Aeries®

2025 GUIDE TO YOUR BENEFITS

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see pages 29-30 for more details.

Welcome to Your Benefits!

We are pleased to provide you with a wide variety of competitive benefits that are a vital part of your total compensation. You have the flexibility to select from a full range of benefits to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement. This guide was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this guide to make sure you understand the benefits that are available to you and your family, and be sure to act before the enrollment deadline.

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

Changes For 2025

- **Medical**: We will be switching from using Blue Cross Blue Shield and Kaiser as our medical provider to Cigna. You will have three different plan options to choose from.
- **Health Savings Account (HSA)**: Your HSA will be offered through Optum.
- **HSA Seed:** Aeries contributes from $600-$1,200 per depending on your election (EE, ES, EC, EF).
- **Long-Term Disability**: This is a new employer-paid benefit offered through Unum.
- **Basic Life and Accidental Death & Dismemberment:** $50,000 of protection for your family
- **Open Enrollment Dates**: Open Enrollment is changing to December in 2025, for a January 1, 2026, effective date.

Eligibility

If you work at least 30 hours per week, you are eligible for benefits. Most of your benefits are effective on the first day of the month following your date of hire. You may also enroll your eligible dependents for coverage.

Eligible dependents could be:

Annual Open Enrollment is currently in November for a December 1 effective. Starting next year in 2025, Open Enrollment will be in December for a January 1 effective date.

Changing Benefits After Enrollment

During the year, you cannot make changes to your benefits unless you have a Qualified Life Event. If you do not make changes to your benefits within 30 days of the Qualified Life Event, you will have to wait until the next annual Open-Enrollment period to make changes (unless you experience another Qualified Life Event).

Qualified Life Event		Documentation Needed
Change in marital status	Marriage	Copy of marriage certificate
	Divorce/Legal Separation	Copy of divorce decree
	Death	Copy of death certificate
Change in number of dependents	Birth or adoption	Copy of birth certificate or copy of legal adoption papers
	Step-child	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
	Death	Copy of death certificate
Change in employment	Change in your eligibility status (i.e., full time to part time)	Notification of increase or reduction of hours that changes coverage status
	Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

Definitions

Definitions Of Common Benefit & Open Enrollment Terms

The following are important terms that will be used throughout this document, as well as their definitions:

- Coinsurance – The amount you pay for certain covered healthcare services under your health plan. It is calculated as a percentage, and you pay it in addition to whatever deductible you may owe.
- Copayment – Amount the insured person pays every time he or she receives a health service. For example: If your copay to see your regular doctor is $20, you pay that amount each time you see your regular doctor.
- Deductible – The amount you owe before your health insurance benefits kick in.
- Flexible Spending Account (FSA) – An account funded by you with before-tax dollars to help pay for qualified medical and/or dependent care expenses. There is a limit to how much you can contribute, and money does not stay in the account from year to year. You determine how much you want to contribute to the FSA during open enrollment or a qualifying event. A Limited Purpose FSA can help pay for dental and vision expenses if you participate in a health savings account (HSA).
- Health Savings Account (HSA) – An HSA allows you to make tax-free payroll contributions to an account that you may then use to pay for certain out-of-pocket medical expenses. To be eligible to open an HSA, you must participate in a qualified High Deductible Health Plan (HDHP). Your employer may also make contributions to your HSA. Unused money stays in the account year to year and can be invested for long-term use. There is a limit on how much you can contribute each year, but there is no limit on how much you can accumulate year to year. If your employer contributes to your HSA, you will need to subtract the employer contribution from the annual maximum to determine what you may contribute for the annual maximum.
- High Deductible Health Plan (HDHP) – A health plan that contains a deductible which must be met before the health plan provides coverage. This typically means that 100 percent of the charges you and your family members incur for health and prescription services are subject to the deductible. This plan has no co-pays for office visits, prescriptions, etc.
- Out-of-pocket maximum – The maximum amount you will pay for covered services during a plan year.
- Preferred Provider Organization (PPO) – A health plan that includes a network of doctors, hospitals, and other healthcare providers that participate in a managed care plan. Members receive greater benefits by staying within the network but also have the option of receiving medical care outside of the network.
- Primary Care Physician (PCP) – The doctor you select to coordinate your care. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.
- Premium – A fee that is paid to provide insurance. Premiums can be paid by you, Aeries, and/or a combination of both.

