# ZEBRA TECHNOLOGIES CORPORATION

# BENEFLEX PLAN

# Summary Plan Description

**Effective as of January 1, 2025**

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## INTRODUCTION

Welcome to the Zebra Technologies Corporation Beneflex Plan (the "Plan") maintained by Zebra Technologies Corporation (the "Company"). The Plan is a health and welfare benefit plan which provides the following benefits (collectively referred to herein as, the "Programs") to eligible employees:

- Medical Program
- Prescription Drug Program
- Dental Program
- Vision Program
- Health Savings Account
- Flexible Spending Account
- Employee Assistance Program (EAP)
- Voluntary Benefits Program
- Wellbeing Plan
- Group Term Life Insurance Program
- Voluntary Life Insurance Program
- Long-Term Disability Insurance Program
- Accidental Death and Dismemberment Insurance Program
- Voluntary Accidental Death and Dismemberment Insurance Program
- Commuter Benefits Program

This Summary Plan Description ("SPD") provides certain information about the Programs offered by the Plan. It is intended to supplement the Program booklets provided to you by the Claims Administrators. As a result, this SPD should be read with such Program booklets. Generally, this SPD explains the eligibility, participation, benefits highlights and administrative provisions under the Programs, and the booklets detail the benefit provisions under each Program. Subject to the limitations provided below, in the event there are any inconsistencies between this SPD and the applicable Program booklets, this SPD shall govern.

Together, this SPD and the Program booklets are a summary of the Programs offered under the Plan, effective January 1, 2025. The Plan also offers a "cafeteria plan" which provides the opportunity to pay premiums on a pre-tax basis, as well as pre-tax savings accounts. This SPD does not attempt to cover every detail concerning the individual Programs or the Plan as a whole.

The terms of the Plan are contained in the Plan document. While every effort has been made to make this SPD as accurate as possible, if there are any inconsistencies between this SPD and the Plan document, the Plan document will govern. Also, any questions concerning the Plan will be determined in accordance with the Plan document and not this SPD.

You may review a copy of the Plan document without charge and obtain a copy of the Plan document for a reasonable copying charge. Please contact the Benefits Department at the Company's Lincolnshire, Illinois location (at the address listed in the General Plan Information section) to examine or obtain copies of the Plan document.

## NOTICE OF GRANDFATHERED STATUS

### *Grandfathered Plan*

With the exception of the BCBS Advantage HSA, Advantage PPO, and Basic HSA options described in this SPD, the Kaiser HMO medical options offered to Zebra employees are considered "grandfathered health plans" under the Patient Protection and Affordable Care Act of 2010 (PPACA). As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the PPACA that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the PPACA, for example, the elimination of lifetime limits on benefits.

### *Non-Grandfathered Plan*

The BCBS Advantage HSA, Advantage PPO, and Basic HSA options are considered non-grandfathered health plans. Being a non-grandfathered health plan means that the plan includes certain consumer protections of PPACA that other grandfathered plans may not have.

### *Questions Regarding Grandfathered Status*

Questions regarding which protections apply and which protections do not apply to grandfathered health plans and non-grandfathered health plans, and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or online at www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

## ELIGIBILITY

### *Who Is Eligible To Participate*

Generally, you are eligible to participate in the Programs immediately upon hire if you are:

- Designated as a regular employee on the Company's payroll records, and regularly scheduled to work 20 or more hours per week.

- A member of the Company's Board of Directors and do not have coverage available under another group health plan; you may participate in the Medical Program and the Dental Program.

- An eligible dependent (except for long-term disability).

You may be eligible to participate in certain self-insured medical and dental options under the Plan if you:

- Provide services for a foreign affiliate of the Company;

- Are subsequently transferred to the United States; and

- Are expected to perform services in the United States for at least six months. Contact the Plan Administrator to learn more about this new eligibility opportunity.

***Dependents Who Are Eligible to Participate***

Your eligible dependents include:

- **Your spouse**, unless you are legally separated. For purposes of the Plan, a "spouse" must be:

  - Recognized as your spouse for purposes of federal tax law; and

  - A U.S. citizen or national or a resident of the U.S., Mexico, or Canada

- **Your domestic partner**. For purposes of the Plan, "domestic partners" are defined as two individuals who, together, each meet all of the following criteria:

  - Are age 18 or older;

  - Are competent to enter into a contract;

  - Are not legally married to, nor the domestic partner of, any other person;

  - Are not related by marriage;

  - Are not related by blood closer than permitted under marriage laws of the state in which they reside;

  - Have entered into the domestic partnership relationship voluntarily, willingly and without reservation;

  - Have entered into a relationship which is the functional equivalent of a marriage, and which includes all of the following:

    - Living together as a couple

        - Mutual support of each other
        - Mutual caring and commitment to each other
    - Have been living together as a couple for at least six months prior to enrollment in the Plan; and
    - Intend to continue the domestic partnership relationship indefinitely with the understanding that the relationship may be terminated at the will of either partner.

- **Your dependent children** who have not reached age 26. **"Children"** for these purposes include the following individuals who meet the above criteria:
    - Your natural and legally adopted children;
    - Any child over whom you have legal guardianship;
    - A child of your spouse or domestic partner

Children are only eligible to participate in the Plan until the end of the month in which they reach age 26. You will have to submit proof of your child's age upon request of the Claims Administrator or Plan Administrator. At your own expense, you may be required to provide an attorney's notarized certification of your eligible dependents.

As long as your Medical (including Prescription Drug), Dental or Vision Program coverage continues, your **disabled child** may remain covered in the Program to any age if they are unmarried and have been determined by the Social Security Administration to be disabled as of age 26. Proof of the Social Security Administration's determination must be submitted no later than 30 days after the date your child reaches age 26. From time to time, you may be required to prove that your child is still considered disabled by the Social Security Administration. There is no requirement that your disabled child must reside with you in order to continue coverage under the Medical (including Prescription Drug), Dental or Vision Program. Additionally, if your disabled child is over age 26 and was covered under an existing plan prior to your enrollment in the Medical (including Prescription Drug), Dental or Vision Program, you may enroll your disabled child as long as your child was determined by the Social Security Administration to be disabled prior to attaining age 26.

Your spouse is <u>not</u> eligible if he or she is:

- Covered by the Plan as an employee; or
- Covered by the Plan as a dependent of another employee.

Below are some examples of individuals who are **<u>not</u>** eligible dependents unless legally adopted by you if they do not qualify as your tax dependent under Section 152 of the Code:

- Your child, if he or she is older than age 26;
- Your grandchildren;
- Your niece or nephew; and
- Your siblings.

It is important for you to provide accurate information to the Company regarding who qualifies as your eligible dependent for purposes of the Company's Programs. The Company has the right to request documentation to verify your dependent's eligibility. Any misrepresentations or inaccuracies could result in a denial of coverage and you may be legally required to repay the Programs for any costs paid for such an ineligible individual's medical care. In addition, the Company may take other disciplinary actions against you. If you have any questions regarding eligibility under the Programs, please contact the Human Resources Department.

***Special Dependent Definition for Life Insurance and Accidental Death and Dismemberment Programs***

For the Voluntary Life Insurance and Voluntary Accidental Death and Dismemberment Programs, dependent children will be covered up to age 26.

***Long Term Disability Program***

Dependents may not be covered under the Long-Term Disability Program.

***Qualified Medical Child Support Order ("QMCSO")***

The Plan also provides healthcare coverage for your child pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO"), even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment season restrictions which might otherwise exist for dependent coverage. If the Plan receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the child on your behalf. For more information on QMCSOs, see the "Qualified Medical Child Support Orders" section or contact the Plan Administrator.

***State Eligibility Laws and the Employee Retirement Income Security Act of 1974 (ERISA)***

States sometimes pass laws that require employee benefit plans to provide benefits and/or coverage to individuals who otherwise are not eligible. For example, a state might require an employer to provide coverage to a former spouse or a child who exceeds the plan age requirements who is not eligible for benefits under the company medical plan.

The federal law known as ERISA supersedes state law. As a result, Zebra only covers the individuals outlined in this SPD.

However, if you elect a fully insured medical option, different eligibility requirements set forth in the policy of an insured benefit might apply.

## PRE-EXISTING CONDITIONS

Your long-term disability coverage may be subject to pre-existing condition exclusions. For more information on pre-existing conditions please contact the Claims Administrator or reference the Program booklet provided by the Claims Administrator for the specific terms and conditions of its pre-existing conditions exclusions.

Notwithstanding anything contained in this Plan to the contrary, this Plan does not place any limitation or exclusion on coverage of pre-existing conditions for individuals for coverage under the Medical (including Prescription Drug), Dental, and Vision, Flexible Spending Account, Employee Assistance Program, Health Savings Account or Wellness Programs.

## ENROLLMENT

### *When Newly Eligible Employees May Enroll*

**Medical** (including Prescription Drug)**, Dental, Vision and Flexible Spending Account Programs.** You may enroll in the Medical (including Prescription Drug), Dental, Vision and Flexible Spending Account Programs within 30 days from the date you are eligible. If you enroll during this 30-day period, your coverage will be retroactive to the date you first became eligible. If you do not enroll during this 30-day period, you must wait until the next annual enrollment period to enroll in the Medical (including Prescription Drug), Dental, Vision and Flexible Spending Account Programs (except in special circumstances described in the "Changing Your Elections Mid-Year" section below).

In general, your spouse and dependents child(ren)s' coverage will begin the same day as your coverage. See the "Changing Your Elections Mid-Year" section for information on the effective date for mid-year changes in your Program elections.

**Group Term Life Insurance Program and Accidental Death and Dismemberment Program.** You will be enrolled automatically in the Group Term Life Insurance and Accidental Death and Dismemberment Programs after becoming eligible. Your coverage under both programs will be paid for by the Company and will begin on the first day of eligibility. The Company also provides basic life insurance for your spouse and dependent children at no cost to you.

**Long-Term Disability Program.** You will be automatically enrolled in the Long-Term Disability Program after becoming eligible.

**Voluntary Life Insurance Program.** You may purchase additional life insurance coverage for yourself, your spouse or your dependent children under the Voluntary Life Insurance Program by applying for coverage within 30 days of your date of hire. If the Company receives your completed enrollment application during this 30-day period, the application will be valid and you and your spouse will be eligible for guarantee issue coverage.

**Voluntary Accidental Death and Dismemberment Program.** You may purchase additional accidental death and dismemberment coverage at any time under the Voluntary Accidental Death

and Dismemberment Program. You may elect coverage for yourself, your spouse or your dependent children.

**Voluntary Insurance Programs (Critical Illness, Hospital Care, and Accident Insurance).** You may enroll in any or all of the Voluntary Insurance Programs within 30 days from your hire date. If you enroll during this 30-day guarantee issue period, your coverage will be retroactive to your hire date.

Your effective date of coverage will be the date of the event in which you elected to enroll in the Critical Illness Insurance Program.

***Social Security Numbers***

Under Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), the Centers for Medicare and Medicaid Services (CMS) generally requires Social Security numbers or HICNs (the Medicare identifying numbers) for employees and dependents to assist with reporting under the Medicare Secondary Payer requirements. Accordingly, Zebra will require that you provide such information at the time of enrollment, to assist its health plan administrators comply with this requirement. If you need to add a dependent to your coverage that does not have a Social Security number, call the Zebra HR Service Center. Coverage may be delayed or denied as a result of your failure to provide the information required by CMS.

***If You Are Rehired***

If you terminate employment and are **rehired in less than 30 days**, you will re-enter the Medical (including Prescription Drug), Dental, Vision and Flexible Spending Account Programs immediately upon re-employment with the same election you had before you left. If you terminate employment and are rehired after 30 days, you will be treated as new employee and must again satisfy any eligibility requirements.

***Annual Enrollment***

After the initial 30-day enrollment period for the Medical (including Prescription Drug), Dental, Vision and Flexible Spending Account Programs, you may only enroll in these Programs during specified enrollment periods. Enrollment periods are held on an annual basis. The Company will determine the length of all enrollment periods for the Plan. During an enrollment period, you may enroll in the Medical (including Prescription Drug), Dental, Vision and/or Flexible Spending Account Programs. Unless a "change in status" or other special event occurs (as defined in the "Changing Your Elections Mid-Year" section), you will not be able to change your elections once the annual enrollment period ends until the next annual enrollment period.

***Re-Enrollment***

- For the Medical (including Prescription Drug), Dental, Vision and Flexible Spending Account Programs, you may change or revoke your elections during any subsequent enrollment period or during a Plan Year following a "change in status" (as described below).

- For the Critical Illness, Voluntary Life Insurance, and Voluntary Accidental Death and Dismemberment Programs, you may change or revoke your elections at any time subject to evidence of insurability provisions. Voluntary Life Insurance and Voluntary Accidental Death and Dismemberment Programs provide the opportunity to increase coverage amounts upon a "life event change." Life event changes include:

    - An employee's marriage or divorce;
    - The commencement or dissolution of your domestic partner relationship;
    - The death of an employee's spouse or a dependent;
    - The birth or adoption of a child;
    - The employee's spouse's/domestic partner's change in employment;
    - The employee or the employee's spouse/domestic partner changing from part-time to full-time or vice versa; and
    - The employee or employee's spouse/domestic partner taking an unpaid leave of absence.

Please note that the Company provides fixed benefits under the Group Term Life Insurance and Accidental Death and Dismemberment Programs, and these benefits may not be changed or revoked. For a description of these benefits, please see the "Benefits" section.

***Changing Your Medical (including Prescription Drug), Dental, Vision and Flexible Spending Account Program Elections Mid-Year***

Your Medical (including Prescription Drug), Dental, Vision and Flexible Spending Account Program elections are valid for an entire Plan Year and you will generally not be allowed to change your elections until the next enrollment period. This is because the Internal Revenue Service ("IRS") requires that you commit to participating in a Program for the entire Plan Year in order to receive the tax advantage of paying for your benefit program premiums, healthcare and dependent care expenses with pre-tax dollars.

However, the IRS does provide exceptions that allow you to change your elections mid-year. You can change your Program elections if you experience a change in status or if you experience a special event that entitles you to make new elections under the Program.

**Change in Status:** The IRS currently defines a change in status as one of the following events:

- A change in your marital status under federal law, including your marriage, legal separation, divorce or annulment;
- The commencement or dissolution of your domestic partner relationship;
- The birth, adoption and placement for adoption of your child;
- The death of your spouse or dependent child;
- The commencement or termination of employment by you, your spouse, or dependent child;
- A change in your, your spouse's/domestic partner's or your dependent's employment status, including a strike or lockout, a layoff, a switch between part-time and full-time employment, or the commencement or return from an unpaid or significantly reduced paid leave of absence;
- Any other change in your, your spouse's/domestic partner's or your dependent's employment status that affects eligibility to participate in one or more benefit plans in which they are enrolled for the Plan Year;
- Your dependent's commencement or termination of eligibility for coverage on account of age, student status or any similar circumstance; or
- A change in your, your spouse's/domestic partner's or your dependent's residence or work location.

