DURA | SHILOH

2025 EMPLOYEE BENEFITS GUIDE

Non-Union

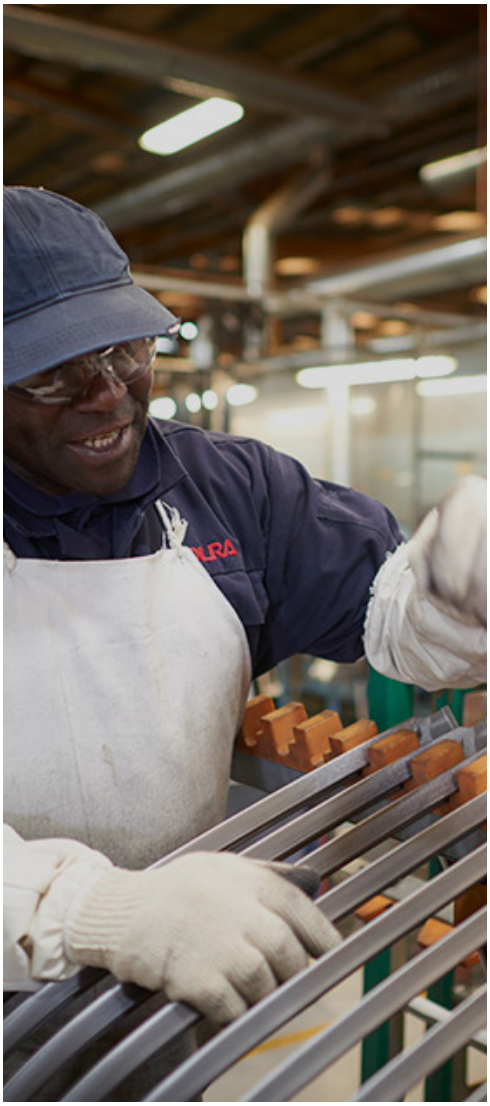
Table of Contents

Introduction to our Employee and Families

We recognize that employees perform their best when they are healthy, and that optimal employee performance is necessary for the company to be a leader in the industry. The benefits program aims to improve the health and wellbeing of our Dura Shiloh family. Each year, the company provides an Open Enrollment period to allow our employees to choose their benefits for the upcoming year.

The employee benefits provided by the company are part of your financial safety net. It's important to invest time and effort to select the right benefits and learn how to use your benefits appropriately to protect your personal and family interests.

This Benefits Guide provides information to our new members as well as current members. During our annual Open Enrollment, you can review current insurance coverage, learn about important changes and updates, and make decisions about benefits for the coming year. It also provides a great opportunity to make well-informed decisions and become a good benefits consumer. It's time to take an active role in this process!



New Hire Eligibility and Open Enrollment

Newly hired employees are eligible for benefits on the date of hire. Once eligible, they have 30 days to make their election. Each year, Dura Shiloh holds an annual Open Enrollment. This means that all eligible employees can either select benefits or elect changes to their current benefit. Per the IRS, you may only make changes to your benefits at Open Enrollment, or, if you experience a Qualified Life Status Change (i.e., birth, adoption, divorce, gain/loss of coverage, and more.)

Dependent Coverage

Your spouse must be your legally married spouse under the law. In addition, proof of legal marriage in the form of a marriage certificate is required to add your spouse to your medical coverage. See the Working Spouse Provision on the next page for additional information when covering your spouse.

Dependent child(ren) can be covered as follows:

- Dependent child(ren) as defined per the IRS regulations up to age 19.
- Child(ren) age 19 to 26 can be covered until the end of the month in which they turn 26.
- Child(ren) of a covered dependent child if the covered dependent child is not yet 18 years of age.
- Unmarried children who, because of a mental or physical handicap, depend solely on you for support may be covered regardless of age. Proof of your adult dependent's disability is required to obtain coverage.
- Proof of dependent status in the form of a birth certificate, legal or adoption paperwork, etc. is required to add a dependent to your medical coverage

Working Spouse Provision

Dura Shiloh requires working spouses of employees to take coverage through their own employer. Spouses with medical insurance available through their employer will not be allowed on the Dura Shiloh medical plans except for the following exceptions:

1. Spouse is unemployed.
2. Spouse is self-employed.
3. Spouse is working but not offered health coverage.
4. Spouse must pay more than 50% of the total cost of their medical plan.

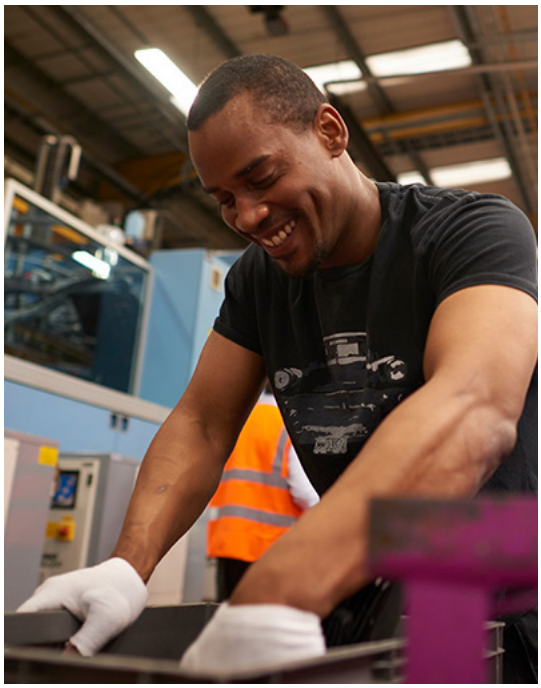
An Affidavit of Spousal Health Care Coverage form will need to be completed and returned to HR for all spouses covered under Dura Shiloh's medical plan to verify the above exceptions.

Enrollment and Benefits

This booklet provides a brief overview of the benefits offered by Dura Shiloh. Additional details about each plan are located at **www.MyDuraShilohBenefits.com** which can be accessed from any computer. Please take time to go through the materials on the site. If you do not have access to a computer, you can use the computer available to employees at your plant. Please contact a member of Human Resources for assistance if needed. Choose your benefits carefully. Once enrolled, you can change your benefits only if you have a qualified status change defined as the occurrence of one of the following events:

- Birth of your child
- Your legal adoption or placement in your home for adoption of a child
- Your marriage
- Loss of eligibility for any reason including legal separation, divorce, death, or a change in employment status of spouse
- Coverage under COBRA continuation has ended, or
- Your coverage under your spouse's plan has changed resulting in a substantial loss of coverage or a substantial increase in the out-of-pocket cost of your spouse's plan, including premium cost

If you have a qualified status change as defined above, you must report the change to Human Resources within 30 days to make changes to your coverage. If you fail to meet the 30-day notification requirement, you will not be allowed to make changes to your coverage until the next Open Enrollment period.



Medical Program

For 2025, Dura Shiloh will maintain our relationship with Allegiance (a Cigna company) and offer 2 Medical Plans – **PPO and HDHP with HSA.**

Your claims administrator is Allegiance, and your network of providers or what is considered "in-network" is the **Cigna PPO** network.

To find an in-network provider near you, go to **www.AskAllegiance.com** and use the "Find Provider" link.

Both plans have embedded deductibles which means that you have both an individual deductible and a two person or family deductible. Claims are applied to each deductible; once one or the other is satisfied, your coinsurance coverage will begin.

