Momentive

2025

Employee Benefits Guide

HELPFUL RESOURCES

Important Contacts

PROGRAM	CARRIER NAME	POLICY GROUP NUMBER	PHONE NUMBER	WEBSITE/EMAIL
Medical	UnitedHealthcare	932965	866-633-2446	www.myuhc.com
Telemedicine/Virtual Visits	UnitedHealthcare	N/A	855-615-8335	www.myuhc.com/virtualvisits
Health Savings Account	Optum Bank	Individual Policy	800-791-9361	https://bit.ly/optumbankcb
Employee Assistance Plan	Unum	N/A	800-854-1446	www.unum.com/lifebalance
Flexible Spending Accounts	WEX	N/A	Benefit Services – 866-451-3399; Claims – 866-451-3245	www.benefitslogin.wexhealth.com customerservice@wexhealth.com
Dental	Unum	918750	866-679-3054	www.unum.com
Vision	Unum/EyeMed	918750	866-679-3054	www.unum.com
Basic and Voluntary Life and AD&D	Unum	923584 (Basic Life) 923585 (Vol. Life)	866-679-3054	www.unum.com
Short and Long Term Disability	Unum	923584 (STD) 923586 (LTD)	866-679-3054	www.unum.com
Accident	Unum	918751	866-679-3054	www.unum.com
Critical Illness	Unum	918752	866-679-3054	www.unum.com
Pet Insurance	Nationwide	Individual Policy	877-738-7874	https://benefits.petinsurance.com/momentivesoftware

What's Inside

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices for your prescription drug coverage. Please see page 25 for more details.

WELCOME

Momentive Software is pleased to offer a comprehensive benefits package to help protect your well-being and financial health. Read this guide to learn about the benefits available to you and your eligible dependents starting with the 2025 plan year.

Each year during Open Enrollment, you may make changes to your benefit plans. The benefit choices you make this year will remain in effect through December 31, 2025. Take time to review these benefit options, and select the plans that best meet your needs. After Open Enrollment, you may only make changes to your benefit elections if you have a Qualifying Life Event.

Availability of Summary Health Information

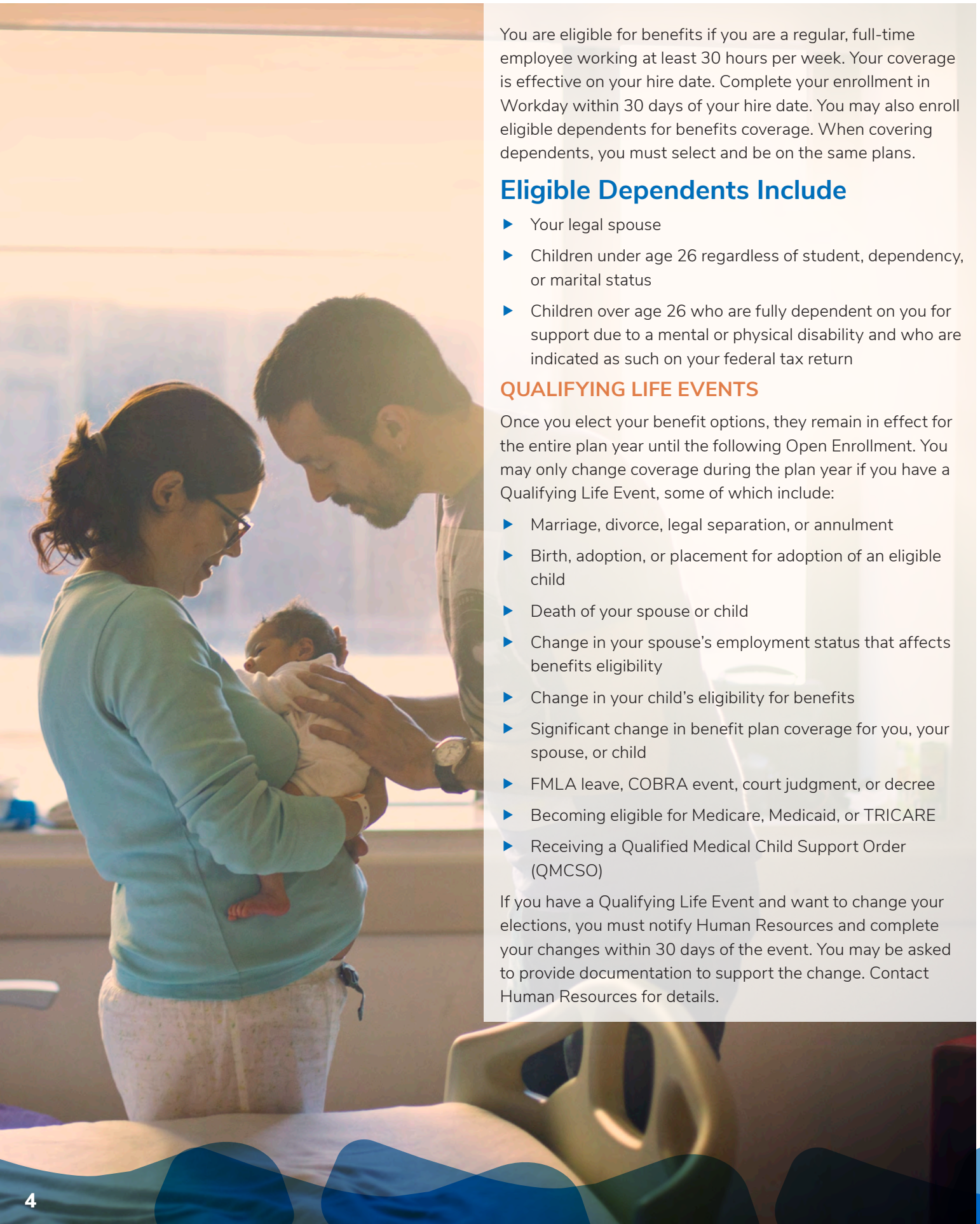
Your plan offers three health coverage options. To help you make an informed choice and compare your options, a Summary of Benefits and Coverage (SBC) is available by contacting Human Resources or visiting your Workday benefits module. A full review of all employee benefits — including all plan summaries — can be found at **momentivebenefits.info**.

Click on the code below for more information

The Momentive Benefits microsite provides easy access to resources such as benefits overview video, plan summaries, network provider searches, preferred drug lists, and more!