Please note, however, that any change in your Program elections must be consistent with the change in status that you experienced. The Plan Administrator, in its sole discretion, will determine whether your elections are consistent with your change in status.

The Plan Administrator may require you to provide proof of your change in status, such as birth certificates, divorce decrees, etc.

**Other Special Events:** In addition to the changes in status described above, you will also have an opportunity to immediately change your Program elections (including an election to not participate in the Medical (including Prescription Drug), Dental, Vision and Flexible Spending Account Programs) in any of the following events:

- **HIPAA special enrollment.** You acquire special enrollment rights in the Medical Program due to your loss of other insurance coverage or the addition of a dependent, as provided under the Health Insurance Portability and Accountability Act

("HIPAA"). Under HIPAA, you have the right to enroll yourself and your dependents for medical coverage, even if you were not previously enrolled, within 31 days after the following special enrollment events:

- You declined medical coverage because you or your dependent had other coverage and the other coverage ends because:
    - You or your dependents are no longer eligible for such coverage (whether such coverage was provided through another employer, private insurance or otherwise);
    - You or your dependents exhaust COBRA coverage under another employer's group health plan (other than due to a failure to pay contributions or cause); or
    - Employer contributions toward the other group health plan coverage terminate.

  If you timely enroll, coverage will take effect on the first day of the month following timely enrollment.

- You acquire a dependent as a result of a marriage, birth, adoption or placement for adoption. In the case of birth, adoption or placement for adoption, if you timely enroll, coverage will take effect on the date you acquired the new dependent. In the case of marriage, if you timely enroll, coverage will take effect on the first day of the month following enrollment.

  If you do not request the change within 31 days of your special enrollment event, you lose special enrollment rights for that event.

Please note these special enrollment rights apply only to changes in medical coverage and permit you to enroll only yourself and your affected dependents. They do not apply to changes in dental or vision coverage. See the Plan Administrator for more information regarding your rights under HIPAA.

- **QMCSO.** The Plan Administrator receives a notice or an order that qualifies as a "Qualified Medical Child Support Order" (as described later in this SPD) that requires you to pay for dependent coverage that is available through the Program.

- **Medicare or Medicaid.** You or your dependent (including your spouse) become enrolled for coverage or lose coverage under Medicare or Medicaid (other than under a program solely providing pediatric vaccinations).

- **State Child Health Plan.** If your dependent loses coverage under a state children's health insurance program or becomes eligible for a state premium subsidy from a plan offered under Medicaid or through a State Child Health Plan and you notify the Plan Administrator within 60 days, you can add or drop coverage for that individual.

- **Substantial change in cost of coverage.** There is a substantial change in your premium rate for benefits. Please note, however, that if the cost of your coverage increases or decreases by an insubstantial amount, you will not be allowed to change your coverage elections and your contributions to the Plan will automatically increase or decrease to cover or account for the rate change. Also note that this exception does not apply to permit changes to your Healthcare FSA election.

- **Significant curtailment of coverage that is not a loss of coverage.** If your coverage is significantly curtailed without a loss of coverage, you may revoke your election, but must make a new election for similar coverage under a different Program benefit option. Also note that this exception does not apply to permit changes to your Healthcare FSA election.

- **Significant curtailment of coverage with a loss of coverage.** If your coverage is significantly curtailed with a loss of coverage, you may revoke coverage under the Program and make a new election for similar coverage under a different Program benefit option, if available, or drop coverage if no similar benefit option is available. Also note that this exception does not apply to permit changes to your Healthcare FSA election.

- **Addition or improvement of benefit package option providing similar coverage.** If during a period of coverage the Program adds a new coverage option or significantly improves a Program benefit option, you may be allowed to elect the new option or improved benefit option prospectively on a pre-tax basis and change your election with respect to the other benefit option providing similar coverage. Also note that this exception does not apply to permit changes to your Healthcare FSA election.

- **Coverage change of another employer plan.** You may prospectively modify or revoke your coverage elections during the Plan Year if such change is on account of and corresponds with a coverage election change made by your spouse, former spouse or dependent under a plan of another employer. For example, you will be able to make a corresponding change under this Plan if your spouse drops his or her plan coverage during an open enrollment period, or makes a change on account of a change in status or a special enrollment. Also note that this exception does not apply to permit changes to your Healthcare FSA election.

- **Change in day care provider cost.** If you have a Dependent Care Spending Account under the Flexible Spending Account Program, a change in cost by the day care provider, provided the day care provider is not related to you.

As with a change in status, any change in your Plan elections that you are allowed to make as a result of one of the above events must be consistent with the event and permitted under the terms of the individual benefit programs in which you are enrolled. The Plan Administrator, in its sole discretion, will determine whether you are eligible to change your election and whether the change is consistent with your situation.

***How to Change Your Elections***

If you experience a change in status or other event described above and you want to change your Plan elections as a result, access your benefit record on the **ZONE** at **https://my.adp.com**. ***You must enroll no later than 31 days (or 60 days in the case of a change related to enrollment in a state's health plan for children) following the date that the change in status or other applicable event occurred.*** Any change in your contributions will become effective with the earliest possible pay period after your election has been received.

***Important Note***

***If you do not make your change within 31 days (or 60 days in the case of a change related to enrollment in a state's health plan for children) of a change in status, you must wait until the next annual enrollment period to change your Plan elections.***

## COST OF COVERAGE

You and the Company generally share the cost of the Programs offered under Plan; however, the Company provides a certain level of life insurance and AD&D coverage at no cost to you. In general, your share of the premium payments for medical (including prescription drug), dental, and vision benefits is made on a pre-tax basis through payroll deduction. You will be notified in advance of your annual contribution requirement and the annual contribution amount for benefits under each Program. In addition to premium contributions, you may also be required to pay other out-of-pocket costs for benefits received under certain Programs.

## BENEFITS OVERVIEW

The Plan offers you a variety of benefits and levels of coverage from which you can choose. You may want some of these benefits, but not others. Some benefits will be provided to you by the Company with no additional cost to you. The list below explains the different benefits available to you to create a mix of benefits that match your needs. Each of these Programs is detailed in the individual Program booklets. Please refer to the individual Program booklets for more detailed information on these benefits.

### *Medical Coverage*

You can choose to participate in the Medical Program which includes prescription drug coverage. The Medical Program gives you the flexibility to choose from the following coverage options:

- BCBS Basic HSA
- BCBS Advantage HSA
- BCBS Advantage PPO
- Kaiser HMO (if you live in California)

### *Snapshot of Your Medical Coverage*

| **2025 Advantage HSA and BCBS PPO Benefit Summary** | | | | | | |
|---|---|---|---|---|---|---|
| | **BCBS Basic HSA** | | **BCBS Advantage HSA** | | **BCBS Advantage PPO** | |
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Annual Deductible | $3,200/individual<br>$6,400/family | $6,400/individual<br>$12,800/family | $1,700/individual<br>$3,400/family | $3,400/individual<br>$6,800/family | $800/individual<br>3x individual/family | $1,600/individual<br>3x individual/family |
| Out-of-Pocket Expense Limit (Medical) | $6,600/individual<br>$13,200/family | $13,200/individual<br>$26,400/family | $5,100individual<br>$10,200/family | $10,200/individual<br>$20,400/family | $3,900/individual<br>3x individual/family | $7,800/individual<br>3x individual/family |
| Out-of-Pocket Expense Limit (Prescription Drug) | Not Applicable | Not Applicable | Not Applicable | Not Applicable | $1,250/ individual<br>$2,500/family | $3,750/individual<br>$7,500/family |
| Lifetime Benefit Maximum | Unlimited | | Unlimited | | Unlimited | |
| Coinsurance | 80% after deductible | 60% after deductible | 80% after deductible | 60% after deductible | 80% after deductible | 60% after deductible |
| Preventive Care | Covered at 100% | | Covered at 100% | | Covered at 100% | |
| Zebra HSA Contribution | Not Applicable | | $500/employee only<br>$1,000/employee + spouse, employee + child(ren), or employee + family | | Not Applicable | |

### *Advantage PPO Plan*

The Advantage PPO option offers access to the PPO network of doctors and hospitals that have agreed to provide medical care at negotiated rates. You and your dependents are not required to use a primary care physician (PCP) to coordinate care under the PPO option. You can receive care from any healthcare provider you choose, but out of pocket costs are higher out-of-network versus in-network. Under these options, you have an out-of-pocket maximum to protect you from the expense of catastrophic illness or injury.

Each family member (up to a maximum of three) must meet the individual deductible separately before the deductible is considered to be met and coinsurance begins.

### *Basic and Advantage HSA Plans*

The Basic and Advantage HSA Plans are consumer-driven health plans paired with a health savings account (HSA).

The Basic and Advantage HSA Plans share many of the familiar features of the BCBS PPO Plan, including the same PPO network of doctors and hospitals. Out of pocket costs are higher out-of-network versus in-network and you still have an out-of-pocket maximum to protect you from the expense of catastrophic illness or injury.

One individual in the family (or a combination of covered individuals) can meet the family deductible and coinsurance will begin for everyone in the family. When you enroll in the Basic or Advantage HSA Plan, you can open an HSA through HSA Bank (discussed in great detail below). The HSA allows you to contribute pre-tax money to pay for eligible out-of-pocket healthcare expenses.

You can use funds in your HSA to pay for out-of-pocket healthcare expenses incurred after the date your individual HSA is established. It is possible for this date to be after your insurance effective date if there is a delay in opening your HSA account. Unused HSA funds roll over from year to year—there is no "use it or lose it" requirement.

You decide when to withdraw money from your HSA to reimburse yourself for qualified healthcare expenses. You either request disbursement from your account or use a debit card to pay for expenses. You also have the option of paying for services out-of-pocket until you reach your deductible and/or out-of-pocket maximum and not using the funds in your HSA. This will allow your HSA balance to grow and earn interest for future qualified expenses.

### *How an HSA Works*

HSAs are intended specifically to pay for healthcare expenses. When you save through an HSA:

- Your contributions are tax-free at the federal level.
- The Company makes a one-time annual contribution to your account if you elect to enroll in the Advantage HSA Plan. You are not subject to federal tax on the

Company's HSA contribution. Interest and any investment earnings grow tax-free over time.

- Your money is tax-free when you take it out, as long as you use it for eligible healthcare expenses.
- Your account is fully portable, which means you can take your money (your contributions plus any contributions made by the Company) with you if you leave the Company.
- Once you reach age 65, your funds can be withdrawn for any reason without penalty.

The Company's HSA administrator, HSA Bank, will provide you with a debit card to use after you enroll in the Advantage HSA Plan. For a complete list of eligible healthcare expenses, see IRS Publication 502 at http://ww.irs.gov/publications/p502/index.html.

***HSA Contribution Limits***

The IRS limits HSA contributions (your savings combined with any Company contributions).

***HSA Eligibility***

To open an HSA, you must meet the following requirements:

- You must be enrolled in the Basic or Advantage HSA Plan.
- You cannot be covered by a non-HSA-compatible medical plan (for example, you cannot be covered as a dependent under anyone else's traditional PPO plan, except for vision and dental coverage).
- You cannot be enrolled in Medicare.
- You cannot be claimed as a dependent on another person's tax return (except as a spouse).
- You cannot be a participant in a general-purpose healthcare FSA.

***Well Track—Wellbeing Program***

Zebra offers a health and wellbeing program free-of-charge to all eligible Company employees and their medical benefit enrolled spouses. Well Track programs and resources are completely confidential and provided through a partnership with Personify Health. Well Track provides access to voluntary and confidential resources such as health coaching and health challenges such activity tracking and weight management challenges. Well Track also provides an interactive program that helps you focus on areas such as stress management, nutrition, weight management, and physical activity. Depending on your involvement with the Well Track programs, you can earn points towards regular incentive rewards.

Well Track representatives are available at (888) 671-9395 from 7 a.m. to 7 p.m. CT, Monday through Friday. You can also learn more about your current health status by taking the free, 15 minute Health Risk Assessment by visiting the Well Track portal at join.personifyhealth.com/ZebraWellTrack.

Zebra's medical providers, Blue Cross Blue Shield and Kaiser, also offers programs that provides access to voluntary and confidential health and wellness resources designed to offer assistance with a broad range of health conditions such as managing:

- Asthma
- Weight
- High cholesterol

In addition to these programs, Zebra partners with Teladoc to offer best in class services for Diabetes and Hypertension management. The programs through Teladoc are free, including any devices and/or supplies needed to monitor these conditions. You may elect to participate in the program by calling **1-800-835-2362** or going to TeladocHealth.com/Go/ZEBRA (use registration code "zebra")

***Wellbeing Credits***

You are eligible for a credit on your payroll contributions to your medical plan if you do the following:

- Complete an online health risk assessment (called "Health Check") on the Well Track portal.
- Complete a biometric screening (forms can be found on the Well Track portal)
- Complete one (1) item from the My Care Checklist on the Well Track portal

The wellbeing credit is applied per pay period that you are active AND enrolled in a Zebra medical plan. The wellbeing credit is $600 per year, or $23.08 per pay period ($11.54 per pay period for hourly employees in NY and RI). If you are a newly eligible Zebra employee you will not have to complete the health risk assessment to receive the credit on your medical premiums for the year

that you are hired. You will have to fulfill those requirements to receive the credit for all years following the year of your hire date. If you are hired on or after October 1st, you will automatically receive the credit for the year that you are hired AND the following plan year.

Your results from the health risk assessment will be completely confidential. The Company will not have access to this information. Participants do not need to satisfy any standard beyond participation to be entitled to the monthly wellness credit.

To ensure compliance with the Genetic Information Nondiscrimination Act of 2008, as amended ("GINA"), if you complete an online health risk assessment, you will still receive a wellness credit even if you do not answer the questions on family medical history and other genetic information. You must provide consent to complete an online health risk assessment.

***Garner Health***

Zebra has hired Garner Health Technology, Inc. to administer a program that utilizes data to identify the high-quality health care providers that participate in the Zebra's Health Plan provider network, based on those providers' past performance practicing evidence-based medicine and avoiding care that is medically inappropriate.

Zebra has agreed to reimburse you for your out-of-pocket deductible, copay, and coinsurance expenses ("Out-of-Pocket Medical Expenses") through the HRA when you receive care from providers that have been recommended to you by Garner, up to the following limits:

- Employee Only Coverage $1,000
- Employee + Spouse/Partner $2,000
- Employee + Child(ren) $2,000
- Employee + Family $2,000

***Kaiser HMO***

If you live in California, you can enroll in the Kaiser HMO plan. Depending on your zip code, you will either be eligible for the Southern California Kaiser HMO plan or the Northern California Kaiser HMO plan. When enrolled with Kaiser, you must use a network provider to receive coverage. If you do not use a network provider, your visit is not covered under the plan. Kaiser also provides your prescription drug coverage.