The High Deductible Health Plan (HDHP) is a qualified plan meaning you are eligible to open/maintain a **Health Savings Account (HSA)** so long as you are enrolled in this plan.

All plans cover in-network preventive care at no cost to you!

Where to go for care:

When it comes to taking care of yourself or your loved ones, you want to get the best care as quickly and affordably as possible. It's important to know, you have options:

TELEHEALTH	PRIMARY CARE PHYSICIAN	URGENT CARE	EMERGENCY ROOM
Open 24/7 Hours	Regular Business	Regular Business	Open 24/7 Hours
$	$$	$$$	$$$$
No Appointment Needed	Appointment Required	No Appointment Needed	No Appointment Needed

LEVEL OF SEVERITY

Go Mobile for 24/7 Access

Access your health plan 24/7 with the Allegiance Mobile App! Simply download the app and login with your participant ID. New users should first create a login at **www.AskAllegiance.com**.

PPO

PLAN BENEFITS	IN- NETWORK	OUT-OF- NETWORK
Annual Deductible	$1,500 EE | $2,000 EE+1 | $2,500 Family	$3,000 EE | $4,000 EE+1 | $5,000 Family
Coinsurance (after deductible)	30%	50%
Out of Pocket Maximum (includes deductible and coinsurance)	$4,000 EE | $6,000 EE+1 | $8,000 Family	$8,000 EE | $12,000 EE+1 | $16,000 Family
Preventive Care	FREE	50% after deductible
INPATIENT SERVICES		
Emergency Use of ER (copay waived if admitted) (diagnostic treatment and/or service subject to deductible)	0% after $300 copay	0% after $300 copay
Room and Board	30% after deductible	50% after deductible
Lab, X-ray & Ancillary Services	30% after deductible	50% after deductible
Mental Health & Substance Abuse	30% after deductible	50% after deductible
OUTPATIENT SERVICES		
Telehealth Visit (MD Live only)	FREE	N/A
Office Visit (diagnostic treatment and or service subject to deductible)	$25 Copay	50% after deductible
Specialist (diagnostic treatment and or service subject to deductible)	$50 Copay	50% after deductible
Urgent Care (diagnostic treatment and or servicesubject to deductible)	$75 Copay	50% after deductible
Physical or Occupational Therapy Office Visits	$50 Copay	50% after deductible
Chiropractic Services	$50 Copay	50% after deductible
Speech Therapy Office Visits	$50 Copay	50% after deductible
Outpatient Surgery	30% after deductible	50% after deductible
Dietician Services (3-day limit)	$50 Copay	50% after deductible
OTHER SERVICES		
Ambulance Services, Hospice Care, Home Health Care, Skilled Nursing	30% after deductible	50% after deductible

See page 15 for Employee Contributions Rates for all medical plans

HDHP with HSA

PLAN BENEFITS	IN- NETWORK	OUT-OF- NETWORK
Annual Deductible	$3,500 EE | $5,000 EE+1 | $6,500 Family	$7,000 EE | $10,000 EE+1 | $13,000 Family
Coinsurance (after deductible)	20%	50%
Out of Pocket Maximum (includes deductible and coinsurance)	$6,000 EE | $9,000 EE+1 | $12,000 Family	$12,000 EE | $18,000 EE+1 | $24,000 Family
Preventive Care	FREE	50% after deductible
INPATIENT SERVICES (*COPAYS APPLY AFTER DEDUCTIBLE HAS BEEN MET)		
Emergency Use of ER (copay waived if admitted)(diagnostic treatment and/or service subject to deductible)	$300 copay after deductible	$300 copay after deductible
Room and Board	30% after deductible	50% after deductible
Lab, X-ray & Ancillary Services	30% after deductible	50% after deductible
Mental Health & Substance Abuse	30% after deductible	50% after deductible
OUTPATIENT SERVICES (*COPAYS APPLY AFTER DEDUCTIBLE HAS BEEN MET)		
Telehealth Services (MD Live Only)	FREE*	Not Covered
Office Visit (diagnostic treatment and or service subject to deductible)	$25 Copay*	50% after deductible
Specialist (diagnostic treatment and or service subject to deductible)	$50 Copay*	50% after deductible
Urgent Care (diagnostic treatment and or service subject to deductible)	$75 Copay*	50% after deductible
Physical or Occupational Therapy Office Visits	$50 Copay*	50% after deductible
Chiropractic Services	$50 Copay*	50% after deductible
Speech Therapy Office Visits	$50 Copay*	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Dietician Services (3-day limit)	$50 Copay*	50% after deductible
OTHER SERVICES		
Ambulance Services, Hospice Care, Home Health Care, Skilled Nursing	20% after deductible	50% after deductible

See page 15 for Employee Contributions Rates for all medical plans

Tobacco/Nicotine Cessation Program

Any employee covered under the Dura Shiloh Medical Plan(s) who has used tobacco and/or nicotine products within the last 6 months will be assessed a surcharge.

Tobacco/nicotine is defined as all tobacco or nicotine-derived or containing products, including but not limited to:

- Cigarettes, electronic cigarettes and any vaping device (e.g., clove, bidis, kreteks)
- Cigars and cigarillos
- Hookah smoked products
- Pipes
- Oral tobacco and nasal tobacco (e.g., smokeless, spit, spitless, chew and snuff)
- Products intended to mimic tobacco products or deliver nicotine

When you log into UKG Pro - **e44.ultipro.com** for the first time, you will be asked to complete a survey indicating whether you are a Tobacco/Nicotine user. Please answer the questions on the survey and submit your response. Should you identify yourself as a tobacco/nicotine user, you will be charged an additional $75 per month surcharge.

Employees who have used tobacco/nicotine products in the past six months but wish to avoid the $75 per month tobacco/nicotine surcharge are invited to complete the UBreathe Tobacco/Nicotine Cessation program administered by Marquee Health.

If I am a tobacco/nicotine user and want to avoid the surcharge, what are my next steps?

1. Enroll in the free UBreathe Program as early as October 30, 2024
2. Complete 4 weekly coaching sessions by March 29, 2025
3. New hires will have 90 days from date of hire to enroll and complete their 4 weekly coaching sessions

The completion of the survey is required each and every year during the Open Enrollment period.

SurgeryPlus

SurgeryPlus is a program designed to lower your out-of-pocket costs associated with planned, non-emergency surgery. Employees are automatically enrolled in SurgeryPlus at no cost to you and your participation is 100% voluntary.

Your Cost When Using SurgeryPlus:	
PPO Plan Members:	FREE
HDHP Plan Members:	Deductible is reduced, if anything

The SurgeryPlus Difference

- **Excellent Care**
  You have access to a network of thousands of highly qualified and best available surgeons.
- **Meaningful Savings**
  Dura Shiloh wants our employees to received the best, most affordable care, so they help cover the most expensive costs of your non-emergency surgeries.
- **Guided Support**
  Your personal Care Advocate will support you at every step of the way.

For more information, visit **DuraShiloh.SurgeryPlus.com**, call 833-227-7581 or email **DuraShiloh@SurgeryPlus.com**

Pharmacy Program

CVS/Caremark will remain our Pharmacy provider in 2025 and maintain its national network of CVS, Walgreens, Target, Walmart, Grocery Stores, Costco, local pharmacies, and more.