Medical

The medical plans offered through Cigna give you access to Preferred Provider Organization (PPO) networks. Please note, the Low and Mid Plans do NOT offer out-of-network coverage. By contrast, the High plan offers both in- and out-of-network coverage. Be aware, you will pay more out-of-pocket when you access out-of-network care.

	Cigna HDHP OAPin Low	Cigna OAPin Mid	Cigna OAP High	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
	You Pay			
Calendar Year Deductible				
Individual	$2,500	$1,000	$250	$5,000
Family	$5,000	$2,000	$500	$10,000
Calendar Year Out-of-Pocket Maximum (Includes Deductible)				
Individual	$8,000	$6,000	$4,000	$10,000
Family	$16,000	$12,000	$8,000	$20,000
Coinsurance / Copays				
Preventive Care	$0	$0	$0	Not covered
Primary Care	$30 copay*	$20 copay	$10 copay	50% coinsurance*
Specialist Visit	$60 copay*	$40 copay	$20 copay	50% coinsurance*
Emergency Room	$300 copay & coins.	$250 copay (waived if admitted)	$200 copay (waived if admitted)	
Retail Prescription Drugs				
Tier 1 (Generic)	$10 copay*	$10 copay	$10 copay	Not covered
Tier 2 (Brand Preferred)	$30 copay*	$30 copay	$30 copay	Not covered
Tier 3 (Brand Non-Preferred)	$50 copay*	$50 copay	$50 copay	Not covered
Tier 4 (Specialty)	20% up to $250*	30% up to $250*	30% up to $250*	Not covered

* After deductible

Cigna Pre-Enrollment Counselors

Choose a Plan With Confidence Cigna One Guide Service Can Help.

Whether you're a current Cigna customer or considering Cigna for the first time, we understand how confusing and overwhelming it can be to review your health plan options. And we want to help by providing the resources you need to make a decision with confidence. That's why Cigna One Guide® is available to you now.

Call a Cigna One Guide representative during pre-enrollment to get personalized, useful guidance.

Your personal guide will help you:

- Easily understand the basics of health coverage
- Identify the types of health plans available to you that best meet the needs of you and your family
- Check if your doctors are in-network to help you avoid unnecessary costs
- Get answers on any other questions you may have about the plans or provider networks available to you

The best part is, during the enrollment period, your personal guide is just a call away.*

Don't Wait Until the Last Minute to Enroll.

Call 888-806-5094 to speak with a Cigna One Guide representative today.*

Together, All the Way. ®

* During enrollment, personal guides available Monday through Friday, 8:00 am–9:00 pm EST. Once your coverage begins, call the number on your ID card to speak with a personal guide. Additional customer service representatives are available 24/7.

After Enrollment, the Support Continues For Cigna Customers.

Your Cigna One Guide representative will be there to guide you through the complexities of the health care system, and help you avoid costly missteps. Our goal is a simpler health care journey for you and your family.

Cigna One Guide Service Provides Personalized Assistance to Help You:

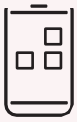
- Resolve health care issues
- Save time and money
- Get the most out of your plan
- Find the right hospitals, dentists and other health care providers in your plan's network
- Get cost estimates and avoid surprise expenses
- Understand your bills

Access Cigna One Guide – After Enrollment – in the Way That's Most Convenient For You:

App

Chat

Phone



Telemedicine

When you need care — anytime, day or night — or when your primary care provider is not available, telemedicine can be a convenient option. With telemedicine, you don't have to drive to the doctor's office or clinic, park, walk into or sit in a waiting room when you're sick — you can see your doctor from the comfort of your own bed or sofa.

Register Today so You Are Ready When You Need Care

Avoid germs in the ER, urgent care clinic, or doctor's office.

See a board-certified, licensed, telehealth-trained doctor on your schedule with on-demand virtual visits 24/7, including nights, weekends and holidays.

Get treated for more than 80 common conditions including colds, flu, allergies and more.