Employee Benefits Momentive Microsite

ELIGIBILITY



You are eligible for benefits if you are a regular, full-time employee working at least 30 hours per week. Your coverage is effective on your hire date. Complete your enrollment in Workday within 30 days of your hire date. You may also enroll eligible dependents for benefits coverage. When covering dependents, you must select and be on the same plans.

Eligible Dependents Include

- Your legal spouse
- Children under age 26 regardless of student, dependency, or marital status
- Children over age 26 who are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return

QUALIFYING LIFE EVENTS

Once you elect your benefit options, they remain in effect for the entire plan year until the following Open Enrollment. You may only change coverage during the plan year if you have a Qualifying Life Event, some of which include:

- Marriage, divorce, legal separation, or annulment
- Birth, adoption, or placement for adoption of an eligible child
- Death of your spouse or child
- Change in your spouse's employment status that affects benefits eligibility
- Change in your child's eligibility for benefits
- Significant change in benefit plan coverage for you, your spouse, or child
- FMLA leave, COBRA event, court judgment, or decree
- Becoming eligible for Medicare, Medicaid, or TRICARE
- Receiving a Qualified Medical Child Support Order (QMCSO)

If you have a Qualifying Life Event and want to change your elections, you must notify Human Resources and complete your changes within 30 days of the event. You may be asked to provide documentation to support the change. Contact Human Resources for details.

HOW TO ENROLL

To begin the enrollment process, go to **www.workday.com.**

Before enrolling, have the personal information handy for any:

- Dependents you are covering
- Beneficiaries you are naming for certain benefits, like Life and AD&D

If you currently use nicotine, you will be assessed a $50 monthly surcharge. To eliminate this surcharge and be nicotine free, **UnitedHealthcare** offers a tobacco cessation program. For more information, contact **benefits@MomentiveSoftware.com**.

MEDICAL COVERAGE

The medical plan options through **UnitedHealthcare** protect you and your family from major financial hardship in the event of illness or injury. You have a choice of three plans:

- Option 1 – This plan is a PPO with a $2,500 individual and a $5,000 family deductible
- Option 2 – This higher deductible PPO plan has a $4,000 individual and an $8,000 family deductible
- Option 3 – This is a Consumer-Directed Health Plan – also known as an CDHP – with a $3,300 individual and a $6,600 family deductible

Traditional PPO Plans

With this type of plan, office visits and prescription drugs are subject to copays, while other services are subject to the plan deductible and coinsurance.

Consumer-Directed Health Plan

With this type of plan, also known as a High Deductible Health Plan (HDHP), most medical services (excluding wellness services) are subject to the deductible and coinsurance. This plan can be paired with a Health Savings Account (HSA) and has the lowest associated premium.

Find an In-Network Provider

Visit – www.myuhc.com

Call – 866-314-0335

Download the **UnitedHealthcare app**

Medical Plan Comparison

	OPTION 1 PPO PLAN		OPTION 2 PPO HIGHER DEDUCTIBLE PLAN		OPTION 3 CONSUMER-DIRECTED HEALTH PLAN (HDHP)	
	Choice Plus		Choice Plus		Choice Plus	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible • Individual • Family	 $2,500 $5,000	 $8,000 $16,000	 $4,000 $8,000	 $8,000 $16,000	 $3,300 $6,600	 $8,000 $16,000
Calendar Year Out-of-Pocket Maximum (includes deductible) • Individual • Family	 $4,500 $9,000	 $8,000 $16,000	 $5,000 $10,000	 $10,000 $20,000	 $5,000 $10,000	 $10,000 $20,000
	You Pay		You Pay		You Pay	
Preventive Care	$0	50%*	$0	50%*	$0	40%*
Telemedicine	$0	Not Covered	$0	Not Covered	$54 copay	Not Covered
Primary Care Physician	$30 copay	50%*	$35 copay	50%*	20%*	40%*
Specialist	$60 copay	50%*	$70 copay	50%*	20%*	40%*
Urgent Care	$60 copay	50%*	$70 copay	50%*	20%*	40%*
Diagnostic X-ray and Lab	30%*	50%*	30%*	50%*	20%*	40%*
Complex Imaging (CT/PET scan, MRI)	30%*	50%*	30%*	50%*	20%*	40%*
Emergency Room	$250 copay	$250 copay	$350 copay	$350 copay	20%*	20%*
Inpatient Hospital Services	30%*	50%*	30%*	50%*	20%*	40%*
Outpatient Services	30%*	50%*	30%*	50%*	20%*	40%*
Retail Pharmacy (up to a 31-day supply) • Preferred Generic • Non-Preferred Generic • Preferred Brand Name • Non-Preferred Brand Name	 $10 copay $35 copay $70 copay N/A	 50%* 50%* 50%* N/A	 $10 copay $35 copay $70 copay N/A	 50%* 50%* 50%* N/A	 20%* 20%* 20%* N/A	 Not covered Not covered Not covered Not covered
Mail Order Pharmacy (up to a 90-day supply) • Preferred Generic • Non-Preferred Generic • Preferred Brand Name • Non-Preferred Brand Name	 $25 copay $88 copay $175 copay N/A	 50%* 50%* 50%* N/A	 $25 copay $88 copay $175 copay N/A	 50%* 50%* 50%* N/A	 20%* 20%* 20%* N/A	 Not covered Not covered Not covered Not covered
Specialty Retail (up to a 31-day supply) • Preferred Generic • Non-Preferred Generic • Preferred Brand Name	 25% coinsurance up to $250 maximum	 N/A N/A N/A	 25% coinsurance up to $250 maximum	 N/A N/A N/A	 20%* 20%* 20%*	 N/A N/A N/A

*What you will pay after your deductible is met.

BIWEEKLY MEDICAL RATES	OPTION 1	OPTION 2	OPTION 3
Employee Only	$97.55	$51.47	$32.80
Employee + Spouse	$403.98	$283.34	$162.35
Employee + Child(ren)	$344.13	$235.46	$134.64
Employee + Family	$671.88	$417.82	$267.27

TELEMEDICINE

Virtual care services through **UnitedHealthcare** connect you anytime day or night with a board-certified doctor via your mobile device or computer. Get a care plan from the comfort of your home, or anywhere on the go, through secure video, chat, or email.