The Affordable Care Act provides you with the following patient protections with respect to benefit packages, such as an HMO, that require the designation of a PCP:

You have the right to designate any PCP who participates in the provider network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of participating PCPs, contact your HMO.

For children, you may designate a pediatrician as the PCP.

You do not need prior authorization from an HMO or from any other person (including a PCP) to obtain access to obstetrical or gynecological care from a healthcare professional in the network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact your HMO.

For your Kaiser HMO benefits, it's important that you reference your separate HMO materials for details. These materials provide an in-depth look at how your particular HMO pays benefits.

***COVID-19 Related Services***

The Medical Program will cover the costs associated with COVID-19 screenings, including antibody testing. The Company does reserve the right to discontinue the coverage of these screenings at any point in time in the future.

**COVID-19 Testing**
Mandatory coverage of COVID-19 diagnostic testing and testing-related services (including coverage of over-the-counter tests) are no longer be required. If you obtain a COVID-19 test, the Plan's coverage of COVID-19 testing are:

- COVID-19 tests and testing-related visits conducted at a doctor's office or other medical facility will be subject to our regular BCBSIL and Kaiser HMO (California only) medical plan benefit levels (i.e. deductibles, coinsurance, copays, etc.)
- COVID-19 test coverage through the Express Scripts prescription plan will work as follows:
    - You can get up to 4 at-home test kits per covered member per month at any in-network pharmacy as long as you show your Prescription Drug ID card
    - **OR**, members can be reimbursed up to $12 per test by visiting www.express-scripts.com/covid-19/resource-center to submit a receipt for reimbursement

**COVID-19 Vaccinations**
The Plan will continue to cover COVID-19 vaccinations approved by the Advisory Committee on Immunization Practices (ACIP) of the CDC at no cost **in-network**. If you obtain a COVID-19 vaccination out-of-network, the vaccination will be subject to plan out of network deductibles and coinsurance.

**Continuity of Care**
In certain circumstances, the Plan will provide continuing coverage for courses of treatment if your network provider moves out-of-network due to a contract termination between the Plan during the course of the plan year. In these situations, you may be able to temporarily maintain access to your provider or facility under the same terms and conditions as they were available in-network.

In order to qualify for continuity of care coverage (also called transitional care), you must already be:

(1) undergoing a course of treatment for a serious and complex condition,
(2) in institutional or inpatient care,
(3) scheduled for non-elective surgery (including receipt of post-operative care with respect to such surgery),
(4) pregnant, or
(5) terminally ill.

For purposes of this provision, a serious and complex condition can be either an acute or chronic illness. In the case of an acute illness, it is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm. In the case of a chronic illness, it is a condition that is life threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time.

If a provider's network status changes during the plan year, the Plan will notify you of the network status change in a timely manner and inform you of the right to request transitional care. If you qualify for continuity of care coverage, you may be able to access services for up to 90 days after this notice is provided or until you are no longer a continuing care patient (whichever comes first).

Providers will not balance bill you for services provided under the continuity of care provisions; they must accept in-network payments from the Plan and cost-sharing amounts from you as payment in full.

**Provider Directory**
In order to provide participants with the most current network information, the Plan is required to maintain a database on a public website that lists accurate information for providers and facilities that participate in its network (either directly or indirectly). The database information will be verified and updated as necessary, no less than every 90 days. This information can be found www.bcbsil.com (www.kaiserpermanente.org for CA). You are also entitled to receive this information by calling BCBSIL at **1-800-634-8644** (for Kaiser in CA **1-800-464-4000)**. For telephone requests, you should receive a response within 1 business day through a written electronic or print communication.

If you are provided information via the online directory or as a response to a telephone request regarding a provider's in-network status that turns out to be incorrect, you will not be responsible for paying a cost-sharing amount higher than the in-network amount that would have applied if you had seen a participating provider. Further, any cost-sharing amounts paid by you will count towards your in-network deductible and out-of-pocket maximum.

***Prescription Drug Program***

Express Scripts (formerly Medco) provides prescription drug coverage for the BCBS Advantage HSA, Advantage PPO and Basic HSA Plans. You and the Company share the cost of in-network

and out-of-network prescriptions you receive throughout the year. If you are enrolled in the Kaiser HMO, Kaiser provides your prescription drug coverage.

***Member Pays the Difference***

If you enroll in a BCBS medical plan, you will save money on retail and mail order prescriptions when you choose a generic drug over a brand name drug. This approach, called "Member Pays the Difference," applies to the Advantage HSA, Advantage PPO and Basic HSA Plans.

Generic drugs are significantly less expensive than brand name drugs, yet they contain the same active ingredients and meet the same manufacturing standards. With the "Member Pays the Difference" approach, if you choose to use a brand name drug when a generic drug is available, you will pay the difference in cost between the brand name drug and the generic drug along with the applicable copay.

***Mail Order Program for Long-Term Medications***

Express Scripts will notify you directly if you or any covered family member(s) have prescription(s) that are considered for this program. If you do have a prescription(s) that Express Scripts identified, you will need to take action to switch to a 90-day supply by following the instructions on the information Express Scripts provided.

If you do not switch to a 90-day supply, you will pay 100% of the cost after the second refill and all other refills after that until you switch to the 90-day supply.

You can avoid paying the full cost for your prescription by:

- Getting a 90-day supply instead of a 30-day supply, and
- Getting your 90-day prescription filled through the Express Scripts mail order pharmacy or at a participating Walgreen-owned pharmacy

***Basic and Advantage HSA Plan***

You must satisfy the entire medical plan deductible before the plan pays benefits for prescription drugs. (You pay 100 percent of the cost of your prescriptions until you meet the annual deductible.) After you meet the deductible, the Basic and Advantage HSA Plans pay 100 percent of the cost of generic drugs. If you purchase a brand name drug when a generic equivalent is available, you are responsible for paying the difference between the cost of the brand name drug and the generic along with the applicable copay. If no generic equivalent exists or your doctor specifies the use of a brand name drug (and you have an approved authorization on file with Express Scripts), the plan pays the full cost of the brand name drug.

***Advantage PPO Plan***

Below are the prescription drug copays for the Advantage PPO option. Under this option, you do not need to meet the medical plan annual deductible before benefits are received.

***Snapshot of Your Prescription Drug Coverage***

| | **Basic and Advantage HSA Medical Plan In-Network / Out-of-Network** | **Advantage PPO In-Network / Out-of-Network** |
|---|---|---|
| **Prescription Drug Out-of-Pocket Maximum** | Not Applicable | $1,250/$3,750 individual<br>$2,500/$7,500 family |
| **Retail Pharmacy (30-day supply)** | | |
| Generic | 100% after deductible | $10 copay |
| Formulary Brand Name | 100% after deductible* | 20% coinsurance*<br>$25 min. / $40 max. |
| Non-Formulary Brand Name | 100% after deductible* | 20% coinsurance*<br>$40 min. / $60 max. |
| **Mail Order and Retail Benefit (90-day supply)** | | |
| Generic | 100% after deductible | $20 copay |
| Formulary Brand Name | 100% after deductible* | 20% coinsurance*<br>$50 min. / $80 max. |
| Non-Formulary Brand Name | 100% after deductible* | 20% coinsurance*<br>$80 min. / $120 max. |
| *Cost impacted by "Member Pays the Difference" program | | |

If no generic equivalent exists or your doctor specifies the use of a brand name drug (and you have an approved authorization on file with Express Scripts), you pay only the applicable brand name copay listed above.

Here's an example of how your costs under a PPO plan could vary based on the "Member Pays the Difference" approach:

- The cost of Lipitor, a brand name drug, is $125. The cost of Atorvastatin Calcium (the generic equivalent of Lipitor) is $40.
- The difference in cost between the two versions is $85.
- If you opt for the brand name drug, Lipitor, you pay $25 coinsurance, plus $85, which is the difference in the cost of the two drugs.
- Therefore, you pay $110 for the brand name drug prescription.

| **Example of "Member Pays the Difference"** | **Lipitor (Brand)** | **Atorvastatin Calcium (Generic)** |
|---|---|---|
| Drug cost | $125 | $40 |
| Cost difference between the brand and generic drug | $85<br>+ | N/A<br>+ |

| Example of "Member Pays the Difference" | Lipitor (Brand) | Atorvastatin Calcium (Generic) |
|---|---|---|
| Coinsurance (20% of $125) | $25 | N/A |
| Generic retail copay | N/A<br>= | $10<br>= |
| Your cost to fill the prescription | $110 | $10 |

If you choose the generic drug, you only pay the generic retail copay of $10. In this example, you save $100 by opting for the generic drug.

***Dental Coverage***

Regular dental care is important to your overall health. Delta Dental is the Company's dental insurance provider. Through Delta Dental, the Company offers two types of coverage networks:

- Delta Dental PPO
- Delta Dental Premier

***Snapshot of Your Dental Coverage – Advantage Dental Plan***

| | Delta Dental PPO Network (Smaller Network) | Delta Dental Premier Network (Larger Network) | Out-of-Network |
|---|---|---|---|
| | • Standard provider network.<br>• Lower out-of-pocket expenses for members.<br>• PPO dentists may not bill you for charges exceeding the contracted fee. | • Expanded provider network.<br>• Higher out-of-pocket expenses for members.<br>• Premier dentists may not bill you for charges exceeding the contracted fee. | • No discounts.<br>• Out-of-network dentists may balance bill you for charges in excess of Delta's reimbursement. |
| **Preventive/Diagnostic**<br>• Oral Evaluations (2 per benefit year) | 100% of the allowed fee | 100% of the allowed fee | 100% of the allowed fee |

| | Delta Dental PPO Network (Smaller Network) | Delta Dental Premier Network (Larger Network) | Out-of-Network |
|---|---|---|---|
| • X-rays (bitewings—2 per benefit year; full mouth—once per benefit year)<br>• Prophylaxis (cleaning; 2 per benefit year)<br>• Fluoride Treatment (2 per benefit year for children under age 19)<br>• Space Maintainers (for children under age 19)<br>• Sealants (for children under age 19)<br>• Emergency Exams and Palliative Treatments | | | |
| **Basic**<br>• Fillings<br>• Oral Surgery<br>• Periodontics<br>• Endodontics<br>• General Anesthesia (in conjunction with oral surgery)<br>• IV Sedation<br>• Pin Retention<br>• Stainless Steel Crowns | 80% of the allowed fee | 80% of the allowed fee | 80% of the allowed fee |

| | Delta Dental PPO Network (Smaller Network) | Delta Dental Premier Network (Larger Network) | Out-of-Network |
|---|---|---|---|
| **Major**<br>• Dental Implants<br>• Crowns, Jackets, Cast Restorations<br>• Fixed/Removable Bridges<br>• Partial/Full Dentures<br>• Repair, Reline, Rebase and Adjustments to Dentures | 50% of the allowed fee | 50% of the allowed fee | 50% of the allowed fee |
| **Orthodontia**<br>• Available for all covered individuals | 50%, up to lifetime maximum | 50%, up to lifetime maximum | 50%, up to lifetime maximum |
| **Annual Maximum** | $2,000 per person | $2,000 per person | $2,000 per person |
| **Annual Deductible (applies to Basic/Major only)** | $50/person; $150 family | $50/person; $150 family | $50/person; $150 family |
| **Lifetime Orthodontia Maximum** | $2,000 | $2,000 | $2,000 |

***Snapshot of Your Dental Coverage – Basic Dental Plan***

| | Delta Dental PPO Network (Smaller Network) | Delta Dental Premier Network (Larger Network) | Out-of-Network |
|---|---|---|---|
| | • Standard provider network.<br>• Lower out-of-pocket expenses for members.<br>• PPO dentists may not bill you for charges | • Expanded provider network.<br>• Higher out-of-pocket expenses for members.<br>• Premier dentists may not bill you for | • No discounts.<br>• Out-of-network dentists may balance bill you for charges in excess of Delta's reimbursement. |

| | Delta Dental PPO Network (Smaller Network) | Delta Dental Premier Network (Larger Network) | Out-of-Network |
|---|---|---|---|
| | exceeding the contracted fee. | charges exceeding the contracted fee. | |
| **Preventive/Diagnostic**<br>• Oral Evaluations (2 per benefit year)<br>• X-rays (bitewings—2 per benefit year; full mouth—once per benefit year)<br>• Prophylaxis (cleaning; 2 per benefit year)<br>• Fluoride Treatment (2 per benefit year for children under age 19)<br>• Space Maintainers (for children under age 19)<br>• Sealants (for children under age 19)<br>• Emergency Exams and Palliative Treatments | 100% of the allowed fee | 100% of the allowed fee | 100% of the allowed fee |
| **Basic**<br>• Fillings<br>• Oral Surgery<br>• Periodontics<br>• Endodontics<br>• General Anesthesia (in conjunction with oral surgery) | 80% of the allowed fee | 80% of the allowed fee | 80% of the allowed fee |

| | Delta Dental PPO Network (Smaller Network) | Delta Dental Premier Network (Larger Network) | Out-of-Network |
|---|---|---|---|
| • IV Sedation<br>• Pin Retention<br>• Stainless Steel Crowns | | | |
| **Major**<br>• Crowns, Jackets, Cast Restorations<br>• Fixed/Removable Bridges<br>• Partial/Full Dentures<br>• Repair, Reline, Rebase and Adjustments to Dentures | 50% of the allowed fee | 50% of the allowed fee | 50% of the allowed fee |
| **Orthodontia** | Not Covered | Not Covered | Not Covered |
| **Annual Maximum** | $1,500 per person | $1,500 per person | $1,500 per person |
| **Annual Deductible (applies to Basic/Major only)** | $50/person; $150 family | $50/person; $150 family | $50/person; $150 family |

With the PPO and Premier networks, you can choose any in-network provider and pay less out of pocket. However, if you choose an out-of-network provider, you will pay more out-of-pocket and you may be billed the difference between what your provider charges and what Delta Dental reimburses.

### *Vision Coverage*

You can choose to participate in the Vision Program, which provides coverage for eye exams, lenses and frame allowances. Vision care coverage is provided by EyeMed. You have access to an expansive provider network. You'll pay less out-of-pocket when you use an in-network EyeMed provider, which includes retailers such as LensCrafters, Pearle Vision, and Target Optical than if you go to an out-of-network provider. If you choose an out-of-network provider, your benefit is based on a reimbursement schedule.

