Momentive
Bring on better™

2027

EMPLOYEE BENEFITS GUIDE

January 1–December 31, 2027



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	Rippling	Individual Policy	800-791-9361	benefits@momentivesoftware.com
Employee Assistance Plan	UnitedHealthcare	N/A	877-660-3806	www.liveandworkwell.com
Flexible Spending Accounts	Rippling	N/A	866-451-3399	benefits@momentivesoftware.com
Dental	UnitedHealthcare	932965	866-314-0335	www.myuhc.com
Vision	UnitedHealthcare	932965	800-638-3120	www.myuhcvision.com
Basic and Voluntary Life and AD&D	UnitedHealthcare	374365	888-299-2070	www.myuhcfp.com
Short and Long-Term Disability	UnitedHealthcare	374365	888-299-2070	www.myuhcfp.com
Accident	UnitedHealthcare	374365	888-299-2070	www.myuhcfp.com
Critical Illness	UnitedHealthcare	374365	888-299-2070	www.myuhcfp.com
Hospital Indemnity	UnitedHealthcare	374365	888-299-2070	www.myuhcfp.com
Pet Insurance	Nationwide	Individual Policy	877-738-7874	Pet insurance portal
Employee Response Center	Higginbotham	Momentive Software	866-890-6763	momentivesoftware@eb.Higginbotham.net
Human Resources				benefits@momentivesoftware.com

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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 28 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 2027 plan year.

Each year during Open Enrollment, you may make changes to your benefit plans. The benefit choices you make this open enrollment will remain in effect through December 31, 2027. 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 Rippling benefits module. A full review of all employee benefits — including all plan summaries — can be found at **www.momentivebenefits.info.**



Scan the code for more information

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

Employee Benefits 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 Rippling 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 your child
- FMLA leave, COBRA event, court judgment, or decree
- Becoming eligible for Medicare, Medicaid, or TRICARE
- Receiving a Qualified Medical Child Support Order

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 at benefits@momentivesoftware.com for details.

HOW TO ENROLL

OPEN ENROLLMENT: NOVEMBER 17–30, 2026

Active enrollment: submit your 2027 benefit elections in Rippling.

Log in to Rippling and submit your 2027 elections by November 30th. Look for an invitation email, a task in your Rippling Inbox, or a prompt in the MyBenefits app.

Before enrolling, have information ready for:

- Dependents you are covering
- Beneficiaries for Life and AD&D insurance

Nicotine surcharge

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



EMPLOYEE RESPONSE CENTER

Employee benefits can be complicated. The Momentive Employee Response Center can help with the following:



Call or text 866-890-6763 (MSOF) to speak with a representative

Monday–Friday, 6:00 a.m.–5:00 p.m. EST

Messages left after 2:00 p.m. ET will be returned the next business day.

Email questions or requests to: MomentiveSoftware@eb.higginbotham.net

Bilingual representatives are also available.

MEDICAL COVERAGE

The medical plan options through **UHC** 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 Consumer-Directed Health Plan (CDHP) has a $3,500 individual and a $7,000 family deductible.

Traditional PPO Plans

With a Preferred Provider Organization (PPO) 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 (CDHP)

With this type of plan, also known as a High-Deductible Health Plan, 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 – **866-633-2446**

Download the **UnitedHealthcare app**



Medical Plan Comparison

	OPTION 1 PPO PLAN		OPTION 2 PPO HIGHER DEDUCTIBLE PLAN		OPTION 3 CONSUMER-DIRECTED HEALTH PLAN (CDHP)	
	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	$3,500 $7,000	$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 copay	50%*	$0 copay	50%*	$0 copay	40%*
Telemedicine	$0 copay	Not Covered	$0 copay	Not Covered	$0 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) • Tier-1 • Tier-2 • Tier-3	 $10 copay $35 copay $70 copay	 50%* 50%* 50%*	 $10 copay $35 copay $70 copay	 50%* 50%* 50%*	 20%* 20%* 20%*	 50%* 50%* 50%*
Mail Order Pharmacy (up to a 90-day supply) • Tier-1 • Tier-2 • Tier-3	 $25 copay $88 copay $175 copay	 50%* 50%* 50%*	 $25 copay $88 copay $175 copay	 50%* 50%* 50%*	 20%* 20%* 20%*	 Not covered Not covered Not covered
Specialty Pharmacy (up to a 31-day supply)	25% coinsurance up to $250 maximum	N/A	25% coinsurance up to $250 maximum	N/A	20%*	N/A

*What you will pay after your deductible is met.