WHEN TO USE UNITEDHEALTHCARE

Non-Emergency Medical Issues	Doctor is Unavailable	Traveling	Rx Refill	Convenience

Use telemedicine services for minor conditions such as:

GENERAL MEDICINE	BEHAVIORAL/MENTAL HEALTH CARE	DERMATOLOGY	BACK/NECK CARE
• Sore throat • Headache • Earache • Fever • Cold/Flu • Bronchitis • Allergies • Stomachache • Urinary tract infection • Pink eye • Rashes	• Addictions • Bipolar disorders • Depression • Eating disorders • Grief/Loss • Panic disorders • Parenting issues • Postpartum depression • Stress • Trauma/PTSD	• Acne • Eczema • Shingles • Psoriasis • And more	• Relieve your back and neck pain through guided videos with a certified health coach

Do not use telemedicine for serious or life-threatening emergencies.

Registration is Easy

Register with **UHC** so you are ready to use this valuable service when and where you need it.

- **Online** – www.myuhc.com/virtualcare
- **Phone** – 855-615-8335
- **Mobile** – Download the UnitedHealthcare mobile app

GET IT ON Google Play Download on the App Store

HEALTH CARE OPTIONS

Becoming familiar with your options for medical care can save you time and money.

HEALTH CARE PROVIDER		SYMPTOMS	AVERAGE COST	AVERAGE WAIT
NON-EMERGENCY CARE				
 **TELEMEDICINE**	Access to care via phone, online video or mobile app whether you are home, work or traveling; medications can be prescribed **24 hours a day, 7 days a week**	▪ Allergies ▪ Cough/cold/flu ▪ Rash ▪ Stomachache	$	**2-5 minutes**
 **DOCTOR'S OFFICE**	Generally, the best place for routine preventive care; established relationship; able to treat based on medical history **Office hours vary**	▪ Infections ▪ Sore and strep throat ▪ Vaccinations ▪ Minor injuries, sprains and strains	$	**15-20 minutes**
 **RETAIL CLINIC**	Usually lower out-of-pocket cost than urgent care; when you can't see your doctor; located in stores and pharmacies **Hours vary based on store hours**	▪ Common infections ▪ Minor injuries ▪ Pregnancy tests ▪ Vaccinations	$	**15 minutes**
 **URGENT CARE**	When you need immediate attention; walk-in basis is usually accepted **Generally includes evening, weekend and holiday hours**	▪ Sprains and strains ▪ Minor broken bones ▪ Small cuts that may require stitches ▪ Minor burns and infections	$$	**15-30 minutes**
EMERGENCY CARE				
 **HOSPITAL ER**	Life-threatening or critical conditions; trauma treatment; multiple bills for doctor and facility **24 hours a day, 7 days a week**	▪ Chest pain ▪ Difficulty breathing ▪ Severe bleeding ▪ Blurred or sudden loss of vision ▪ Major broken bones	$$$$	**4+ hours**
 **FREESTANDING ER**	Services do not include trauma care; can look similar to an urgent care center, but medical bills may be 10 times higher **24 hours a day, 7 days a week**	▪ Most major injuries except trauma ▪ Severe pain	$$$$$$	**Minimal**

Note: Examples of symptoms are not inclusive of all health issues. Wait times described are only estimates. This information is not intended as medical advice. If you have questions, please call the phone number on the back of your medical ID card.

PRESCRIPTION DRUG COVERAGE

Your prescription drug coverage is provided through **UnitedHealthcare**.

Prescription Drug List

To save money on overall prescription costs, UHC uses a Prescription Drug List (PDL). This document is a list of the most commonly prescribed medications, and includes both brand-name and generic prescription medications approved by the Food and Drug Administration (FDA). Medications are listed by common categories or classes and placed in tiers that represent the cost you pay out-of-pocket. They are then listed in alphabetical order. You and your doctor can consult the PDL to help you select the most cost-effective prescription medications. This guide tells you if a medication is generic or a brand name, and if there are coverage requirements or limits. Bring this list with you when you see your doctor. If your medication is not listed here, call the toll-free member phone number on your member ID card.

Retail and Home Delivery

Use a retail pharmacy or home delivery for non-specialty medication. Home delivery is a convenient, low-cost option for long-term medications to treat chronic conditions, such as diabetes and heart disease.

Specialty Medications

If you need specialty drugs to treat complex or chronic conditions, use Optum Specialty Pharmacy for new or transfer orders and specialty medication support, including virtual visits. Call **855-427-4682** to speak to a pharmacist or patient care coordinator. Specialty medication can only be filled through Optum. Certain exclusions and limitations apply.

UHC WELLNESS PROGRAMS

Advocate4Me

Help is just a call away, whether you have a question about a new claim, need to find a doctor, or want to better understand your benefits. UHC Advocates are available 24/7 to help you:

- Understand your benefits and claims
- Get answers about a bill or payment
- Locate care and cost options
- Learn more about your prescriptions
- Find support if you have a child with complex needs
- Discover your plans' health and wellbeing benefits

Sign in to **www.myuhc.com** to get started or call the number on your medical ID card.

Calm Health – Mental Health Support

The Calm Health app from UHC provides programs and tools to help support your mental health and well-being at no additional cost to you. Access a library of support — including mindfulness content and programs created by psychologists — for a variety of health experiences and life stages. This information is designed to help you:

- Learn techniques to improve well-being
- Work toward goals
- Support your mind and body

Sign in to your account on **www.myuhc.com** or the UnitedHealthcare app. If you don't have an account, select *Register* to create one. Scan this QR code to get started.

UHC One Pass Select

UHC One Pass Select makes it easy to prioritize your health and wellness through a low-cost, extensive nationwide gym network, digital fitness, and grocery delivery service. Four gym membership options are available, or get started with a digital only plan. One Pass Select offers:

- No long-term contracts or annual gym registration fees
- Flexible fitness options with the ability to change tiers monthly
- Access to multiple locations and no waiting period
- A monthly discount for family members (ages 18+)

Visit **www.onepassselect.com** and enjoy a healthier you.

Maternity Support

Whether you are thinking about having a baby or have one on the way, UHC maternity support is there to provide information and resources — from planning for a pregnancy to postpartum. Support includes 24/7 access to online maternity courses, as well as ongoing support after birth. Visit **www.myuhc.com/maternity** to complete the pregnancy assessment and learn more about maternity support.

