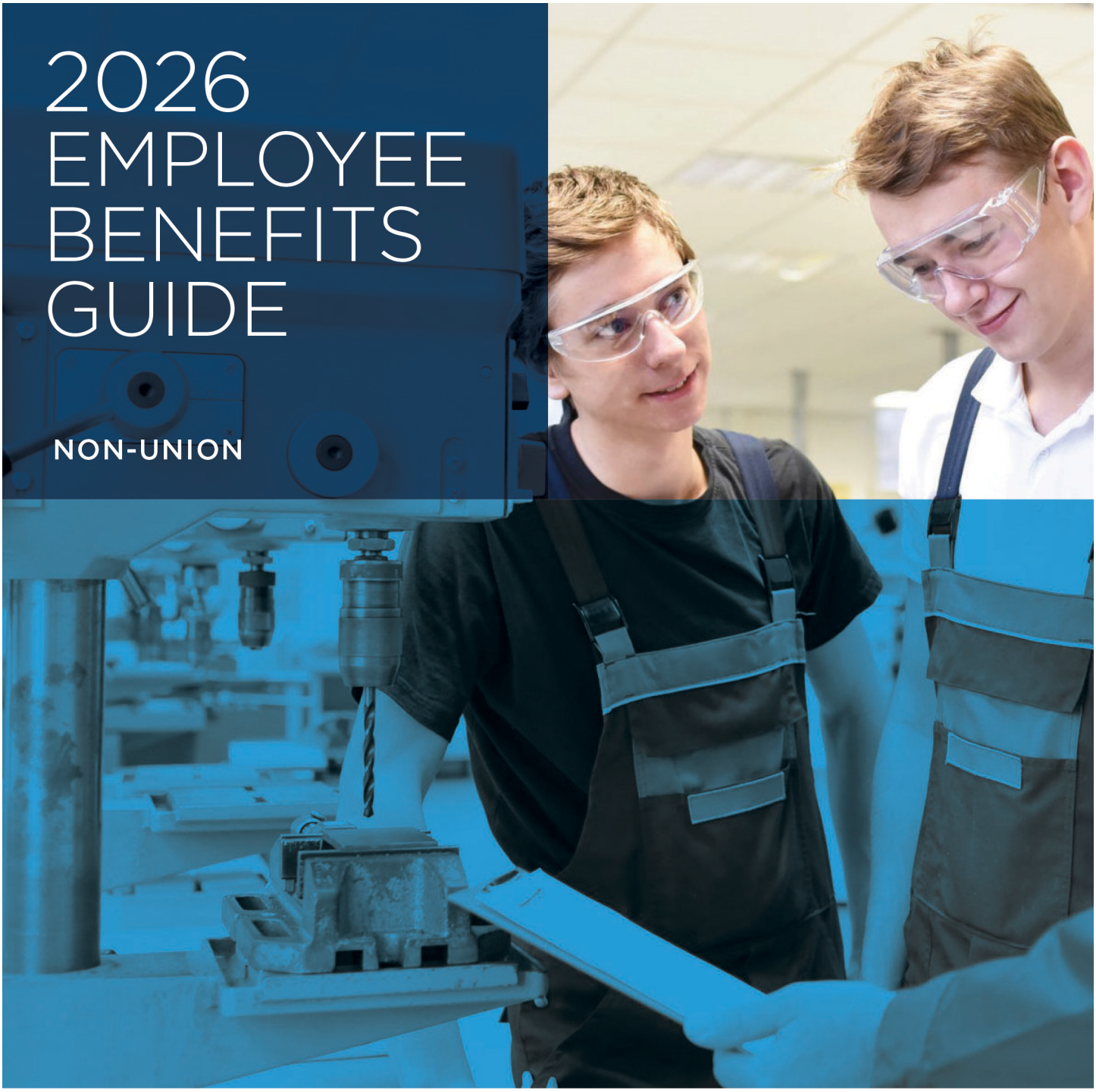
2026 EMPLOYEE BENEFITS GUIDE

NON-UNION



DURA | SHILOH

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 well-being 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 most benefits on the date of hire. The one exception is for Disability benefits for hourly employees, for which new hires become eligible after 90 days of employment. 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 benefits. Per the IRS, you may only make changes to your benefits at Open Enrollment or if you experience a Qualified Family Status Change (i.e., birth, adoption, divorce, gain/loss of coverage, and more.)