BIWEEKLY MEDICAL RATES	OPTION 1	OPTION 2	OPTION 3
Employee Only	$107.82	$56.94	$36.24
Employee + Spouse	$446.42	$313.10	$179.40
Employee + Child(ren)	$380.27	$260.20	$148.85
Employee + Family	$742.48	$462.08	$295.43

Employee benefit premiums are deducted from 24 biweekly paychecks each year. No benefit premiums are deducted from the third paycheck in months containing three pay dates.

TELEMEDICINE

Virtual care services through **UHC** 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.

Virtual visits for general medicine are free through UHC; however, Behavioral Health and Dermatology services may require a copay.

WHEN TO USE TELEMEDICINE

- 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 app with the below QR code**

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	**$0**	**2-5 minutes**
 **DOCTOR'S OFFICE**	Generally, the best place for routine preventive care; established relationship; able to treat based on medical history **Office hours vary**	■ Infections ■ Sore and strep throat ■ Vaccinations ■ Minor injuries, sprains and strains	**$**	**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 **UHC**.

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 WELL BEING 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

Cost Estimator Tool

The cost of medical procedures and prescription drugs can vary greatly among facilities. Visit **www.myuhc.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.

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.

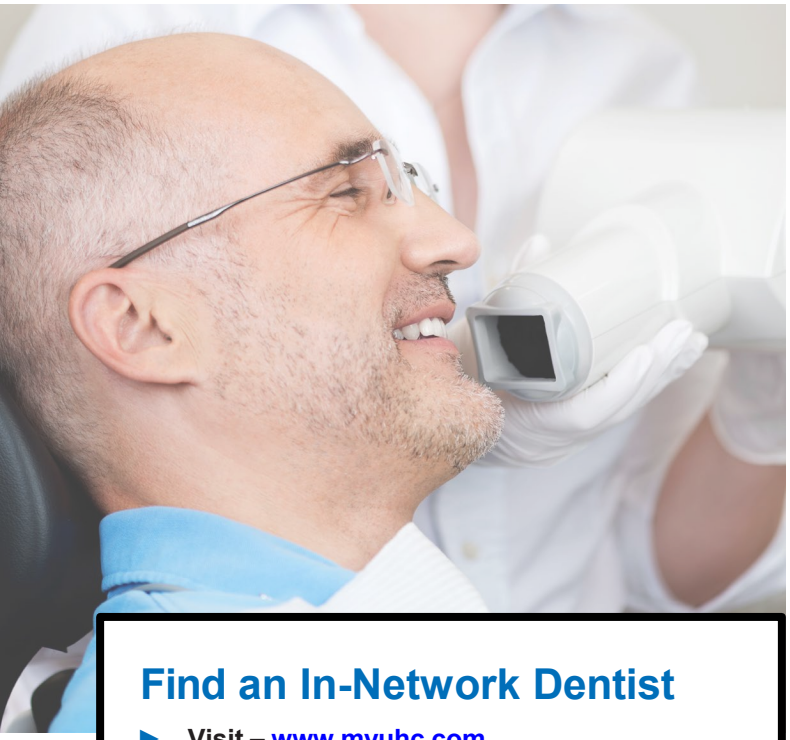
UHC Mobile App

Get the **UnitedHealthcare 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
- Sign in to your account on **www.myuhc.com** or the UnitedHealthcare app. Scan this QR code to get started.

DENTAL COVERAGE

United Healthcare



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 **UHC**.

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

UHC offers a carryover benefit on the base plan that rewards 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.

If your base plan total claims are less than $500, you'll earn a reward of $250. You can earn an extra $100 if all claims are filed with an in-network dentist for a total of $350 in carryover benefits for use in the following year!