UHC Mobile App

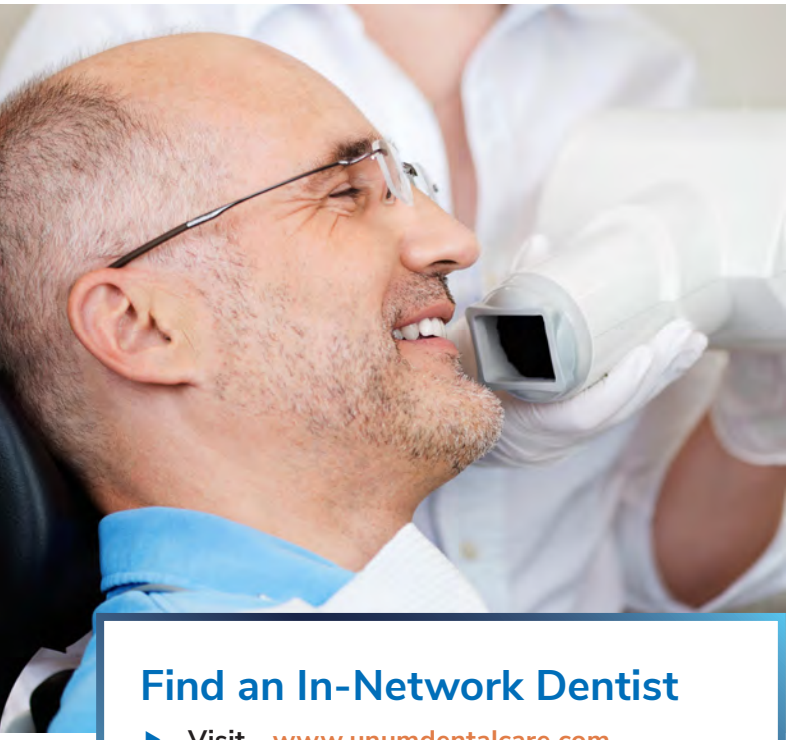
Get the UHC Mobile App for convenient, on-the-go access to your benefit information.

- Access your member ID card
- Find in-network doctors and hospitals
- Estimate the costs of common procedures
- Review claim history and status
- Review your benefit plans
- Manage mail-order prescription refills
- Speak with a doctor 24/7

Cost Estimator Tool

The cost of medical procedures and prescription drugs can vary greatly among facilities. Visit **www.member.uhc.com** to save yourself time and money by using the Cost Estimator tool. The tool shows what your projected cost would be for an upcoming medical procedure and compares pricing among in-network facilities.

DENTAL COVERAGE



Find an In-Network Dentist

- **Visit** – www.unumdentalcare.com
- **Call** – 866-679-3054
- Virtual dental care is available 24/7 for dental emergencies. **Visit** www.unumdentalcare.com and click *Virtual Dental Visits*.

Our dental plans help you maintain good oral health through affordable options for preventive care, including regular checkups and other dental work. Coverage is provided by **Unum**.

DPPO Plans

Two levels of benefits are available with the DPPO plans: in-network and out-of-network. You may see any dental provider for care, but you will pay less and get the highest level of benefits with in-network providers. You could pay more if you use an out-of-network provider.

Carryover Benefits

Unum offers carryover benefits that reward you with extra benefits in future years if you take care of your teeth, but use only part of your annual maximum benefit during a benefit period. Carryover benefits are accrued and stored in your carryover account to be used in the next benefit year.

NO RATE CHANGES FOR 2025!

BIWEEKLY DENTAL RATES	Base Plan	Buy-Up Plan
Employee Only	$6.87	$8.30
Employee + Spouse	$20.04	$23.56
Employee + Child(ren)	$23.59	$29.93
Employee + Family	$26.90	$34.73

DENTAL PLANS	BASE PLAN		BUY-UP PLAN	
Network	Unum Dental		Unum Dental	
Calendar Year Maximum Benefit (Per Covered Person)	$1,000		$5,000	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Orthodontia Lifetime Maximum Benefit	N/A	N/A	$2,000	$2,000
	You Pay		You Pay	
Calendar Year Deductible • Individual • Family	$50 $50 maximum 3 per family		$50 $50 maximum 3 per family	
Type A - Preventive Care Exams, cleanings, complete series X-rays	$0	$0	$0	$0
Type B - Basic Restorative Fillings, extractions, periodontics, root canals, endodontics, oral surgery	20%	20%	20%	20%
Type C - Major Restorative Crowns, bridges, dentures	50%	50%	50%	50%
Type D - Orthodontia • Covered Individuals • Benefit	N/A	N/A	50%	50%
Annual Carryover Benefit Threshold Limit Carryover Account Limit Maximum	$250 $500 $1,000		$400 $800 $1,500	

[1]Payment for covered services received from an out-of-network dentist is based on the 90th percentile of Usual, Customary and Reasonable (UCR) charges.

VISION COVERAGE

Our vision plans offer quality care to help preserve your health and eyesight. Regular exams can detect certain medical issues such as diabetes and high cholesterol, in addition to vision and eye problems. Coverage is provided through **Unum** using the **EyeMed Insight** network. Please note that vision benefits are substantially reduced when using an out-of-network provider, so be sure to choose a provider within the EyeMed Insight vision network. The network offers independent, national retail, and regional retail providers like Lens Crafters, Pearle Vision, and Target Optical. You may also buy glasses and contact lenses online at **www.Glasses.com** and **www.ContactsDirect.com**. Laser vision correction discounts are available with participating surgery providers across the country (not an insured benefit).

VISION PLAN				
Unum Vision	**Low Plan**		**High Plan**	
	You Pay	Reimbursement	You Pay	Reimbursement
Exam Routine Examination	$10 copay	Up to $40	$0 copay	Up to $40
Standard Lenses Single Vision Lined Bifocal Lined Trifocal Lenticular	 $25 copay $25 copay $15 copay $25 copay	 Up to $30 Up to $50 Up to $70 Up to $70	 $0 copay $0 copay $0 copay $0 copay	 Up to $30 Up to $50 Up to $70 Up to $70
Frame	$130 allowance	Up to $91	$130 allowance	Up to $91
Contact Lenses (in lieu of eyeglasses) • Fitting and Evaluation • Elective • Necessary	 Up to $40 $130 allowance $0 (covered in full)	 Not covered Up to $130 Up to $210	 Up to $40 $130 allowance $0 (covered in full)	 Not covered Up to $130 Up to $210
Benefit Frequency				
Exam **Lenses** **Frames** **Contacts**	Once every 12 months Once every 12 months Once every 24 months Once every 12 months		Once every 12 months Once every 12 months Once every 12 months Once every 12 months	

Find an In-Network Vision Provider

- **Visit** – www.unum.com
- **Call** – 866-679-3054

NO RATE CHANGES FOR 2025!

