Plan and each Benefit Program, you must satisfy the following requirements:

- You must be an active full-time or part-time employee of the Company; and
- You are regularly scheduled to work 20 or more hours per week.

If you are classified by the Company as a temporary employee, intern, leased employee, or an independent contractor, you are not eligible to participate in the Plan.

In addition, if you are not classified as an eligible employee by the Company but are later reclassified as such either by action of the Plan Administrator or by a governmental or judicial authority, you will be deemed to have become an employee eligible to participate in the Plan only prospectively and not retroactively to the date on which you are found to have first become an employee, assuming all other eligibility requirements are met.

Employees who meet the eligibility requirements to participate in the Plan are referred to in this document as "**Eligible Employees**".

Eligible Dependents

Your Spouse, Domestic Partner and Children are eligible to participate in the Benefit Programs that provide benefits to eligible dependents if they satisfy the eligibility requirements described below. Your dependents who meet the eligibility requirements for one or more Benefit Programs are referred to in this document as **"Eligible Dependents."** For the insured Benefit programs, your Spouse, Domestic Partner and Children must also satisfy any additional eligibility requirements that may be imposed by the insurer. Please refer to the Booklets for the insured Benefit Programs for additional information.

Spouses

Your legal **Spouse** may participate in those Benefit Programs that provide benefits to eligible dependents. An individual will be recognized as your spouse if you and the individual are legally married under the laws of the state or foreign law in which the marriage occurred, and not legally separated or divorced.

Domestic Partners

An individual qualifies as your Domestic Partner if he or she meets the Plan's requirements to be a domestic partner as defined below. Please contact your Plan Administrator for further details.

To cover your Domestic Partner, you and your partner must either:

- Have registered properly your domestic partnership with an approved governmental domestic partnership registry;

Or

- Be at least 18 years old,
- Share a committed and exclusive relationship for at least six months,
- Not be married to another person,
- Not be related by marriage or blood, which would otherwise prohibit legal marriage in the state of residence, and
- Live together in the same household;

Or

- Enter into a civil union in accordance with the laws of a state which permits couples to enter into civil unions.

If any of the above eligibility requirements are no longer being met, domestic partner coverage ends. You must notify the Dun & Bradstreet Benefits Center immediately if your domestic partner is no longer eligible.

Dependent Children

Your or your spouse's/domestic partner's **Child** if he or she is less than 26 years of age may participate in those Benefit Programs that provide benefits to eligible dependents.

For eligibility purposes, the term "Child" includes your biological child, stepchild, adopted child (or child placed for adoption), foster child and a child placed in your care by court order/legal guardianship. (A child is considered "placed for adoption" with you when you have assumed and retained a legal obligation for total or partial support of the child in anticipation of adoption.)

For the insured Benefit Programs, the insurer may have additional eligibility requirements, including age limitations, for your Child to be eligible for coverage. The life and AD&D Benefit Programs do not provide coverage for foster children or those who are dependents due to a court order/legal guardianship. For additional information, you should refer to the insurer booklets.

It is your responsibility to review the Plan definitions of a Spouse, Domestic Partner and Child(ren) and to only enroll those individuals who meet the requirements for eligibility for each specific Benefit Program. It is also your responsibility to report a change in your Dependent's eligibility to the Plan Administrator within 31 days of the change in eligibility status in the manner required to complete an election change under the Plan.

Enrollment of an Eligible Dependent is contingent on the employee providing the requested documentation in a timely manner. Failure to provide the required documentation will result in an individual not being enrolled in the Plan. For example, if you fail to provide the required documentation within the required timeframe for a Spouse, that individual will not be covered under the Plan even if he or she is your legal spouse.

Special Rules for Overage Disabled Dependent Children

There are special eligibility rules which may allow your Child to continue to participate in the Plan after he or she reaches the age at which time coverage terminates, such as age 26. The different insurers of the Benefit Programs may impose different rules and have different processes for determining disability. For additional information, you should refer to the insurer Booklets or contact the Benefits Center.

Your disabled Child may continue to participate in the Plan if he or she is unmarried, totally physically or mentally disabled, is unable to work or support themselves financially, is mainly supported by you, and was enrolled in the Plan prior to the date on which coverage terminates on account of age (such as when turning age 26). In addition, the proof of disability must be approved by the Claims Administrator at least 15 days before the end of the year in which your Child reached age 26.

For your Child's coverage to continue, you must contact and provide the Claims Administrator proof of your child's qualifying disability 90 days prior to the dependent turning 26 and any additional information required by the Claims Administrator.

As a condition of this extended coverage, the Plan Administrator may require that a physician chosen by the Plan Administrator examine your child at no cost to you. You may also be required to provide periodic proof that your child continues to meet these conditions of incapacity and dependency. Failure to provide such proof within the required period will result in termination of your child's coverage.

If you drop coverage for an overage Disabled Child at any time, he or she may not be re- enrolled.

For any Benefit Program that is insured, the Disabled Child must meet any additional requirements imposed by the insurer (refer to the applicable insurer booklets for additional information) to be eligible for that program.

Qualified Medical Child Support Orders

Your Child who is named in a Qualified Medical Child Support Order approved by the Plan Administrator which requires you to provide medical coverage under this Plan to the extent required under federal law may participate in the Benefit Programs providing health benefits. Your Dependent's coverage will not be effective until you provide all the information required by the Plan Administrator to verify eligibility.

A **"qualified medical child support order"** or **"QMCSO"** is a legal order requiring a parent to provide medical support to a child (for example, in cases of legal separation or divorce). To qualify as a QMCSO, it must be a judgment, decree or order that is issued by an appropriate court or administrative agency, which contains certain information. A QMCSO must be specific as to the plan, the participant whose child(ren) is (are) to be covered, the type of coverage, the child(ren) to be covered and the length of coverage. The QMCSO may not require the Plan to provide coverage for any type or form of benefit, or any option, not otherwise provided under the terms of the Plan. You and the affected child will be notified if an order is received and will be provided with a copy of the QMCSO procedures for this Plan. You may also obtain a copy of the QMCSO procedures for this Plan, free of charge, by contacting the Benefits Center.

Eligibility Determinations

The Plan Administrator, in its sole discretion and in accordance with the Plan documents, will determine whether an individual is eligible to participate in the Plan. Any such determination will be conclusive and binding on all parties involved. You may be asked to provide proof of eligibility for your Eligible Dependents upon enrollment, annually, or during an audit. If you cannot provide the requested proof within the required time period, your Eligible Dependent will be disenrolled from the Plan, possibly retroactively.

Providing false or misleading information regarding a Spouse, Domestic Partner or Child, enrolling an individual who does not satisfy the eligibility criteria or failing to timely drop an enrolled individual when he/she no longer satisfies the eligibility criteria may constitute a misrepresentation. If the Plan Administrator determines that a misrepresentation has occurred, it may also terminate or suspend your coverage, require repayment of the ineligible individual's prior claims, require payment of the total value of the ineligible individual's coverage or take other corrective action.

Dependent Eligibility Verification Documentation

The Plan reserves the right to conduct audits and reviews of all dependent eligibility to ensure that individuals covered by the Plan meet the eligibility requirements.

When you first enroll a dependent in the Plan, you may be asked to provide documentation which provides proof that your dependent satisfies the applicable eligibility requirements. This includes any dependent that you enroll in the Plan when you first become eligible after

your date of hire, as well as any dependent that you enroll following a qualifying life event (i.e., marriage, birth) or during the annual Open Enrollment (OE) period in the fall. As part of the audit process, Gainwell will send you a letter requesting certain documents intended to prove that your dependent is eligible under the terms of the Plan. Required documentation may include a government-issued marriage certificate, government-issued birth certificate, and a Federal tax return. If a dependent that you enrolled is ineligible or you fail to verify the dependent's eligibility, he or she will be dropped from coverage under the Plan and COBRA continuation coverage will not be offered.

Plan Participation

Generally, you may enroll in the Plan during your Initial Enrollment Period or during an Annual Enrollment Period. As explained below, you may also be able to enroll following certain events. You may not revoke or otherwise change your elections during the plan year, except as explained below.

If you are an Eligible Employee on July 1, 2026, special rules apply to your enrollment in the Plan as of that date as explained in the employee communications provided previously.

Initial Enrollment Period

After July 1, 2026, if you are a new Eligible Employee, you may elect to participate in the Plan at any time up to 31 days following your date of hire or the date you otherwise first satisfy the eligibility requirements. The period during which you are first eligible to enroll in a Benefit Program is referred to as your **"Initial Enrollment Period."**

You may enroll yourself and your Eligible Dependents in the Plan by completing the enrollment process and submitting any written or electronic forms or other information required by the Plan Administrator on or before the specified date. The enrollment materials will be provided to you, along with instructions for completing enrollment and an explanation of any required contribution for coverage. In some cases, you are not required to enroll in the Benefit Program. Rather, you will be automatically enrolled on the first date that you are eligible to participate. This is true, for example, with EAP benefits.

You must also satisfy any additional enrollment requirements that may be imposed with respect to a particular insured Benefit Program, as indicated in the booklets applicable to the Benefit Program. You will be notified of these additional requirements at the time of enrollment.

You must enroll yourself in a Benefit Program to enroll your Eligible Dependents in the same Benefit Program. If the parents of an Eligible Dependent are both Eligible Employees, only one may enroll the Eligible Dependent in a Benefit Program. No person can be covered both as an Eligible Employee and as an Eligible Dependent.

If you enroll in the Medical Plan, Dental Plan, or Vision Plan, you will be deemed to have elected to have a portion of your compensation applied on a pre-tax basis towards the cost of coverage under the Benefit Program to the extent permitted under the terms of the MDM Technology USCo, LLC Cafeteria Plan, which is one of the benefit programs offered under this Plan. Special rules apply for the payment of contributions with respect to Domestic Partners (discussed below).

When Coverage Begins

In most cases, if you enroll yourself (or yourself and your Eligible Dependent(s)) (or are enrolled in the case of default elections) during the Initial Enrollment Period, coverage will begin on the date you are first eligible. Coverage is effective on the first day that you report to work provided you complete the enrollment process within 31 days of your date of hire.

If you fail to enroll yourself and/or your Eligible Dependents during your Initial Enrollment Period, your next opportunity to enroll will be during the next Annual Enrollment Period or when you experience an event that permits a Mid-Year Coverage Change (discussed below).

Annual Enrollment Period

You will be given an opportunity to enroll in the Plan or change your benefit elections under the Plan during the Annual Enrollment Period, which is typically held in October or November of each year. Any changes that you make to your benefit elections during the Annual Enrollment Period will be effective as of the following January 1. You must complete the enrollment process during the Annual Enrollment Period to be a participant in the Plan for the following year except for those Benefit Programs which are fully employer-paid.

When Coverage Ends

Coverage under the Plan or a Benefit Program under the Plan will end for you when any one of the following occurs:

- You cancel coverage,
- You terminate employment for any reason,
- The Company terminates the Plan or Benefit Program,
- You are no longer eligible for benefits,
- You fail to make the required contributions on a timely basis, or
- You die.