Find an In-Network Dentist

- Visit – www.myuhc.com
- Call – 866-314-0335

United Healthcare

BIWEEKLY DENTAL RATES	Base Plan	Buy-Up Plan
Employee Only	$10.06	$12.15
Employee + Spouse	$29.34	$34.50
Employee + Child(ren)	$34.54	$43.84
Employee + Family	$39.39	$50.84

DENTAL PLANS	BASE PLAN		BUY-UP PLAN	
Network	National Options PPO 30		National Options PPO 30	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Calendar Year Deductible • Individual • Family	 $50 $150	 $50 $150	 $50 $150	 $50 $150
Calendar Year Maximum Benefit	$1,000 + rollover[2]	$1,000 + rollover[2]	$5,000	$5,000
	You Pay		You Pay	
Preventive Services Exams, cleanings, complete series X-rays	$0	$0	$0	$0
Basic Services Endodontics, extractions, fillings, oral surgery, periodontics, root canals	20%[3]	20%[3]	20%[3]	20%[3]
Major Services Crowns, bridges, dentures	50%[3]	50%[3]	50%[3]	50%[3]
Orthodontia • Children and adults	Not covered	Not covered	$2,000 lifetime maximum	$2,000 lifetime maximum

[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.
[2]This plan includes a rollover maximum benefit. Some of the unused portion of your annual maximum may be available in future periods. See Momentive Employee Benefits website for more details.
[3]The amount you pay after the deductible has been met.

VISION COVERAGE

United Healthcare

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 **UHC** using the **Spectera** 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 Spectera network.

VISION PLAN				
UHC 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 $25 copay $25 copay	 Up to $40 Up to $60 Up to $80 Up to $80	 $0 copay $0 copay $0 copay $0 copay	 Up to $40 Up to $60 Up to $80 Up to $80
Frame	30% off balance over $130 allowance	Up to $45	30% off balance over $130 allowance	Up to $45
Contact Lenses (in lieu of eyeglasses) Fitting and evaluation Elective Necessary	 $25 copay Formulary: $25 copay Non-formulary: $130 allowance $25 copay	 Not covered Up to $130 Up to $210	 $25 copay Formulary: $25 copay Non-formulary: $130 allowance $25 copay	 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.myuhcvision.com
- Call – 866-801-4409

BIWEEKLY VISION RATES	Low Plan	High Plan
Employee Only	$2.92	$4.64
Employee + Spouse	$5.54	$8.80
Employee + Child(ren)	$6.50	$10.31
Employee + Family	$9.13	$14.52

HEALTH SAVINGS ACCOUNT (HSA)

An HSA is a tax-exempt tool to supplement your retirement savings and to cover current and future health costs.

As 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

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

Annual HSA contribution limits are set by the IRS and depend on your coverage tier:

2027 Maximum Annual Contributions			
	Momentive Software Contribution	Employee Contribution	Total Contribution
Individual	$1,000	$3,500	**$4,500**
Family	$1,500	$7,500	**$9,000**

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.

Momentive continues to contribute $41.66 each paycheck when a benefit deduction occurs, up to **$1,000**/year into the HSA account of every eligible employee enrolled in Option 3 who elects the HSA with employee only coverage. Employees enrolled in Option 3 with dependent coverage who elect the HSA will receive a contribution of $62.50, up to **$1,500**/year.

Opening an HSA

If you meet the eligibility requirements, an HSA will be opened for you with **Rippling**. 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. Questions? Email benefits@momentivesoftware.com for assistance.

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 **Rippling** are eligible for automatic payroll deduction and company contributions.



QUALIFIED HSA AND FSA EXPENSES

The products and services listed below are examples of medical expenses eligible for payment under your HSA and Health Care FSA. 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)
- Ultraviolet 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 **Rippling**.

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 $3,500 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 are enrolled in an HDHP and contribute to an HSA.

Limited Purpose Health Care FSA

A Limited Purpose Health Care FSA is available if you are 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 through the Rippling My Benefits portal.