BIWEEKLY VISION RATES	Low Plan	High Plan
Employee Only	$2.70	$4.28
Employee + Spouse	$5.11	$8.12
Employee + Child(ren)	$6.00	$9.52
Employee + Family	$8.43	$13.40

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is a tax-exempt tool to supplement your retirement savings and to cover current and future health costs.

An HSA is a type of personal savings account that is always yours even if you change health plans or jobs. The money in your HSA (including interest and investment earnings) grows tax-free and spends tax-free if used to pay for current or future qualified medical expenses. There is no "use it or lose it" rule — you do not lose your money if you do not spend it in the calendar year — and there are no vesting requirements or forfeiture provisions. The account automatically rolls over year after year.

HSA Eligibility

You are eligible to open and contribute to an HSA if you are:

- Enrolled in an HSA-eligible HDHP
- Not covered by another plan that is not a qualified HDHP, such as your spouse's health plan
- Not enrolled in a Health Care Flexible Spending Account
- Not eligible to be claimed as a dependent on someone else's tax return
- Not enrolled in Medicare, Medicaid, or TRICARE
- Not receiving Veterans Administration benefits

You can also use HSA funds to pay health care expenses for your dependents, even if they are not covered by the HDHP.

Maximum Contributions

Your HSA contributions may not exceed the annual maximum amounts established by the Internal Revenue Service (IRS). The annual contribution maximums are based on the coverage option you elect:

2025	
Individual – $4,300	Family – $8,550

You decide whether to use the money in your account to pay for qualified expenses or let it grow for future use. If you are age 55 or older, you may make a yearly catch-up contribution of up to $1,000 to your HSA. If you turn 55 at anytime during the plan year, you are eligible to make the catch-up contribution for the entire plan year.

Opening an HSA

If you meet the eligibility requirements, an HSA will be opened for you with **Optum Bank**. You will receive a debit card to manage your HSA account reimbursements. Keep in mind, available funds are limited to the balance in your HSA. Visit **www.optumbank.com/health-accounts/hsa.html** to open an account.

IMPORTANT HSA INFORMATION

- Always ask your in-network doctor to file claims with your medical, dental, or vision carrier so you will get the highest level of benefits. You can pay the doctor with your HSA debit card for any balance due.
- You, not your employer, are responsible for maintaining ALL records and receipts for HSA reimbursements in the event of an IRS audit.
- You may open an HSA at the financial institution of your choice, but only accounts opened through Optum Bank are eligible for automatic payroll deduction and company contributions.

ABBREVIATED LIST OF QUALIFIED HSA EXPENSES

The products and services listed below are examples of medical expenses eligible for payment under your Health Care HSA. This list is not all-inclusive; additional expenses may qualify and the items listed are subject to change in accordance with IRS regulations. Please refer to IRS *Publication 502 Medical and Dental Expenses* at **www.irs.gov** for a complete description of eligible medical and dental expenses.

- Abdominal supports
- Acupuncture
- Air conditioner (when necessary for relief from difficulty in breathing)
- Alcoholism treatment
- Ambulance
- Anesthetist
- Arch supports
- Artificial limbs
- Autoette (when used for relief of sickness/disability)
- Blood tests
- Blood transfusions
- Braces
- Cardiographs
- Chiropractor
- Contact lenses
- Convalescent home (for medical treatment only)
- Crutches
- Dental treatment
- Dental X-rays
- Dentures
- Dermatologist
- Diagnostic fees
- Diathermy
- Drug addiction therapy
- Drugs (prescription)
- Elastic hosiery (prescription)
- Eyeglasses
- Fees paid to health institute prescribed by a doctor
- FICA and FUTA tax paid for medical care service
- Fluoridation unit
- Guide dog
- Gum treatment
- Gynecologist
- Healing services
- Hearing aids and batteries
- Hospital bills
- Hydrotherapy
- Insulin treatment
- Lab tests
- Lead paint removal
- Legal fees
- Lodging (away from home for outpatient care)
- Metabolism tests
- Neurologist
- Nursing (including board and meals)
- Obstetrician
- Operating room costs
- Ophthalmologist
- Optician
- Optometrist
- Oral surgery
- Organ transplant (including donor's expenses)
- Orthopedic shoes
- Orthopedist
- Osteopath
- Oxygen and oxygen equipment
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Postnatal treatments
- Practical nurse for medical services
- Prenatal care
- Prescription medicines
- Psychiatrist
- Psychoanalyst
- Psychologist
- Psychotherapy
- Radium therapy
- Registered nurse
- Special school costs for the handicapped
- Spinal fluid test
- Splints
- Surgeon
- Telephone or TV equipment to assist the hard-of-hearing
- Therapy equipment
- Transportation expenses (relative to health care)
- Ultra-violet ray treatment
- Vaccines
- Vitamins (if prescribed)
- Wheelchair
- X-rays

FLEXIBLE SPENDING ACCOUNTS

A Flexible Spending Account (FSA) allows you to set aside pretax dollars from each paycheck to pay for certain IRS-approved health and dependent care expenses. We offer three different FSAs: two for health care expenses and one for dependent care expenses. All FSA accounts are administered by **WEX**.

Health Care FSA

The Health Care FSA covers qualified medical, dental, and vision expenses for you or your eligible dependents. You may contribute up to $3,300 annually to a Health Care FSA, and you are entitled to the full election from day one of your plan year. Eligible expenses include:

- Dental and vision expenses
- Medical deductibles and coinsurance
- Prescription copays
- Hearing aids and batteries

You may not contribute to a Health Care FSA if you enrolled in a High Deductible Health Plan (HDHP) and contribute to a Health Savings Account (HSA).

Limited Purpose Health Care FSA

A Limited Purpose Health Care FSA is available if you enrolled in the HDHP medical plan and contribute to an HSA. You can use a Limited Purpose Health Care FSA to pay for eligible out-of-pocket dental and vision expenses only, such as:

- Dental and orthodontia care (e.g., fillings, X-rays, and braces)
- Vision care (e.g., eyeglasses, contact lenses, and LASIK surgery)

How the Health Care and Limited Purpose FSAs Work

You can access the funds in your Health Care or Limited Purpose FSA two different ways:

- Use your FSA debit card to pay for qualified expenses, doctor visits, and prescription copays.
- Pay out-of-pocket, and submit your receipts for reimbursement:
  - **Submit a form** – **forms@wexhealth.com**
  - **Online** – **http://www.wexinc.com/solutions/benefits/participants-employees**

Benefit App and Portal

Access your benefits 24/7 with the WEX mobile app. It is free, convenient, and offers real-time access to all your benefits accounts. To access the portal, go to **www.wexinc.com**. If you have FSA questions, call **866-451-3399**.