Your dependent's coverage will end for the following reasons:

- The Company terminates all dependent coverage under this plan,
- The Company terminates the Plan or Benefit Program,

- Your dependent becomes covered as a Company employee,
- Your dependent is no longer eligible for benefits,
- You fail to make the required contributions on a timely basis,
- Your coverage terminates, or
- You or your dependent dies.

In general, Medical, Dental and Vision Plan coverage will end at the end of the month in which the event occurs. Typically, coverage under the other Benefit Programs ends on the date on which the event occurs, but please refer to each booklet for specific information.

You or your eligible dependents may be able to continue medical, dental and/or vision coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA). In special situations described below, you may be able to continue your coverage beyond your termination of employment without electing COBRA. See the section "When Your Employment Ends" later in this SPD.

Your coverage (or your dependent's coverage) will also terminate on the date you revoke your election for such coverage (which generally must be prospectively) provided the revocation is otherwise permitted under the terms of the Plan.

If the Plan Administrator determines that you or your dependent have engaged in fraud or have intentionally misrepresented a material fact in connection with the Plan, including enrollment and participation, your coverage and/or your dependent's coverage will be terminated on the date specified by the Plan Administrator.

Rehired Employees

If you terminate employment and are rehired within 30 days (and within the same calendar year), your coverage under the same Benefit Programs which you were enrolled in when you terminated employment will be automatically reinstated at the same level of coverage and dependent status subject to timely payment of the required premiums. If you do not want to be enrolled in the same Benefit Programs due to an intervening qualifying event, such as a change in your marital status or a change in your spouse's eligibility for benefits coverage, you may be able to modify your previous elections. Please see the section, *Mid-Year Coverage Changes* for further information.

In most cases, if you are rehired after 30 days or during a different calendar year, you will be treated like a new hire. If, however, you terminate your employment in December and you are rehired within 30 days, but after the start of a new year, you will be defaulted into the elections you made during the prior annual enrollment.

Mid-Year Coverage Changes

Generally, the benefits that you elect during your Initial Enrollment Period or the Annual Enrollment Period remain in effect until the next year begins. However, in certain situations, described below, you may be able to change your benefit elections during the middle of the year, although there may be limitations on your ability to make mid-year changes as a result of Internal Revenue Service ("IRS") rules for pre-tax premium plans.

Qualifying Change in Status

If you experience a Qualifying Change in Status and you would like to change your coverage, you must notify the Plan Administrator and make a new election within 31 days of the event. A qualifying change in status is defined as one of the following events:

- Marriage;
- Divorce, annulment or legal separation;
- Entering into a Domestic Partnership;
- Termination of a Domestic Partnership;
- Birth, adoption or placement for adoption of an eligible Child;
- Gain or loss by your Spouse or your eligible Child of eligibility status;
- Death of your Spouse or your eligible Child;
- Change in your Spouse's or your eligible Child's place of employment;
- Change in your, your Spouse's or your eligible Child's employment from full-time to part-time or vice versa;
- Taking or returning from an unpaid leave of absence by you, your Spouse or your eligible Child;
- Your Spouse's or eligible Child's loss or gain of benefits coverage through their employer's plan;
- You move out of an HMO or PPO service area;
- A QMCSO requiring coverage under this Plan;
- HIPAA special enrollment event (discussed below);
- Entitlement to or loss of Medicare or Medicaid;
- A significant cost or coverage change (does not apply to the Health Care FSA);
- For the Dependent Care FSA, any change in a dependent care provider; or
- A change in coverage under another employer plan for a period of coverage that is different from the period of coverage under the Plan, such as during an open enrollment period.

In some cases, to be allowed, the event must affect eligibility for the type of coverage that you wish to change and your election change must be consistent (under IRS rules) with the event that has occurred. For example, generally, if you have or adopt a child, you can add the child to the Medical Plan, but you would not be able to drop medical coverage unless it is to enroll in your spouse's or domestic partner's plan.

If the Benefit Program is insured, the insurer may impose additional requirements or restrictions on your ability to make a mid-year election change. For additional information, refer to the applicable booklet for the insured Benefit Program. In all cases, your election change must be permitted under IRS rules and approved by the Plan Administrator.

You may change your election to contribute to a health savings account at any time by submitting a new election in the time and manner directed by the Plan Administrator. Your election change must be prospective and will take effect with the first payroll period following the date that it is approved.

For additional information about election changes, including whether you have experienced an event that will allow you to change your election mid-year, contact the Benefits Center.

Once the Plan Administrator determines that your election change is permitted, your election change will ordinarily take effect on the date of the event (or, if the Benefit Program is insured, the later date (if any) specified in the insurer booklets). Your payroll deductions will change as of the first payroll period after the change is processed or such other date specified by the Plan Administrator. The Plan Administrator, in its sole discretion, is responsible for making the determination of whether your mid-year election change is permitted.

Special Enrollment Rights

Federal law provides you with special enrollment rights in some circumstances. These special enrollment rights allow you and/or your Eligible Dependents to enroll in the Medical Plan provided you do so in a timely manner. The period of time that you are given to enroll yourself and/or your Eligible Dependents in the Plan is referred to as a **"Special Enrollment Period."**

Loss of other Health Coverage (Medical Plan Only). If you previously declined to enroll yourself and/or your Eligible Dependents in the Medical Benefit Program during the Initial Enrollment Period, Annual Enrollment Period or a Special Enrollment Period because you or your Eligible Dependents had other health coverage, you may enroll yourself and/or your Eligible Dependents in the Medical Benefit Program if that other coverage was lost involuntarily because of one of the following reasons:

- The other coverage was provided under COBRA (federal law providing for continuation of health coverage) and the entire COBRA coverage period was exhausted;

- The other coverage terminated because of a loss of eligibility for coverage (such as divorce, death, termination of employment);

- The other coverage terminated because the plan no longer offers coverage to a class of similarly situated individuals (e.g., part-time employees);

- The other coverage was lost as a result of reaching the lifetime maximum benefits;

- The contributions by another employer for the coverage terminated; or

- The other coverage was lost for any other reason identified by the Department of Labor in its regulations governing special enrollment rights.

If you or your Eligible Dependent lost the other coverage because of a failure to pay the required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan), there is no special enrollment right.

You must notify the Benefits Cetner within 31 days of the loss of coverage. The Plan Administrator may request proof of your (or your dependent's) previous coverage and proof of the reason that such coverage terminated.

Marriage or Acquisition of a New Dependent (Medical Plan Only). Your marriage or your acquisition of a new dependent through birth, adoption or placement for adoption also triggers a special enrollment right, which allows you to enroll yourself, your Spouse and your newly-acquired Eligible Dependent in the Medical Plan. You must notify the Benefits Center and enroll within 31 days of the event. Coverage will be retroactive to the date of the event.

Medicaid and SCHIP (Medical Plan Only). If you or your Eligible Dependent (1) becomes eligible for state-granted health premium assistance or (2) loses health coverage under Medicaid or State Children's Health Insurance Plan (known as SCHIP or CHIP), you will have a separate enrollment right under the Medical Benefit Program. To enroll, you must notify the Benefits Center within 60 days of either of these two events.

There may be other events, not discussed above, which may allow you to make a mid-year election change. For additional information, please contact the Benefits Center.

Special Circumstances Allowing Extended Coverage

As discussed above, in most cases your coverage will terminate at the end of the month in which your employment ends, but in special circumstances, your coverage may continue beyond that date. For example, if you terminate

employment at a time when you are receiving LTD benefits or you die, you or your surviving dependents may be eligible to continue to participate in one or more Benefits Programs for a limited period of time. For additional information, you should contact the Benefits Center. If these special circumstances do not apply to you, you will be given an opportunity to continue health plan coverage for yourself and your dependents by electing and paying for COBRA coverage (unless your employment was terminated for gross misconduct). See the section "COBRA Continuation" in this SPD for more information. Please refer to the life and disability benefit booklets for information about continuation of coverage for those benefits.

Paying For Your Benefits

While the Plan provides you with an array of Benefit Programs and options to choose from, it is up to you to select those Benefit Programs and options which meet your specific family and financial needs. The Company pays for some Benefit Programs and subsidizes the cost of others. Additional information regarding the cost of the Benefit Programs is provided in this SPD and in your enrollment materials.

Cost of Coverage for Domestic Partners and their Child(ren)

Generally, medical, dental, and vision care coverage are not taxable benefits if they are provided to you, your Spouse, or your Eligible Dependents. However, if your Domestic Partner and their children do not qualify as your dependent for health plan purposes under the Internal Revenue Code, the value of their coverage is considered income to you. This is the case for most domestic partners. This additional income, known as "imputed income," will be shown on your pay statement and Form W-2 Wage and Tax Statement for the year in which coverage was effective. You will be required to pay taxes on this additional income, as required by the Internal Revenue Service (IRS). This also means that the premium that you pay to cover your Domestic Partner and/or their child(ren) is deducted post-tax.

If your Domestic Partner and his/her child(ren) qualifies as your tax dependent under Section 105(b) of the Internal Revenue Code, please request to complete the Certification of Domestic Partner Tax Dependents form. This form must be submitted during annual enrollment (for coverage effective January 1) or within 30 days of either enrolling your dependent when you are a new hire, or the tax status of your dependent has changed for health care purposes.

For additional information about covering your domestic partner and your domestic partner's child(ren), you may contact the Dun & Bradstreet Benefits Center.

Spousal Surcharge

If you enroll your Spouse or Domestic Partner in the Medical Plan, you will pay a spousal surcharge each time you pay the premium for coverage under this Medical Plan unless you

can certify during new hire or at annual enrollment that one of the following conditions applies:

- Your spouse/domestic partner is not employed or is self-employed;
- Your spouse/domestic partner works at the Company;
- Your spouse/domestic partner is employed but not eligible for medical coverage through his/her employer;
- Your spouse's/domestic partner's employer charges 100% of the cost of coverage; or
- Your spouse/domestic partner is covered by COBRA, Medicare or Medicaid.

If it is determined that the spousal surcharge applies, it will apply for the entire year (or the remainder of the year if enrollment occurs mid-year). However, if your Spouse or Domestic Partner satisfies one of the conditions listed above during the middle of the year (e.g., your spouse terminates employment), the spousal surcharge will be removed if you report the event to the Benefits Center within 31 days of the loss. If the spousal surcharge does not apply and your Spouse or Domestic Partner ceases to satisfy one of the conditions listed above (e.g., your spouse gains employment with other medical coverage), you must report the new access to such coverage and the spousal surcharge will apply. Alternatively, you may terminate his or her coverage under the Medical Plan. You will not receive any retroactive reimbursement for amounts already collected.

The spousal surcharge is subject to audit. It may be applied retroactively if it is determined (upon audit or otherwise) that the surcharge should be applied to you.