Mandatory Mail-Order Maintenance Medication Program

- You may fill prescriptions for maintenance medications up to 2 refills at a retail pharmacy.
- Additional 90-day refills must be processed through mail-order or at a CVS or Target Pharmacy.
- Mail-order saves you money as you are getting a 3-month supply for the cost of only 2 months of medication (Buy 2, Get 1 FREE!).

Mandatory Generic Prescription Program

- If you OR your provider directs the pharmacy to fill a brand name medication when a generic is available, you will pay the cost difference between the brand medication and the generic medication.
- In addition, you will also pay the applicable brand level copay for the medication.

Specialty medication will be filled exclusively by CVS Specialty (IMPORTANT)

- Medication can be delivered anywhere nationwide (within certain state restrictions), including to your local CVS Pharmacy or Provider for pickup.
- Contact **www.CVSSpecialty.com** for help with managing your specialty medications and/or download the CVS Specialty mobile app.

PRESCRIPTION DRUGS	RETAIL	MAIL ORDER
Generic (Mandatory)	$10 copay (30-day supply) $20 copay (90-day supply) CVS/Target only	$20 copay (90-day supply)
Brand Name Formulary	$30 copay (30-day supply) $60 copay (90-day supply) CVS/ Target only	$60 copay (90-day supply)
Brand Name Non-Formulary	$60 copay (30-day supply) $120 copay (90-day supply) CVS/Target only	$120 copay (90-day supply)
Specialty (CVS Mandatory)	25% of drug cost to a maximum of $250	N/A

PPO: Copays apply immediately
HDHP: Copays apply after the deductible has been met

Telehealth

When you can't get to your doctor, MD Live is there for you!

Allegiance provides access to MD Live's telehealth services as part of your medical plan. MD Live lets you get the care you need for a wide range of minor conditions including most prescriptions. Now you can connect with a board-certified doctor via video chat or phone without leaving your home or office when, where and how it works best for you!

When: Day or night, weekdays, weekends and holidays

Where: Home, work or on-the-go

How: Phone or video chat

Who: MD Live

Say it's the middle of the night and your child is sick or you're at work and not feeling well. If you pre-register on MDLive, you can quickly speak with a doctor for help with:

Cold & Flu	Rash	UTI	Stomach
Fever	Allergies	Acne	Headache
& Many More!			

Telehealth visits with MDLive are a cost-effective alternative to a convenience care clinic or urgent care center and costs less than going to the emergency room. MDLive is a national telehealth provider, so you can choose your care confidently.

The cost to use MDLive is less than visiting a doctor/Urgent Care in person.

PPO - FREE
HDHP - $55 or less; Free after deductible is met

This service is intended for nonlife threatening conditions. In an emergency, call 911 or go to the nearest hospital.

Register here: www.MDLive.com/Allegiance

Dental Program

Dura Shiloh offers two comprehensive dental plans to fit your needs. Your coverage is provided through Delta Dental of Ohio which offers you an extensive network of dental providers. Remember, using an in-network PPO dentist can save you money. If you use an out-of-network dentist, Delta Dental will send payment for the claim to you, and you will be responsible for paying the out-of-network dentist.

To find a dentist, review your benefits, download or print your ID card and much more, go to www.deltadentaloh.com or call **800-524-0149**.

Delta Dental has two networks to choose your dentist from:

PPO Network: Deepest discounts available and balance billing protection.

Premier Network: Broader network, discounts available, balance billing protection.

Out-of-Network: Claim is processed under "reasonable & customary" limits. Delta Dental will send payment for the claim to you, and you will be responsible for paying the dentist.

Benefits	Low Plan	High Plan
Annual Deductible(single | family)	$50 | $150	$50 | $150
Calendar Year Maximum Benefit (excludes ortho)	$1,000 Per Person	$2,000 Per Person
Orthodontia	Not Covered	50%, $2,500 Lifetime Maximum
Diagnostic & Preventive Services (annual deductible does not apply)	100%	100%
Brush Biopsy–to detect oral cancer	100%	100%
Radiographs–X-rays	100%	100%
Basic Services		
Emergency Palliative Treatment	80%	80%
Sealants	80%	80%
Minor Restorative Services	80%	80%
Endodontic/Periodontics Services	80%	80%
Oral Surgery & All Other Basic Services	80%	80%
Major Services		
Major Restorative Services	50%	50%
Relines and Repairs	50%	50%
Prosthodontic Services	50%	50%

Go Mobile for 24/7 Access

Visit the Delta Dental site at www.deltadentaloh.com or download the mobile app.

Vision Program

Dura Shiloh offers 2 vision plans to help fit the needs of all employees. The High Vision Plan includes $0 copays on annual exams and lenses, an increased frame and contact lenses allowance, and frames every 12 months.

Both plans will continue to be offered through EyeMed. To find more information about in-network providers and additional discounts, visit **www.eyemed.com**.

Low Plan		
BENEFITS	IN- NETWORK	OUT-OF-NETWORK*
Exam with Dilation (as necessary)	$10 Copay	Up to $30
Exam Options:	**Standard Contact Lens Fit & Follow Up:** Up to $40 **Premium Contact Lens Fit & Follow Up:** 10% off Retail	N/A
Standard Plastic Lenses	**Single:** $25 copay **Bifocal:** $25 copay **Trifocal:** $25 copay **Lenticular:** $25 copay **Standard Progressive Lens:** $90 Copay	$25 $40 $55 $55 $40
Frames	$0 Copay; $120 Allowance	$60
Contact Lenses	**Conventional:** $0 Copay; $130 Allowance **Disposable:** $0 Copay; $130 Allowance **Medically Necessary:** $0 Copay; Paid in Full	$104 $104 $200
Frequency	**Exam:** Once Every 12 Months **Lenses or Contact Lenses:** Once Every 12 Months **Frames:** Once Every 24 Months	N/A
Laser Vision Correction	15% Off Retail Price or 5% Off Promotional Price	

*Using an in-network vision provider can save you money, but out-of-network providers can be used. When an out-of-network provider is used, you pay the bill and then submit for a reimbursement through EyeMed.

Vision Program (continued)

High Plan		
BENEFITS	IN- NETWORK	OUT-OF-NETWORK*
Exam with Dilation (as necessary)	$0 Copay	Up to $30
Exam Options:	**Standard Contact Lens Fit & Follow Up:** Up to $40 **Premium Contact Lens Fit & Follow Up:** 10% off Retail	N/A
Standard Plastic Lenses	**Single:** $0 copay **Bifocal:** $0 copay **Trifocal:** $0 copay **Lenticular:** $0 copay **Standard Progressive Lens:** $65 Copay	$25 $40 $55 $55 $40
Frames	$0 Copay; $200 Allowance	$100
Contact Lenses	**Conventional:** $0 Copay; $200 Allowance **Disposable:** $0 Copay; $200 Allowance **Medically Necessary:** $0 Copay; Paid in Full	$160 $160 $200
Frequency	**Exam:** Once Every 12 Months **Lenses or Contact Lenses:** Once Every 12 Months **Frames:** Once Every 12 Months	N/A
Laser Vision Correction	15% Off Retail Price or 5% Off Promotional Price	

*Using an in-network vision provider can save you money, but out-of-network providers can be used. When an out-of-network provider is used, you pay the bill and then submit for a reimbursement through EyeMed.