Benefit App and Portal

To access the portal, go to **www.rippling.com**.

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.

RIPPLING

Important FSA Rules

• The maximum per plan year you can contribute to a Health Care or Limited Purpose FSA is $3,500. The maximum per plan year you can contribute to a Dependent Care FSA is $7,500 when filing jointly or head of household and $3,750 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 $700 in your Health Care or Limited Purpose 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 **United Healthcare** 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, and 25% at age 75.

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 additional Life and AD&D insurance for yourself and your eligible dependents. During this transition enrollment, coverage up to the applicable guaranteed issue limits is available without medical underwriting. If you waive coverage and enroll later, or request a later increase, you will need to answer medical questions and coverage may be declined. You must elect coverage for yourself before covering a spouse or children. If you leave the company, you may be able to take the insurance with you.

VOLUNTARY LIFE AND AD&D INSURANCE	
Employee	• Coverage: $10,000 increments up to 5× annual base earnings ($500,000 maximum) • **Guaranteed issue: $250,000** (limited to 5× annual base earnings)
Spouse	• Coverage: $5,000 increments up to $250,000 (maximum of 100% of employee coverage amount) • **Guaranteed issue: $50,000.**
Child(ren)	• 15 days – 6 Months: $250 • Six months to age 26: $10,000

2027 enrollment opportunity

During this initial enrollment with UHC, you and your spouse may elect coverage up to the applicable guaranteed issue limits without medical underwriting. If you waive coverage and enroll later, medical underwriting will be required and UHC may deny 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 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 any time. If you name more than one beneficiary, you must identify how much benefit each beneficiary will receive (e.g., 50% or 25%).

EMPLOYEE AGE	EMPLOYEE BIWEEKLY COST PER $10,000	SPOUSE* BIWEEKLY COST PER $5,000
18-34	$0.32	$0.16
35-39	$0.395	$0.20
40-44	$0.665	$0.33
45-49	$1.20	$0.60
50-54	$1.78	$0.89
55-59	$2.97	$1.49
60-64	$5.01	$2.50
65-69	$8.77	$4.39
70+	$13.49	$6.75
Child life and AD&D: $10,000 of coverage	$1.09	

Rates include life and AD&D

DISABILITY INSURANCE

United Healthcare

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 offers two Long Term Disability (LTD) insurance plans for you to buy through **United Healthcare.**

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	1st day Accident/8th day Illness
Percentage of Earnings You Receive	60%
Maximum Weekly Benefit	$2,400
Maximum Benefit Period	13 weeks



DISABILITY INSURANCE

United Healthcare

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, **United Healthcare** will waive your cost until you return to work.

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.

2027 enrollment opportunity

During this initial enrollment with UHC, you may elect long-term disability coverage without medical underwriting. If you waive coverage and enroll later, medical underwriting will be required and UHC may deny coverage.

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: 18-29	$0.08	$0.10
30-34	$0.13	$0.17
35-39	$0.20	$0.28
40-44	$0.31	$0.43
45-49	$0.43	$0.59
50-54	$0.56	$0.76
55-59	$0.71	$0.98
60-64	$0.60	$0.82
65-69	$0.47	$0.64
70+	$0.41	$0.55
Maximum Covered Annual Earnings	$240,000	$200,000

Lower LTD rates for 2027!

DISABILITY COST WORKSHEET

1. Calculate your maximum monthly benefit

Annual earnings $_____ ÷ 12 × selected benefit percentage _____% = monthly benefit $_____.
Use 50% for Option 1 or 60% for Option 2. Maximum monthly benefit: $10,000.

2. Calculate your cost per premium deduction

Annual earnings $_____ ÷ 100 × monthly rate $_____ ÷ 24 = cost per deduction $_____.
Use the rate for your age and selected option from the table above. There are 24 premium deductions per year.

SUPPLEMENTAL BENEFITS

You and your eligible family members can 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 **United Healthcare** and are portable if employment is ended.