Dependent Coverage

Your spouse must be your legally married spouse. 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 considering coverage for your spouse.

Key requirements for a dependent child:

- **Age:** The child must be under the age of 26.
- **Relationship:** The child must have a qualifying relationship such as a biological child, an adopted child, a stepchild or a foster child.
- **Disability Exception:** A child with a physical or mental disability that prevents them from being self-supporting may be eligible for coverage past age 26, provided the disability existed before their 26th birthday.
- 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 Human Resources (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 **MyDuraShilohBenefits.com** which can be accessed from any computer. Please take time to review 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 HR for assistance, if needed. Choose your benefits carefully. Once enrolled, you can change your benefits only if you have a Qualified Family 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 Family Status Change as defined above, you must report the change to HR 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 2026, Dura Shiloh will maintain our relationship with Allegiance (a Cigna company) but will add a second PPO medical plan option, totaling three available plans:

- Base PPO Plan
- Buy-Up PPO Plan
- HDHP with HSA

Allegiance is your medical claim administrator and your in-network provider listing will be from the Cigna PPO network.

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

All three plans have embedded deductibles which means that you have an individual deductible, a two-person deductible and a 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 and contribute to 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!

When in-network care is unavailable and out-of-network (OON) becomes a necessity, Dura Shiloh works with **6 Degrees Health** to help our members understand and resolve OON bills. 6 Degrees Health can work with patients and providers to negotiate lower costs on the member's behalf. If you think you require OON care, you can contact 6 Degrees at 888-615-6398 to inform them about a desired provider and they can begin assisting with your service from the start.

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

Base PPO Plan

PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	EE Only = $2,500 EE + 1 Dependent = $2,500 per Individual | $3,000 per Family EE + 2 or More Dependents = $2,500 per Individual | $5,000 per Family	EE Only = $5,000 EE + 1 Dependent = $5,000 per Individual | $6,000 per Family EE + 2 or More Dependents = $5,000 per Individual | $10,000 per Family
Coinsurance (after deductible)	25%	50%
Out of Pocket Maximum (includes deductible and coinsurance)	EE Only = $5,000 EE + 1 Dependent = $5,000 per Individual | $10,000 per Family EE + 2 or More Dependents = $5,000 per Individual | $10,000 per Family	EE Only = $10,000 EE + 1 Dependent = $10.000 per Individual | $15,000 per Family EE + 2 or More Dependents = $10,000 per Individual | $20,000 per 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	25% after deductible	50% after deductible
Lab, X-ray & Ancillary Services	25% after deductible	50% after deductible
Mental Health & Substance Abuse	25% 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)	$15 Copay	50% after deductible
Specialist (diagnostic treatment and or service subject to deductible)	$30 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	$30 Copay	50% after deductible
Chiropractic Services	$30 Copay	50% after deductible
Speech Therapy Office Visits	$30 Copay	50% after deductible
Outpatient Surgery	25% after deductible	50% after deductible
Dietitian Services (3-day limit)	$30 Copay	50% after deductible
OTHER SERVICES		
Ambulance Services, Hospice Care, Home Health Care, Skilled Nursing	25% after deductible	50% after deductible

See page 15 for Employee Contributions Rates for all medical plans

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 creat a login at **www.AskAllegiance.com**.

Buy-Up PPO Plan

PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	EE Only = $1,000 EE + 1 Dependent = $1,000 per Individual | $1,500 per Family EE + 2 or More Dependents = $1,000 per Individual / $2,000 per Family	EE Only = $2,000 EE + 1 Dependent = $2,000 per Individual | $3,000 per Family EE + 2 or More Dependents = $2,000 per Individual | $4,000 per Family
Coinsurance (after deductible)	20%	50%
Out of Pocket Maximum (includes deductible and coinsurance)	EE Only = $4,000 EE + 1 Dependent = $4,000 per Individual | $6,000 per Family EE + 2 or More Dependents = $4,000 per Individual | $8,000 per Family	EE Only = $8,000 EE + 1 Dependent = $8,000 per Individual | $12,000 per Family EE + 2 or More Dependents = $8,000 per Individual | $16,000 per 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	20% after deductible	50% after deductible
Lab, X-ray & Ancillary Services	20% after deductible	50% after deductible
Mental Health & Substance Abuse	20% 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 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
Dietitian 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

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 creat a login at **www.AskAllegiance.com**.