*Snapshot of Your Vision Coverage*

| Plan Feature | In-Network Coverage<br>You Pay | Out-of-Network Coverage<br>Plan Reimburses |
|---|---|---|
| **Exam With Dilation as Necessary** | $10 Copay | Up to $50 |
| **Contact Lens Fit and Follow-Up (Contact lens fit and 2 follow-up visits are available once a comprehensive eye exam has been completed)** | | |
| **Standard Contact Lens Fit & Follow-Up** | Up to $55 | N/A |
| **Premium Contact Lens Fit & Follow-Up** | 10% off retail | N/A |
| **Frames** | $0 Copay; $150 allowance; 20% of charge over $150 | Up to $70 |
| **Standard Plastic Lenses** | | |
| **Single Vision** | $15 Copay | Up to $50 |
| **Bifocal Lenses** | $15 Copay | Up to $75 |
| **Trifocal Lenses** | $15 Copay | Up to $100 |
| **Lenticular Lenses** | $15 Copay | Up to $125 |
| **Standard Progressive Lenses** | $80 | Up to $75 |
| **Premium Progressive Lenses (Add-on to Bifocal)** | $100 - $125 | |
| **Tier 1** | $100 - 125 | Up to $75 |
| **Tier 2** | $100 -125 | Up to $75 |
| **Tier 3** | $100 -125 | Up to $75 |
| **Tier 4** | $80, 80% of charge less than $120 | Up to $75 |
| **Lens Options (paid by the member and added to the base price of the lens)** | | |
| ▪ UV treatment | $15 | N/A |

| Plan Feature | In-Network Coverage<br>You Pay | Out-of-Network Coverage<br>Plan Reimburses |
|---|---|---|
| ▪ Tint (solid and gradient) | $15 | N/A |
| ▪ Standard plastic scratch coating | $0 | Up to $5 |
| ▪ Standard polycarbonate | $40 | N/A |
| ▪ Standard polycarbonate (children under age 19) | $0 | Up to $5 |
| ▪ Standard anti-reflective coating | $45 | N/A |
| ▪ Premium anti-reflective coating | $57 - $68 | N/A |
| ▪ Tier 1 | $57 | N/A |
| ▪ Tier 2 | $68 | N/A |
| ▪ Tier 3 | 80% of charge | N/A |
| Photochromic/Transitions | $75 | N/A |
| Polarized | 20% off retail price | N/A |
| Other Add-Ons and Services | 20% off retail price | N/A |
| **Contact Lenses** | Conventional: $0 Copay; $120 allowance, 15% off retail price over $120 | Up to $105 |
| | Disposable: $0 Copay, $120 allowance, plus balance over $120 | Up to $105 |
| | Medically Necessary: $0 Copay, paid in full | Up to $210 |
| **Laser Vision Correction (LASIK or PRK from U.S. Laser Network)** | 15% off retail price OR 5% off promotional pricing through U.S. Laser Network Call **877.5LASER6** (877.552.7376) to locate a provider | N/A |

Under the Vision Program, the Plan limits the benefits you can receive for the following:

| | |
|---|---|
| Eye Exams | One exam every calendar year |
| Lenses or Contact Lenses | One pair every calendar year |
| Frame | One pair every calendar year |

PLUS Providers
You can choose to visit an in-network PLUS Provider for access to enhanced benefits to help you save even more. At PLUS Providers, you'll receive a $0 exam copay, plus an additional $50 frame allowance (on top of your base benefits and standard discounts). PLUS Providers are located nationwide and easy to find – just look for them using our Provider Locator at www.eyemed.com.

***Voluntary Insurance Programs***

The diagnosis of a critical illness, injuries sustained in an accident, and hospital admissions can be devastating and costly, even if you have health and disability coverage. There are many expenses associated with your treatment or recovery from an accident or illness (such as travel, child care and other unexpected costs) that you may not have considered. To help manage such costs, you can enroll in any or all of the following voluntary coverages:

- Critical Illness Insurance provided by Lincoln Financial
- Accident Insurance provided by Lincoln Financial
- Hospital Care provided by Cigna

These voluntary insurance plans will provide a lump sum cash benefit in the event of covered diagnosis (Critical Illness), injuries and related care as a result of a covered accident (Accident Insurance), or admission to a hospital (Hospital Care)
For Critical Illness only, you are not required to provide evidence of insurability if you elect Critical Illness Insurance coverage during your new hire enrollment period. If you decline coverage during your initial enrollment period and decide to enroll at a later time, you may be required to submit evidence of insurability.

Evidence of insurability is not required for Accident Insurance or Hospital Care.

***Flexible Spending Accounts (FSAs)***

The Company offers FSAs (Healthcare FSA and a Dependent Care FSA), which let you set aside pre-tax money to pay for qualified health and/or dependent care expenses. You must elect to participate in an FSA plan each year; enrollment does not automatically carry over from the prior year. Optum Financial (formerly ConnectYourCare) administers the Company's FSA plans. You can manage your account online at secure.optumfinancial.com.

***Snapshot of How FSAs Work***

- You decide the amount you want to contribute based on your expected healthcare and/or dependent care expenses.

- The Company deducts your contributions from each paycheck before income and Social Security taxes, and deposits that money into your FSA.

- You can pay for eligible healthcare expenses with the Optum Financial debit card or you can pay for your expenses and then submit a reimbursement claim directly to Optum Finacial. For dependent care expenses, you pay for eligible expenses, and then submit a reimbursement claim.

- The Healthcare FSA and Dependent Care FSA are separate accounts that are subject to different rules and regulations. Amounts credited to your Healthcare FSA may not be used to reimburse you for your dependent care expenses, and amounts credited to your Dependent Care FSA may not be used to pay your healthcare expenses.

***Eligible Dependents Under Your Healthcare FSA***

You can use your Healthcare FSA for expenses for both yourself and your eligible dependents. Your dependents **do not** have to be covered under your Medical Program for you to claim reimbursement from your Healthcare FSA for expenses that you incur for their care.

For purposes of the Healthcare FSA, your dependents include:

- Your current spouse (for purposes of federal tax laws), unless legally separated or divorced;

- Your children who qualify as your dependents for federal tax purposes, who have the same principal residence as you for more than one-half of the taxable year; do not provide more than one-half of their own support;

- Your children who are under age 27 and who will not reach age 27 by the end of the calendar year

The word "children" for these purposes includes your natural children, legally adopted children (including children for whom legal adoption proceedings have been started and of whom you have legal custody) and stepchildren. Grandchildren and foster children are NOT considered dependent children, unless they qualify as your tax dependent under Internal Revenue Code Section 105(b) or have been legally adopted by you.

***Types of Accounts***

***General Purpose Healthcare FSA***

For the general-purpose healthcare FSA you can:

- Contribute pre-tax dollars (up to $3,050 for 2025) through automatic payroll deductions. You must make a minimum contribution of $100 per year to participate.
- Receive reimbursement for eligible out-of-pocket medical, prescription drug, dental and vision expenses that are not paid through insurance or other sources.

Eligible expenses include, but are not limited to the following:

- Insurance deductibles;
- Insurance copayments;
- Orthodontia and other dental care expenses;
- Vision care, including LASIK surgery, eyeglasses and contact lenses;
- Hearing aids;
- Weight loss treatment (with the exception of food costs) associated with a diagnosed disease or ailment such as obesity or hypertension;
- Prescription drugs;
- Over-the-counter drugs to alleviate or treat personal injuries or sickness, but only if you have a physician's written prescription for the drug;
- Insulin (no prescription necessary for reimbursement);
- Stop-smoking programs prescribed by a physician; and
- Expenses for most medically necessary treatments and procedures that are not covered by insurance.

For a complete list of eligible expenses, visit www.irs.gov.

***Limited Purpose Healthcare FSA***

If you enroll in the Advantage HSA Plan, you can participate in a limited purpose healthcare FSA where you can.

- Contribute pre-tax dollars (up to $3,050 for 2025) through automatic payroll deductions. You must make a minimum contribution of $100 per year to participate.

- Receive reimbursement for eligible out-of-pocket dental and vision expenses.

Eligible expenses include, but are not limited to the following:

- Non-cosmetic dental care (cleaning, fillings, crowns or orthodontics);
- Vision care (contact lenses, eyeglasses, refractions or vision correction procedures); and
- Over-the-counter dental or vision expenses, but only if you have a physician's written prescription for the drug.

**Advantages of a Limited-Purpose FSA**

- IRS regulations prevent you from contributing to both an HSA and a general-purpose healthcare FSA in the same year. But a limited purpose FSA works in conjunction with an HSA by allowing FSA reimbursements for dental and vision care expenses. Participating in both plans allows you to maximize your savings and tax benefits.

***Examples of Non-Reimbursable Expenses for Healthcare FSAs***

- Cosmetic surgery expenses (except to correct congenital abnormality, personal injury or disfiguring disease);
- Expenses incurred in connection with an illegal operation or treatment;
- Vitamins taken for general health purposes;
- Transportation expenses to and from work, even though a physical condition may require special means of transportation;
- Membership fees or weight loss programs or medications to promote general health; and
- Stop-smoking drugs that do not require a prescription (such as nicotine gum or patches).

***Debit Card***

The general-purpose and limited-purpose Healthcare FSA plans include a debit card which you can use to pay for eligible purchases at qualified merchants. If you use the debit card, funds are taken directly from your account once you make a purchase.

Upon enrollment in the Healthcare FSA, you will receive a debit card from the Claims Administrator. The debit card makes it easy to pay for many eligible healthcare expenses at the time services are rendered (i.e., prescription copayments) or for coinsurance claims after you receive your carrier's Explanation of Benefits (EOB) and your provider's bill. The debit card can only be used at merchants that provide healthcare products or services. Your card cannot be used

to purchase over-the-counter drugs (other than insulin, and certain other limited over-the-counter products).

When the card is used at a valid merchant, eligible expenses are automatically deducted from your Healthcare FSA. Additional documentation may be required to substantiate certain debit card transactions. You will be notified by the Claims Administrator if additional documentation is needed. Be sure to keep all of your receipts in the event you are required to substantiate a transaction.

If substantiation is required but not submitted, the transaction will be deemed invalid and the amount of the transaction will be considered an overpayment. You must either refund the amount of overpayment and/or the amount of the overpayment will be offset by future claims. If your account is in overpayment status at the end of the plan year, the equivalent dollar amount will be treated as taxable income to you.

***A Special Tax Note About Your Healthcare FSA Benefits***

The Healthcare FSA is an alternative to claiming an expense as a federal income tax deduction. The IRS allows you to deduct healthcare expenses only if they exceed 10% of your adjusted gross income (7.5% of your adjusted gross income if you or your spouse has attained age 65 before the end of the year). The Healthcare FSA allows you to claim reimbursement beginning with the first dollar of eligible healthcare expenses you incur. For this reason, the FSA is usually more advantageous for most people. You should consult a personal tax advisor to determine the best choice for your individual circumstances.

***FSAstore.com***

General-purpose healthcare FSA participants have access to FSAstore.com, an e-commerce site stocked with thousands of FSA-eligible products and services for purchase. The site also offers helpful tools and resources to help you better understand your FSA benefits.

If you use your Optum Financial debit card, purchases made via FSAstore.com may reduce the number of receipts you need to provide to Optum Financial. If you file claims, you'll be able to download your purchase receipt and immediately file an online FSA claim, allowing for easier claim submission and faster reimbursement.

If you have questions about FSAstore.com or your FSA benefits, contact the Optum Financial Solution Center at (877) 292-4040.

***How to Request Reimbursement From Your Healthcare FSA***

All Healthcare FSA claims are processed by the Claims Administrator. Visit secure.optumfinancial.com to do any of the following:

- Complete a claim submission form;
- Review the status of claims;

- Check your current account balance;
- Learn about eligible expenses; and
- Learn about the debit card available for the Healthcare FSA.

To obtain reimbursement for eligible expenses, complete and sign a claim form and return it with supporting documentation to the Claims Administrator at the address on the form. Upon receipt, review and approval of the claim, the Claims Administrator will reimburse you from your Healthcare FSA. Reimbursement for qualifying healthcare expenses will be made up to the total amount of your Plan Year contribution, less any previous reimbursements. For reimbursement of expenses partially covered under another healthcare plan:

- Submit expenses through your primary healthcare plan (i.e., insurance provider) for processing of covered expenses.
- If you also have coverage through a second healthcare plan, such as under a spouse's plan, you must also submit claims to this source for processing.
- Once processed by all your healthcare plan carrier(s), complete the FSA Claim Form and attach a copy of the Explanation of Benefits (EOB) form(s) showing the remaining amount of unpaid expenses.
- Send the completed form (and applicable EOBs) to the address on the claim form.

For reimbursement of expenses not covered under another healthcare plan:

- Complete and sign the FSA claim form;
- Attach itemized bills for the eligible medical expenses; and
- Send the completed form and itemized bills to the address on the form.

***Special Rules for Orthodontia Expenses***

If you pay for the ongoing care of orthodontia, your expenses will be reimbursable if payment for the current year's services is made by you during the current Plan Year, even if full treatment will not be performed until a future date within that current Plan Year.

***Dependent Care FSA***

The Dependent Care FSA reimburses you for some or all of the expenses you incur for the care of a child or disabled dependent while you work. If you are married and live with your spouse, you will only be eligible to contribute to the Dependent Care FSA if your spouse works, attends school full-time or mentally or physically incapable of self-care with the same principal place of abode as you for more than half of the year.

***Qualified Dependents Under Your Dependent Care FSA***

You may only receive reimbursement from your Dependent Care FSA for expenses related to the care of your ***"qualified dependents."*** A qualified dependent spends at least eight hours per day in your home and is one of the following:

- A child under age 13 who qualifies as your dependent as a "qualifying child" under the Internal Revenue Code. For purposes of your Dependent Care FSA, a "qualifying child" is your child who:
  - Is your child, a descendant of your child, your brother, sister, stepbrother, or stepsister or a descendant of any such relative;
  - Has the same principal residence as you for more than one-half of the taxable year; and
  - Does not provide more than one-half of his or her own support.

  If you are divorced or legally separated, your child may qualify if you satisfy custody requirements specified by the Internal Revenue Service. Contact the Plan Administrator for more information.
- A dependent of any age who is physically or mentally incapable of self-care who qualifies as a "qualifying child" (as defined above) or a "qualifying relative." For purposes of your Dependent Care FSA, a "qualifying relative is an individual who:
  - Is your child (or descendant of your child), brother, sister, stepbrother, stepsister, father, mother (or an ancestor of your father or mother), stepfather, stepmother, a son or daughter of your brother or sister, a brother or sister of your mother or father, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law or an individual who has the same principal residence as you and is a member of your household;
  - Receives more than one-half of his or her support from you; and
  - Is not a qualifying child of you or of any other taxpayer for the year.
- Your spouse (recognized under federal tax law) if he or she is physically or mentally incapable of self-care and has the same principal residence as you for more than one-half of the taxable year.

***Contributions to Your Dependent Care FSA***

If you elect to participate in the Dependent Care FSA, you must contribute a minimum of $100 per year. The maximum depends on your filing status for federal income tax purposes:

- If your filing status is married filing separately, the maximum you can contribute is $2,500 per year.

- If your status is (a) married filing jointly, (b) single, or (c) head of household, the maximum you can contribute is $5,000 per year.