Go Mobile for 24/7 Access

Visit the EyeMed site at **www.eyemed.com** or download the mobile app.

Health Savings Account

Dura Shiloh is pleased to announce the offering of a Health Savings Account option for employees and their families. Administered by HealthEquity, a Health Savings Account (HSA) is like a 401(k) for healthcare. It is a tax-advantaged personal savings or investment account that individuals can use to save and pay for qualified healthcare expenses, now or in the future. The HSA is only available for those who enroll in the HDHP medical plan.

Unlike other financial savings vehicles (Roth IRA, Traditional IRA, 401K, etc.), an HSA has the unique potential to offer triple tax savings through:

- Federal & State Tax-deductible contributions to the HSA.
- Tax-free interest or investment earnings.
- Tax-free distributions when used for qualified healthcare expenses.

Contributions to your HSA

If enrolled in the HDHP, we will contribute funds to your HSA, administered through HealthEquity:

In addition to the contribution that we are making to your HSA, you are also able to contribute. We will payroll deduct your contributions and deposit them directly into your account. The annual limits for 2024 are listed below and include both employee and employer contributions. "Front Loading" your HSA contribution can result in not receiving the full Employer Contribution as the UKG system adds the Employee Contribution plus the Employer Contribution together when tracking Annual Contributions and will stop all contributions once the Combined Annual limit is met. Employees aged 55 or older can make up to $1,000/yr "catch-up" contributions to their HSA.

Coverage Type	2025 Employer Contribution
Employee Only	$41.66 per month ($500 per year)
Employee + Spouse Employee + Child Employee + Children Employee + Family	$83.33 per month ($1,000 per year)

Coverage Type	Maximum Employee Contribution	Total Annual Maximum Combined Contribution
Employee*	$316.66 per month ($3,800 per year)	$4,300
Employees Age 55+	Up to $1,000 catch-up/yr.	$5,300
Employee + Spouse Employee + Child Employee + Children Employee + Family	$629.16 per month ($7,550 per year)	$8,550
Employees Age 55+*	Up to $1,000 catch-up/yr.	$9,550

It is the member's responsibility to ensure HSA eligibility requirements are met

Go Mobile for 24/7 Access

Visit the HealthEquity site at **www.healthequity.com** or download the HealthEquity app.

2025 Monthly Employee Contributions

2025 Monthly Medical Contributions

COVERAGE TIER	PPO	HDHP	SAVINGS WITH HDHP (PREMIUMS + HSA CONTRIBUTION)
Employee Only	$220	$35	$2,720 a year
Employee + Spouse	$451	$120	$4,972 a year
Employee + Child	$330	$100	$3,760 a year
Employee + Children	$429	$115	$4,768 a year
Family	$550	$150	$5,800 a year

Tobacco/nicotine users will be charged an additional surcharge of $75 per month.

2025 Monthly Dental Contributions

	LOW PLAN	HIGH PLAN
Employee Only	$8.94	$11.44
Employee + Spouse	$17.37	$22.25
Employee + Child	$20.74	$30.58
Employee + Children	$20.74	$30.58
Family	$32.56	$46.70

2025 Monthly Vision Contributions

	LOW PLAN	HIGH PLAN
Employee Only	$4.59	$12.12
Employee + Spouse	$8.96	$23.64
Employee + Child	$8.96	$23.64
Employee + Children	$8.96	$23.64
Family	$8.96	$23.64

Flexible Spending Account

A Flexible Spending Account is an account that allows you to reimburse yourself with pretax dollars for eligible out-of-pocket healthcare costs and/or the daycare costs associated with caring for a qualified dependent. It is administered through HealthEquity and is available for all employees who work more than 30 hours per week. You may contact Health Equity at 877-924-3967 or at **www.healthequity.com**.

If you wish to start or continue participation in the Flexible Spending Account (FSA) programs, you must make a new election at every Open Enrollment. Current elections will not automatically carry over into 2025.

Dependent Flex Plan

You can designate up to $5,000 a year on a pre-tax basis; $2,500 if filing separate tax returns. You can then use the funds to pay dependent care expenses (IRS reportable). Funds you contribute to this type of FSA must be spent during the calendar year or forfeited (use-it-or-lose-it).

Medical Flex Plan (Full)

Not available to those enrolled in the HDHP with HSA.

You can designate up to $3,300 a year on a pre-tax basis. The Full Medical FSA has a carryover provision – up to $660 of unused 2024 funds can be carried over into the 2025 plan year. You can use the funds to pay qualified out-of-pocket expenses such as:

- Medical expenses
- Pharmacy expenses
- Dental expenses
- Vision expenses
- Some over-the-counter medications (OTC) prescribed by your physician

Medical Flex Plan (Limited) – HSA Compatible

Available to those enrolled in the HDHP with HSA in the Health Savings Account. You can designate up to $3,300 a year on a pre-tax basis. You can only use the funds to pay qualified out-of-pocket expenses for **dental and vision expenses** until you have met your deductible. The Limited Medical FSA has a carryover provision – up to $660 of unused 2024 funds can be carried over into the 2025 plan year.

Once your deductible has been met, qualified out-of-pocket medical/Rx expenses could be reimbursed as well through available funds.

How Does it Work?

The money you set aside is never counted as income. That means it is not subject to federal income tax, Social Security, Medicare, and in most cases, state and local taxes. This lowers your taxable income and increases your spendable income. Depending on your tax situation, you could save 20-40% on expenses you would be paying anyway.

Go Mobile for 24/7 Access

Visit the WageWorks site at **www.healthequity.com** or download the HealthEquity app.

Basic Life and AD&D Insurance

Life Insurance is often one of the cornerstones of financial planning. Should the unexpected happen, life insurance can help safeguard your family's needs. Dura Shiloh is pleased to provide Life and Accidental Death & Dismemberment (AD&D) Insurance to all employees. This is an employer paid benefit through New York Life (formerly Cigna).

We pay the full cost of Basic Life and AD&D insurance for all eligible employees.

- Basic Life Insurance is the greater of an amount of one times your base annual pay or $25,000.
- Accidental Death & Dismemberment Insurance (AD&D) provides financial protection by paying an additional amount in the event of an accidental death, as well as a benefit in the event of dismemberment.
- Accidental Death benefit is equal to one times your base annual pay or $25,000 whichever is greater. The dismemberment benefit is a scheduled defined benefit.

There are no medical questions for coverage to be issued. This group insurance is offered as guaranteed issue coverage. Please note: Benefits are reduced as of the next policy year starting at age 65. See your Basic Life certificate for the full details.

Voluntary Life & Dependent Life Insurance

While we provide employees with a company-paid Life and AD&D Insurance policy, sometimes individuals and families need additional protection to accomplish their goals. We are pleased to offer additional Voluntary Life and AD&D Insurance to all eligible employees through New York Life. This is a voluntary, employee-paid program.