Benefit Programs

The following Benefit Programs are available under the Plan, but you will only receive benefits under a Benefit Program in which you are eligible to participate.

These benefits, and important exclusions, limitations and restrictions for each Benefit Program are described in more detail in the applicable benefits booklets that, together with this document, constitute the SPD for such benefits. These benefits booklets are provided to you at particular times and can be requested, at no cost, at any time.

Medical Plan

The Medical Plan provides fully-insured medical and prescription drug benefits, currently insured and administered by Cigna. There are currently two options for medical coverage described in the Enrollment Guide and in separate booklets. If you enroll, you share the cost of the Medical Plan with the Company, but your share of the cost is paid on a pre-tax basis (with an exception for Domestic Partner benefits).

Health Savings Account

If you elect to participate in the OAP HSA medical plan, you may be eligible to contribute to a health savings account and receive employer contributions on a pre-tax basis. Additional information is provided below.

Dental Benefits

The Dental Plan provides two fully-insured dental options (Delta PPO and PPO Plus Premier plans) that are described in a separate booklet; additional information is included in the Enrollment Guide. If you enroll, your share of the cost is paid on a pre-tax basis.

Vision Benefits

The Vision Plan provides one insured vision option with EyeMed that is described in a separate booklet; additional information is also included in your Enrollment Guide. If you enroll, your cost is paid on a pre-tax basis.

Health Savings Account Contributions

If you are a participant in the OAP HSA (HDHP) option under the Medical Plan and you qualify as an eligible individual under rules that apply under federal tax law, you may elect to make pre-tax salary reduction contributions to a Health Savings Account (HSA) established in your name. An HSA is a special type of savings account that you can use to pay your eligible medical expenses on a pre-tax basis, including amounts that are counted towards the deductible for the Medical Plan. An HSA account is established at a financial institution in your name and is portable if your employment changes. You must complete the required process for setting up an HSA account within the required time period. Your HSA grows through the contributions you make to this account. Any remaining balance at the end of the year rolls over to be available in the next calendar year. It is important to enroll in your HSA as soon as you enroll in your medical option. Expenses incurred prior to the date on which the financial institution opens your HSA cannot be reimbursed tax-free from your HSA account.

If you have enrolled in the OAP HSA Medical Plan and you have established an HSA through Wex, the Company may make contributions to your HSA each year. These amounts are described in the enrollment materials. Any limits on the amount that you may contribute to your Health Savings Account will be determined by the Company and announced to participants from time to time. Health Savings Account contributions also are subject to limits that apply under the Internal Revenue Code, and the Company may limit the amount you may contribute to your Health Savings Account through the Plan if it appears that contributions to the HSA exceed any limit that applies to you.

To be an "eligible individual" for purposes of HSA contributions, you must meet the following criteria:

- Must be covered under a qualifying HDHP, such as the OAP HSA option under the Medical Plan.

- May not be covered under any other non-HDHP "disqualifying" health coverage. Examples of disqualifying coverage include:
    - Coverage under a spouse's or parent's health insurance coverage unless it is a qualifying HDHP coverage;
    - Access to your spouse's general purpose flexible spending account (FSA) (even if you do not request reimbursement);
    - Access to your spouse's health reimbursement arrangement (HRA) which covers pre-deductible medical expenses (even if you do not request reimbursement); and
    - Medicare and TRICARE coverage.

- May not be claimed as a dependent on someone else's tax return.

If you are covered under Medicare, you are not an eligible individual and you may not receive or make HSA contributions through the Plan. If you plan to retire this year, you should talk to your advisor about how your retirement will affect your eligibility to contribute to an HSA. Whether you are an eligible individual is determined on a monthly basis. If you have any questions about whether any other coverage you have disqualifies

you from being an "eligible individual," please contact the Benefits Center. However, keep in mind that it is your responsibility to determine if you are eligible, and the Company cannot provide tax or legal advice.

Your HSA is considered your property and is not an employer-sponsored plan. Payments provided through your HSA are not provided under this Plan and are not subject to the federal law known as ERISA or to the claims procedures described in this SPD. The "Your ERISA Rights" section of this SPD does not apply to these benefits. For details about the HSAs that may be funded through the Plan, you should contact the financial institution that maintains your HSA.

It is your responsibility to notify the Benefits Center if you are enrolled in the OAP HSA (HDHP) medical plan but do not satisfy the IRS rules for HSA eligibility.

EAP Benefits

The Company's Employee Assistance Program (EAP) provides employee assistance program benefits at no cost to you.

The EAP is offered to provide you and members of your household with confidential assistance with personal situations which become overwhelming. You may elect to call the EAP yourself for assistance, or your immediate supervisor may ask you to seek help from an EAP counselor if your job performance is being impacted by your personal concerns.

Please note that voluntary use of the EAP is confidential and no information regarding your self-referral will be released to the Company without your prior written consent.

Whenever participation in the EAP or compliance with program recommendations are required by the Company as part of employee counseling or in conjunction with a formal warning or disciplinary action, the EAP provider will release the following information to the Company, provided you sign a written release to do so – (1) whether or not you kept the appointment, (2) whether you have complied with and completed recommendations for treatment, and (3) whether you will require time off from work for treatment.

The EAP Provider, by law, must disclose credible threats of serious harm to self or others, including child, elder and disabled-person abuse.

What is Covered

The primary reason for offering an EAP is to provide you and your eligible family members with the resources necessary to deal with any personal issues that may affect job performance and well-being. Through the confidential assistance available from professional counselors and, if necessary, with referred treatment options, you and/or members of your household may obtain assistance in finding resolutions to personal issues which may interfere with emotional well-being or job performance, including but not limited to:

- Relationships, such as marriage, family, friends and coworkers,

- Addiction, including alcohol, drugs, gambling,
- Depression and anxiety,
- Emotional concerns,
- Co-dependence,
- Work,
- Legal matters,
- Housing,
- Parenting,
- Lifestyle,
- Grief and loss,
- Stress,
- Adult children of alcoholics,
- Financial,
- Daycare,
- Retirement, and
- Eating disorders.

The EAP provides the following types of services:

Telephone Counseling: Under the EAP, you and your eligible dependents have access to a behavioral health assessment by telephone. EAP consultants are available 24 hours a day, seven days a week. When you call, an EAP consultant will work with you to:

- Clarify the problem – Help you understand the issues that caused you to seek help,
- Identify options – Explore alternatives for addressing the problem,
- Develop a plan – Determine a course of action customized to meet your needs, and
- Help you follow through – Work with you to help you achieve your treatment goals.

The EAP consultant will refer you to a community resource or another behavioral health care provider (See the section "Referrals" in this SPD for more information).

Short Term Counseling: During the telephone assessment, your EAP consultant may recommend face-to-face or televideo confidential counseling sessions. The program covers up to five face-to-face or televideo EAP sessions per problem type. During the face-to-face or televideo counseling, the EAP counselor may provide feedback to help you put your problem in perspective, help you with your coping skills and/or serve as someone you can talk to in times of stress. In some cases, follow-up sessions may be necessary. If you use all five sessions and need further assistance, the EAP consultant will refer you to other behavioral health resources.

Chat Therapy: Members can use chat therapy to connect with a counselor virtually. With chat therapy you share secure text messages whenever you like and your counselor will respond within one working day up to five days a week.

Referrals: Your EAP consultant may refer you to another community resource or behavioral health provider if (1) he or she determines that you need long-term or more intensive assistance beyond the scope of the EAP or (2) you have used up all five of your face-to-face or tele video sessions for a specific problem and need further assistance.

Legal Resources: Members receive a 30-minute telephonic or face-to- face attorney consultation, per each new issue, for any number of issues. There is a 25% discount with the attorney or mediator beyond the initial 30 minutes.

Identity Theft Resolution: Provides members with a 60-minute free consultation with a highly trained Fraud Resolution Specialist™ and conducts seven emergency response activities. Also, provides members with a free "ID Theft Emergency Response Kit™".

Financial Resources: Members receive a 30-minute telephonic financial consultation, per each new issue, per year. Members may also access online resources such as articles and calculators.

Mind Companion Self Care: We now provide Mind Companion Self Care, a unique online emotional wellness portal. It can help your employees with mild or moderate depression and anxiety. The program offers practical ways to improve emotional and overall well-being through digital cognitive behavioral therapy, eLearning programs, simple tools, trusted resources and daily motivation.

If appropriate, the EAP Provider may refer you to a medical service provider for further care. In the event of such a referral, you should check with your medical plan provider, if any, to determine if the expenses resulting from this additional care will be covered under your medical plan. You will be responsible for any expenses not covered by your medical plan.

How to Receive Benefits

You have several different options for receiving EAP benefits:

1. **Call the EAP**. You will be connected with an EAP consultant who can assist you with your concerns. Contact information for the EAP provider is provided at the end of this SPD.

2. **Receive counseling or advice**. In most cases you will be able to speak with an EAP consultant immediately.

3. **Schedule your own face-to-face or televideo assessment online.** Members can schedule online through the EAP website for your own chat, televideo or face to face counseling sessions.

4. **Schedule a face-to-face or tele video assessment**. The EAP consultant will schedule an appointment for a confidential assessment session as quickly as possible. Every effort will be made to accommodate your location and work schedule.

5. **Refer you to a qualified professional, if applicable**. The EAP consultant will refer you to a qualified professional in your community if you need additional assistance.

What is Not Covered

The EAP does not cover the following services:

- Services provided before you were covered under the EAP,

- Face-to-face or tele video assessment sessions in excess of five sessions per problem type,
- Services not provided or coordinated by the EAP, and
- Medical expenses you incur as the result of a referral to a medical plan service provider.
- Diagnostic testing and/or treatment.
- Visits with psychiatrist, including medication management.
- Prescription medications.
- Services for remedial education.
- Inpatient, residential treatment, partial hospitalizations, intensive outpatient.
- Ongoing counseling for a chronic diagnosis that requires long term care.
- Biofeedback.
- Hypnotherapy.
- Aversion therapy.
- Examination and diagnostic services required to meet employment, licensing, insurance coverage, travel needs.
- Services with a non-contracted EAP provider.
- Fitness for duty evaluations.
- Legal representation in court, preparation of legal documents, or advice in the areas of taxes, patents, or immigration, except as otherwise described in this document.
- Investment advice (nor does the plan loan money or pay bills).

Flexible Spending Accounts

The Health Care and Dependent Care Flexible Spending Accounts (FSAs) allow you to use tax-free dollars you have deducted from your paycheck to pay for eligible healthcare and/or dependent care expenses -- which means that you keep more money in your pocket. The two types FSAs are described in more detail in the next section.

Flexible Spending Accounts

Eligible Employees may elect two types of FSAs – the Health Care FSA and the Dependent Care FSA.

The FSAs are designed to help you save on certain eligible healthcare and dependent care expenses. The FSAs allow you to elect an amount of your pay each month to be credited to the applicable account (e.g., Health Care FSA or Dependent Care FSA). You can then use this money during the year to reimburse yourself for qualified healthcare and dependent care expenses. Your taxable pay is reduced by the amount you contribute to your account(s), which reduces your federal income taxes, most state and local income taxes, and your Social Security (FICA) taxes (if you earn less than the Social Security wage base).