HDHP Plan with HSA

PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	EE Only = $3,500 EE + 1 Dependent = $3,500 per Individual / $4,000 per Family EE + 2 or More Dependents = $3,500 per Individual / $6,500 per Family	EE Only = $7,000 EE + 1 Dependent = $7,000 per Individual / $8,000 per Family EE + 2 or More Dependents = $7,000 per Individual / $13,000 per Family
Coinsurance (after deductible)	20%	50%
Out of Pocket Maximum (includes deductible and coinsurance)	EE Only = $6,000 EE + 1 Dependent = $6,000 per Individual / $9,000 per Family EE + 2 or More Dependents = $6,000 per Individual / $12,000 per Family	EE Only = $12,000 EE + 1 Dependent = $12,000 per Individual / $18,000 per Family EE + 2 or More Dependents = $12,000 per Individual / $24,000 per 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	20% after deductible	50% after deductible
Lab, X-ray & Ancillary Services	20% after deductible	50% after deductible
Mental Health & Substance Abuse	20% after deductible	50% after deductible
OUTPATIENT SERVICES (*COPAYS APPLY AFTER DEDUCTIBLE HAS BEEN MET)		
Telehealth Visit (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
Dietitian 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

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 creat a login at **www.AskAllegiance.com**.

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 Tobacco//Nicotine Cessation Program as early as October 2025
2. Start the 4-week coaching program by March 2, 2026 and complete the program by April 3, 2026
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.

Lantern (formerly SurgeryPlus)

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

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

The Lantern Care Difference

- **The Care You Need:** Lantern covers more than 1,500 planned, non-emergency surgeries. If you need a procedure, we can assist you with finding an excellent surgeon.
- **The Best Surgeons for You:** Lantern surgeons are individually vetted and among the best in their field. Your Care Advocate will work to match you with an excellent surgeon in the Lantern network.
- **Care Close to Home:** Whenever possible, your Care Advocate will match you with a surgeon that's close to your home.

Make Lantern Your First Call When You Need to Plan a Surgery.
For more information, visit **My.Lanterncare.com** or call **833-227-7581.**

Pharmacy Program

CVS/Caremark will remain our Pharmacy provider in 2026 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

Welcome to the RxBenefits Family!

Dura Shiloh has selected CVS/Caremark and RxBenefits to administer and service our pharmacy benefits coverage for the upcoming plan year. Your benefits are still being provided by CVS/Caremark, but RxBenefits administers the services for a more personal approach.

As part of your NEW pharmacy benefits plan, you will receive:

- New pharmacy ID card (will be combined with your medical ID card, so only one card to carry)
- Prescription Drug Coverage Statement
- Friendly, high-touch service from RxBenefits' professional Member Services Team
- Commitment to issue resolution

Access to My RxBenefits (NEW)

- View pharmacy benefits coverage
- View 18 months of pharmacy claims (including claims for eligible dependents)
- Establish and manage communications preferences
- Access to online Prior Authorization (PA) status

Access to caremark.com

- Review medication tiers, drug pricing, local pharmacies, plan details, and ways to maximize benefits
- New Members will need to make an account

You should contact RxBenefits at 800.334.8134 with any pharmacy-related questions.

You may be eligible to participate in the PrudentRx program, designed to help you save money on your specialty drug prescriptions.

PrudentRx Co-Pay Program for Specialty Medications

Specialty medications are used to treat complex chronic conditions; they mimic compounds found within the human body. These high-cost oral or injectable medications are typically biology-based and highly complex. Dura Shiloh is offering the PrudentRx Co-Pay program to help you manage the cost of these medications by applying financial co-pay assistance from drug manufacturers. By enrolling in the PrudentRx program, your out-of-pocket costs for covered medications would be $0.

If you currently take one or more medications included in the PrudentRx Copay Program Drug List or in the PrudentRx HDHP with HSA Program Drug List, you will receive a welcome letter and phone call from PrudentRx with specific information about the program and your medication. The PrudentRx patient advocate will help you enroll in the PrudentRx Co-Pay Program or HDHP with HSA Co-Pay Program if you choose, along with other available manufacturer copay assistance programs.

For more information, please contact PrudentRx at 1.888.203.1768.

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 - FREE after meeting your deductible

This service is intended for non-life 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)	$1,500 Per Person	$2,500 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

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.