- **Voluntary Life and AD&D insurance** is paid by the employee.
- There are no medical questions for coverage to be issued under the guarantee issue amount when you are first eligible.
- Guarantee Issue coverage is available for employees, spouses and children.
  - **Employee Options:** in multiples up to 4 times your base pay. Guarantee issue is $500,000 or 3x your base pay at time of new hire. At subsequent Open Enrollments, you can enroll or increase your Voluntary Life and AD&D insurance in increments of 1- times your base pay. Amounts that exceed guarantee issue require medical underwriting.
  - **Spouse Options:** $10,000 or $20,000 options.
  - **Child Options:** $5,000 or $10,000 options. Available for children from birth to age 26.

Go Mobile for 24/7 Access

Visit the NY Life site at **www.mynylgbs.com** or download the New York Life app.

Worksite Benefits

Worksite Benefits through Cigna Supplemental Health Solutions can provide you and your family with the coverage and additional financial protection you may need for expenses associated with an unplanned covered accident, illness or hospitalization. These plans pay benefits directly to you. What you do with the money is up to you.

Critical Illness

When a serious illness strikes, critical illness insurance can provide financial support to help you through a difficult time. It can pay you a lump-sum cash benefit up to $30,000 which you can use to meet your needs. You can get coverage for your spouse and dependents too. This plan can also pay you an annual cash benefit when you complete a covered wellness screening test.

Accident Insurance

You can't always avoid accidents – but you can protect yourself from accident-related costs that can strain your budget. Accident insurance pays a benefit directly to you if you have a covered non-workplace injury and need treatment. You can get coverage for your spouse and dependents too. As medical costs continue to rise, accident insurance provides a necessary layer of financial protection. The plan also has an annual cash benefit when you complete a covered wellness screening.

Hospital Indemnity Insurance

A trip to the hospital can be stressful, and so can the bills. Even with major medical insurance, you may still be responsible for co-payments, deductibles and other out-of-pocket costs. The hospital indemnity plan pays a cash benefit directly to you whenever you or your covered family members are admitted to the hospital.

Please note – Children can be covered under all three policies until age 26.

Disability

Short Term Disability

- 100% Paid by Dura Shiloh
- Administered by New York Life
- Please refer to full benefit summaries for your coverage levels

Long Term Disability

- 100% Paid by Dura Shiloh
- Administered by New York Life
- Please refer to full benefit summaries for your coverage levels

Life Assistance Program (LAP)

Balance work, life and everything in-between

We offer a Life Assistance Program through New York Life. Employee Life Assistance & Work/Life Support is here to help you with not only the big things in life that challenge us but the small stuff too. Each member receives 3 free face-to-face counseling visits per issue.

New York Life can help you with a range of issues, including:

- Managing stress
- Dealing with depression, anxiety and other mental issues
- Grief and loss
- Legal needs and financial questions
- Repairing and growing relationships
- Finding caregiver solutions

Offered to all employees and family members

Go Mobile for 24/7 Access
Visit the NY Life site at www.mynylgbs.com or download the New York Life app.

New York Life Value-Add Programs

As a New York Life member, these benefits are provided at no cost to you.

FinancialConnect® provides you and your family with unlimited access to a team of financial planning experts (CPA and CFP level) to help guide through financial challenges and/or planning. Referrals to financial professionals in your local area are also provided.

LegalConnect® provides you with unlimited phone consultations with a staff of attorneys who can provide guidance on issues such as divorce, adoption, estate planning, real estate and identity theft. If needed, you can be referred to a local attorney for a free 30-minute consultation and a discount up to 25% off fees thereafter.

Well-being Coaching Sometimes you may need help with personal challenges and physical issues that can be overwhelming. To help you achieve your goals, you will have access to a certified coach who will work with you, one on one, to address health and well-being issues such as burnout, time management and coping with stress. You have access to five sessions per year. All sessions are conducted telephonically.

EstateGuidance® is an 24/7 online tool to write a last will and testament, living will and document outlining your wishes for final arrangements.

Contact Info:	**Phone**	**Website**
Financial, Legal & Estate Support 24/7	(800) 344-9752	guidanceresources.com Web ID: NYLGBS

MyDuraShilohBenefits.com

Looking for more information?

Our website **www.MyDuraShilohBenefits.com** is available to all employees and their families. This website provides information regarding:

- Detailed benefit information
- Frequently asked questions
- Discount programs
- Plan Select Tool through Health Equity: **www.comparemyhsa.com/shiloh**
  - No username or password to login is required.
  - Copy the link, answer a few questions about who will be on your medical coverage, and the tool will calculate and display a side-by-side comparison of the three medical plans. Use this information to help make your choice as to which medical plan is the best fit for you!

401(k)

Dura Shiloh has established a 401(k) Plan through Principal **www.principal.com** with the goal of providing the tools and resources to help you plan for and achieve financial security in retirement.

Through the 401(k) plan, you elect to save a percentage of your pay each pay period through payroll deduction. Because your savings are deducted from your pay before income taxes, your taxable income will be reduced when you contribute to the plan. To encourage you to save through the plan and increase your benefit, Shiloh makes a matching contribution. Employees will be eligible to participate in the plan when they meet the conditions below:

Plan Eligibility

- Age 18
- Active VC-Steel Union Employees
- Eligible after January 1, April 1, July 1 or October 1 after 6 months of continuous service

SOME ADVICE!

Saving towards retirement and making wise 401(k) decisions is tougher than ever. Many employees have asked for more assistance and retirement planning advice and we're happy to deliver! You will have access to a financial expert who will be able to answer the question "What should I do?" Dura Shiloh has partnered with an independent plan investment advisor, Waypoint Partners, to provide expanded investment education and participate in advisory sessions. They are available to meet and/or speak with you individually to provide you the help you need. You can contact them directly at 216-765-7400 or by speaking with your local HR Department.