Accident Insurance

Accident insurance provides affordable protection against a sudden, unforeseen accident. The Accident plans help 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	BENEFITS	
	Option 1	Option 2
Emergency Room	$150	$200
Ambulance • Ground • Air	 $300 $1,000	 $400 $1,200
Initial Hospitalization	$1,000	$1,500
Hospital Confinement (Starting on Day 2 of Confinement)	$200 per day up to 365 days	$300 per day up to 365 days
Intensive Care Unit Admission	$2,000	$3,000
Intensive Care Unit Confinement (Starting on Day 2 of Confinement)	$400 per day up to 30 days per accident	$600 per day up to 30 days per accident
Specific Sum Injuries Concussions, dislocations, eye injuries, fractures, lacerations, ruptured discs, and more.	$25 - $10,000	$50 - $20,000
Accidental Death & Dismemberment* • Employee • Spouse • Child	 $25,000 $25,000 $12,500	 $50,000 $50,000 $25,000

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

Accident Cost Per Pay Period	Option 1	Option 2
Employee Only	$2.62	$3.80
Employee + Spouse	$5.18	$7.47
Employee + Child(ren)	$6.24	$8.97
Employee + Family	$8.80	$12.63

Accident benefits are paid directly to you



Critical Illness

Critical Illness insurance through **United Healthcare** 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 the plan document for the full list of covered illnesses and services.

BENEFIT AMOUNTS	AVAILABLE BENEFIT
Employee	$10,000, $20,000, $30,000 or $40,000
Spouse	$5,000–$40,000, up to 100% of employee benefit
Child(ren) to age 26	50% of employee benefit
Condition	**First Occurrence Benefit**
Advanced Alzheimer's Disease, Heart Attack, Stroke, Major organ failure; Invasive Cancer, Advanced MS, Advanced Parkinson's, Advanced ALS	100% of benefit amount
Coronary Artery Disease	25% - 50%
Non-Invasive Cancer	25% of benefit amount
Health Screening Benefit - One per covered person per calendar year	$50

Critical Illness Cost Per Pay Period		
Employee Age	**Employee Coverage $10,000**	**Spouse* Coverage $10,000**
<25	$1.15	$1.15
25-29	$1.45	$1.45
30-34	$1.85	$1.85
35-39	$2.55	$2.55
40-44	$3.75	$3.75
45-49	$5.90	$5.90
50-54	$9.15	$9.15
55-59	$12.75	$12.75
60-64	$19.60	$19.60
65-69	$24.60	$24.60
70-74	$33.63	$33.63
Child(ren) $5,000	$0.50	

*Spouse premium is based on employee age



NEW! Hospital Indemnity Insurance

Hospital indemnity insurance through UnitedHealthcare helps pay non-medical expenses related to hospital admission and care. The plan provides fixed cash payments you can use any way you wish, including lost income, groceries, rent, daily living, and household upkeep costs.

Hospital indemnity benefits are paid directly to you

United Healthcare

SERVICE	BENEFITS
Initial Hospitalization	$1,000 (Up to 3 times per year)
Hospital Confinement	$150 per day (up to 364 days per year)
Intensive Care Unit Admission	$2,000 (Up to 3 times per year)
Intensive Care Unit	$300 per day (up to 30 days per year)
Hospital Observation Over 20 hours; once per year	$500
Newborn Nursery Confinement Up to 2 days per newborn	$150
Wellness Benefit 1 time per year per insured	$50

Hospital Indemnity Cost Per Pay Period	
Employee Only	$6.06
Employee + Spouse	$12.60
Employee + Child(ren)	$11.67
Employee + Family	$19.45

VALUE ADDED PROGRAMS

The following programs and services are available with **United Healthcare** at no additional cost to you, based on your benefit elections. Contact UHC for additional details at **fpcustomersupport@uhc.com**

Employee Assistance Program

The Member Assistance Program offers 24/7 counseling and confidential support to help you and your family members cope with a variety of issues.

PERSONAL MATTERS

Get in-person help for short-term issues (up to 3 sessions per person, per issue, per year).

- Relationships
- Work-life balance
- Stress
- Grief and loss
- Childcare and eldercare
- Addictions

LEGAL OR FINANCIAL MATTERS

Get one free 30-minute meeting per legal issue and 25% off follow-up meetings.