It is important to note that, regardless of your filing status, your contributions to the Dependent Care FSA cannot exceed your earned income or your spouse's earned income, whichever is less.

However, if your spouse is disabled or is a full-time student, you still may use the Dependent Care FSA even if your spouse has no earned income. In this situation, you may not contribute more than $250 per month if you have one qualifying individual, or $500 per month if you have two or more qualifying individuals, for each month your spouse is enrolled as a full-time student or is disabled.

***How to Request Reimbursement From Your Dependent Care FSA***

For the Dependent Care FSA, you must have both incurred and paid the expense in order to receive reimbursement. You will not be reimbursed more than your account balance.

All Dependent Care FSA claims are processed by the Claims Administrator. Visit secure.optumfinancial.com to do any of the following:

- Complete a claim submission form;
- Review the status of claims;
- Check your current account balance; and
- Learn about eligible expenses.

To obtain reimbursement for eligible expenses, complete and sign a claim form and return it with supporting documentation to the Claims Administrator at the address on the form. Upon receipt, review, and approval of the claim, the Claims Administrator will reimburse you from your Dependent Care FSA. When completing a Claim Form, you must include the following information:

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

The Claims Administrator will reimburse the claim up to the available balance in your Dependent Care FSA at the time you submit the claim. If there aren't sufficient funds in your Dependent Care FSA to reimburse the entire claim, the remaining amount of the claim will be paid as soon as there have been enough payroll deductions credited to your account. You will not have to re-submit the claim.

Eligible expenses include, but are not limited to the following:

- Fees for child care centers;
- Fees for pre-school;
- Fees for certain before- and after-school programs;
- Fees for certain summer camps;
- Salaries for day care providers and baby-sitters; and
- Care for disabled dependents.

**Please note: If a dependent care center provides care for more than six non-resident individuals, it must meet all applicable state and local regulations in order for its charges to be reimbursable from your Dependent Care FSA.**

***Examples of Non-Reimbursable Expenses***

- Services which are primarily educational or medical in nature;
- Educational expenses at kindergarten level or higher;
- Services provided on behalf of a qualified dependent while the employee (or spouse) is not working;
- Household services provided by individuals who are not responsible for providing care to the dependent;
- Transportation costs to and from a dependent care facility;
- Overnight camp costs; and
- Dependent day care fees paid to certain individuals who are related to you, such as:
    - Your child, stepchild or foster child who is under age 19 at the close of the taxable year;
    - Your qualifying child or qualifying relative;
    - Your spouse; or
    - The parent (who is not your spouse) of your qualifying child under age 13.

Contact the Plan Administrator if you have any questions about reimbursing care expenses paid to someone who is related to you.

### *Choosing Between the Dependent Care FSA and Income Tax Credit*

The dependent care expenses that are reimbursable from your Dependent Care FSA are the same expenses that may qualify you for a credit on your federal income tax. **However, you cannot take a tax credit for dependent care expenses that are reimbursed from your Dependent Care FSA.**

The approach that offers you the better financial advantage will depend on your income and expenses. Be sure to consult your professional tax advisor.

### *Nondiscrimination Testing*

Under the Code and related federal regulations, flexible spending accounts are subject to nondiscrimination testing each year to ensure the Plan does not provide an unfair advantage to highly compensated employees. The Dependent Care FSA is also subject to an average benefits test.

Depending on the results of the annual tests, contributions of certain colleagues may be reduced or returned. You will be notified if this affects you.

### *Claims Submission Deadline*

All general-purpose Healthcare FSA, limited purpose Healthcare FSA and Dependent Care FSA expenses incurred from January 1 through December 31 must be submitted (with a postmark date) for reimbursement by March 31 of the following year.

### *If You Terminate Employment*

If you terminate employment during the Plan Year, you must submit all claims for reimbursement within 90 days of your date of termination. You may claim reimbursement for eligible expenses incurred during the period of coverage up to and including your termination date. Once the applicable deadline passes, you will forfeit any balance remaining in your FSA after all eligible claims have been submitted and paid.

### *"Use-It-or-Lose-It" Rules*

You decide how much to contribute to your Healthcare (General Purpose and Limited Purpose) FSA. Because you make this decision when you enroll in the Flexible Spending Account Program (i.e., before you have incurred your expenses for the year), it is possible that you may overestimate your expenses and contribute more than you need to cover your healthcare and/or dependent care expenses.

However, the tax laws require that all amounts that you contribute to your Healthcare FSA during the year be used to reimburse eligible expenses that you incur during the same year. If you overestimate your expenses, the tax laws require that any unused pre-tax contributions over $570 be forfeited. Any amount over $570 will not "carry over" into the next year. The $570 will

automatically be carried over and requires no action by you. This rollover provision does not apply to Dependent Care FSA.

You may not use excess amounts left in your Healthcare FSA to pay your dependent care expenses, and vice versa, even if you will otherwise forfeit those amounts.

That is why you must carefully estimate your healthcare and dependent care expenses when you elect to participate in the Flexible Spending Account Program. **If you budget for emergencies or rare occurrences and they do not occur, you will be likely to end up losing the money**.

***Long-Term Disability Coverage***

You will be automatically enrolled in the Long-Term Disability Program after becoming eligible. The Program provides regular payments in the event that you become unable to perform your employment duties due to a covered disability.

***Snapshot of Your Long-Term Disability Coverage***

The Company provides Long-Term Disability insurance at no cost to you. If you are disabled and unable to work, you may be eligible for long-term disability benefits after 180 days of continuous and total disability. The monthly benefit is 60 percent of your base salary up to $10,000 per month for the duration of your disability.

***Important Information for Residents of Certain States***

There are state-specific disability requirements that may change the provisions under the coverage described above and the corresponding group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage and are made a part of your group insurance certificate. The insurer will coordinate these benefits and provide you with information on how mandated state benefits may impact your disability benefits.

***Life Insurance Coverage***

The Company provides a certain level of income protection for your survivors upon your death, and for you upon your dependent child's death, through the Group Term Life Insurance Program. In addition, the Company gives you the opportunity to increase that level of protection by purchasing additional life insurance for yourself, your spouse and your dependent children.

Lincoln Financial administers the Company's Life and Accidental Death and Dismemberment (AD&D) insurance plan.

***Group Term Life and AD&D Insurance Coverage***

The Company provides basic life and AD&D insurance at no cost to you. The benefit is 1.5 times your annual base salary, up to $1,000,000. The cost of coverage for basic life insurance above $50,000 will be included as imputed income for tax purposes.

### *Dependent Life Insurance Coverage*

The Company provides life insurance for your spouse and dependent children at no cost to you. Spouses receive $5,000 in coverage and dependent children receive $1,000 in coverage.

### *Voluntary Life and AD&D Insurance Coverage*

### *Employee Voluntary Life Insurance Coverage*

You can enroll in additional life insurance in increments of $10,000, up to a maximum of $1,000,000. Rates are determined by your age and smoker status. You may be required to submit evidence of insurability.

### *Spouse and Child Voluntary Life Insurance Coverage*

You can also enroll in additional life insurance for your spouse and/or dependent children. To enroll your dependent children, you or your spouse must be approved for Voluntary Life coverage. You may elect up to $500,000 (in $10,000 increments) for your spouse. You may be required to submit evidence of insurability. You may elect up to $10,000 (in $2,500 increments) for your dependent children. Child Voluntary Life is not subject to evidence of insurability requirements. The combined elections for spouse and child Voluntary Life coverage cannot exceed the amount elected for employee Voluntary Life coverage.

### *Accidental Death and Dismemberment Insurance Coverage*

The Company provides a certain level of income protection for your survivors upon your death or dismemberment as a result of an accident. You may purchase additional accident coverage for yourself, your spouse and children.

### *Employee, Spouse and Child Voluntary AD&D Insurance Coverage*

You can enroll in additional AD&D insurance for yourself, spouse and dependent children. Employee and spouse coverage can be purchased in increments of $10,000, up to $500,000. Dependent child coverage can be purchased in increments of $2,500, up to $10,000. The combination of spouse and child coverage cannot exceed your employee election amount. Evidence of insurability may be required.

### *Evidence of Insurability*

If you did not enroll in employee and/or spouse Voluntary Life Insurance when you first became eligible, you will be required to submit evidence of insurability to Lincoln Financial to verify your health status. Lincoln Financial will review your health status before approving your coverage. Additionally, if, in the future, you would like to increase your coverage amount, you will be required to submit evidence of insurability. To complete the evidence of insurability, log in to the ZONE and go the ‘Featured Content’ tile in the ‘Benefits’ tab.

### *Naming a Beneficiary*

A beneficiary is the person, persons, estate, trust or charity that will receive benefits if you die. You can designate one person or several individuals to receive benefits.

If you would like to make a change in your beneficiaries, log in to the ZONE and go to the 'Manage Information' tile in the 'Benefits' tab.

### *Commuter Benefits*

The Company offers Commuter Benefits through Optum Financial, which allow you to use pre-tax dollars to pay for eligible parking and transit expenses. Participants elect to have a set amount deducted from their paycheck, up to the IRS maximum. Contributions can be used to reimburse parking expenses incurred at or near your office or near a location from your commute to work by mass transit or qualifying vanpool. In addition, the contributions can be used to purchase monthly bus, ferry, train or metro passes used for your commute to the office.

For calendar year 2025, the IRS maximum a participant may defer is $315 for mass transit and $315 for parking expenses. Because your enrollment rolls over from one month to the next, you do not need to re-elect this benefit during annual enrollment. You can manage your Commuter Benefits online at secure.optumfinancial.com..

### *Employee Assistance Program (EAP)*

The EAP is designed to assist you and immediate family members with personal problems, planning for life events or simply managing daily life. This free service offers confidential support, resources and a wealth of information. You can access the EAP by calling Telus Health at (877) 695-6327 or logging on to one.telushealth.com, to access tools and resources 24 hours a day, seven days a week. All assistance is confidential.

Examples of services include:

- Counseling (up to five face-to-face sessions)
    - Marital/family issues
    - Drug/alcohol abuse
    - Stress/anger management
- Financial
    - Money management and credit questions
    - Financial counseling sessions
- Legal

- One 30-minute phone or face-to-face session to discuss issues including divorce, real estate or civil matters
- 25 percent discount on fees if additional assistance is required

- Family
  - Child care and elder care
  - Adoption information/referrals

***Advocacy Services***

When you have tough benefits questions and don't know where to turn for answers, you can reach out to an Advocacy Service representative. To help you get the most out of your benefits, the Company provides Advocacy Services at no cost to you.

Representatives will work with you to:

- Understand and use all of your benefits, from healthcare to your 401(k) plan.
- Decide the best course of action when you have a question or concern.
- Resolve healthcare billing and insurance claim disputes.
- Locate doctors, hospitals and other healthcare providers.
- Be an informed, effective healthcare consumer.
- Navigate your Medicare questions.

Learn more by contacting an advocate at alighthealthpro@alight.com or call (800) 715-4015, Monday through Friday between 7 a.m. and 6 p.m. (CT).

***Required Notices***

***Your Maternity Rights (Newborns' and Mothers' Health Protection Act)***

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

***Your Rights Following a Mastectomy (Women's Health and Cancer Rights Act of 1998)***

Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

Benefits will be subject to the same annual deductibles and coinsurance provisions as all other medically necessary procedures under your medical option.

## SUBROGATION AND REIMBURSEMENT

You or a covered dependent may have a claim for an illness, injury, disability or death, such as from a car accident, that someone else is responsible to pay. The portion of the expense that the other party (which may be an individual, a company or an insurer) is responsible for paying is not considered a covered expense under the Medical Program or Dental Program. In addition, the Plan does not provide benefits if there is other coverage under any automobile policy, homeowner's policy, workers' compensation or similar insurance coverage. However, the Plan may advance you payment of the expense as a benefit in exchange for you and your dependents granting the Plan the right of subrogation, reimbursement and recovery. By enrolling in the Plan, as well as by applying for payment of covered expenses, you and your covered dependents are subject to and agree with the following rules:

**Reimbursement agreement** – If you or your covered dependents have expenses that are excluded because they are or may be the responsibility of a third party, you or your covered dependent must sign the Plan's reimbursement agreement in order to receive Plan benefits. The agreement acknowledges you or your covered dependent's obligation to reimburse the Plan from the first dollars recovered from any source. If expenses are incurred by a minor dependent, the Plan Administrator may require that the minor's parent or legal guardian execute the reimbursement agreement and agree to be bound by it. The Plan Administrator may, in its discretion, withhold benefit payments that might otherwise be advanced, and/or prosecute an action at law or in equity in its own name or in your name, in order to enforce, secure or protect the Plan's rights. If you or

your covered dependent does not execute the agreement, the Plan is not obligated to provide any benefit payments.

**Right of reimbursement** – Whether or not you or your covered dependent executes a reimbursement agreement, in the event that the Plan provides benefits and you or your covered dependent recovers a payment, either by settlement, judgment, no-fault automobile insurance statute or otherwise, from any third party, then you or your covered dependent must immediately reimburse the Plan for the full amount of any and all benefits paid in connection with the injury, illness, disability or death, up to the amount of the recovery. This right of reimbursement applies regardless of the label assigned to the recovery, and regardless of any purported allocation or itemization of such recovery to specific types of injuries. This right provides the Plan with priority over any funds paid by a third party or insurer, without regard to whether you or your covered dependent has been made whole. If the recovery is for damages other than for medical or dental care expenses, such as pain and suffering, you or your covered dependent will still be required to reimburse the Plan first. The Plan has a lien on any such recovery in the amount of the benefits paid by the Plan.

**Right of subrogation** – Whether or not you or your covered dependent executes a reimbursement agreement, if the Plan pays for an expense for which another party was responsible, the Plan is subrogated to all of your or your covered dependent's rights of recovery against any party to the extent of the benefits provided. This means that the Plan shall also have a lien on any recovery from such third party to the full amount of benefits paid and may, at its option, file suit or intervene in any pending lawsuit to secure and protect its rights. The Plan's right of subrogation shall apply to the first dollar of any recovery obtained from the third party, even if the recovery obtained is less than the amount needed to make you whole. If the Plan is precluded from exercising its right of subrogation or chooses not to exercise that right, the Plan has discretion whether or not to pay benefits.

Following are some examples of when the subrogation and reimbursement rights described above apply:

- Payments made directly by a third party or any insurance company on behalf of the third party or any other payments on behalf of the third party;
- Any payments or settlements or judgment or arbitration awards paid by any insurance company under any uninsured or underinsured motorist coverage;
- Any other payments from any source designed or intended to compensate a participant for injuries sustained as the result of negligence or alleged negligence of a third party;
- Any workers' compensation award or settlement;
- Any recovery made pursuant to no-fault insurance; and
- Any medical payments made as the result of such coverage in any automobile or homeowners insurance policy.