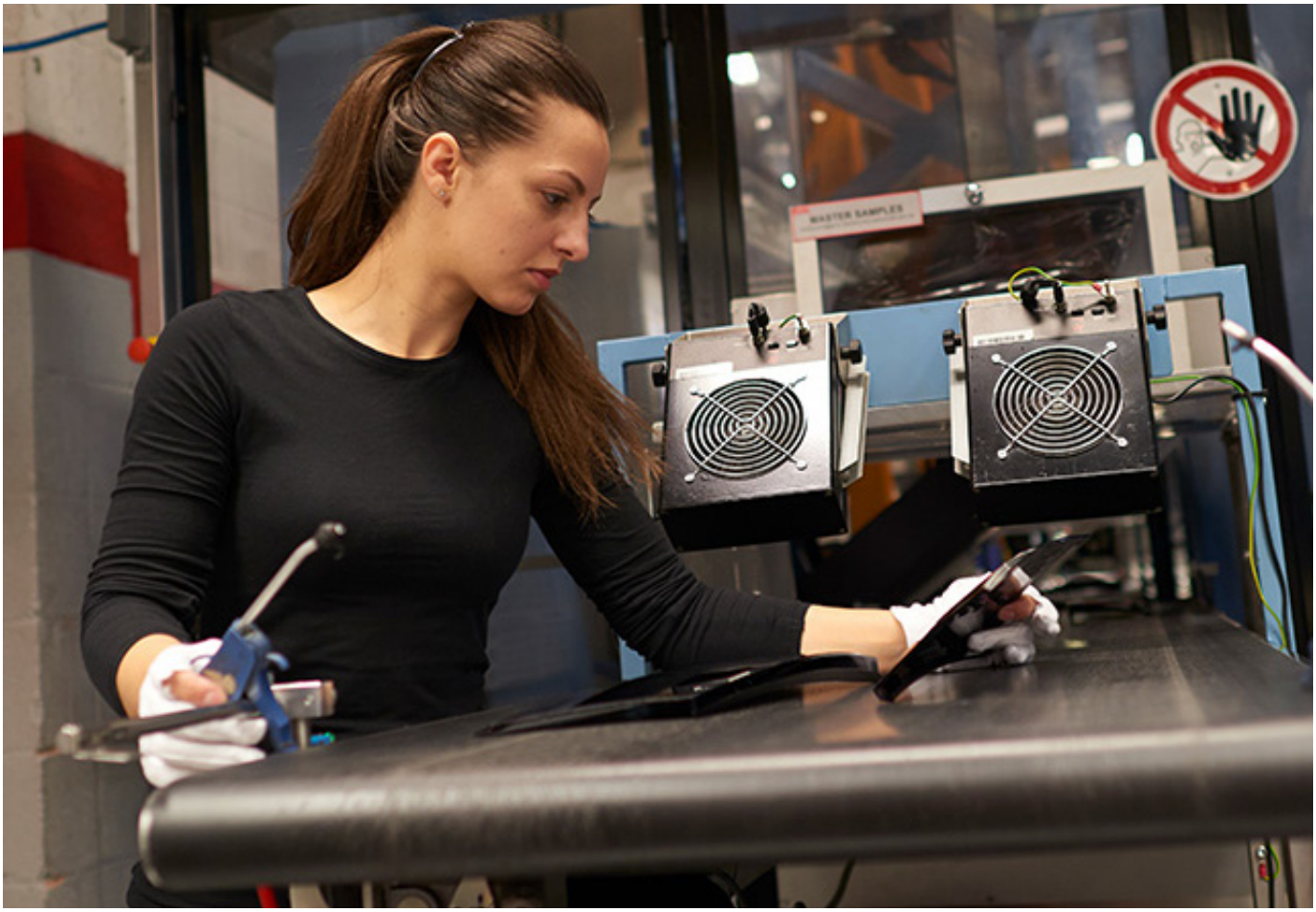
How Do I Elect My Benefits?

Log into UKG Pro – e44.ultipro.com

Under Myself, navigate to Benefits > Manage My Benefits > Shop and Enroll in Benefits – Get Started

Additional Necessary Actions:

- Complete the Tobacco/Nicotine Survey Question in UKG Benefits.
- Upload a completed Affidavit of Spousal Health Care Coverage form using the Upload button in UKG Benefits if you have answered "Yes" that your spouse works and you have elected to cover your spouse on your medical plan. You have 30 days from the date you complete your enrollment to get this document uploaded into UKG; otherwise, your spouse will be removed from coverage.
- Upload all required dependent verification documents (marriage certificates, birth certificates, etc.) to support all dependents on your healthcare and dependent life insurance into UKG Benefits. You have 30 days from the date you complete your enrollment to get these documents uploaded into UKG; otherwise, your dependents will be removed from coverage. If you previously supplied these documents during a previous New Hire Open Enrollment, documentation is not required.
- Be sure to review and/or add your Beneficiaries for Life Insurance Products which is located under your Profile.



Important Employee Notices

Women's Health and Cancer Rights Act of 1998 (WHCRA)

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

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

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

Please contact you're your HR team with any questions.

HIPAA General Notice or Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

HIPAA: Wellness Program Disclosure

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, please contact your HR team and we will collaborate with you to develop an alternative option to qualify for the reward.

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs.

If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

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

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

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

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ **Phone:** 1-855-692-5447	The AK Health Insurance Premium Payment **Program Website:** http://myakhipp.com/ **Phone:** 1-866-251-4861 **Email:** CustomerService@MyAKHIPP.com **Medicaid Eligibility:** https://health.alaska.gov/dpa/Pages/default.as px
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ **Phone:** 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program **Website:** http://dhcs.ca.gov/hipp **Phone:** 916-445-8322 **Fax:** 916-440-5676 **Email:** hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ **Health First Colorado Member Contact Center:** 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health- plan-plus CHP+ **Customer Service:** 1-800-359-1991/State Relay 711 **Health Insurance Buy-In Program (HIBI):** https://www.mycohibi.com/ **HIBI Customer Service:** 1-855-692-6442	**Website:** https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html **Phone:** 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp **Phone:** 678-564-1162, Press 1 GA **CHIPRA Website:** https://medicaid.georgia.gov/programs/third- party-liability/childrens-health-insurance- program-reauthorization-act-2009-chipra **Phone:** 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 **Website:** http://www.in.gov/fssa/hip/ **Phone:** 1-877-438-4479 **All other Medicaid Website:** https://www.in.gov/medicaid/ **Phone:** 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members **Medicaid Phone:** 1-800-338-8366 **Hawki Website:** http://dhs.iowa.gov/Hawki **Hawki Phone:** 1-800-257-8563 HIPP **Website:** https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	**Website:** https://www.kancare.ks.gov/ **Phone:** 1-800-792-4884 HIPP **Phone:** 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) **Website:** https://chfs.ky.gov/agencies/dms/member/Pag es/kihipp.aspx **Phone:** 1-855-459-6328 **Email:** KIHIPP.PROGRAM@ky.gov **KCHIP Website:** https://kidshealth.ky.gov/Pages/index.aspx **Phone:** 1-877-524-4718 **Kentucky Medicaid Website:** https://chfs.ky.gov/agencies/dms	**Website:** www.medicaid.la.gov or www.ldh.la.gov/lahipp **Phone:** 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US **Phone:** 1-800-442-6003 TTY: Maine relay 711 **Private Health Insurance Premium Webpage:** https://www.maine.gov/dhhs/ofi/applications- forms **Phone:** 1-800-977-6740 TTY: Maine relay 711	**Website:** https://www.mass.gov/masshealth/pa **Phone:** 1-800-862-4840 TTY: 711 **Email:** masspremassistance@accenture.com

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care- programs/programs-and-services/other- insurance.jsp **Phone:** 1-800-657-3739	**Website:** http://www.dss.mo.gov/mhd/participants/pages/hipp.htm **Phone:** 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcare Progra ms/HIPP **Phone:** 1-800-694-3084 **Email:** HHSHIPPProgram@mt.gov	**Website:** http://www.ACCESSNebraska.ne.gov **Phone:** 1-855-632-7633 Lincoln: 402-473-7000 **Omaha:** 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov **Medicaid Phone:** 1-800-992-0900	**Website:** https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program **Phone:** 603-271-5218 **Toll free number for the HIPP program:** 1-800- 852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ **Medicaid Phone:** 609-631-2392 **CHIP Website:** http://www.njfamilycare.org/index.html **CHIP Phone:** 1-800-701-0710	**Website:** https://www.health.ny.gov/health_care/medicaid/ **Phone:** 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ **Phone:** 919-855-4100	**Website:** https://www.hhs.nd.gov/healthcare **Phone:** 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org **Phone:** 1-888-365-3742	**Website:** http://healthcare.oregon.gov/Pages/index.aspx **Phone:** 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx **Phone:** 1-800-692-7462 CHIP **Website:** Children's Health Insurance Program (CHIP) (pa.gov) **CHIP Phone:** 1-800-986-KIDS (5437)	**Website:** http://www.eohhs.ri.gov/ **Phone:** 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov **Phone:** 1-888-549-0820	**Website:** http://dss.sd.gov **Phone:** 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services **Phone:** 1-800-440-0493	**Medicaid Website:** https://medicaid.utah.gov/ **CHIP Website:** http://health.utah.gov/chip **Phone:** 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access **Phone:** 1-800-250-8427	**Website:** https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs **Medicaid/CHIP Phone:** 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ **Phone:** 1-800-562-3022	**Website:** https://dhhr.wv.gov/bms/ http://mywvhipp.com/ **Medicaid Phone:** 304-558-1700 **CHIP Toll-free phone:** 1-855-MyWVHIPP (1-855- 699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm **Phone:** 1-800-362-3002	**Website:** https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ **Phone:** 1-800-251-1269