Dependent Care FSA

The Dependent Care FSA helps pay for expenses associated with caring for elder or child dependents so you or your spouse can work or attend school full-time. You can use the account to pay for daycare or babysitter expenses for your children under age 13 and qualifying older dependents, such as dependent parents. Reimbursement from your Dependent Care FSA is limited to the total amount deposited in your account at that time. To be eligible, you (and your spouse, if married) must be gainfully employed, looking for work, a full-time student, or incapable of self-care.

DEPENDENT CARE FSA GUIDELINES

- Overnight camps are not eligible for reimbursement (only day camps can be considered).
- If your child turns age 13 midyear, you may only request reimbursement for the part of the year when the child is under 13.
- You may request reimbursement for care of a spouse or dependent of any age who spends at least eight hours a day in your home and is mentally or physically incapable of self-care.
- The dependent care provider cannot be your child under age 19 or anyone claimed as a dependent on your income taxes.

Important FSA Rules

- The maximum per plan year you can contribute to a Health Care or Limited Purpose FSA is $3,300. The maximum per plan year you can contribute to a Dependent Care FSA is $5,000 when filing jointly or head of household and $2,500 when married filing separately.
- You cannot change your election during the year unless you experience a Qualifying Life Event.
- Your Health Care or Limited Purpose FSA debit card can be used for health care expenses only. It cannot be used to pay for dependent care expenses.
- The IRS has amended the “use it or lose it" rule to allow you to carry over up to $660 in your Health Care FSA into the next plan year. The carryover rule does not apply to your Dependent Care FSA.

LIFE AND AD&D INSURANCE

Life and Accidental Death and Dismemberment (AD&D) insurance through **Unum** are important to your financial security, especially if others depend on you for support or vice versa. With Life insurance, you or your beneficiary(ies) can use the coverage to pay off debts such as credit cards, loans, and bills. AD&D coverage provides specific benefits if an accident causes bodily harm or loss (e.g., the loss of a hand, foot, or eye). If death occurs from an accident, 100% of the AD&D benefit would be paid to you or your beneficiary(ies). Life and AD&D coverage amounts reduce to 65% at age 65, 40% at age 70, 25% at age 75, and 15% at age 80.

Basic Life and AD&D

Basic Life and AD&D insurance are provided to all full-time employees at no cost to you. You are automatically covered at $50,000 for each benefit.

Voluntary Life and AD&D

You may buy more Life and AD&D insurance for you and your eligible dependents. If you do not elect Voluntary Life and AD&D insurance when first eligible, or if you want to increase your benefit amount at a later date, you will need to answer medical questions and you could be declined for coverage. You must elect Voluntary Life and AD&D coverage for yourself before you may elect coverage for your spouse or children. If you leave the company, you may be able to take the insurance with you.

LIFE AND AD&D INSURANCE	
Employee	• Increments of $10,000 up to 5x annual earnings ($500,000 maximum) • Guaranteed Issue $250,000
Spouse	• Increments of $5,000 up to $250,000 (not to exceed 100% of employee amount) • Guaranteed Issue: $50,000
Child(ren)	• Birth to six months: $250 • Six months to age 19 or until age 25 if a full-time student: $10,000 coverage

Living Benefit

If you are diagnosed with a terminal illness with less than 12 months to live, you can request 75% of your life insurance benefit (up to $500,000) while you are still living. This amount will be taken out of the death benefit and may be taxable.

Designating a Beneficiary

A beneficiary is the person or entity you elect to receive the death benefits of your Life and AD&D insurance policies. You can name more than one beneficiary, and you can change beneficiaries at anytime. If you name more than one beneficiary, you must identify how much benefit each beneficiary will receive (e.g., 50% or 25%).

EMPLOYEE AGE	BIWEEKLY COST PER $10,000 OF COVERAGE	BIWEEKLY COST PER $5,000 OF COVERAGE*
15-24	$0.3554	$0.1777
25-29	$0.3554	$0.1777
30-34	$0.3554	$0.1777
35-39	$0.4477	$0.2238
40-44	$0.7708	$0.3854
45-49	$1.4169	$0.7085
50-54	$2.1092	$1.0546
55-59	$3.5400	$1.7700
60-64	$5.9862	$2.9931
65-69	$10.4769	$5.2546
70-74	$16.1862	$8.0931
75+	$27.0785	$13.5392
Child coverage per $10,000 of coverage	$1.00	

*Based on Employee age

DISABILITY INSURANCE

Disability insurance provides partial income protection if you are unable to work due to a covered accident or illness. Momentive Software provides Short Term Disability (STD) to you at no cost, and offer two Long Term Disability (LTD) insurance coverages for you to buy through **Unum**.

Employer-Paid Short Term Disability

STD coverage pays a percentage of your weekly salary if you are temporarily disabled and unable to work due to an illness, pregnancy, or non-work-related injury. STD benefits are not payable if the disability is due to a job-related injury or illness. If a medical condition is job-related, it is considered under Workers' Compensation, not STD.

SHORT TERM DISABILITY	
Benefits Begin	8th day
Percentage of Earnings You Receive	60%
Maximum Weekly Benefit	$1,500
Maximum Benefit Period	12 weeks

DISABILITY INSURANCE

Voluntary Long Term Disability

LTD insurance pays a percentage of your monthly salary for a covered disability or injury that prevents you from working for more than 90 days. Choose either Option 1 which offers 50% of your pre-disability base monthly income, or Option 2 which offers 60% of your pre-disability base monthly income. Benefits begin at the end of an elimination period and continue while you are disabled up to Social Security Normal Retirement Age (SSNRA).

ADDITIONAL LTD BENEFITS

Survivor Benefit – If you die while you have been disabled and have received LTD benefits for at least 180 days, your family could get a benefit equal to three months of your gross disability payment.

Waiver of Premium – If you are disabled and receiving benefit payments, Unum will waive your cost until you return to work.