- College planning
- Will and estate planning
- Legal counsel
- Financial planning
- Moving
- Budgeting

RESOURCES

Access a wide range of information, tools, and resources.

- Articles and courses
- Videos
- Online tools

Get Help Now:

- Call **1-877-660-3806**
- Visit **www.liveandworkwell.com.** Use access code **FP3EAP**

Travel Assistance

UHCGlobal.com services to give you timely help and support when you travel. These benefits are available 24/7 and apply if you are 100 or more miles from home. For a complete list of Travel Connect services, please visit **www.worldwatch.uhcglobal.com** register and enter **UHC Global ID policy number 358231.**

EMERGENCY SUPPORT

- Arrange travel if you are injured and need to be taken for help.
- Plan and pay for evacuations due to natural disasters or threats.
- Board or return pets.
- Transport mortal remains.

TRAVEL SUPPORT

- Recover lost or stolen items.
- Get translation/interpreter services.
- Replace medical devices or eyewear.
- Deliver medications.
- **Phone: 1-800-527-0218 For Assistance**



Support for Beneficiaries

It's nice to know your beneficiary will have a team of professionals ready to help provide support.

- Grief Support
- Financial and Legal Support
- Get support and resources on a wide variety of issues.

Contact UHC Services

Call: **888-299-2070**

Email: fpcustomersupport@uhc.com

Will Preparation

If you do not have a will or if you need to update your will, **UHC** can help. Having a will allows you to designate who will receive your property and assets when you pass away. Without a valid will, your home state will determine how your estate will be distributed. UHC can securely walk you through each step of documenting your final wishes and executing a will. Go to www.liveandworkwell.com and enter access code LIFEBENSVS. For assistance, call **866-302-4480**

Beneficiary Companion

The Beneficiary Companion program provides 24/7 guidance for your beneficiary on a variety of topics including closing your estate and protecting your identity. The program can also assist with

- Guidance Services
- Social Media Shutdown
- Fraud Resolution

Get assistance or request the guidebook by calling **1-866-643-4241**

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 30 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
360 Central Ave Suite 1120
St. Petersburg, FL 33701
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. For the 2027 plan year, Momentive Software has determined that prescription drug coverage under Option 1 PPO, Option 2 PPO Higher Deductible, and Option 3 Consumer-Directed Health Plan (CDHP/HSA) is, for each option, expected to pay on average at least as much as standard Medicare prescription drug coverage. All three options provide Creditable Coverage.

LEGAL NOTICES

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, or each year from October 15 through December 7.
If you lose this employer coverage, you generally have a Special Enrollment Period lasting two full months after the month coverage ends.
If you delay enrollment, avoid a gap of 63 days or more without Medicare Part D or other creditable prescription drug coverage, or a penalty may apply.

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, after your Medicare Part D Initial Enrollment Period, you go 63 days or more in a row without Medicare Part D or other creditable prescription drug coverage, you may owe a late enrollment penalty. Medicare calculates it as 1% of the national base beneficiary premium for each full, uncovered month you were eligible for Part D.
The penalty is added to your monthly Part D premium, generally for as long as you have Part D, and may change each year.

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.

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, 2027
Momentive Software
Human Resources
360 Central Ave Suite 1120
St. Petersburg, FL 33701
800-295-2392

LEGAL NOTICES

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.

LEGAL NOTICES

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.

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 30 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.

LEGAL NOTICES

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
360 Central Ave Suite 1120
St. Petersburg, FL 33701
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 July 31, 2026. 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

LEGAL NOTICES

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

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)

LEGAL NOTICES

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

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
360 Central Ave Suite 1120 St.
Petersburg, FL 33701
800-295-2392

LEGAL NOTICES

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™

Momentive

Questions about your benefits?

benefits@momentivesoftware.com

Your Higginbotham team

Marilyn Cameron

mcameron@higginbotham.net | 865-288-5022

James Duke

jduke@higginbotham.net | 865-288-5006

This brochure highlights the main features of the Momentive Software employee 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 employee benefits plans anytime.