You can access a listing of in-network providers by going to **www.eyemed.com**. Click on *Members & Consumers*, then *Find An Eye Doctor*. When prompted to Choose your network, be sure to select the "Select Network" before beginning your search.

Hearing Aid Discounts Available to EyeMed Members

It affects 1 in 9 Americans and can come on so gradually you may not even notice it. But the good news is that 95% of hearing loss can be easily treated with hearing aids. That's why your hearing discount through Amplifon includes:

SIGNIFICANT SAVINGS
Save up to 64%[2] off the retail price on thousands of hearing aids from the top brands

FULL SATISFACTION
60-day hearing aid trial period with no restocking fees

FREE BATTERIES
2 years of free batteries mailed directly to your home

COMMITTED SERVICE
1 year of unlimited follow-up care and a 3-year warranty including coverage for repairs, loss or damage

CONVENIENT LOCATIONS
Access thousands of hearing health providers nationwide

Call 1-877-203-0675 to find a hearing care provider near you and schedule a hearing exam.

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.

You can access a listing of in-network providers by going to **www.eyemed.com**. Click on *Members & Consumers*, then *Find An Eye Doctor*. When prompted to Choose your network, be sure to select the "Select Network" before beginning your search.

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	2026 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*	$325.00 per month ($3,900 per year)	$4,400
Employees Age 55+	Up to $1,000 catch-up /year	$5,400
Employee + Spouse Employee + Child Employee + Children Employee + Family	$645.83 per month ($7,750 per year)	$8,750
Employees Age 55+	Up to $1,000 catch-up/year	$9,750

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.

2026 Monthly Employee Contributions

2026 Monthly Medical Contributions

COVERAGE TIER	BASE PPO	BUY-UP PPO	HDHP	SAVINGS WITH HDHP (PREMIUMS + HSA CONTRIBUTION)	
				Versus Base PPO Plan	Versus Buy-Up PPO Plan
Employee Only	$114.10	$262.45	$43.38	$1,349 a year	$3,129 a year
Employee + Spouse	$368.63	$558.60	$146.41	$3,667 a year	$5,946 a year
Employee + Child	$278.52	$422.05	$110.62	$3,015 a year	$4,737 a year
Employee + Children	$344.06	$521.36	$136.65	$3,489 a year	$5,617 a year
Family	$450.55	$682.73	$178.95	$4,259 a year	$7,045 a year

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

2026 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

2026 Monthly Vision Contributions

	LOW PLAN	HIGH PLAN
Employee Only	$4.43	$11.69
Employee + Spouse	$6.64	$17.54
Employee + Child	$7.08	$18.70
Employee + Children	$7.08	$18.70
Family	$10.14	$25.99

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 2026.

Dependent Flex Plan

You can designate up to $7,500 a year on a pre-tax basis; $3,750 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 $3,400 a year on a pre-tax basis. The Full Medical FSA has a carryover provision – up to $680 of unused 2026 funds can be carried over into the 2027 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 $3,400 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 $680 of unused 2026 funds can be carried over into the 2027 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 HealthEquity 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 lesser of an amount of 1.5-times your base annual pay or $500,000 for Hourly employees or $650,000 for Salaried employees.
- 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 1.5-times your base annual pay or $500,000 for Hourly employees or $650,000 for Salaried employees, whichever is less. 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.

Voluntary Life & Dependent Life Insurance (continued)

		2025	NEW for 2026
Employee Options	Benefit	Multiples of base pay to the lesser of 4-times your base pay or $1,000,000	Units of $10,000 to the lesser of 5-times your base pay or $1,000,000
	Guarantee Issue	Lesser of 3-times base pay or $500,000	Lesser of 3-times base pay or $500,00
	Annual Enrollment Increase	Up to 5 units of $10,000 not to exceed the guarantee issue without Evidence of Insurability	
Spouse Options	Benefit	$10,000 or $20,000	Units of $10,000 to the lesser of $250,000 or 100% of the Employee's Voluntary Life Volume (inclusive of the company-paid Basic Life Benefit)
	Guarantee Issue	$25,000	$30,000
	Annual Enrollment Increase	Up to 2 units of $10,000 not to exceed the guarantee issue without Evidence of Insurability	
Child(ren) Options	Benefit	Live birth to 14 days: $1,000 After: $5,000 or $10,000	$5,000 or $10,000
	Guarantee Issue	All amounts guaranteed	All amounts guaranteed
	Annual Enrollment Increase	All amounts guaranteed	

Any amount of coverage exceeding the guarantee issue amounts will require Evidence of Insurability.