You can participate in one or both accounts. You decide whether you'd like to participate and how much money you'd like to contribute to each account each year.

General Information about the FSAs

If you are an Eligible Employee, you may enroll in the FSAs. If both you and your eligible spouse are Eligible Employees, each of you may elect to contribute to the Health Care FSA and/or the Dependent Care FSA. Certain annual limits may apply (refer to the Health Care FSA and Dependent Care FSA sections for annual contribution limitations).

If you elect the Health Care FSA, you are not eligible to receive or make contributions to the HSA.

You cannot obtain reimbursement for the expenses of your Domestic Partner or their eligible dependents unless they are your federal tax dependents due to IRS rules.

Your Contributions

When you enroll in an FSA, you authorize the deduction of the contributions you elected to contribute to the Health and/or Dependent Care FSA(s) from your paycheck on a pre-tax basis.

Your FSA elections are binding for the Plan Year for which the elections were made unless a Qualifying Change in Status event occurs during the Plan Year (refer to Mid-Year Coverage Changes for further information). IRS regulations require the FSAs to satisfy non-discrimination standards, which are intended to limit benefits to highly compensated employees. To satisfy these tests, it may be necessary to limit the contributions or benefits available to highly compensated employees. If any such limitation occurs and you are a highly compensated employee who is affected, you will

be notified.

If you experience a Qualifying Change in Status event, you may not reduce your contribution election below an amount that will result in your total contributions for the Plan Year being less than the total amount of reimbursements you will receive for claims incurred in the same Plan Year prior to the date of the change. If you experience a Qualifying Change in Status event and increase your contribution election, the increased contribution amount can only be used to reimburse eligible expenses incurred on or after the date of the Qualifying Change in Status event.

"Pre-tax" means that your contribution is taken from your paycheck before federal and Social Security (FICA) taxes (and, in most cases, state and local taxes) are deducted.

This reduces your taxable income (your gross pay minus contributions), so you pay less in taxes. Because the contributions to the FSAs are pre-tax, the IRS limits the instances when you may change your contributions to those that are considered Qualifying Change in Status events (refer to *Mid-Year Coverage Changes* for further information).

"Use it or Lose It" – Choose Your Benefits Carefully!

An FSA is a great way to pay for certain healthcare and dependent care expenses AND save money. However, the FSAs have a "use it or lose it" rule. If you do not submit claims for all the money that you contribute to your FSA for a Plan Year for claims incurred during the Plan Year (and submitted on or before March 31 following the end of the year or such other date communicated by the Plan Administrator), your remaining funds are forfeited. You cannot convert this money to cash or roll it over to the next Plan Year. Be sure to estimate your expenses carefully AND submit your claims by the deadline.

Uniform Reimbursement Requirement

This rule applies to the Health Care FSA only and is one of its most attractive features. Once you have made your initial contribution to the Health Care FSA, the FSA will reimburse you for the total amount that you have elected for the Plan Year regardless of the actual balance in your account.

For example, if you elect $1,200 for the year, two months into the Plan Year you would have contributed $200; however, if you submit an eligible expense for $400, you will be reimbursed $400. Your Health Care FSA will then show a negative balance which you will pay back each pay period with your payroll contributions to your FSA.

This rule does not apply to the Dependent Care FSA. For the Dependent Care FSA, you will only be reimbursed up to the amount in your Dependent Care FSA. Any reimbursement requested beyond your current balance will not be paid until further

contributions are received.

The Health Care and Dependent Care FSAs are Separate

Your Health Care FSA and Dependent Care FSA are separate accounts. You cannot use balances from your Health Care FSA to reimburse dependent day care expenses and vice versa. In addition, you cannot transfer amounts between the Health Care FSA and the Dependent Care FSA.

How the FSAs Work

Participation is voluntary. If you choose to enroll, you can elect to contribute pre-tax dollars from your paychecks each year for the Health Care FSA and/or Dependent Care FSA to pay for eligible out-of-pocket healthcare or dependent day care expenses not paid by insurance or reimbursed from any other source. You have the option to make a pre-tax annual election amount when you are first eligible to participate and during the Annual Enrollment period each year. The amount you elect should be based on your best estimate of what your family's healthcare and dependent care needs will be for that year. You must make new elections each year.

Expenses Must Be Incurred During the Current Plan Year

Any expenses submitted for reimbursement from either the Health Care FSA or Dependent Care FSA must be incurred during the current Plan Year and while you are enrolled in the applicable FSA. For example, the first Plan Year begins on July 1, but if your enrollment is effective on October 1, you may not submit claims incurred prior to October 1. For future years, the plan year will begin each January 1. As another example, if you terminate coverage in a Dependent Care FSA on September 1 because of a Qualifying Change in Status event, such as termination of employment, expenses incurred after September 1 are not eligible for reimbursement.

A Few Words About Taxes

The Pre-Tax Advantage

When you elect to use pre-tax dollars in an FSA to pay your expenses, you save federal and FICA taxes on that money – and possibly state taxes as well. That's because money in your FSAs is taken out of your pay before federal taxes (and in most cases state taxes as well) are determined.

That can mean a savings of 15% to 30%, based on your federal income tax bracket - or about $15 to $30 on every $100 you spend for healthcare or dependent care services.

The actual amount of your savings will depend on your income tax rate.

Because you don't pay Social Security taxes on your FSA contributions, the earnings used to calculate your Social Security benefits at retirement will not include these amounts. This could result in a reduction in your Social Security benefit at retirement. However, your savings on current taxes will usually outweigh any reduction in future Social Security benefits.

Tax Deductions vs. FSAs

You may choose to take direct tax deductions for eligible healthcare expenses instead of using the Health Care FSA, but you cannot deduct expenses paid from the Health Care FSA from your taxes. Subject to certain minor exceptions, if your healthcare expenses are less than 7.5% of your adjusted gross income, it is usually to your advantage to use the Health Care FSA rather than deducting the amount from your taxes. It is important to consult a tax advisor to determine the best way for you to pay out-of-pocket healthcare expenses.

Also, you may choose to take a direct tax credit for your dependent care expenses instead of using the Dependent Care FSA. You may pay part of your expenses from the Dependent Care FSA and take a tax credit for other expenses, but you cannot deduct expenses paid from the Dependent Care FSA from your taxes. The amount you contribute to your Dependent Care FSA decreases, dollar for dollar, by the amount you can deduct from your taxes for dependent care expenses. If you exceed the limits set by the IRS for the Dependent Care FSA, you must pay taxes on the excess. It is important to contact a tax advisor to find the best way for you to pay out-of-pocket dependent care expenses.

Any money that you contribute to the Dependent Care FSA will be reported on your W-2 tax form. You will be required to report the name, address, and tax identification number (or Social Security number) of your dependent care provider on your income tax forms, unless the provider is a tax-exempt entity.

Health Care Flexible Spending Accounts

For 2026, you may elect up to $3,300 to be credited to your Health Care FSA to reimburse yourself for qualifying health expenses not covered by your medical, dental or vision plans or reimbursed under any other source. However, you cannot use the account for healthcare premiums, or expenses for care that are cosmetic in nature or are not medically necessary (refer to *Eligible Healthcare FSA Expenses* and *Ineligible Healthcare FSA Expenses*). The annual maximum limit is subject to change each year by the Internal Revenue Service. Please refer to the enrollment material for up-to-date maximums (and any minimum) that you can contribute to the Health Care FSA.

If you incur eligible medical expenses during the portion of the plan year in which you participate in the Health Care FSA, you can use the Health Care FSA to reimburse yourself for these expenses with tax-free contributions, if they cannot be reimbursed from other sources, such as under your group medical plan.

- There are strict rules as to what medical expenses are eligible for reimbursement (described further below).

- Expenses are incurred on the date the service is provided, not on the date billed or paid.

- Please contact the Claims Administrator to determine when orthodontic expenses can be reimbursed (generally, monthly reimbursements during the period of service are permitted).

If you have a family member who participates in an HSA, please review the rules that apply to HSA eligibility carefully before enrolling in a Health Care FSA because participation in a Health Care FSA that reimburses medical expenses makes an individual ineligible for an HSA, even if you do not submit expenses for that individual to the Health Care FSA.

Eligible Health Care FSA Expenses

You can use your Health Care FSA to reimburse yourself for healthcare expenses that are considered "medical care" under section 213(d) of the Internal Revenue Code, to the extent that the expenses are not covered by insurance or reimbursed by any other source and are incurred during the applicable Plan Year. You cannot receive reimbursement for expenses that were paid by an insurance company or other source. This is true whether the payments were made directly to you, to the patient, or directly to the provider.

Expenses for over-the-counter medicine, such as antacids, allergy medicines, pain relievers and cold medicines, are eligible without a prescription. In addition, expenses for certain menstrual care products are also eligible. Expenses that are purely beneficial to a person's general health, such as vitamins and dietary supplements, cannot be reimbursed.

Examples of eligible expenses include: amounts used to satisfy your deductible, co-payments, amounts over the maximum your plan pays for hospital rooms, reasonable and customary allowances, and coinsurance amounts. Other health care charges that may be covered include vision care, laser eye surgery, hearing care, dental and orthodontic care.

Cosmetic procedures (such as teeth whitening or cosmetic surgery) are NOT eligible medical expenses. In addition, insurance premiums and expenses that are considered to be premiums for health coverage, such as Concierge Physician charges and Pharmacy Discount cards, are NOT eligible medical expenses.

IRS Publication 502 provides a detailed list of eligible medical expenses, though not all of them may be eligible for reimbursement under the Health Care FSA. You can

obtain a copy of this publication at www.irs.treas.gov/formspubs or by contacting the Claims Administrator. If you have any questions regarding a particular medical expense, please contact the Claims Administrator.

Eligible Expenses Incurred by Family Members

Eligible health care expenses incurred by any individual who is defined as a dependent for health plan purposes under the Internal Revenue Code are allowable for reimbursement. For the Health Care FSA, you can be reimbursed for eligible expenses of:

- your legal spouse; and
- your biological child, stepchild, adopted child (or child placed with you for adoption), through the year in which your child turns age 26 (for example, if your child turns age 27 in 2026, that child is not an eligible dependent for the Health Care FSA for any month in 2026).