Disability Plus Benefit – This provides an additional monthly benefit when there is a loss of two or more activities of daily living or cognitive impairment.

VOLUNTARY LONG TERM DISABILITY	
Benefits Begin	91st day
Percentage of Earnings You Receive	Option 1: 50% up to $10,000 per month Option 2: 60% up to $10,000 per month
Maximum Monthly Benefit	$10,000
Maximum Benefit Period	SSNRA
Pre-existing Condition Exclusion	3/12*

*Benefits may not be paid for any consultation or care for a condition three months prior to your effective date until you have been covered under the plan for 12 months.

VOLUNTARY LONG TERM DISABILITY RATES		
EMPLOYEE AGE	MONTHLY RATE PER $100 OF PAYROLL	MONTHLY RATE PER $100 OF PAYROLL
	Option 1 – 50% of base monthly earnings	Option 2 – 60% of base monthly earnings
Age: 15-24	$0.100	$0.130
25-29	$0.100	$0.130
30-34	$0.160	$0.210
35-39	$0.250	$0.350
40-44	$0.390	$0.540
45-49	$0.540	$0.740
50-54	$0.700	$0.950
55-59	$0.890	$1.220
60-64	$0.750	$1.020
65-69	$0.590	$0.800
70+	$0.510	$0.690
Maximum Covered Annual Earnings	$240,000	$200,000

DISABILITY WORKSHEET

1. Enter your annual earnings and calculate your maximum monthly benefit available.

$ _____ ÷ 12 =	$ _____ ×	_____% =	$ _____
Your annual earnings	Your monthly earnings	(The % plan you want)	Maximum monthly benefit available (if amount exceeds the plan maximum of $10,000, enter $10,000)

2. Calculate your cost per paycheck

$ _____ ÷ 100 =	$ _____ × $ _____ = $ _____ ÷	26 =	$ _____
Your annual earnings	Rate for the option you choose	Number of paychecks per year	Total cost per paycheck

SUPPLEMENTAL BENEFITS

You and your eligible family members have the opportunity to enroll in additional coverage that complements our traditional health care programs. Health insurance covers medical bills, but if you have an emergency, you may face unexpected out-of-pocket costs such as deductibles, coinsurance, travel expenses, and non-medical-related expenses. The plans are offered through **Unum** and are portable.

Accident Insurance

Accident insurance provides affordable protection against a sudden, unforeseen accident. The Accident plan helps offset the direct and indirect expenses resulting from an accident such as copayments, deductibles, ambulance, physical therapy, and other costs not covered by traditional health plans. An Organized Sports Benefit is included for each eligible family member and increases the payable benefit by 25%. Children may be covered to age 26. See plan documents for the full scope of covered accidents and exclusions.

SERVICE	BENEFIT	
	Option 1	Option 2
Emergency Room	$200	$150
Ambulance • Ground • Air	 $400 $1,200	 $300 $1,000
Initial Hospitalization	$1,500	$1,000
Hospital Confinement	$300	$200
Intensive Care Unit	$300	$200
Specific Sum Injuries Dislocations, ruptured discs, eye injuries, fractures, lacerations, concussions, etc.	$50 - $10,000	$35 - $7,500
Accidental Death & Dismemberment* Common Carrier • Employee • Spouse • Child	 $50,000 $25,000 $12,500	 $25,000 $12,500 $6,250

*Percentage of benefit paid for dismemberment is dependent on type of loss.

Accident Rates Per Pay Period	Option 1	Option 2
Employee Only	$4.13	$2.85
Employee + Spouse	$8.11	$5.62
Employee + Child(ren)	$9.73	$6.78
Employee + Family	$13.72	$9.55

Critical Illness

Critical Illness insurance helps pay the cost of non-medical expenses related to a covered critical illness or cancer. The plan provides a lump sum benefit payment to you upon first and second diagnosis of any covered critical illness or cancer. The benefit can help cover expenses such as lost income, out-of-town treatments, special diets, daily living, and household upkeep costs. See plan for the full list of covered illnesses and services.

BENEFIT AMOUNTS	AVAILABLE BENEFIT
Employee **Spouse** **Child(ren) to age 26**	**$10,000, $15,000 or $30,000** **50% of Employee benefit** **50% of Employee benefit at no additional cost**
Condition	**First Occurrence Benefit**
Alzheimer's Disease, Heart Attack; Stroke; Heart, Kidney or Organ Failure; Invasive Cancer, Dementia, MS, Parkinson's, ALS	100% of benefit amount
Major Coronary Artery Disease	50%
Coronary Artery Bypass	10%
Non-Invasive Cancer	25% of benefit amount
Health Screening Benefit - One per covered person per calendar year	$50
Pre-existing Condition Limitation	12/12*

* If you were treated for a condition 12 months prior to your effective date, benefits may not be paid until you have been covered under this plan for 12 months.

BIWEEKLY PREMIUM EMPLOYEE COVERAGE: $10,000		
Attained Age	Employee Only	Spouse
<25	$1.60	$1.18
25-29	$1.92	$1.34
30-34	$2.47	$1.62
35-39	$3.17	$1.97
40-44	$4.27	$2.52
45-49	$5.84	$3.30
50-54	$8.01	$4.39
55-59	$11.01	$5.89
60-64	$15.67	$8.22
65-69	$22.92	$11.84
70-74	$34.87	$17.82
75-79	$49.87	$25.32
80-84	$70.46	$35.61
85+	$112.00	$56.38

BIWEEKLY PREMIUM EMPLOYEE COVERAGE: $15,000		
Attained Age	Employee Only	Spouse
<25	$2.01	$1.39
25-29	$2.50	$1.63
30-34	$3.33	$2.04
35-39	$4.37	$2.57
40-44	$6.03	$3.40
45-49	$8.38	$4.57
50-54	$11.64	$6.20
55-59	$16.14	$8.45
60-64	$23.13	$11.95
65-69	$34.00	$17.38
70-74	$51.93	$26.34
75-79	$74.43	$37.60
80-84	$105.30	$53.04
85+	$167.61	$84.19

BIWEEKLY PREMIUM EMPLOYEE COVERAGE: $30,000		
Attained Age	Employee Only	Spouse
<25	$3.26	$2.01
25-29	$4.23	$2.50
30-34	$5.89	$3.33
35-39	$7.97	$4.37
40-44	$11.29	$6.03
45-49	$16.00	$8.38
50-54	$22.50	$11.64
55-59	$31.50	$16.14
60-64	$45.49	$23.13
65-69	$67.23	$34.00
70-74	$103.09	$51.93
75-79	$148.09	$74.43
80-84	$209.84	$105.30
85+	$334.46	$167.61

UNUM VALUE ADDS

The following programs and services are available with **Unum** at no additional cost to you, based on your benefit elections. Contact Unum for details.