**Duty to cooperate** – You and your covered dependent are required to cooperate fully with the Plan in connection with the exercise of its rights, to provide such information, assistance and documents as the Plan may require to help enforce its rights, and to not do anything to hurt such rights. You or your covered dependent must notify the Plan before filing any suit and may not settle any claim against a third party without giving notice to and obtaining the consent of the Plan Administrator. If you or your covered dependent notifies the Plan before suit or settlement, the Plan may retain your or your covered dependent's attorney to represent the Plan. If the Plan hires your or your covered dependent's attorney, the Plan will agree with the attorney on the amount of attorneys' fees and expenses that the Plan will pay. The Plan is not bound by the amount or percentage of your or your covered dependent's attorneys' fees, nor may they be subtracted from the amount that is required to be repaid to the Plan without the Plan's consent. If you do not timely notify the Plan of suit or settlement, or do not cooperate with the Plan, or oppose the Plan in enforcing the Plan's subrogation or reimbursement rights, you must pay the Plan's attorneys' fees and costs incurred because of your actions or failure to act, in addition to any other rights or remedies that the Plan may have.

**Equitable Lien and other Equitable Remedies –** The Plan will have an equitable lien against any rights you or your covered dependent may have to recover the reimbursable expenses from any party, including an insurer or another group health program, but limited to the amount of reimbursable payments made by the Plan. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, you, your covered dependent, your or your covered dependent's attorney and/or a trust) as a result of an exercise of your or your covered dependent's right of recovery (sometimes referred to as "proceeds"). The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the Company, the Plan may reduce any future covered expenses otherwise available to you or your covered dependent under the Plan by an amount up to the total amount of reimbursable payments made by the Plan that is subject to the equitable lien.

This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court's decisions entitled, Sereboff v. Mid Atlantic Medical Services, Inc., 126 S.Ct. 1869 (2006) and Great-West Life & Annuity Insurance Co. v. Knudson, 122 S.Ct. 708 (2002).

**Right of recovery or offset** – The Plan has the right to withhold the payment of benefits under this Plan if you or your covered dependent does not comply with these requirements, and has the right to recover any benefits paid to you, your covered dependent or your or your covered dependent's healthcare provider in error. The Plan may stop paying benefits under a reimbursement agreement if, the Plan Administrator determines that, you have failed or are failing to fulfill your duty to cooperate. These rights are in addition to any other rights and remedies that

the Plan may have. In connection with this right of recovery or offset, please consider the following:

- You or your adult covered dependents may not assign any rights to recover medical expenses from any party to any of your or your covered dependent's minor child or children without the prior express written consent of the Plan. The Plan's right to recover (whether by subrogation or reimbursement) applies to settlements or recoveries of decedents, minors and incompetent or disabled persons.

- You may not make any settlement that reduces or excludes, or attempts to reduce or exclude the benefits provided by the Plan.

- The Plan's rights described above cannot be defeated nor reduced by the application of any "made-whole doctrine" or similar doctrine or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

- You or your covered dependents may not incur expenses on behalf of the Plan in pursuit of the Plan's rights. Specifically, neither court costs nor attorney fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right cannot be defeated by any so-called "fund doctrine" or similar doctrine.

- The Plan has the right to recover the full amount of benefits provided without regard to any claim of fault on the part of any participant, whether under comparative negligence or otherwise.

- The benefits under the Plan are secondary to any coverage under no-fault or similar insurance.

- If you do not honor your obligations, the Plan will be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to attorney fees, litigation, court costs and other expenses.

## TERMINATION OF PARTICIPATION

### *When Your Participation Ends*

Once you begin participation in any of the Programs, whether by election or automatic enrollment, you will continue to participate in that Program until your participation ends under the following conditions:

- **For all Programs except Flexible Spending Accounts and Long-Term Disability,** coverage ends on the last day of the month when:

    - You are no longer eligible to participate in the Program for any reason, including the termination of your employment;

- You fail to make any "Required Contribution" (as described below);
- Your election expires; or
- The Program or Plan is terminated.

- **Flexible Spending Account Program.** Coverage ends on:
  - The date you are no longer eligible to participate in the Program for any reason, including the termination of your employment;
  - The date on which you fail to make any "Required Contribution" (as described below);
  - The last day for which your election to participate in the Program remains effective; or
  - The date the Program or Plan is terminated.

- If your participation in the Flexible Spending Account Program terminates for any reason, you may be entitled to receive ***"termination benefits."***
  - You may receive reimbursement from your Healthcare FSA for the eligible healthcare expenses that you incur up until the date that your participation in the Healthcare FSA terminates. You may also elect to continue your participation in the Healthcare FSA through COBRA for the rest of that Plan Year. Your COBRA contributions to your account for the remainder of the Plan Year will be on an after-tax basis.
  - You may receive reimbursement from your Dependent Care FSA for the eligible dependent care expenses while you are actively employed with the Company. If you terminate employment, you may be reimbursed for all eligible expenses incurred through your date of termination, up to the balance credited to your Dependent Care FSA when your employment terminates.

- If you terminate employment, you must submit all claims for reimbursement within 90 days of your date of termination. In the event of your death, your beneficiaries have until March 31 of the year following the year in which your participation terminates to submit your expenses for reimbursement. Any balance remaining in your FSA after the applicable deadline will be forfeited.

When your participation in the Medical (including Prescription Drug), Dental, Vision and Flexible Spending Account Programs end, your Program benefits will generally cease, except that you may have the right to continue your participation by electing continuation coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA applies to your coverage under health programs and your Healthcare FSA, but not your Dependent Care FSA. See the "COBRA" section for more details.

- **Long-Term Disability Program.** Coverage ends on:
    - The date you are no longer eligible to participate in the Program for any reason, including the termination of your employment; or
    - The date the Program is terminated.

***When Your Dependent's Participation Ends***

Your dependent's coverage ends on the last day of the month of the earlier of:

- When your coverage ends; or
- Your dependent no longer meets the definition of "dependent."

***Effect of Leaves of Absence***

You must remain eligible to participate in the Programs during your leave in order to remain enrolled.

***Paid Leave of Absence***

If you take a paid leave of absence, you may continue to participate in the Medical (including Prescription Drug), Dental, Vision and Flexible Spending Account Programs during your leave. You will be eligible to make contributions as though you were still actively employed. You may continue to participate in the Group Term Life, Voluntary Life Insurance, Accidental Death and Dismemberment, Voluntary Accidental Death and Dismemberment and Long-Term Disability Programs for up to one month during an approved paid leave of absence. You may continue to participate in the Critical Illness Program for up to three months during an approved paid leave of absence.

***Unpaid Leave of Absence***

If your leave is unpaid or your pay is significantly reduced while you are on leave, you may be eligible to continue your participation in the Medical (including Prescription Drug), Dental, Vision and Flexible Spending Account Programs (as provided below), but are not required to do so. You may instead revoke your election to participate. If you do, your participation in the Medical (including Prescription Drug), Dental and Vision Programs will end on the last day of the month that you were actively at work. For the Flexible Spending Account Program, your participation in the Program will end on the day before the effective date of your leave.

You may elect to continue to participate in each of the Programs, provided you are still eligible and:

- You are still considered an employee of the Company, and
- You make any **"**Required Contributions**."**

Notwithstanding the above criteria, you may continue to participate in the Group Term and Voluntary Life Insurance Programs, Accidental Death and Dismemberment Program, and Voluntary Accidental Death and Dismemberment Program during an unpaid leave of absence only if such leave of absence is approved by the Company and only for up to **30 days** from the beginning of the leave of absence.

You may continue to participate in the Long-Term Disability Program during an unpaid leave of absence only if such leave of absence is approved by the Company and only for up to **one month** from the beginning of the leave of absence.

You may continue to participate in the Critical Illness Program during an unpaid leave of absence only if such leave of absence is approved by the Company and only for up to three months from the beginning of the leave of absence.

**"**Required Contributions**"** are the amounts necessary to pay for your continued participation in the Program during your leave of absence. Your Required Contributions should equal the pre-tax and after-tax contributions that would be taken from your regular paycheck if you were actively employed and participating in the Program, unless the cost of your benefits changes as a result of your leave.

You make your Required Contributions in one of two ways:

- ***After-Tax Contributions on a Pay-as-You-Go Basis: For unpaid leaves of absence greater than 30 days,*** you make your Required Contributions on an after-tax, pay-as-you-go basis. Under this method, you will pay the Company for the cost of participating in the Plan during your leave. Payments that you make on this basis will not be excluded from your taxable income. Contact the Human Resources Department for details about where and when to send these payments.

- ***Catch-Up Basis: For unpaid leaves of absence less than 30 days,*** you pay your Required Contributions for the period of your unpaid leave when you return to work. The Company will deduct these payments from your paycheck once you return to work. If you do not return to work after your leave, you will be required to repay the Company directly.

***FMLA or Military Leave***

Notwithstanding any other provision of the Plan or this SPD, if you take a paid ***or*** unpaid leave of absence under either (i) the Family Medical Leave Act, or ***"FMLA"*** (to care for yourself or an immediate family member, or following the birth or adoption of your child), or(ii) the Uniformed Services Employment and Reemployment Rights Act, or ***"USERRA"*** (to perform military service), you will have the same right to continue your participation in the Medical (including Prescription Drug), Dental, Vision and Flexible Spending Account Programs during your leave as described above for paid and unpaid leaves (as the case may be), except as provided otherwise under the FMLA or USERRA. If you revoke your participation in the Medical (including Prescription Drug), Dental, Vision and Flexible Spending Account Programs during your leave and then return to active employment in the same year, ***you may immediately re-enroll in the***

***Medical*** (including Prescription Drug)***, Dental, Vision and Flexible Spending Account Programs.***

You may continue to participate in the Group Term and Voluntary Life Insurance Programs, Accidental Death and Dismemberment Program, Voluntary Accidental Death and Dismemberment Program, Critical Illness Program and the Long-Term Disability Program for up to 12 weeks in a 12-month period if you take a paid or unpaid leave of absence under the FMLA. If you become Totally Disabled, as defined in the booklets for the Group Term and Voluntary Life Insurance Programs, Accidental Death and Dismemberment Program, and Voluntary Accidental Death and Dismemberment Program, then you may be eligible to continue coverage under those Programs beyond the FMLA period and your premium obligations may be waived.

The booklets for the Group Term and Voluntary Life Insurance Programs, Accidental Death and Dismemberment Program, and Voluntary Accidental Death and Dismemberment Program explain your rights under USERRA in the section entitled "Military Services Leave of Absence Coverage." Also, the Plan Administrator can provide you with more information about your rights under both USERRA and the FMLA.

***Flexible Spending Account Program Benefits Following Termination***

You may receive reimbursements from your FSA following the termination of your employment, as follows:

- ***Healthcare FSA:*** You may be reimbursed for eligible expenses that you incur through the date your employment terminates. Also, you may continue your account under COBRA on an after-tax basis for the remainder of the Plan Year.

- ***Dependent Care FSA:*** You may be reimbursed for eligible expenses that you incur through the date your employment terminates.

You will need to submit a timely request for reimbursement. See the "If You Terminate Employment" section.

**COBRA**

A federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) allows you and your covered dependents to continue your medical, dental and vision care coverage (on an after-tax basis) in certain situations when coverage would otherwise end. Upon a qualifying event (described below), you and your covered dependents may be able to continue these coverages. If otherwise eligible, you and each of your covered dependents have an independent right to elect COBRA continuation coverage.

COBRA also allows you the right to continue to participate in the Healthcare FSA following the termination of your employment (the Dependent Care FSA is not subject to COBRA and not available to terminated participants, except with respect to the termination benefits described above.) Upon the occurrence of a "qualifying event" (the termination of your employment or a reduction of your hours worked that causes you to lose eligibility), the Plan Administrator will inform you as to how you can continue to receive Healthcare FSA coverage under the Flexible

Spending Account Program and pay for such benefits through contributions you make to this Program on an after-tax basis.

***When to Elect COBRA***

If you and/or your dependents choose continuation coverage through COBRA, you and your covered dependents are offered coverage on the same basis as other participants, except you or your affected dependents pay the entire cost plus an administrative fee, as allowed by law. COBRA coverage is intended to extend the coverage that is in effect for you and your covered dependents on the day before your qualifying event. COBRA coverage does not create new classes of covered individuals. To be eligible for continuation of coverage, your Company-provided healthcare coverage must be in effect on the date before the qualifying event. For your dependents to be eligible for continuation of coverage, they must also be enrolled for coverage on the day before the qualifying event.

As noted above, if you elect COBRA coverage, you will receive the coverage that was in effect on the day before the qualifying event. However, you may change your coverage choices during the annual enrollment period that falls during your COBRA continuation coverage period. If your covered dependents elect COBRA, these same rights apply.

COBRA coverage takes effect on the date coverage is lost on account of the qualifying event if a timely election is made. While the Company will notify its COBRA Administrator of your qualifying event in the case of your termination from employment, reduction in hours or death, ***it is your (or your covered dependent's) responsibility to notify the COBRA Administrator of any other qualifying event (e.g., divorce)*** You will not need to notify the COBRA Administrator in the event of a dependent child's attainment of age 26, the COBRA Administrator will automatically identify when that event has occurred. Failure to do so may result in a loss of COBRA rights. In addition, you may add a newborn or an adopted child during the COBRA continuation period in accordance with the HIPAA "special enrollment" rules outlined earlier. Your newborn or adopted child's coverage begins immediately.

To continue coverage, you or your affected covered dependents (each, a "qualified beneficiary") are required to pay the entire cost, plus an administrative fee, as allowed by law.

***Administration of COBRA***

If you have any questions about COBRA or if you are required to notify the Company of any event to trigger the Company's COBRA obligations, please contact the Plan Administrator. Upon any required notification by you, the Plan Administrator will contact the COBRA Administrator to send you any necessary paperwork. The name and contact information for the COBRA Administrator is included in the "General Plan Information" section. The COBRA Administrator assists the Company with the sending and receiving of COBRA information, including the collection of COBRA premiums if elected by participants.

***Snapshot of COBRA Coverage***

Here is a snapshot of who is eligible for COBRA continuation coverage, under what circumstances, and how long COBRA continuation coverage continues for healthcare coverage. If one of the events listed in the chart occurs, you and your enrolled dependents may apply for COBRA coverage.

| Qualifying Event | Who Is Eligible for COBRA | Maximum COBRA Period* |
|---|---|---|
| Termination of your employment for any reason (including retirement) except gross misconduct | You and your enrolled dependents | 18 months |
| Reduction in hours of employment (including a military leave of absence)** | You and your enrolled dependents | 18 months |
| You are laid off | You and your enrolled dependents | 18 months |
| You do not return from a FMLA leave of absence | You and your enrolled dependents | 18 months |
| You or your covered dependent becomes disabled | You and your enrolled dependents | 18 months up to 29 months*** |
| Your death | Your enrolled dependents | 36 months |
| Divorce or legal separation (unless a QMCSO provides otherwise) | Your enrolled dependents | 36 months |
| Your child no longer meets the definition of dependent under the Plan | Your covered dependent | 36 months |

*The maximum COBRA period is measured from the date you lose coverage on account of the qualifying event.