Ineligible Expenses

Just as important as understanding what is eligible for reimbursement through your Health Care FSA is knowing what is not generally eligible. Examples of expenses for which reimbursement is not permitted under the Health Care FSA include:

- Expenses for which you have already been reimbursed by other health care plans (including Medicare, Medicaid or any other medical, dental and vision plans)
- Expenses incurred by anyone other than you or your qualified dependents
- Expenses that would not be deductible on your federal income tax return
- Expenses incurred before you start participating in the Health Care FSA
- Expenses incurred after you stop making contributions to the Health Care FSA
- Cosmetic surgery and procedures
- Membership fees or costs of weight loss programs done for your general health
- Dietary or vitamin supplements
- Premiums paid for insurance coverage

Process for Reimbursement of Qualifying Medical Expenses

To be reimbursed for eligible expenses, you can use the debit card or complete and sign the claim form and return it with the required supporting documentation to the address on the form or online. Upon receipt, review, and approval of the claim, you will be reimbursed from your Health Care FSA. Reimbursement for qualifying health care expenses will be made up to the total amount of your plan year contribution, less any previous reimbursements. Expenses are reimbursable only to the extent the Claims Administrator determines they are payable pursuant to the Plan and have been adequately substantiated. If your claim is denied, please review the section regarding appeals.

If you receive an overpayment, you must repay the Plan. If you fail to do so, the Claims Administrator or Plan Administrator may offset future benefits or take any other permissible action to recover these amounts. You may be required to certify that you will not seek reimbursement for the same expense from another plan.

Debit Card

In addition to submitting paper claims, you also can pay eligible medical expenses by using debit cards ("cards") provided by the Claims Administrator, subject to the terms and the procedures established by the Claims Administrator.

- **It is very important that you keep back-up documentation and receipts for all expenses you pay through the use of cards.** Failure to provide the required documentation will result in the deactivation of your card.

Card only for Eligible Medical Care Expenses. If you are a participant, you will be issued a card, and by using the card you are certifying that you will only use this card for eligible medical expenses, that the expense has not been reimbursed or cannot be reimbursed from a medical plan, that you will not seek reimbursement from any other plan for any expenses for which you use this card and that you will retain sufficient documentation for expenses paid with the card. Each time you use the card, you are reaffirming these requirements.

Card expiration. This card will be automatically cancelled upon your death or termination of employment or the date you cease to be a participant and as otherwise determined by the Claims Administrator. Cards are not typically issued each year, so keep your card for future years. Charges for additional cards may apply.

Only available for use with certain service providers. The cards will only be accepted by those merchants and service providers that have been approved by the Claims Administrator and have a maximum balance of the amount of your coverage.

Substantiation. Purchases by the cards are subject to substantiation by the Claims Administrator, usually by submission of a receipt from a service provider describing the service or expense, the date and the amount. All charges are conditional pending confirmation and substantiation. You are required to obtain and retain the documentation necessary to substantiate your claim.

Correction methods. If the Claims or Plan Administrator later determines that a purchase is not eligible, the Plan will use the following correction methods to make the Plan whole. Until the amount is repaid, the Claims Administrator will take action to ensure that further violations of the terms of the card do not occur, which may include deactivating the card, and by:

- Demanding repayment of the improper amount;
- Withholding the improper payment from the participant's wages or other

compensation to the extent consistent with applicable federal or state law;
- Applying claims substitution or offset of future claims; and
- If the above fails to recover the improper amount, the Company may treat the amount as any other business indebtedness.

Dependent Care Flexible Spending Account

You may elect to reimburse yourself for eligible dependent care expenses so that you – and your spouse if you're married – can work outside the home or attend school full-time. The amount you choose to set aside may differ based on your tax status and/or family situation.

In general, effective January 1, 2026, the maximum you can contribute to the Dependent Care FSA each year is the lesser of:

- $7,500 ($3,750 if married and filing a separate tax return); or
- Your earned income or your spouse's earned income
- If your spouse is either a full-time student or disabled, the IRS deems that your spouse has earned income of $3,000 per year ($250 per month) if you have one child or $6,000 per year ($500 per month) if you have two or more children (this amount may be adjusted by the IRS for future years). This means that if your spouse is a full-time student and you have one child, the maximum you can contribute to the Dependent Care FSA is $3,000.

Remember that if you are married and file jointly, and your spouse works and can contribute to a separate Dependent Care FSA with his or her employer, the maximum you can both contribute, combined, is the IRS maximum (you cannot each contribute $7,500).

Eligibility for the Dependent Care FSA

To be eligible to use the Dependent Care FSA, you must be working during the time your eligible dependent receives care. You must also meet one of the following eligibility guidelines:

- You are a single parent
- You have a working spouse
- Your spouse is a full-time student at least five months during the year while you are working
- Your spouse is physically or mentally unable to provide for his/her own care
- You are divorced or legally separated and have custody of your child most of the year, even though your former spouse may claim the child for income tax purposes. If you are divorced, the rules can get complicated and sometimes change, so please check with your tax advisor as to whether you are eligible for the Dependent Care FSA.

Eligible Dependents

To be an eligible dependent whose care expenses are eligible for reimbursement under the Dependent Care FSA, the individual must be your:

- qualifying child younger than age 13, or
- spouse or dependent who is mentally or physically incapable of caring for himself/herself (a "disabled dependent").

A qualifying child is someone who is your child (including step children, adopted children and certain foster children) or your sister or brother (including step-sisters and brothers) who has not provided over one-half of their own financial support for the taxable year and who lives with you for more than ½ of your taxable year (special rules apply to divorced parents).

A disabled dependent is someone (such as a spouse, disabled parent or a disabled child older than age 13) you claim on your income tax return as your dependent (or whom you could have claimed except that the individual's income exceeded the earnings permitted for income tax exemption purposes) and who lives with you for more than ½ of your taxable year.

Eligible Dependent Care FSA Expenses

For purposes of the Dependent Care FSA, to be considered an eligible expense, the expense must be for the care of an eligible dependent and must:

- Be incurred while you are a participant in the Dependent Care FSA;
- Be incurred for the care of such individual or for related household services;
- Be incurred to enable you to be gainfully employed;
- If the expense is incurred for services outside your household, be incurred for the care of (a) a qualifying dependent under the age of 13 who is your child or certain other of your relatives, or (b) a qualifying dependent who is physically or mentally incapable of caring for himself or herself, who has the same principal place of abode as you for more than ½ of your taxable year, and who regularly spends at least 8 hours per day in your household;
- If the expense is incurred for services provided by a dependent care center that provides care for more than 6 individuals, the center complies with all applicable state and local laws and regulations; and
- The expense is not paid or payable to a child of yours under age 19, or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

To be eligible for reimbursement, your dependent care expenses must be "work-related." Expenses are work-related if you incur them to allow you (and your spouse if you are married) to work or look for work. You can work for others or in your own business, you can work full-time or part-time, or your spouse can be working at home for pay.

However, unpaid volunteer work or volunteer work for a nominal salary does not qualify as "work-related."

Similarly, expenses incurred while you or your spouse is off work because of an extended illness or during a leave (such as a maternity leave) are not work-related. However, if you are on a short, temporary absence, expenses incurred during the short absence may be eligible.

Certain types of expenses are not eligible for reimbursement under the Dependent Care FSA. Examples of ineligible expenses may include:

- School expenses for kindergarten or higher
- Services provided while the employee (or spouse) is not working
- Overnight camp costs
- Expenses incurred after the child turns 13

If you would like more information about qualified dependent care expenses, please refer to IRS Publication 503 (go to http://www.irs.treas.gov/formspubs) or call the Claims Administrator. Expenses cannot be reimbursed until they have been incurred, even if they are prepaid. Expenses are incurred when the care is provided.

Qualifying Dependent Care Providers

To be an eligible expense, the care must be provided by a Qualifying Dependent Care Provider. A qualifying dependent care provider is a provider whose services qualify for reimbursement from your Dependent Care Flexible Spending Account. Qualifying providers may include:

- Dependent care centers (if the center provides care for more than six non-resident individuals, it must meet all applicable state and local regulations);
- An individual who provides care inside or outside your home (but not a child of yours under age 19 or any other individual for whom you can claim a tax deduction);
- Facilities for pre-school children; and
- A housekeeper whose services include, in part, providing care for a qualifying dependent.

Process for Reimbursement of Qualifying Dependent Care Expenses

To be reimbursed for eligible expenses, simply complete a signed form and send it with the required supporting documentation to the address on the form. Upon receipt, review, and approval of the claim you will be reimbursed from your spending account. Expenses are reimbursable only to the extent the Claims Administrator determines they are payable pursuant to the Plan and have been adequately substantiated. Additional information regarding reimbursement of qualifying dependent care expenses can be found at the claim administrator's website (see the end of the booklet for information about the claims administrators).

When completing a claim form, you must include the following information:

- The dates of service
- The amount of the charge
- The name of the providers of the services
- The tax ID of the provider
- Signature of provider on the claim, or receipt or other proof of payment

The Plan will reimburse the claim up to the available balance in your Dependent Care FSA at the time you submit the claim. If there aren't sufficient funds in your Dependent Care FSA to reimburse the entire claim, the remaining amount of the claim will be paid as soon as there have been enough payroll deductions credited to your account. You will not have to re-submit the claim. If you receive an overpayment, you must repay the Plan. If you fail to do so, the Claims Administrator or Plan Administrator may offset future benefits or take any other permissible action to recover these amounts.

Termination of Coverage - Special Rules for FSAs

If you terminate participation in the FSAs (e.g., you terminate employment or are no longer eligible), your FSA contributions will stop.

- You may file claims against your Health Care FSA account if the expenses were incurred before your participation terminated.

- You may file claims against your Dependent Care FSA if the expenses were incurred before your participation terminated up to the amount available in your account on your termination date.

- Under certain circumstances, you can continue your Health Care FSA through COBRA coverage. If you elect to continue your coverage under COBRA, any contributions for continuation coverage are made on an after-tax basis. As a result, the pre-tax advantage of contributing to the Health Care FSA is lost. However, if you do not use your entire account balance by the time your employment ends, the only way you can continue submitting receipts for expenses incurred after your employment ends is to continue Health Care FSA coverage under COBRA through the end of the plan year in which the qualifying event occurred, as described in the COBRA section of this SPD.

Continuation of Coverage

COBRA Continuation Coverage

COBRA is a federal law that requires most employers sponsoring group health plans to offer employees (and former employees) and their eligible covered dependents the opportunity to continue health coverage (called COBRA coverage) in certain circumstances when coverage would otherwise be lost. (For COBRA purposes, a loss of coverage includes an increase in the cost of such coverage.) Continuation of Health Care FSA coverage is subject to special rules discussed in this section.

See the Claims Administrator section at the end of the SPD for information about the COBRA Administrator.

COBRA continuation coverage is a continuation of coverage under the health plans sponsored by the Company (referred to as, "COBRA Eligible Plans") when coverage would otherwise be lost because of a life event known as a "qualifying event." Specific qualifying events are identified below. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary" and will lose coverage under a COBRA Eligible Plan because of a qualifying event. Depending on the type of qualifying event, employees, former employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay for that coverage. Generally, references to "you" and "your" in this discussion are to the Eligible Employees who are covered under a COBRA Eligible Plan.

1. Eligibility and Coverage

You will become a qualified beneficiary if you lose your coverage under a COBRA Eligible Plan because either one of the following qualifying events happens:

a. Your hours of employment are reduced; or
b. Your employment ends for any reason other than your gross misconduct.