Work/life Balance Employee Assistance Program

The Employee Assistance Program (EAP) from Unum helps you and family members cope with a variety of personal or work-related issues. This program provides confidential counseling and support services at little or no cost to you to help with:

- Relationships
- Work/life balance
- Stress and anxiety
- Financial planning
- Will preparation and estate resolution
- Grief and loss
- Childcare and eldercare resources
- Substance abuse

Call **800-854-1446** or visit **www.unum.com/lifebalance** for support at any hour of the day or night.

Worldwide Emergency Travel Assistance

One phone call gets you and your family immediate help anywhere in the world, as long as you are traveling 100 or more miles from home. However, a spouse traveling on business for his or her employer is not covered.

PET INSURANCE

You may elect payroll-deducted pet insurance through **Nationwide**, one of the leading pet insurance companies in the country. There are two plan choices: My Pet Protection and My Pet Protection with Wellness500. Both plans are guaranteed issuance, have a $250 annual deductible, and include medical coverage with the choice of 50% or 70% reimbursement levels. Call **877-738-7874** or access **https://benefits.petinsurance.com/momentivesoftware** for more details.

	My Pet Protection	My Pet Protection with Wellness500
Accidents	✓	✓
Injuries	✓	✓
Illnesses	✓	✓
Hereditary and congenital conditions	✓	✓
Procedures and surgeries	✓	✓
Wellness exams	X	✓
Vaccinations	X	✓
Flea protection	X	✓
Spay or neuter	X	✓
And more	✓	✓

LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Special Enrollment Rights

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for, such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact:

Momentive Software
Human Resources
9620 Executive Center Dr
St. Petersburg, FL 33702
800-295-2392

Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Momentive Software and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription 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. Momentive Software has determined that the prescription drug coverage offered by the Momentive Software medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. The HSA plan is considered Creditable Coverage.

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

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7 but as a general rule, if you delay your enrollment in Medicare Part D after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting Momentive Software at the phone number or address listed at the end of this section.

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

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

For more information about this notice or your current prescription drug coverage:

Contact the Human Resources Department at 800-295-2392.

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also request a copy.

LEGAL NOTICES

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 will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription 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 **877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you can call them at **800-772-1213**. TTY users should call **800-325-0778**.

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

January 1, 2025
Momentive Software
Human Resources
9620 Executive Center Dr
St. Petersburg, FL 33702
800-295-2392

Notice of HIPAA Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date of Notice: September 23, 2013

Momentive Software's Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan's uses and disclosures of Protected Health Information (PHI);
2. your privacy rights with respect to your PHI;
3. the Plan's duties with respect to your PHI;
4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1 – Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations.
2. Enrollment information can be provided to the Trustees.
3. Summary health information can be provided to the Trustees for the purposes designated above.
4. When required by law.
5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.

6. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In which case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
7. The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
8. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.
9. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
10. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
11. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and disclosures that require your written authorization.

Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2 – Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

Protected Health Information (PHI)

Includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

Designated Record Set

Includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

LEGAL NOTICES

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan's Privacy Official.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice. Such requests should be made to the Plan's Privacy Official.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes;
2. a court order of appointment of the person as the conservator or guardian of the individual; or
3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Section 3 – The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted, you will also receive a copy of the Notice or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach

The Plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

Section 4 – Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 5 – Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at:

Momentive Software
Human Resources
9620 Executive Center Dr
St. Petersburg, FL 33702
800-295-2392

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

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 March 17, 2025. Contact your State for more information on eligibility.

Alabama – Medicaid

Website: http://www.myalhipp.com/
Phone: 1-855-692-5447

Alaska – Medicaid

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.aspx

Arkansas – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

California– Medicaid

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) and Child Health Plan Plus (CHP+)

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

Florida – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

Georgia – 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

Indiana – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://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)

Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

Kansas – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

Kentucky – Medicaid

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

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Louisiana – Medicaid

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

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

Massachusetts – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

Minnesota – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

Missouri – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

Montana – Medicaid

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

Nebraska – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

Nevada – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

New Hampshire – Medicaid

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. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

New Jersey – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

New York – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

North Carolina – Medicaid

Website: https://medicaid.ncdhhs.gov
Phone: 919-855-4100

North Dakota – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

Oklahoma – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

Oregon – Medicaid

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

Pennsylvania – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

Rhode Island – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)

South Carolina – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

South Dakota - Medicaid

Website: https://dss.sd.gov
Phone: 1-888-828-0059

Texas – Medicaid

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

Utah – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

Vermont– Medicaid

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

Virginia – Medicaid and CHIP

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

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

West Virginia – Medicaid and CHIP

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
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
Wyoming – Medicaid
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 **March 17, 2025**, or for more information on special enrollment rights, you can 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

Continuation of Coverage Rights Under COBRA

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if you are covered under the Momentive Software group health plan you and your eligible dependents may be entitled to continue your group health benefits coverage under the Momentive Software plan after you have left employment with the company. If you wish to elect COBRA coverage, contact your Human Resources Department for the applicable deadlines to elect coverage and pay the initial premium.

Plan Contact Information

Momentive Software
Human Resources
9620 Executive Center Dr
St. Petersburg, FL 33702
800-295-2392

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.

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.

"Out-of-network" describes providers and facilities that have not 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.

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 cannot be balance billed for these emergency services. This includes services you may get after you are 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 cannot 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 cannot balance bill you, unless you give written consent and give up your protections.

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

When balance billing is not 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 (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 have been wrongly billed, you may contact your insurance provider. Visit **www.cms.gov/nosurprises** for more information about your rights under federal law.

Higginbotham™

This brochure highlights the main features of the Momentive Software benefits program. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Momentive Software reserves the right to change or discontinue its benefits plans at anytime.

If you have additional questions regarding your benefits, please contact HR at **benefits@momentivesoftware.com**

You may also contact our broker Higginbotham.
Marilyn Cameron **mcameron@higginbotham.net** | **865-288-5022**
James Duke **jduke@higginbotham.net** | **865-288-5006 X 106**