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

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

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

Important Employee Notices (continued)

HIPAA Notice of Privacy Practices for Protected Health Information

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

Notice of Privacy Practices

You are receiving this Privacy Notice because you are eligible to participate in a Dura Shiloh sponsored group health plans. The Health Plans are committed to protecting the confidentiality of any health information collected about an individual. This Notice describes how the Health Plan may use and disclose, "protected health information" (PHI). In order for information to be considered "PHI", it must meet three conditions:

Information is created or received by a health care provider, health plan, employer, or health care clearinghouse; Information relates past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and the information either identifies the individual or provides a reasonable basis for believing that it can be used to identify the individual.

The Health Plan is required by the Health Insurance Portability and Accountability Act (HIPAA) to provide this Notice to an individual. Additionally, the Health Plan is required by law to:

Maintain the privacy of an individual's "protected health information" (PHI), and provide you with the Privacy Notice of its legal duties and privacy practices with respect to an individual's PHI, and follow the terms of its Privacy Notice that is currently in effect.

Employees of the plan sponsor who administer and manage this Health Plan may use PHI only for appropriate plan purposes (such as for payment or health care operations), but not for purposes of other benefits not provided by this plan, and not for employment-related purposes of the plan sponsor. These individuals must comply with the same requirements that apply to the Health Plan to protect the confidentiality of PHI.

Uses and Disclosures of Protected Health Information (PHI).

The following categories describe the ways that the Health Plan may use and disclose protected health information. For each category of uses and disclosures, examples will be provided. Not every use or disclosure in a category will be listed. However, all the ways the Health Plan is permitted to use and disclose information will fall within one of these categories.

Treatment Purposes. The Health Plan may disclose PHI to a health care provider for the health care provider's treatment purposes. For example, if an individual's Primary Care Physician (PCP) or treating medical provider refers the individual to a specialist for treatment, the Health Plan can disclose the individual's PHI to the specialist to whom they have been referred so (s)he can become familiar with the individual's medical condition, prior diagnoses and treatment, and prognosis.

Payment Purposes. The Health Plan may use or disclose health information for payment purposes; such as, determining eligibility for plan benefits, obtaining premiums, facilitating payment for the treatment and services an individual receives from health care providers, determining plan responsibility for benefit payments, and coordinating benefits with other benefit plans. Examples of payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a specific treatment is covered under the plan.

Health Care Operations. The Health Plan may use PHI for its own health care operations and may disclose PHI to carry out necessary insurance related activities. Some examples of Health Care Operations may include: underwriting, premium rating and other activities related to plan coverage; conducting quality assessment and improvement activities; placing contracts; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration of the Health Plan.

Important Employee Notices (continued)

To a Business Associate of the Health Plan. The Health Plan may disclose PHI to a Business Associate (BA) of the Health Plan, provided a valid Business Associate Agreement is in place between the Business Associate and the Health Plan. A Business Associate is an entity that performs a function on behalf of the Health Plan and that uses PHI in doing so, or provides services to the Health Plan such as legal, actuarial, accounting, consulting or administrative services. Examples of Business Associates include the Health Plan's Third Party Administrators (TPAs), Actuary, and Broker.

To the Health Plan Sponsor. The Health Plan may disclose PHI to the Plan Sponsor as long as the sponsor has amended its plan documents, provided a certification to the Health Plan, established certain safeguards and firewalls to limit the classes of employees who will have access to PHI, and to limit the use of PHI to plan purposes and not for non-permissible purposes, as required by the Privacy Rule. Any disclosures to the plan sponsor must be for purposes of administering the Health Plan. Some examples may include: disclosure for claims appeals to the Plan's Benefits Committee, for case management purposes, or to perform plan administration functions.

The Health Plan may also disclose enrollment/disenrollment information to the plan sponsor, for enrollment or disenrollment purposes only, and may disclose "Summary Health information" (as defined under the HIPAA medical privacy regulations) to the plan sponsor for the purpose of obtaining premium bids or modifying or terminating the plan.

Required by Law or Requested as Part of a Regulatory or Legal Proceeding. The Health Plan may use and disclose PHI as required by law or when requested as part of a regulatory or legal proceeding. For example, the Health Plan may disclose medical information when required by a court order in a litigation proceeding, or pursuant to a subpoena, or as necessary to comply with Workers' Compensation laws.

Public Health Activities or to Avert a Serious Threat to Health or Safety. The Health Plan may disclose PHI to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Law Enforcement or Specific Government Functions. The Health Plan may disclose PHI to law enforcement personnel for purposes such as identifying or locating a suspect, fugitive, material witness or missing person; complying with a court order or subpoena; and other law enforcement purposes. Other uses and disclosures will be made only with an individual's written authorization or that of their legal representative, and the individual may revoke such authorization as provided by section 164.508(b) (5) of the Privacy Rule. Any disclosures that were made when the individual's Authorization was in effect will not be retracted.

An Individual's Rights Regarding PHI An individual has the following rights with respect to their PHI:

Right to Inspect and Copy PHI. An individual has the right to inspect and copy health information about them that may be used to make decisions about plan benefits. If they request a copy of the information, a reasonable fee to cover expenses associated with their request may be charged.

Right to Request Restrictions). An individual has the right to request restrictions on certain uses and disclosures of their PHI (although the Health Plan is not required to agree to a requested restriction).

Right to Receive Confidential Communications of PHI). An individual has the right to receive their PHI through a reasonable alternative means or at an alternative location if they believe the Health Plan's usual method of communicating PHI may endanger them.

Important Employee Notices (continued)

Right to Request an Amendment. An individual has the right to request the Health Plan to amend their health information that they believe is incorrect or incomplete. The Health Plan is not required to change the PHI, but is required to provide the individual with a response in either case.

Right to Accounting of Disclosures. An individual has the right to receive a list or "accounting of disclosures" of their health information made by the Health Plan, except the disclosures made by the Health Plan for treatment, payment, or health care operations, national security, law enforcement or to corrections personnel, pursuant to the individual's Authorization, or to the individual. An individual's request must specify a time period of up to six years and may not include dates prior to May 1, 2010 (effective date of this regulation). The Health Plan will provide one accounting of disclosures free of charge once every 12 month period.

Breach Notification. An individual has the right to receive notice of a breach of your unsecured medical information. Notification may be delayed if so required by a law enforcement official. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Optional if covered entity engages in underwriting Genetic Information An individual's genetic information will not be used for under writing except for long term care plans.

Right to Paper Copy. An individual has a right to receive a paper copy of this Notice of Privacy Practices at any time.