Your covered spouse will become a qualified beneficiary if they lose coverage under a COBRA Eligible Plan because any of the following qualifying events happens:

a. You die;
b. Your hours of employment are reduced;
c. Your employment ends for any reason other than your gross misconduct; or
d. You and your Spouse divorce.

Also, if you reduce or eliminate your spouse's coverage under a COBRA Eligible Plan in anticipation of a divorce, and a divorce later occurs, the divorce may be considered a qualifying event for your spouse even though their coverage was reduced or eliminated before the divorce.

Your children will become qualified beneficiaries if they lose coverage under a COBRA Eligible Plan because any of the following qualifying events happens:

a. You die;
b. Your hours of employment are reduced;
c. Your employment ends for any reason other than your gross misconduct;
d. You and your Spouse divorce; or
e. The child stops being eligible for coverage as a "dependent child."

Children born to or placed for adoption with you during the continuation coverage period may also elect continuation coverage, as long as you have elected COBRA coverage for yourself. The coverage period will be determined according to the date of the qualifying event that gave rise to your COBRA coverage.

Special Rule for Health Care FSA. For those qualified beneficiaries who are covered by the Health Care FSA, COBRA coverage will consist of the Health Care FSA coverage in force at the time of the qualifying event (*i.e.*, the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year. Further, COBRA coverage will terminate at the end of the plan year and cannot be extended beyond the plan year in which the qualifying event occurs.

2. Required Notice of Qualifying Events

Under the law, you or a covered dependent (or a representative) has the responsibility to inform the Plan Administrator of a divorce or a child's loss of dependent status under a COBRA Eligible Plan. To be eligible for continued coverage, you or your covered dependent (or a representative) must inform the Plan Administrator within 60 days after the later of the event or the date on which coverage would otherwise end because of the event. In addition, in the event of the birth or adoption of a child after the qualifying event, you must notify the COBRA Administrator of the birth or adoption of the child whom you wish to enroll under the COBRA Eligible Plan. The notice procedures are described below. (Your employer must notify the COBRA Administrator of your death, termination of employment or reduction in work hours.) If this notice is not timely and properly provided, the qualified beneficiary will not be permitted to elect COBRA continuation coverage.

3. COBRA Election Period

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered, when appropriate, to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage for 60 days from the later of the date coverage is lost under the COBRA Eligible Plan or the date of notification to elect continuation coverage.

To inform the COBRA Administrator that you want COBRA coverage, you must complete the election form and return it as directed in the election notice that you receive. If the election form can be mailed, it must be postmarked no later than sixty 60 days after the date of the COBRA election notice provided at the time of the qualifying event.

You may elect COBRA continuation coverage on behalf of your eligible spouse, and you or your spouse may elect COBRA coverage on behalf of your eligible children. If you or your eligible spouse elects COBRA continuation coverage without specifying whether the election is for self-only coverage, the election will be considered to be made on behalf of all other qualified beneficiaries with respect to that qualifying event.

Other Health Coverage Options. When making the decision of whether to elect COBRA continuation coverage, you should keep in mind that you may have other options. Instead of enrolling in COBRA coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Medicare 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 or by calling 1-800-318-2596.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible. When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice and the election period expires, it can be difficult or impossible to switch to another coverage option.

Additional information is provided below.

4. Description and Maximum Length of COBRA Coverage

If you continue coverage, you will receive coverage identical to that provided under the COBRA Eligible Plan for similarly situated employees or family members. If the Company changes any regular group health plan benefits during your COBRA continuation period, your COBRA coverage will also be changed in the same manner.

COBRA coverage is a temporary continuation of coverage and may only be continued for certain specified time periods depending upon the qualifying event. These time periods are described in general below.

- ***36-Month Period.*** When the qualifying event causing loss of coverage is your death, your divorce, or a child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

- ***18-Month Period.*** When the qualifying event causing loss of coverage is the end of your employment or reduction in your hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. However, if you became entitled to Medicare benefits less than 18 months before your termination or reduction in hours of employment, COBRA continuation coverage for other qualified beneficiaries lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 8 months before your employment terminates, COBRA continuation coverage for your Spouse and children can last up to 36 months after the date of Medicare

entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

If you become entitled to Medicare or first learn that you are entitled to Medicare after submitting your Election Form, you must notify the COBRA Administrator of the date of your Medicare entitlement at the address specified herein. The notice procedures are described below.

The maximum COBRA coverage period for your newborn or newly-adopted child is measured from your original Qualifying Event. To be enrolled in the COBRA Eligible Plan, the child must satisfy the otherwise applicable eligibility requirements. A person who becomes the spouse of a qualified beneficiary (including a new spouse of an employee) or dependent child of a qualified beneficiary (other than one born to or placed for adoption with an employee) during COBRA continuation is not a qualified beneficiary and may not extend COBRA if a second event results in the loss of COBRA coverage.

Described below are two ways in which the general 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18 month period of continuation coverage: If you or anyone in your family covered under a COBRA Eligible Plan is determined by the Social Security Administration to be disabled and the COBRA Administrator is notified in a timely fashion, you and your family members who are receiving COBRA coverage may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The Social Security Administration must determine that the disability started at some time before the 60th day of COBRA continuation coverage, and the disability must last at least until the end of the regular 18-month period of continuation coverage. In order to qualify for the extension, you or the disabled qualified beneficiary (or a representative) must notify the COBRA Administrator in writing of the Social Security Administration's determination before the end of the 18- month period of COBRA continuation coverage and within 60 days after the later of (1) the date the qualified beneficiary is determined to be disabled by the Social Security Administration; (2) the date you terminated or reduced your hours of employment; and (3) the date on which the qualified beneficiary would lose coverage under the COBRA Eligible Plan as a result of your termination or reduction in hours of employment. The procedures for providing this notice are described below.

Second qualifying event extension of 18 month period of continuation coverage: If your family experiences another qualifying event while receiving 18 months (or 29 months in case of a disability extension) of COBRA continuation coverage, your Spouse/Domestic Partner and your children can get additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to your Spouse/Domestic Partner and any children receiving continuation coverage if you die or divorce, or if your child stops being eligible under the COBRA Eligible Plan as a dependent child, but only if the event would have caused your Spouse/Domestic Partner or child to lose such coverage under the COBRA Eligible Plan had the first qualifying

event not occurred. In no event may a qualifying event give rise to a maximum coverage period that ends more than 36 months after the date of the first qualifying event. For cases of second qualifying events, the qualified beneficiary must notify the COBRA Administrator in writing within 60 days after the later of (1) the date of the second qualifying event; or (2) the date on which the qualified beneficiary would have lost coverage under the COBRA Eligible Plan due to the second qualifying event if it had occurred before the first qualifying event. The procedures for providing this notice are described below.

Failure to provide timely and properly provide notice of a disability determination or second qualifying event will eliminate the right to extend the period of COBRA coverage.

5. Termination of COBRA Coverage

COBRA coverage will terminate before the end of the indicated time period if any one of the following events occurs:

a. The qualified beneficiary receiving COBRA coverage becomes covered under another group health plan after electing COBRA provided the plan does not have pre-existing condition exclusions affecting the covered individuals.
b. The qualified beneficiary receiving COBRA coverage becomes entitled to Medicare after electing COBRA continuation coverage.
c. The first required premium is not paid within 45 days or any subsequent premium is not paid within 30 days of the due date.
d. If coverage is extended beyond 18 months because of disability, the Social Security Administration makes a final determination that the qualified beneficiary is no longer disabled.
e. All group health plans for active employees of the Company are terminated.

Coverage may also end for certain other reasons, like fraud or misusing your ID card.

If, during the period of COBRA coverage, a qualified beneficiary becomes covered, after electing COBRA, under other group health plan coverage, you or the qualified beneficiary (or a representative) must notify the COBRA Administrator in writing within 30 days of the later of: (1) the date the other coverage becomes effective, or (2) the exhaustion or satisfaction of any preexisting condition exclusions affecting the qualified beneficiary. If, during the period of COBRA coverage, a qualified beneficiary becomes entitled, after electing COBRA, to Medicare Part A, Part B, or both, you or the qualified beneficiary (or a representative of either) must notify the COBRA Administrator in writing within 30 days after the beginning of Medicare entitlement (as shown on the Medicare card). The procedures for providing this notice in both of these circumstances are described below.

If the Social Security Administration determines that a qualified beneficiary is no longer disabled, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the date of the

determination. The qualified beneficiary must notify the COBRA Administrator in writing within 30 days after the Social Security Administration's determination that they are no longer disabled. The procedures for providing this notice are described below.

If notice of these events is not timely and properly provided, the qualified beneficiary's COBRA coverage may be terminated retroactively, and the qualified beneficiary may be required to repay a portion of the benefits received.

A qualified beneficiary does not have to show that they are insurable to choose COBRA coverage. However, COBRA coverage is provided subject to the qualified beneficiary's eligibility for coverage. The COBRA Administrator reserves the right to terminate a qualified beneficiary's COBRA coverage retroactively if they are determined to be ineligible.

6. Premium Payments

A qualified beneficiary who elects coverage will be charged a premium of no more than 102% of the total cost of providing coverage. The premium for a Social Security disabled person can be as much as 150% of the cost of coverage for the 19th through the 29th month of coverage.

Qualified beneficiaries will be notified of the cost of continuing benefits if they experience a qualifying event. The qualified beneficiary will have 45 days from the election date to pay the first premium; after that, premiums will be due and payable on the first day of the month. Generally, the first payment will cover the premium due from the date coverage is lost through the date COBRA is elected, plus any monthly premium that becomes due during the 45 day payment period. There will be a 30 day grace period to pay each subsequent monthly premium.

If the initial premium payment is not made by the end of the 45 day payment period, the qualified beneficiary will lose all COBRA rights and coverage will not take effect. If a subsequent monthly premium payment is not received by the first day of the coverage period to which it applies (e.g., the first day of the month), COBRA coverage will be suspended as of that day and then retroactively reinstated if the monthly payment is received prior to the end of the 30 day grace period. If the premium is not paid prior to the end of the grace period, the qualified beneficiary will lose all COBRA rights. The first payment and all monthly payments must be mailed to the COBRA Administrator at the address above.

The required monthly premiums may also change during your COBRA continuation period in the manner allowed by law. Qualified beneficiaries will be notified of any changes in benefits and/or rates during the applicable COBRA continuation period.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA coverage. You can learn more about the Marketplace below.

7. Notice Procedures

As a condition of receiving COBRA coverage, you or your covered dependent (or a representative) must notify the COBRA Administrator when certain events occur which

impact COBRA continuation coverage. These COBRA-related events include:

- Certain initial qualifying events
- Second qualifying events
- A qualified beneficiary's determination of disability or cessation of disability
- Enrollment in another group health plan while receiving COBRA coverage
- Medicare entitlement while receiving COBRA coverage

Each of these events, including the time period for providing notice of the event, has been discussed previously.