**Note that in the event you become entitled to COBRA coverage due to a loss of coverage triggered by a military leave of absence covered by the Uniformed Services Employment and Reemployment Rights Act of 1994, you will receive continued coverage at the same cost paid by active employees for the first 30 days of your military leave. Also, your continuation coverage period is 24 months, not 18 months.

***See "COBRA Coverage for Disabilities" below for details.

**Medicare and COBRA**

If you become covered under Medicare while on COBRA, you will lose your COBRA coverage, but your dependents will not. Your dependents, however, may not extend their COBRA coverage beyond the original continuation period if you become covered by Medicare.

If you become covered under Medicare before electing COBRA, you still have the right to COBRA coverage upon your termination, but Zebra's coverage will become the secondary payer. If your termination (or other COBRA qualifying event) occurs within 18 months of your coverage under Medicare, your spouse and dependents may be eligible for an extension of COBRA coverage. You should check with the Plan Administrator for more details if you are eligible or covered under Medicare.

***Other COBRA information***

If a second qualifying event occurs within the 18- or 29-month period, the COBRA continuation period for healthcare coverage may be extended up to 36 months from the date you lost coverage on account of the first qualifying event.

Please keep the Plan Administrator informed of any change in your or your covered dependents' address so that you and your covered dependents can receive the necessary information concerning your rights to COBRA continuation coverage.

***COBRA Coverage for Disabilities***

As shown in the chart above, COBRA coverage can be extended from 18 months up to 29 months if you (or another qualified beneficiary) are totally disabled when you (or the other qualified beneficiary) become eligible for COBRA coverage or become disabled during the first 60 days of COBRA coverage. Monthly contributions for continuation coverage increase to 150% (from 102%) of the monthly amount for each of the 11 additional months of continuation coverage. (Any covered dependents can also continue their COBRA coverage during this extension period.)

To be eligible for this extension, the individual must:

- Receive a determination of disability from the Social Security Administration (SSA) that the individual was disabled on the date coverage ended, or become disabled during the first 60 days of COBRA coverage, and
- Notify the Plan Administrator within 60 days after the later of:
    - The date of the SSA's determination of disability; or
    - The date of the qualifying event.

    If the SSA determines that the individual is no longer totally disabled, continuation of coverage will cease. The individual must notify the Plan Administrator within 30 days of any such finding. Coverage will terminate on the earlier of the first day

of the month that is at least 30 days after the SSA's findings or at the end of the 29-month period.

***You Must Report Some Qualifying Events***

You or your affected covered dependent must notify the Plan Administrator within 60 days after the date on which coverage is lost on account of any of the following qualifying events:

- You divorce or become legally separated.
- Your child no longer meets the definition of a dependent (e.g., due to age limit).
- You (or your covered dependent) are determined to have been disabled under the Social Security Act when coverage ended or at anytime during the first 60 days of receiving COBRA continuation coverage.
- You become covered by Medicare.

When you or your affected covered dependent contact the Plan Administrator, be sure to inform the Plan Administrator of the specific event, the date of the event and who is affected.

The COBRA Administrator will send you and/or your affected covered dependent a notice and election form, including the cost of coverage, within 14 days of receiving this notification.

The Plan Administrator will inform the COBRA Administrator within 30 days of the loss of your coverage on account of any of the following qualifying events:

- Reduction in hours that makes you ineligible for coverage.
- You are laid off.
- You do not return from an FMLA leave of absence.
- Your termination of employment for any reason other than gross misconduct.
- Your death.

The COBRA Administrator will send you and/or your affected covered dependents a notice and election form, including the cost of coverage, within 44 days after one of these qualifying events occur.

***Deciding Whether or Not to Continue Coverage***

You have 60 days from the day coverage would otherwise end (or from the day the notice is sent to you, if later) to choose ***continuation coverage***.

In order to continue your healthcare coverage, you and/or your covered dependents must pay the full cost of coverage, plus a 2% fee for administrative costs (or a 50% administrative fee in the case of an 11-month extension due to disability).

Your first payment (due within 45 days of your election) must include your COBRA contribution for the entire period from the date coverage ended through the month of the payment. Subsequent contributions are due on the first of the month, whether or not you receive a bill. If the COBRA Administrator does not receive your monthly contribution within 30 days of the first of the month, coverage is canceled as of the last day of the month in which you paid a contribution. If you do not choose to continue coverage, you should make the appropriate election on the election form and return it to the COBRA Administrator. In that case, your healthcare coverage ends on the day on which the qualifying event occurred.

***Health Insurance Marketplace and Medicaid***

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace, which coverage began effective January 1, 2014. Please note that certain exempted benefits such as health flexible spending accounts, integrated health reimbursement arrangements or standalone vision or dental plans will not be offered under the Marketplace or included as a special enrollment right. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You may be eligible for Medicaid. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

***When COBRA Coverage Ends***

COBRA coverage ends for either you or your covered dependents when any of the following events occurs:

- Reaching the end of the applicable maximum COBRA period for coverage;
- Failure to pay a monthly contribution within 30 days of its due date;
- Upon written request to cancel coverage;
- Becoming covered by Medicare;
- Becoming covered under another group medical or dental plan; or
- When the Company ceases to provide any group health plan coverage.

Please inform the Plan Administrator of any changes in address or in personal circumstances so that you and your covered dependents can receive the necessary information concerning your rights to continuation of coverage. However, if you are already receiving COBRA, please contact the COBRA Administrator to update any changes in address or in personal circumstances.

### *CalCOBRA*

If you reside in California and are enrolled in a fully insured HMO option offered in California, you and your covered dependents may have additional continuation rights under CalCOBRA. Generally, if you work in California at the time of a qualifying event, you, your spouse and your dependents may be eligible to extend continuation coverage for insured health plan benefits after the end of the 18-month period (or 29-month period, in the case of a disability extension) of federal COBRA coverage, up to a maximum of 36 months. The extension of continuation coverage is also available to a spouse and covered dependents who are qualified beneficiaries. If you are eligible for CalCOBRA continuation coverage, you will be notified prior to the end of the 18-month or 29-month federal COBRA period. Please contact your HMO at the address listed in your evidence of coverage booklet if you have any questions or for additional information.

## PLAN ADMINISTRATION

### *General*

The Plan Administrator, or its delegate, has the exclusive power and discretionary authority to construe and interpret the terms of the Plan based on the Plan document, existing laws and regulations and to determine all questions that arise under it. The Plan Administrator's (or, if applicable, its delegate's) interpretations and determinations are final and binding on all participants, employees, former employees and their beneficiaries. The Plan Administrator, or its delegate, has the discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan will be paid only if the Plan Administrator or its delegate decides in its discretion that the applicant is entitled to them.

No person has the authority to make any verbal statements of any kind at any time that are legally binding on the Company or the Plan, or alter the actual Plan document and contracts maintained in connection with the Plan.

Zebra has designated Utah as its benchmark plan for purposes of dollar limits on essential health benefits (EHBs). Infertility is not an EHB and therefore, a dollar limit is permitted under the Affordable Care Act as explained in this SPD.

### *Claims Procedures*

### *Filing a Claim*

Please review the applicable Program booklet provided by the Claims Administrator for information on how to file a claim.

### *Medical and Dental Benefit Claims Process*

These procedures apply to Medical Program and Dental Program claims, which are all referred to in this subsection "benefit claims process."

As noted above, the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Plan. A Claims Administrator has the authority to decide the level of benefits

that are available to an individual. See the "General Plan Information" section for contact information for the Claims Administrator.

*Urgent Care Claim*

An "**urgent care claim**" is any benefit claim where applying the non-urgent care time frames (i) could seriously jeopardize your health or ability to regain maximum function, or (ii) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain without the care or the treatment that is the subject of the claim.

*Pre-Service Claim*

A "**pre-service claim**" is a benefit claim that requires approval before you can receive Plan coverage (in whole or in part) for the medical care.

*Post-Service Claim*

A "**post-service claim**" is any other benefit claim, for example, a claim for reimbursement after the medical care is received.

*Initial Claim Decision*

An "initial claim decision" is when a claim is received for a benefit, the Plan Administrator must decide whether the individual is covered under the Plan or the Claims Administrator must decide whether (or at what level) the benefit is covered under the Plan. When a benefit is provided or denied, you will receive a notice explaining how the benefit level was calculated or why benefits have been denied (the Explanation of Benefits or "EOB", generally). How fast this notice must be given to you depends on whether the claim is an urgent care claim, a pre-service claim or a post-service claim. The deadline for this notice is no later than:

- For an urgent care claim, 72 hours after the claim is received.
- For a pre-service claim, 15 days after the claim is received (may be extended up to an additional 15 days).
- For a post-service claim, 30 days after the claim is received (may be extended up to an additional 15 days).

For a pre-service or post-service claim, these time periods may be extended for up to 15 days as long as the Claims Administrator determines that such an extension is necessary due to matters beyond the Plan's control and notifies you before the original deadline. This notice will describe why the extension is necessary. If you do not properly submit all the necessary information for your request for benefits, the Claims Administrator must notify you and tell you what information is missing. You have 45 days to provide the information needed to process your request for benefits. While the Claims Administrator is waiting on your additional information, that time period does not count toward the time frame in which the Claims Administrator must decide your claim.

For an urgent care claim, you may be notified of an initial decision orally, if a written or electronic notice is provided no more than three days after the oral notice.

**Failure to Follow Urgent Care or Pre-Service Claims Procedures** - If you fail to follow the procedures for filing an urgent care claim or a pre-service claim, you will be notified of the failure and the proper procedure to be followed. This notice must be provided to you no later than 24 hours after the failure for urgent care claims or five days after the failure for pre-service claims. This notice may be oral unless you (or your representative) request a written notice. This notice is triggered when:

- You (or your authorized representative) make a communication that is received by a person or organization unit customarily responsible for handling benefit matters; and

- The communication names a specific participant or covered dependent, a specific medical condition and a specific treatment, service or product for which approval is requested.

**Notice of Incomplete Urgent Care Claim** - If you (or your authorized representative) submit an urgent care claim that is missing necessary information, you will receive a notice. This notice will tell you the specific information needed to complete the claim. The notice will be given to you no later than 24 hours after receiving the claim. You must be given a reasonable time to provide the information but not less than 48 hours. You will be notified of the decision concerning your urgent care claim as soon as possible but no later than 48 hours after the earlier of:

- When the Plan receives the requested information; or

- The end of the period you were given to provide the information.

**Concurrent Care Claim** - At times, the Claims Administrator may approve a course of treatment that is provided over time or for a specific number of treatments. If the Claims Administrator later terminates or reduces approval for a course of treatment, it will notify you of this decision so you will have sufficient time to appeal that decision before the course of treatment is reduced or terminated.

If you need to extend a course of treatment and the original request for the treatment was an urgent care claim, you should contact the Claims Administrator at least 24 hours before the approved course of treatment will expire. If you do so, the Claims Administrator will provide you with a notice of its decision concerning the requested extension within 24 hours of your request. If you request an extension later, you will receive written notice of the Claims Administrator's decision based on whether that request is an urgent care or pre-service claim.

### *Flexible Spending Account Claims Process*

You may file a claim under the Flexible Spending Account Program for eligibility or reimbursement from your FSA. You should submit claims for reimbursement from your FSA first to the Claims Administrator. Claims for reimbursement of eligible expenses submitted on the

appropriate forms and accompanied by acceptable documentation will be paid promptly by the Claims Administrator on behalf of the Plan Administrator.

You should file any claims regarding eligibility directly to the Plan Administrator. See "General Plan Information" for contact information.

***All Claims Other Than Medical (including Prescription Drug), Dental and Flexible Spending Account Claims***

See the specific Program booklet for information on filing claims for any benefits other than Medical and Dental.

***Appealing a Medical or Dental Claim Denial***

If you disagree with a coverage decision or denial, you (or your authorized representative) may request a full review by the Claims Administrator.

You must submit a request for review within 180 days after you receive the denial notice. In connection with your appeal, you or your representative can review relevant documents and submit issues and comments in writing. If you want to appeal a decision on benefits, send your appeal to the Plan Administrator (for eligibility claims), or the Claims Administrator (for benefit level claims) at the address listed in the "General Plan Information" section. With respect to a claim for benefits under a non-grandfathered Medical Program (such as the BCBS Advantage HSA), you may request to review your claim file and in addition to submitting written documents, you may also present evidence and testimony.

Your appeal will be reviewed. No deference will be given to the initial adverse determination. Someone other than the person or a subordinate of this person who made the first decision on your claim must make this review. The Claims Administrator must disclose the identity of any medical or vocational experts who were consulted in connection with your claim. If the benefit decision is based on a medical judgment, the Claims Administrator must consult with a healthcare professional who has the appropriate training and experience in the field of medicine involved. Any healthcare professional consulted in making a medical judgment shall be an individual who was neither consulted within connection with the adverse determination that is the subject of the appeal or their subordinate. In the case of a claim involving urgent care, an expedited review process will be available pursuant to which (a) a request for an expedited appeal may be submitted orally or in writing, and (b) all necessary information, including the Plan's determination on review, shall be submitted by telephone, facsimile or other available similarly expeditious method.

With respect to a claim for benefits under a non-grandfathered Medical Program (such as the BCBS Advantage HSA), You will be provided with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for denial. You will have a reasonable opportunity to respond to such new evidence or rationale.

After a decision is made concerning your appeal, you will be notified of the Claims Administrator's findings and decision in writing.

Generally, this notice will be provided within a certain period after receiving the appeal, as follows:

| **Claim Type** | **Deadline** |
|---|---|
| Urgent Claim | 72 hours |
| Pre-Service Claim | 30 days |
| Post-Service Claim | 60 days |

**Claims Decisions Notices** - The notice given to you concerning the decision on either your initial claim or your appeal (except as noted) will constitute an adverse benefits determination and will be provided in writing or electronically in a culturally and linguistically appropriate manner calculated to be understood by you, and will include all of the following that pertain to the determination:

- The specific reason or reasons for the decision;
- The specific Plan provisions upon which the benefit decision is based;
- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary;
- If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document, or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request;
- If the decision is based on a medical limit (for example, a decision that the proposed service is not medically necessary or that it is experimental), either an explanation of the scientific or clinical judgment for the decision (applying the Plan's terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request;
- For an initial claim, a description of the appeal procedures; and
- A statement of your right to bring a civil action under ERISA following a denial of the claim upon review.

  With respect to a claim for benefits under a non-grandfathered Medical Program (such as the BCBS Advantage HSA), the availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793 and a statement that you may have other voluntary alternative dispute resolution options such as mediation and that one way to find out what may be available is to contact the local U.S. Department of Labor office and state insurance regulatory agency.