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 Benefit Plans will be transitioning from Cigna Health to New York Life as of January 1, 2026. Worksite Benefits 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

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 Non-Union Employees
- Eligible on the first of the month following your date of hire

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 professional who will be able to answer the question "What should I do?" Dura Shiloh has partnered with the professionals at Risk Strategies to provide expanded investment education and the opportunity to 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 516-209-2075 or by speaking with your local HR Department.

How Do I Select 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

If you (and/or your dependents) have Medicare or will become eligible for Medicare within the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please read the notice on Page 29 for more details.

COBRA RIGHTS

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Company plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact your Human Resources department or (248) 299-7528.

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 days of the event.

If applicable, your participation in the Health Care Flexible Spending Account (FSA) can also continue on an after-tax basis through the remainder of the plan year in which you qualify for COBRA. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries. If you make contributions to the Health Care FSA for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the plan year.

You may be offered to continue your coverage under the Health Care FSA if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the plan year; (2) the total reimbursable claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent. You may not re-enroll in the Health Care FSA during any annual enrollment for any plan year that follows your qualifying event.

Important Employee Notices (continued)

Supporting documentation like a divorce decree, death certificate or proof of other insurance may be required as proof of a qualifying event. This general notice does not fully describe COBRA or the plan. More complete information is available from the Plan Administrator and in the summary plan document.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a dependent child.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify the Plan Administrator of the qualifying event.

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his 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). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Important Employee Notices (continued)

Disability extension of 18-month period of continuation coverage

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

Documentation from the Social Security administration certifying a disability will be required.

Second qualifying event extension of 18- month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit **medicare.gov/medicare-and-you**

If you have questions

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

Important Employee Notices (continued)

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

Plan Administrator Contact Information:
Megalodon Midco, LLC, Human Resources
(248) 299-7528
1780 Pond Run
Auburn Hills, MI 48326

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 ("GINA")

GINA protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

HIPAA SPECIAL ENROLLMENT RIGHTS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, including: if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage) provided that you meet participation requirements. You must request enrollment, however, within 30 days or any longer period that applies under the plan, after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Administrator indicated in this notice.

If you have declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. You must, however, request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. You must, however, request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the Plan Administrator indicated in this notice.

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 Base PPO Plan, Buy-Up PPO Plan, High-Deductible Health Plan and Fremont $1,500 PPO 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).

Date:	October 16, 2025
Name of Entity/Sender:	Megalodon Midco, LLC
Contact-Position/Office:	Human Resources
Address:	1780 Pond Run Auburn Hills, MI 48326
Phone Number:	(248) 299-7500

Important Employee Notices (continued)

MENTAL HEALTH PARITY

The Mental Health Parity and Addiction Equity Act (MHPA/ MHPAEA) of 2008 requires that group health plans must not unfairly restrict treatment with respect to coverage and cost sharing requirements for mental health or substance use disorders relative to the coverage and cost sharing requirements offered under the plan's medical and surgical benefits. Additional information and details can be found by visiting the Department of Labor's **Mental Health Parity website**.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Newborns' and Mothers' Health Protection Act (NMHPA) requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your Human Resources department or (248) 299-7528.

For additional information about NMHPA provisions and how self-funded non-Federal governmental plans may opt- out of the NMHPA requirements, visit **www.cms.gov**.

PAPERWORK REDUCTION ACT STATEMENT

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20220 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

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**.

Important Employee Notices (continued)

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, 2025. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: myalhipp.com Phone: 1-855-692-5447	**The AK Health Insurance Premium Payment Program** Website: myakhipp.com Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: health.alaska.gov
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: myarhipp.com Phone: 1-855-MyARHIPP (855-692-7447)	**Health Insurance Premium Payment (HIPP) Program** Website: dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) and Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: healthfirstcolorado.com Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): www.mycohibi.com HIBI Customer Service: 1-855-692-6442	Website: www.flmedicaidtplrecovery.com Phone: 1-877-357-3268

Important Employee Notices (continued)