Notice of an initial qualifying event must be given to the Benefits Center. Notice of any other event must be given in writing and must be mailed to the COBRA Administrator (see below). The notice must contain the name, address and phone number of the covered employee (or formerly covered employee) and/or each qualified beneficiary experiencing the COBRA-related event, the name of the COBRA Eligible Plan, the COBRA-related event being reported and the date of such event. You must also provide evidence that the COBRA-related event has occurred. Acceptable evidence is your signed certification that the event has occurred, except in the case of a Social Security disability determination. For a Social Security disability determination, you must provide a copy of your Social Security Disability Award letter, or if you are no longer disabled, you must provide a copy of the Social Security's determination that you are no longer disabled. **The notice must be postmarked no later than the applicable deadline for giving the notice.**

Additional documentation supporting the Notice may be required. If such information is requested and it is not provided within the requested period, the Notice will not be considered timely and continuation coverage may not be available.

If the Notice is timely and properly provided, the notice will be deemed to have been provided on behalf of all Qualified Beneficiaries who are required to give the notice.

8. Health Insurance Marketplace

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

Time Limits on Enrolling in Marketplace Coverage. You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because

losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll until annual enrollment, so you should take action right away if you think that you may want Marketplace coverage. In addition, you may also enroll in Marketplace coverage annually during what is called an "open enrollment" period. The open enrollment period is the time during which anyone can purchase coverage through the Marketplace.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

Enrolling in COBRA Coverage May Temporarily Limit Your Options. If you sign up for COBRA coverage, you can switch to a Marketplace plan during a

Marketplace open enrollment period. You can also end your COBRA coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." If, however, you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if you enroll outside of the Marketplace open enrollment.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage once your election period ends.

9. Enrolling in Another Group Health Plan

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA coverage.

10. Enrolling in Medicare instead of COBRA continuation coverage

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 initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period to sign up, beginning on the earlier of (1) the month after your employment ends; or (2) the month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare Part B 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 then 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 will pay second. Certain COBRA continuation coverage 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.

11. Factors to Consider when Choosing Coverage Options

When considering your options for health coverage, you may want to think about:

- *Premiums*: You can be charged up to 102% of total plan premiums for COBRA coverage (more if you qualify for an extension of coverage on account of a disability). Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- *Provider Networks*: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- *Drug Formularies*: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- *Service Areas*: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- *Other Cost-Sharing*: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

12. For more information

If you have questions about the information in this section of the SPD notice or your right to coverage, contact the COBRA Administrator.

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, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area

who you can talk to about the different options, visit www.HealthCare.gov.

13. Keep the Plan Informed

To protect your family's rights, you should keep the Company and the COBRA Administrator informed of any changes in the addresses of your family members. If you have changed your marital status, or you or your Spouse/Domestic Partner have changed addresses, it is your responsibility to notify the COBRA Administrator. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees with regards to military service. If you go on a qualifying military leave of absence, you are generally entitled to participate in any rights under benefits not based on seniority that are available to employees on comparable non-military leaves. Upon reinstatement to active employment with your employer, you are generally entitled to the seniority, and all seniority-based rights and benefits associated with the position that you held at the time your employment was interrupted, plus the additional seniority; and seniority-based rights and benefits that you would have attained with reasonable certainty if your employment had not been interrupted.

If you or your Eligible Dependents lose coverage under a COBRA Eligible Plan as a result of your qualifying service in the uniformed services, you have the right to elect to continue such coverage under Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). To be entitled to USERRA rights, you must give advance notice of your service unless it is impossible or unreasonable under the circumstances to give such notice or giving such notice is precluded by military necessity. Service in the uniformed services includes performance of duty on a voluntary or involuntary basis in the Armed Forces (including the Coast Guard and the Reserves), the Army National Guard, the Air National Guard, and the commissioned corps of the Public Health Service.

Your right to continued health coverage under USERRA is very similar, but not identical, to your right to continued health coverage under COBRA. In those instances where your rights under COBRA and USERRA are not the same, whichever law gives you the greater benefit will apply. The administrative policies and procedures, which govern your right to COBRA continuation coverage, also apply to your right to USERRA continuation coverage, with a few limited exceptions.

Any election that you make under COBRA will also be an election to continue your health coverage under USERRA. If, however, you are unable to elect COBRA within the required period because of military necessity or because it is impossible or unreasonable for you to do so, the period for electing USERRA coverage will be tolled until the military necessity is abated or it is no longer impossible or unreasonable for you to make the required election. The period for electing COBRA coverage, however, will

not be tolled in this situation.

You are the only one that has the right to make an election under USERRA to continue health coverage for yourself and any covered dependents. Your covered dependents do not have an independent right to make an election for USERRA continuation coverage. As a result, if you do not elect USERRA / COBRA coverage on behalf of your covered dependents, your covered dependents will still have a right to elect to continue their health coverage under COBRA, but they will not be entitled to receive any additional benefits provided under USERRA.

If you take a qualifying military leave of absence, your benefits will continue as required by law and as allowed under your employer's leave policies. However, this coverage will terminate earlier if any one of the following events occurs:

- A premium payment is not made within the required time;
- You fail to return to work within the time required under USERRA following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Contact the Benefits Center for more information on applicable military leaves of absence.

Continuation of Coverage While on a Family and Medical Leave

Under the federal Family and Medical Leave Act (FMLA), employees are generally allowed to take up to 12 weeks of unpaid leave (26 weeks in the case of a military caregiver leave) for certain family and medical situations. If eligible, you can take up to 12 weeks of unpaid leave (26 weeks in the case of a military caregiver leave) in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care,
- For the care of a spouse, child, or parent who has a serious health condition,
- For your own serious health condition,
- For a qualifying exigency relating to the active duty, or call to active duty, of a family member who is a member of the US Armed Forces or of the reserves and who is deployed to a foreign country, or
- To care for a family member who is a member of the US Armed Forces or a veteran and who is being treated for or recovering from a serious injury or illness incurred or aggravated by service in the course of active duty (known as a "military caregiver leave").

Depending on the state you live in, the number of weeks of leave available to you for family and medical reasons may vary based on state law requirements.

During an approved FMLA leave, your benefits will continue as required by law and as allowed by your employer's leave of absence policies. Your participation in the MDM health and welfare plans will continue while you are on an approved FMLA leave (paid or unpaid) as long as you pay the required premium for coverage in a timely manner. If your leave is unpaid, you will be billed for the cost of coverage under the MDM health and welfare plans. If you do not pay the required premium in a timely manner, your coverage will terminate. If you are on an unpaid FMLA leave of absence, you also have the right to terminate your coverage during your leave of absence and reinstate your coverage if you return to work at the end of the FMLA leave. If you do not return to work at the end of the FMLA leave and your leave of absence is not extended, your coverage under the Medical Plan will terminate unless you qualify for extended coverage. If you do not return to work at the end of your FMLA leave, you will be given an opportunity to elect to continue your health coverage through COBRA.

Continuation of Coverage While on an Employer-Approved Leave of Absence

If you take an approved leave of absence (other than pursuant to the FMLA or USERRA), your benefits will continue in accordance with your employer's leave of absence policies. Your coverage will continue at active rates during your approved leave of absence subject to timely payment of the required premium, with the exception of an FMLA or USERRA leave where you may choose to decline your benefit continuation.

If your leave of absence is paid, the cost of your coverage will be deducted from your pay. If your leave of absence is unpaid, you may be required to send in monthly payments for the required premium or contribution on a timely basis to continue coverage, otherwise your coverage will be terminated. The Benefits Center will bill you on a monthly basis for the cost of coverage starting the first of the month following the start of your approved unpaid leave. Payroll deductions will resume the first of the month following your return from the approved unpaid leave.

The insured Benefit Programs may limit your ability to continue to participate in the Benefit Program during an approved leave of absence. You should review the booklets for those Benefit Programs for additional information.

Your coverage may terminate before the end of your approved leave of absence if any of the other termination events described previously occur, including your failure to pay the required contributions for coverage on a timely basis. (See the *Participation* section of this SPD for additional information.) For additional information regarding your continued participation in the Plan during a leave of absence, you should contact the Benefits Center.

Claims and Appeals Procedures

Internal Claims and Review Procedure

Usually, benefits are paid in the ordinary course using the forms and procedures described in this SPD or the applicable Booklets. However, occasionally you may wish to file a formal claim. The procedures for filing a formal claim for benefits are set forth below.

A participant or beneficiary has a right to file a claim for benefits under the Plan, ask if they have a right to any benefits under the Plan, or appeal the denial of a claim for benefits under the Plan. For purposes of the Plan's claims procedure, the term "you" will include any participant or beneficiary making a claim, inquiry or appeal and the authorized representative of such person. The Plan's procedures for appointing an authorized representative are discussed at the end of this section.

Generally, the insurers or third party administrators of the benefits provided under the Benefit Programs have the responsibility and authority for making decisions about claims for benefits under each respective Benefit Program (the "Claims Administrators"). The Plan Administrator will be the Claims Administrator with respect to all matters that are not the responsibility of the third party administrators and insurers, including, but not limited to, determinations regarding eligibility. The names and contact information of each such "Claims Administrator" is provided in the chart below.

In general, the booklets for each Benefit Program contain a description of the procedure for filing a claim for benefits and appealing the denial of an adverse benefit determination. Please refer to these booklets for the applicable claims and appeals procedure. The following is a description of the procedure for handling (1) most eligibility and non-benefit claims and appeals; and (2) claims and appeals filed with respect to the EAP and the Flexible Spending Accounts. If you have a claim, you should always first refer to the applicable booklet for the Benefit Program.

If you file a claim, you generally will receive written notice of the determination within 30 days for health plan claims, 45 days for disability plan claims and 90 days for all other claims of the date the Claims Administrator receives the claim. If additional information is needed to process the claim, the Claims Administrator will notify you.
You then have 45 days to provide the requested information (or such other period specified by the Claims Administrator in writing). If, for reasons beyond the control of the Claims Administrator, an extension of time is required to process the claim, you will receive written notice of the extension, an explanation of the circumstances requiring the extension and the expected date of the decision prior to the end of the 30-day period, 45-day period or 90-day period, as applicable. In no event will the extension exceed a period of an additional 15 days from the end of the initial 30-day period, 30 days from the end of the initial 45-day period and 90 days from the end of the initial 90-day period.

If your claim is denied, in whole or in part, you will receive a written explanation of the denial that will include all information required under applicable law. This includes the specific reason or reasons for the denial, specific reference to the plan provision on which

the denial is based, a description of additional information necessary to perfect the claim and a description of the Plan's claims review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA following an adverse determination on review. If the claim relates to disability benefits, the notice may have additional information.

You may request that your claim be reviewed by the Plan Administrator. To appeal the denial of a claim, you must notify the Plan Administrator within 180 days of the date of the denial (for group health and disability claims) and 60 days for other claims. In connection with an appeal, you have the right to review pertinent documents, records, and other information relevant to your claim and to submit written comments, documents, records, and other information relevant to the appeal of your claim for benefits. Copies of all information relevant to your claim will be provided free of charge by the Plan Administrator, upon request. The determination of what information is "relevant" will be made by the Plan Administrator in accordance with ERISA.