Get a prescription or short-term refill of any existing prescription sent to a pharmacy nearby in less time than your usual doctor visit.

Avoid costly copays and deductibles of the ER and urgent care clinic.

Using Telemedicine Is as Easy as One, Two, Three

STEP 1

Access MDLIVE

Login to myCigna.com, click on "Talk to a doctor." Or call MDLIVE at 888-726-3171.

STEP 2

Select care needed

Select medical care or counseling, cost will be displayed on both myCigna.com and MDLIVE.

STEP 3

Schedule Appointment

Schedule a future appointment or start your visit today.

Health Savings Account

A Health Savings Account (HSA) is a personal savings account you can use to pay for qualified out-of-pocket medical expenses with pretax dollars — now or in the future. Once you're enrolled in the HSA, you'll receive a debit card to help manage your HSA reimbursements. Your HSA can also be used for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP medical plan.

How a Health Savings Account Works

Eligibility

You must be enrolled in the Qualified High-Deductible Health Plan.

Contributions

The company contributes: Employee Only (EE): $600; Employee + Spouse (ES): $900; Employee + Child(ren) (EC): $900; Employee + Family (EF): $1,200. You contribute on a pretax basis and can change how much you contribute from each paycheck up to the 2025 annual IRS maximum of $4,300 if you enroll only yourself or $8,550 if you enroll in family coverage. You can make an additional $1,000 catch-up contribution if you are age 55 or older.

Eligible Expenses

You may use your HSA funds to cover medical, dental, vision, and prescription drug expenses incurred by you and your eligible family members.

Using Your Account

Use the debit card linked to your HSA to cover eligible expenses, or pay for expenses out of your own pocket and save your HSA money for future health care expenses.

Your HSA is always yours — no matter what.

One of the best features of an HSA is that any money left in your account at the end of the year rolls over so you can use it next year or sometime in the future. And if you leave the Company or retire, your HSA goes with you so you can continue to pay for or save for future eligible health care expenses.

SaveOnSP

Specialty medications can cost a lot of money. That's why your plan offers you access to a service called SaveOnSP. With SaveOnSP, you'll pay $0 out-of-pocket for your medication. There's no extra cost to participate – it's available through your pharmacy benefit.

Pay $0 with SaveOnSP

If you're filling a medication through Accredo that's available at $0 with SaveOnSP, you should consider using this service.

- With SaveOnSP, you'll pay $0 out-of-pocket for your medication. The medication's full cost will be paid through a manufacturer copay assistance program.
- Without SaveOnSP, you'll pay the scheduled coinsurance to fill your medication. You can use the Price a Medication tool on the myCigna® App or myCigna.com® to see how much your medication will cost.

How it Works

John's taking an eligible specialty medication. His copay is currently $70. He has a choice to make.

- With SaveOnSP, he won't pay anything ($0) out-of-pocket. However, the cost won't count toward his deductible (if he has one) and/or out-of-pocket maximum.
- Without SaveOnSP, he'll pay his full 30% coinsurance (which is $1,000) out-of-pocket. Also, the cost won't count toward his deductible (if he has one) and/or out-of-pocket maximum.

Dental

Taking care of your oral health is not a luxury; it is a necessity to long-term optimal health. With a focus on prevention, early diagnosis and treatment, Dental insurance can greatly reduce your costs when it comes to restorative and emergency procedures. Preventive services are covered at no cost to you and include routine exams and cleanings. You will pay only a small deductible and coinsurance for basic and major services.

When you visit a dentist in the network, you will maximize your savings. These dentists have agreed to reduced fees, which means you won't get charged more than your expected share of the bill.