The Health Plan's Responsibilities Regarding an Individual's PHI

The Health Plan is a "covered entity" (CE) and has responsibilities under HIPAA regarding the use and disclosure of PHI.

The Health Plan has a legal obligation to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. The Health Plan is required to abide by the terms of the current Notice of Privacy Practices (the "Notice"). The Health Plan reserves the right to change the terms of this Notice at any time and to make the revised Notice provisions effective for all PHI the Health Plan maintains, even PHI obtained prior to the effective date of the revisions. If the Health Plan revises the Notice, the Health Plan will promptly distribute a revised Notice to a ll actively enrolled participants whenever a material change has been made. Until such time, the Health Plan is required by law to comply with the current version of this Notice.

The Health Plan's Complaint Procedures
Complaints about this Privacy Notice or if an individual believes their PHI has been impermissibly used or disclosed, or their privacy rights have been violated in any way, the individual may submit a formal complaint. Complaints should be submitted in writing to:

Please contact your HR team in regards to any complaints regarding this matter.

The complaint will be investigated and a written response will be provided to the individual within 30 days from receipt of the complaint. A written summary of the complaint and any correction action taken will be filed with the Privacy Officer. The Health Plan will not retaliate against the individual in any way for filing a complaint.

If an individual would like their complaint reviewed by an outside agency, they may contact the Department of Health and Human Services at the following address:

Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Important Employee Notices (continued)

Right to Request an Amendment. An individual has the right to request the Health Plan to amend their health information that they believe is incorrect or incomplete. The Health Plan is not required to change the PHI, but is required to provide the individual with a response in either case.

Right to Accounting of Disclosures. An individual has the right to receive a list or "accounting of disclosures" of their health information made by the Health Plan, except the disclosures made by the Health Plan for treatment, payment, or health care operations, national security, law enforcement or to corrections personnel, pursuant to the individual's Authorization, or to the individual. An individual's request must specify a time period of up to six years and may not include dates prior to May 1, 2010 (effective date of this regulation). The Health Plan will provide one accounting of disclosures free of charge once every 12 month period.

Breach Notification. An individual has the right to receive notice of a breach of your unsecured medical information. Notification may be delayed if so required by a law enforcement official. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Optional if covered entity engages in underwriting Genetic Information An individual's genetic information will not be used for under writing except for long term care plans.

Right to Paper Copy. An individual has a right to receive a paper copy of this Notice of Privacy Practices at any time.

The Health Plan's Responsibilities Regarding an Individual's PHI

The Health Plan is a "covered entity" (CE) and has responsibilities under HIPAA regarding the use and disclosure of PHI.

The Health Plan has a legal obligation to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. The Health Plan is required to abide by the terms of the current Notice of Privacy Practices (the "Notice"). The Health Plan reserves the right to change the terms of this Notice at any time and to make the revised Notice provisions effective for all PHI the Health Plan maintains, even PHI obtained prior to the effective date of the revisions. If the Health Plan revises the Notice, the Health Plan will promptly distribute a revised Notice to a ll actively enrolled participants whenever a material change has been made. Until such time, the Health Plan is required by law to comply with the current version of this Notice.

The Health Plan's Complaint Procedures
Complaints about this Privacy Notice or if an individual believes their PHI has been impermissibly used or disclosed, or their privacy rights have been violated in any way, the individual may submit a formal complaint. Complaints should be submitted in writing to:

Please contact your HR team in regards to any complaints regarding this matter.

The complaint will be investigated and a written response will be provided to the individual within 30 days from receipt of the complaint. A written summary of the complaint and any correction action taken will be filed with the Privacy Officer. The Health Plan will not retaliate against the individual in any way for filing a complaint.

If an individual would like their complaint reviewed by an outside agency, they may contact the Department of Health and Human Services at the following address:

Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Important Employee Notices (continued)

Important Notice from Megalodon Midco, LLC About Your Prescription Drug Coverage and Medicare

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Megalodon Midco, LLC has determined that the prescription drug coverage offered by the Allegiance/Cigna PPO Copay Plan and Allegiance/Cigna High Deductible Health Plan are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. Plan participants are eligible if they are within three months of turning age 65, are already 65 years old or if they are disabled. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Megalodon Midco, LLC coverage will not be affected, and benefits will coordinate with Medicare. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the Plan Administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare-eligible individuals when you become eligible for Medicare Part D.

Visit **www.cms.hhs.gov/CreditableCoverage** which outlines the prescription drug plan provisions/options Medicare-eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and current coverage is dropped, be aware you and your dependents will not be able to get this coverage back. Refer to plan documents or contact your provider or the Plan Administrator before making any decisions.

Note: In general, different guidelines exist for retirees regarding cancellation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the Plan Administrator for details.

Important Employee Notices (continued)

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Megalodon Midco, LLC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. NOTE: You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period and if this coverage changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

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

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

Please contact your local Human Resource Department should you have any questions.

Contact Information

Benefit	Vendor	Group Number	Contact Number	Website/ Email
401(k) Administrator	Principal	633647	800-547-7754	www.principal.com
AD&D(Basic and Voluntary)	New York Life	OK969996 Vol: OK969997	800-362-4462	www.mynylgbs.com
Accident/ CriticalIllness/ Hospital	Cigna	Acc: AI111813 CI: CI111745 H: HC111442	800-754-3207	www.mycigna.com
Dental	Delta Dental of Ohio	2290	800-524-0149	www.deltadentaloh.com
EAP	New York Life	Web ID “NYLGBS”Co. Name “Shilo"	800-344-9752	www.guidanceresources.com
Financial Advisor	Waypoint Partners		216-765-7400	www.waypoint.com
Flexible SpendingAccounts	HealthEquity	41768	877-924-3967	www.healthequity.com
Health SavingsAccount	HealthEquity	48682	866-346-5800	www.healthequity.com
Leave of Absence	New York Life	FML963235	888-842-4462	www.mynylgbs.com
Life Insurance (Basic, Voluntary Employee & Dependent)	New York Life	FLX968524 Vol: FLX968525	800-362-4462	www.mynylgbs.com
Long Term Disability	New York Life	LK965747	800-842-4462	www.mynylgbs.com
Medical	AllegianceCigna PPO Network	2004010	1-855-999-6827	www.AskAllegiance.com www.mycigna.com
Prescription Drug	CVS/Caremark	004336	1-866-818-6911	www.caremark.com
Telehealth	MD Live		888-726-3171	www.MDLive.com/Allegiance
UBreatheTobacco/ NicotineCessation Program	Marquee Health		800-882-2109	Coaching@marqueehealth.com
Non-Emergency Surgery Concierge	SurgeryPlus	Dura Shiloh	833-227-7581	www.durashiloh.surgeryplus.com/
Financial, Legal & Estate Guidance	New York Life	NYLGBS	800-344-9752	www.GuidanceResources.com
Vision	EyeMed	Low: 9731415 High: 1024706	866-299-1358	www.eyemed.com

This summary of benefits is designed to provide a high-level overview of Dura Shiloh’s 2025 Employee Benefits. Should there be any conflict between the explanation in this summary and the actual terms and provisions of the plan documents, the terms of the plan documents and contracts will govern in all cases. You will not gain any new benefits because of a misstatement or omission in this overview.