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: medicaid.georgia.gov Phone: 678-564-1162, Press 1 GA CHIPRA Website: medicaid.georgia.gov Phone: 678-564-1162, Press 2	**Health Insurance Premium Payment Program** **All other Medicaid** Website: www.in.gov/medicaid www.in.gov/fssa/dfr **Family and Social Services Administration** Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) HIPP Phone: 1-888-346-9562	Website: 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: chfs.ky.gov Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: 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: www.mymaineconnection.gov Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: www.maine.gov Phone: 1-800-977-6740 TTY: Maine relay 711	Website: www.mass.gov Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: mn.gov Phone: 1-800-657-3672	Website: www.dss.mo.gov Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: dphhs.mt.gov Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

Important Employee Notices (continued)

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: www.dhhs.nh.gov Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: www.state.nj.us Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: www.njfamilycare.org CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: www.health.ny.gov Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: medicaid.ncdhhs.gov Phone: 919-855-4100	Website: www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: www.insureoklahoma.org Phone: 1-888-365-3742	Website: healthcare.oregon.gov Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: www.pa.gov Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) CHIP Phone: 1-800-986-KIDS (5437)	Website: www.eohhs.ri.gov Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: www.scdhhs.gov Phone: 1-888-549-0820	Website: dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program Phone: 1-800-440-0493	**Utah's Premium Partnership for Health Insurance (UPP)** Website: medicaid.utah.gov Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: medicaid.utah.gov Utah Medicaid Buyout Program Website: medicaid.utah.gov CHIP Website: chip.utah.gov

Important Employee Notices (continued)

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Phone: 1-800-250-8427	Websites: coverva.dmas.virginia.gov coverva.dmas.virginia.gov/learn Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: www.hca.wa.gov Phone: 1-800-562-3022	Website: dhhr.wv.gov Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: www.dhs.wisconsin.gov Phone: 1-800-362-3002	Website: health.wyo.gov Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, 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)

PREVENTIVE CARE

Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, visit: **www.HealthCare.gov.**

PRIVACY PRACTICES NOTICE REMINDER

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information.

We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated. To obtain a copy of the Privacy Practices, or for more information regarding the Plan's privacy policies or your rights under HIPAA, contact your Human Resources department or (248) 299-7528.

SUMMARY OF BENEFITS AND COVERAGE (SBCs)

You may request a paper copy of the SBCs (free of charge), from your employer. Your employer is required to make SBCs available that summarize important information about health benefit plan options in a standard format, to help you compare across plans and make an informed choice. The health benefits available to you provide important protection for you and your family and choosing a health benefit option is an important decision. If you would like a paper copy of the SBCs (free of charge), you may contact your Human Resources department or (248) 299-7528.

SURPRISE MEDICAL BILLS NOTICE

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

Important Employee Notices (continued)

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact HHS, in coordination with the Department of the Treasury, Department of Labor and the Office of Personnel Management at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Important Employee Notices (continued)

USERRA NOTICE

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free From Discrimination and Retaliation

If you are a past or present member of the uniformed service, have applied for membership in the uniformed service or are obligated to serve in the uniformed service, an employer may not deny you initial employment, reemployment, retention in employment, promotion or any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 866-4-USA-DOL or visit **www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **webapps.dol.gov**.

If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: **www.dol.gov/vets**.

Important Employee Notices (continued)

WELLNESS PROGRAM (HEALTH-CONTINGENT)

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your Human Resources department or (248) 299-7528 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your Human Resources department or (248) 299-7528.

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/Critical Illness/Hospital	New York LIfe	Acc: GAI0100291 CI: GCI0100291 H: GHI0100291	English 888-842-4462 or Spanish 866-562-8421	www.myNYLGBS.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	Risk Strategies Richard Specht		516-209-2075	www.venrollment.com/v/dura-shiloh
Flexible Spending Accounts	HealthEquity	41768	877-924-3967	www.healthequity.com
Health Savings Account	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	855-999-6827	www.AskAllegiance.com www.mycigna.com
Out-of-Network Care	6 Degrees Health	Dura Shiloh	888-615-6398	Info@6degreeshealth.com
Prescription Drug	CVS/Caremark RxBenefits	004336	866-818-6911 800-334-8134	www.caremark.com
Telehealth	MD Live		888-726-3171	www.MDLive.com/Allegiance
UBreatheTobacco/ Nicotine Cessation Program	Marquee Health		800-882-2109	Coaching@marqueehealth.com
Non-Emergency Surgery Concierge	Lantern Care	Dura Shiloh	833-227-7581	www.mylanterncare.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 2026 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.