**Relevant Documents** - The relevant documents that must be made available to you include documents, records and other information that:

- Were relied on in deciding your benefit claim;
- Were submitted, considered or generated in the course of deciding your benefit claim;
- Demonstrate that the decision complied with the Plan's administrative procedures or safeguards; or
- For a medical claim, state the Plan's policy or guideline regarding the benefits for your diagnosis, whether or not it was relied upon.

***Appealing a Flexible Spending Account Claim Denial***

In the event that the Claims Administrator or Plan Administrator denies, in whole or in part, a claim for benefits under the Flexible Spending Account Program, the claimant (or his or her duly authorized representative) may appeal the decision to the Plan Administrator within 180 days after receiving written notice of the claim denial. The claimant may:

- Submit a written request to the Plan Administrator asking it to consider the decision on his or her claim;
- Receive reasonable access to and copies of all documents, records and other information relevant to the claimant's claim; and
- Submit issues and comments to the Plan Administrator in writing.

The review of the denial of the claimant's healthcare claim will be performed by someone who is not the original decision maker nor the subordinate of such individual(s). In reviewing such a decision, the decision maker will not give any deference to the initial decision. In reviewing any denial, the Plan Administrator will consider all information relevant to the claim, not just information relied upon (or available) when the original decision was made.

If the benefit determination is based in whole or in part on medical judgment, the Plan Administrator reviewing the healthcare claim will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment at issue; provided, that such healthcare professional will be an individual who is neither an individual who was consulted during the initial claim denial that is the subject of the appeal nor the subordinate of any such individuals. The Plan Administrator will disclose to the claimant the identity of the medical or vocational experts whose advice was obtained by the Plan in connection with the review, even if the advice was not relied upon in making the final decision.

The Plan Administrator will furnish the claimant with a written decision providing the final decision of the claim. The decision will be issued as soon as reasonably possible after the date of the appeal, but not later than 60 days after receipt by the Plan Administrator of the claimant's request for review of a benefit claim determination.

The final decision concerning the claim will be written in a manner calculated to be understood by the claimant and will include:

- The specific reason or reasons for the benefit determination;
- References to specific Plan provisions on which the benefit determination is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim;
- If an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied upon and that a copy will be furnished (free of charge) upon request; and
- A statement that the claimant has the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

***Exhaustion of Administrative Remedies***

Claimants may not seek benefits under the Plan in judicial or administrative proceedings without first complying with and fully exhausting the Claims Procedures and the procedures described in this document.

***Limits on Legal Action***

The Plan Administrator's decision on a claimant's appeal will be final and binding on the claimant and any other party. In the event the claimant wishes to further challenge the decision of the Plan Administrator, the claimant will have 12 months from the date of the Plan Administrator's final decision to bring civil action challenging the decision. After 12 months from the date of the Plan Administrator's final decision, any such further challenge under ERISA will be time barred. Any such civil action must be filed in the United States District Court for the Northern District of Illinois.

## MISCELLANEOUS INFORMATION

***Plan Amendment and Termination***

The Company, in its sole discretion, reserves the right to amend, modify, suspend, withdraw or terminate any Program or the Plan in whole or in part at any time. Any such change or termination in benefits will be solely the decision of the Company. Any amendment or termination of any Program or Plan may be made effective by a written instrument executed by a duly authorized officer of the Company.

### *No Guarantee of Employment*

Under no circumstances does the Company's maintenance of the Plan constitute a contract of employment or alter or affect the terms and conditions of your employment. Nor does this summary constitute a contractual agreement as to the terms and conditions of your employment.

### *No Vested Right to Benefits*

Your participation in the Plan does not guarantee your right to receive or to continue to receive Plan benefits in the future.

### *Protection Against Creditors*

To the extent permitted by law, and except for monies owed to the Company, no Plan benefit payment will be subject in any way to alienation, sale, transfer, assignment, garnishment, execution or encumbrance of any kind, and any attempt to do so will be void.

### *No Assignment of Benefits*

Your right to receive any benefits under the Plan shall not be subject to any claims by any creditor of or claimant against you. Any attempt to reach such amounts by any such creditor or claimant, or any attempt by you to confer on any such creditor or claimant any right or interest with respect to such amounts, shall be null and void, except with respect to QMCSOs. For more information on QMCSOs, see the "Qualified Medical Child Support Orders" section or contact the Plan Administrator.

### *Fraud*

The benefits under this Plan are for you and your eligible dependents only. If you allow anyone other than your eligible dependent to use your benefits, you will be subject to adverse employment consequences up to and including termination of employment. Additionally, the Plan Administrator reserves the right to retroactively terminate your benefits if it decides that you have committed fraud or intentional misrepresentation with respect to the benefits offered under the Plan. If you suspect that someone is using your benefits fraudulently, you should report it immediately to the Plan Administrator.

### *Possibility of Lower Social Security Benefits*

Your pre-tax contributions to the Plan may also have an effect on the amount of Social Security benefits you will receive later in life. If you earn less than the Social Security "taxable wage base" ($168,600 in 2025) after making contributions to the Plan, your pre-tax contributions to the Plan will lower the portion of your wages that is subject to Social Security taxes. As a result, your Social Security taxes will be lower, which may in turn cause your Social Security benefits to be slightly lower when you retire or if you become disabled. The amount of benefit reduction will depend on the amount of your pre-tax contributions and how long you participate in the Plan before you retire. In most instances, the current tax savings under the Plan will outweigh the slight impact on future Social Security benefits. You should consult with your financial advisor if you have specific questions about the effects of your participation in the Plan.

***Restrictions on Benefits Provided to Highly Compensated Employees***

The tax laws place certain limits on the amount of benefits that the Plan can provide to employees who are considered "highly-compensated." In addition, the law may limit the amount of pre-tax contributions that highly compensated employees may make to the Plan. These limits are intended to prohibit the Plan from discriminating in favor of highly paid individuals. In some cases, the Plan Administrator may have to return all or a portion of the pre-tax contributions of participants who are highly compensated. If you are affected by these limits, the Plan Administrator will notify you.

***Qualified Medical Child Support Orders***

A Qualified Medical Child Support Order ("QMCSO") is a judgment or order issued by a court or through a state law administrative process, usually as part of a settlement agreement or divorce decree, which provides for support or healthcare coverage for a child of a covered person. The Plan will honor a QMCSO so long as it meets the following requirements:

- It creates or recognizes the existence of a child's right to receive Plan benefits (if the covered person is eligible) or to assign those rights;
- It clearly specifies the name and last known mailing address of the covered person and each child covered by the court order;
- It specifies a reasonable description of the Plan coverage to be provided for each child, or the manner in which the type of coverage is to be determined;
- It specifically identifies the Plan and the period the order applies to the Plan; and
- It does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan to other employees.

When the Plan Administrator receives a medical child support order, it will notify the employee and each covered child of the receipt of the order, furnish an explanation of the Plan's procedure for determining whether the order is a QMCSO, and determine if the order is qualified and notify the employee and each covered child of its determination.

The Plan Administrator is responsible for deciding if the order satisfies the conditions of a QMCSO. A copy of the Plan's QMCSO procedures is available upon request to the Plan Administrator.

***HIPAA Privacy and Security***

Any information collected by the Plan will be treated as confidential information, and will not be disclosed to anyone without your written consent, except as follows:

- Information will be disclosed to those who require that information to administer the Plan or to process claims.

- Information with respect to duplicate coverages will be disclosed to the Plan or insurer that provides duplicate coverage.

- Information needed to determine if healthcare services or supplies are medically necessary or if the charges for them are usual (or reasonable) and customary will be disclosed to the individual or entity consulted to assist the Plan Administrator or its delegate to make those determinations.

- Information will be disclosed as required by law or regulation or in response to a duly issued subpoena.

As a participant in the Plan, your "protected health information" is subject to safeguards under the privacy and electronic security provisions of the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, the Plan has adopted policies and procedures that restrict the use and disclosure of your protected health information and imposes security measures for protected health information in electronic form. Generally, under HIPAA's privacy rules, use and disclosure are limited to payment and healthcare operation functions, and only the "minimum necessary" information may be used or disclosed. Under HIPAA's final regulations, the privacy provisions went into effect on April 14, 2003, and the security provisions went into effect on April 20, 2005. Under HIPAA's electronic security rules, additional safeguards have been implemented to protect information that is in electronic form.

This is only a brief summary of HIPAA. As a participant, you have received a "privacy notice" that more fully describes the important uses and disclosures of protected health information and your rights under HIPAA. If you have questions or if you would like a free copy of the HIPAA Privacy Notice, you can contact the Plan's HIPAA Privacy Officer at:

Zebra Technologies Corporation
3 Overlook Point
Lincolnshire, IL 60069
(847) 634-6700

***Electronic Delivery***

This SPD and other important Plan information may be delivered to you through electronic means. This SPD contains important information concerning your rights and benefits under the Plan. If you receive this SPD (or any other Plan information) through electronic means, you are entitled to request a paper copy of this document, free of charge, from the Human Resources Department. The electronic version of this document contains substantially the same style, format and content as the paper version.

### *Right of Recovery*

The Plan has the right to recover any benefits paid to you in error. You must reimburse the Plan in full. The Plan will determine the method by which the repayment is to be made. This right is in addition to any other rights and remedies that the Plan may have.

## STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under ERISA.

### *Receive Information About Your Plan and Benefits*

You have the right to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. You have the right to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies. You have the right to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

### *Continue Group Health Plan Coverage*

You have the right to continue healthcare coverage for yourself, spouse or dependent children if there is a loss of coverage as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

### *Prudent Actions by Fiduciaries*

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you, other Plan participants and beneficiaries. No one, including the Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a retirement benefit or exercising your rights under ERISA.

### *Enforce Your Rights*

If your claim for a benefit under the Plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. The Plan' agent for legal service of process in the event of a lawsuit is the Plan

Administrator. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court after you have exhausted the Plan's claims procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

***Assistance With Your Questions***

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

## GENERAL PLAN INFORMATION

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| **Plan Name:** | Zebra Technologies Corporation Beneflex Plan<br><br>(The Medical [including Prescription Drug], Dental, Vision, Flexible Spending Account, Health Savings Account, Group Term Life Insurance, Accidental Death and Dismemberment, Long-Term Disability, Voluntary Life Insurance, Voluntary Accidental Death and Dismemberment, Voluntary Benefits and Commuter Benefits Programs are component programs of this Plan.) |
| **Plan Number:** | 501 |
| **Plan Sponsor:** | Zebra Technologies Corporation.<br>Attn: Human Resources Department<br>3 Overlook Point<br>Lincolnshire, IL 60069<br>(847) 634-6700 |
| **Employer Identification Number:** | 36-2675536 |
| **Plan Administrator:** | Benefits and Investment Committee<br>Zebra Technologies Corporation<br>Attn: People Team Department<br>3 Overlook Point<br>Lincolnshire, IL 60069<br>(847) 634-6700 |

**Medical Program Claims Administrator**

**Blue Cross/Blue Shield**

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601
(800) 634-8644
www.bcbsil.com

Claims Submittal Address:
Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, Illinois 60680-4112
(800) 634-8644

Claims Appeal Address:
Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690

Utilization Review Procedure Appeal Address:
Medical Director
Health Care Services Corporation
P.O. Box A3957
Chicago, IL 60601

**Kaiser**

Kaiser Permanente
Attn: Member Services
2130 E. Gonzales Road
Oxnard, CA 93036
(800) 464-4000
www.kaiserpermanente.org

Claims Submittal Address (Southern California):
Claims Administration Department
P.O. Box 7004
Downey, CA 90242-7004

Claims Submittal Address (Northern California):
Claims Administration Department
P.O. Box 12923
Oakland, CA 94604-2923

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| **Dental Program Claims Administrator** | Delta Dental<br>111 Shuman Boulevard<br>Naperville, IL 60563<br>(800) 323-1743<br>www.deltadentalil.com |
| **Prescription Drug Program Claims Administrator** | |
| **Express Scripts, Inc. (formerly Medco Health Solutions)** | Express Scripts, Inc.<br>P.O. Box 2872<br>Clinton, IA 52733-2872<br>(800) 711-0917<br>www.express-scripts.com |
| **Vision Program Claims Administrator:** | EyeMed Vision<br>4000 Luxottica Place<br>Mason, OH 45040<br>(866) 939-3633<br>www.eyemedvisioncare.com/member |
| **Employee Assistance Program** | Telus Health<br>(877) 695-6327<br>one.telushealth.com |
| **Flexible Spending Account Program Claims Administrator** | Optum Financial<br>307 International Circle, Suite 200<br>Hunt Valley, MD 21030<br>(877) 292-4040<br>secure.optumfinancial.com |
| **Health Savings Account Program Claims Administrator** | HSA Bank<br>P.O. Box 939<br>Sheboygan, WI 53082-0939<br>(800) 357-6246<br>www.hsabank.com |

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| **COBRA Administrator:** | Optum Financial<br>307 International Circle, Suite 200<br>Hunt Valley, MD 21030<br>(855) 687-2021<br>www.cobra.optumfinancial.com<br><br>COBRA Claims Appeal Fax Number:<br>(443) 681-4606 |
| **Life, AD&D, and Long Term Disability Claims Administrator:** | Lincoln Life Assurance Company of Boston<br>100 Liberty Way<br>Dover, MA 03821<br>(603) 749-2600 |
| **Critical Illness and Accident Insurance Claims Administrator** | The Lincoln National Life Insurance Company<br>PO Box 2609<br>Omaha, NE, 68103-2609<br>(800) 423-2765<br>lincolnfinancial.com |
| **Hospital Care Insurance Claims Administrator** | Cigna Life Insurance Company of New York<br>PO Box 55290<br>Phoenix, AZ, 85078<br>(800) 754-3207<br>SuppHealthClaims.com |
| **Advocates** | Alight Advocacy Services<br>(800) 715-4015 |
| **Plan Year:** | January 1 to December 31 |
| **Agent for Service of Legal Process:** | Service of legal process may be made upon the Plan Administrator. |
| **Type of Plan and Administration:** | The Plan is a welfare plan providing healthcare, dental care, vision care, life insurance, accidental death and dismemberment insurance, long term disability insurance, health savings account and flexible spending account benefits. |
| **Funding:** | The Medical Program option administered by Blue Cross and Blue Shield of Illinois is self-funded. The Medical Program options administered by Kaiser are insured by Kaiser. The Dental Program administered by Delta Dental is self-funded. The Vision Program is insured by EyeMed. The Flexible Spending Account is funded exclusively through payroll |

deductions from participants. The Group Term Life Insurance, Accidental Death and Dismemberment, Long-Term Disability, Critical Illness, Accident Insurance, Voluntary Life Insurance and Voluntary Accidental Death and Dismemberment Programs are insured by Lincoln Life Assurance Company of Boston. The Hospital Care Insurance is insured by Cigna.