Your claim will be given a full and fair review. To the extent required by law, the decision on review will not give deference to the initial adverse claim determination and will be conducted by an individual who is not the same individual who made the initial adverse claim determination or a subordinate of such individual.

If you file an appeal of a claim denial, the decision regarding the appeal will be made by the Plan Administrator promptly, but not later than 60 days after receipt of your appeal of a health plan claim, 45 days for disability plan claims (with the possibility of one 45- day extension) and 60 days for all other claims (with the possibility of one 60-day extension). When the appeal is decided, you will be notified in writing of the results of the review. This notice will include all information required under applicable law. This includes the specific reason or reasons for the denial; specific references to the Plan provision on which the denial is based; a statement of your right to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim; and a description of the Plan's voluntary appeal procedures and a statement of your right to bring a civil action under ERISA following an adverse determination on review. If the claim relates to disability benefits, the notice may have additional information.

Exhaustion of Administrative Remedies and Limitations on Actions

You must use and fully exhaust all of your actual or potential rights under the administrative claims and appeals procedures for each Benefit Program by filing an initial claim and then seeking a timely appeal of any denial before bringing filing suit. The Plan does not offer any voluntary levels of appeal to the Plan Administrator. The exhaustion requirement relates to claims for benefits, eligibility and to any other issue, matter or dispute (including any plan interpretation or amendment issue).

Any claim or action that is filed in court or other tribunal against or with respect to the Plan and/or the Plan Administrator must be brought within the following time frames.

If your claim or action relates to the alleged wrongful denial of Plan benefits provided under a Benefit Program that is not insured or eligibility for a Benefit Program, it must be filed within –

- Two years after the Plan's final decision on review; or

- If you do not exhaust the administrative remedies described above in a timely manner (e.g., you do not file an initial claim or appeal an adverse benefit determination within the required time period), two (2) years after the date the claim arose.

Keep in mind that even if you file suit within these time periods, the Plan and the Plan Administrator reserve the right to assert that your claim is barred because you failed to exhaust the Plan's administrative remedies described above.

For the insured Benefit Programs, you should review the applicable booklet to determine the time period for filing suit with respect to the alleged wrongful denial of Plan benefits.

For any other claim or action (including one that does not relate to an alleged wrongful denial of Plan benefits), it must be filed within two (2) years of the date you had constructive knowledge of the actions or events that gave rise to your claim or action.

Any such suit may only be brought in the federal court in the Middle District of Florida, within the time periods described in this paragraph. Notwithstanding, the preceding sentence will not apply with respect to any suit which is filed against an insurer of an insured Benefit Program. You should refer to the booklet(s) for the insured Benefit Programs for information regarding any time limits or geographical restrictions on filing suit. Failure to follow the administrative claims and appeals procedures in a timely manner will cause you to lose your right to sue regarding an adverse benefit determination.

Discretionary Authority

With respect to those matters that the Plan Administrator and each of the Claims Administrators have been authorized to handle, each such entity has the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and their decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority will be upheld on judicial review, unless it is shown that the interpretation or determination was an abuse of discretion (i.e., arbitrary and capricious). Benefits under the Plan will be paid only if the Plan Administrator or Claims Administrator decides in its discretion that you are entitled to them.

No Assignment Permitted

- Your rights and benefits under this Plan cannot be assigned, sold or transferred to any person, including your healthcare provider.
- At its option, the Claims Administrator may make payments directly to a

healthcare provider, but a direct payment to a healthcare provider will not constitute an assignment of health benefits or rights under the Plan. Any purported assignments of benefits or rights under the Plan will be void and will not apply to the Plan.

- You may authorize the Claims Administrator, on behalf of the Company, to make payments directly to participating network providers for covered services. These are assignments of payments, and not assignments of benefits. To the extent that a healthcare provider's assignment of payment includes an assignment of benefits, any assignment of benefits will be void and will not apply to the Plan.
- The Claims Administrator may also make payments directly to you. Payments, as well as notice regarding the receipt and/or adjudication of claims, may also be made to an alternate recipient or that person's custodial parent or authorized representative. This payment will fulfill the Plan's obligation to pay for covered services. You cannot assign your right to receive payment to anyone else, except as allowed by a "Qualified Medical Child Support Order."
- In addition to the above, any assignment of payments to a healthcare provider or any direct payments from a carrier to a healthcare provider will not be an assignment of benefits.

Authorized Representatives

You may appoint an authorized representative to act on your behalf for purposes of any Benefit Program. If you need to appoint an authorized representative, you must follow the rules and procedures of the Claims Administrator for such claim or appeal. In the case of an urgent health care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

To the extent the Claims Administrator has no rules or procedures, or does not impose stricter requirements, your appointment of an authorized representative must follow these requirements –

- must be in writing and dated, AND
- must clearly indicate the authorized representative, the scope of the appointment and any limitations on the authorized representative, AND
- must be signed by you and be notarized (unless the authorized representative is a family member or your attorney), AND
- must satisfy any other legal requirement applicable to appointments under applicable law, AND
- must be approved by the Plan Administrator in writing.

The Plan will also recognize a court order appointing a person as your authorized representative. The Plan Administrator may also provide different rules and procedures for an appointment of an authorized representative in emergency situations. If you appoint an authorized representative, notices and other communications will go to you and your authorized representative unless the Plan Administrator specifies otherwise. You should contact the Plan Administrator with any questions or to qualify someone as your authorized representative.

Administrative Information

Name of Plan and Plan Number

The MDM Technology USCo, LLC Welfare Benefit Plan

Plan Number 501

Name, Address and EIN of Plan Sponsor:

MDM Technology USCo, LLC
5335 Gate Parkway
Jacksonville, FL 32256
Phone: 1-904-648-6350

Employer Identification Number (EIN): 39-5064974

Name and Address of Plan Administrator:

The Dun & Bradstreet Plan Administration Committee
c/o MDM Technology USCo, LLC
5335 Gate Parkway
Jacksonville, FL 32256
Phone: 1-904-648-6350

Agent for Service of Legal Process

The name, address and telephone number of the agent for service of legal process are:

The Dun & Bradstreet Plan Administration Committee
c/o MDM Technology USCo, LLC
5335 Gate Parkway
Jacksonville, FL 32256
Phone: 1-904-648-6350

Plan Type

Most of the Benefit Programs offered under the Plan comprise a single "welfare benefit plan" for purposes of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan provides insured medical (including prescription drug), dental, vision, life, and disability benefits to Eligible Employees and, in certain cases, their Eligible Dependents. The Plan also provides an EAP, Health Care and Dependent Care FSA benefits, but the Dependent Care FSA is not an ERISA plan and is included in this SPD for informational purposes only.

Plan Year

The financial and other records for the Plan are kept on a Plan Year basis. The Plan Year is the twelve month period beginning January 1 and ending the following December 31, except that the first plan year is a short year from July 1, 2026 through December 31, 2026.

Health and Welfare Plan Funding and Source of Contributions

The cost of participating of the benefit programs that are part of the Plan re based on the premium charged by the insurer. The benefits provided under the insured Benefit Programs are funded through one or more fully-insured policies. The benefits provided under the self-insured Benefit Programs are paid by the Company out of its general assets.

The Flexible Spending Accounts and EAP are self-insured and are administered on a contract- administration basis by the Claims Administrator. Under federal tax law, participants' flexible spending account contributions are treated as Company contributions for their benefit and are intended to be non-taxable to the participant when used for eligible expenses.

Plan Administration

The Plan Administrator is responsible for administering the Plan. The Plan Administrator or a participating employer may retain one or more third parties to provide certain administrative services with respect to administration of the Plan. For those Benefit Programs that are insured, the insurer is responsible for administering the benefits provided under the Benefit Program. The third party administrators and insurers are referred to in this document as the "Claims Administrator." The Claims Administrator for each Benefit Program is listed in a table in the *Claims and Appeals Procedures* section.

Amendment and Termination

The Company reserves the right to discontinue or terminate the Plan or any of the Benefit Programs, to modify the Plan or any of its Benefit Programs to provide different cost sharing between the Company and participants, or to reduce, amend or modify the Plan or any Benefit Programs in whole or in part and in any respect. This may be done at any time and without advance notice.

All statements in this SPD and all representations by the Company or its personnel are subject to this right of amendment and termination. This right applies without limitation even after an individual's circumstances have changed by termination, retirement or otherwise. The benefits of the Plan and any of the Benefit Programs do not become vested at any time.

Compliance with the Affordable Care Act

It is the Company's policy and intent to comply with all applicable provisions of the Affordable Care Act and its related regulations and other governmental guidance.
The Company will investigate fully any complaint that the Company or the Plan has not complied with such laws and regulations and will take steps to remedy any violations should they occur. If you believe that the Company or the Plan has violated a provision of the Affordable Care Act, you are encouraged to share your complaint with the Company by contacting the Benefits Center. Please provide as much information as you can regarding your complaint to help with the investigation. The Company will not retaliate or otherwise discriminate against you if you assert a complaint or take any other action which is protected under the Affordable Care Act.

Your ERISA Rights

The following statement is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). (The ERISA protections do not apply to the Dependent Care FSA or the HSA benefits.) ERISA provides that all participants will be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, Spouse or dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

- In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

- No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

- If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. However, in no event will you be allowed to file suit in state or Federal court until you have exhausted the administrative remedies available under the Plan, including following the appropriate claims procedure as described above.

- In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain

publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Program, Funding, Administrator

Benefit Program	Claims Administrator/Insurer
Medical Plan (insured)	Cigna 1-888-806-5094 www.my.cigna.com/web
Dental Plan (insured)	Delta Dental Claims 1-800-521-2651 www.Deltadentalins.com
Vision Plan (insured)	EyeMed Vision 1-866-800-5457 www.eyemed.com
Long Term Disability (insured)	The Hartford 1-888-301-5615 https://mybenefits.thehartford.com/login
Life and AD&D (insured)	The Hartford 1-888-301-5615 https://mybenefits.thehartford.com/login Claims: Ph:888-563-1124 Fax:866-954-2621 Email: gbclaimcslife@thehartford.com
Business Travel Accident (insured)	Chubb Travel Assistance Program 1-855-327-1414 (Inside the USA or Canada) -630-694-9764 (Outside the USA Call Collect) MedAssist-USA@AXA-Assistance.us
EAP (self-insured)	Aetna EAP 1-888-238-6232 www.resourcesforliving.com (username /password: dnb)
Flexible Spending Accounts (self-insured) Health Savings Account (HSA)	WEX 1-866-451-3399 www.WEXinc.com
The Dun & Bradstreet Benefits Center	1-877-362-8953 www.netbenefits.com/dnb
COBRA Administrator	1-877-362-8953 www.netbenefits.com/dnb