	MetLife Dental Plan - In-Network	
	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Plan Maximum		
Per Individual	$5,000 per individual (Basic and Major Services combined)	
	You Pay	
Calendar Year Deductible		
Individual	$25 per individual	$50 per individual
Family	$75 per family	$150 per family
Preventive Care		
Exams, Cleanings, X-rays	$0	$0
Basic Services		
Fillings, Sealants, Extractions, Emergency Exams	20%*	20%*
Major Procedures		
Crowns, Inlays/Onlays, Dentures and Bridgework, Repairs	50%*	50%*

Vision Plan

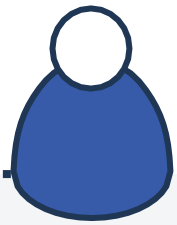
Healthy eyes and clear vision are an important part of your overall health and quality of life. You may enroll yourself and your eligible dependents or you may waive vision coverage. You do not have to be enrolled in medical coverage to elect vision coverage or cover the same dependents under medical and vision. The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

	MetLife Vision Plan – VSP Network
	IN-NETWORK
	You Pay
Exam	$20 up to $39
Single Vision Lenses	$0 after copay
Bifocals Lenses	$0 after copay
Trifocals Lenses	$0 after copay
Frames	Balance over $180 allowance after copay
Contacts in lieu of Frames/Lenses	Balance over $180 allowance after maximum $60 copay
Benefit Frequency	
Exams	Once every 12 months
Lenses	Once every 12 months
Frames	Once every 12 months
Contacts	Once every 12 months

Income Protection

Life and Accidental Death & Dismemberment (AD&D) insurance pays a lump-sum benefit to your beneficiary(ies) to help meet expenses in the event of your death or in the case of a covered accidental injury. Basic Life is provided for you at no cost, and you have the option to purchase coverage for your dependents.

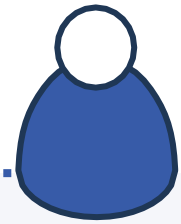
Basic Life and AD&D



For You

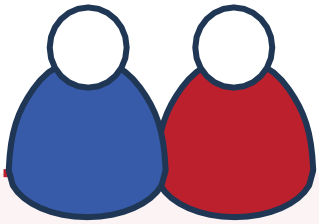
$50,000 employer-paid

Voluntary Life and AD&D



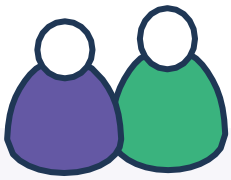
For You

Increments of $10,000
up to $500,000, not to exceed
5 times your salary



For Your Spouse

Increments of $5,000
up to $250,000, not to exceed
100% of employee coverage



For Your Child

Increments of $2,000
up to $10,000 (Maximum
benefit of $250 for children
14 days to 6 months)

Guaranteed Issue and Evidence of Insurability

Employees and spouses who elect Voluntary Life and AD&D coverage when they are first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective.

Disability Insurance

Disability insurance can keep you financially stable should you experience a qualifying disability and become unable to work. It can help provide a sense of security, knowing that if the unexpected should happen, you'll still receive a monthly income. A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience.

Disability Benefits at a Glance

First 7 Days

PTO replaces 100% of your pay.

Next 12 Weeks

Approved STD replaces 60% of your earnings to a $2,000 maximum for 12 weeks.

Benefit begins after 7 days of disability.

After 90 Days

LTD replaces 60% of your earnings to a $10,000 maximum per month.

Benefit begins after 90 days of disability and payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

Planning for Retirement

As a part of your plan, your account dashboard gives you a real-time view of spending, saving, debt and more so you can track, manage and plan all your financial priorities in one place.

1. Know your estimated monthly retirement income
   - See what your retirement might look like and what percentage of your goal you're on track to reach.
   - Adjust the sliders to see how changes affect yoursavings in real time.
   - Put your savings in context.
   - Make changes with just one click.
2. See and understand your net worth

Your net worth is a good measure of where you stand at a point in time. The more accounts you link, the clearer view you'll have of what you own (your assets) and what you owe (your liabilities).

3. Manage progress toward your goals

Your dashboard includes a progress meter and personalized next steps to help you reach your individual goals.

4. Easily and securely link other accounts

Advanced security measures are taken to protect your privacy and information and ensure your accounts can't be viewed by your employer or plan administrators.

5. Access an expanded financial toolbox

Designed to help you better plan and manage your finances, it includes a retirement planner, a savings planner, budgeting tools and more.

View Tips and Best Practices to Protect Yourself

See what you can do to help defend against cybersecurity threats. Visit empowermyretirement.com and click on the Security Tips link at the bottom of the page.

Log in to Your Accounts and Start Linking Accounts

Take advantage of all the tools available to you and link outside accounts to enjoy a 360° view of your finances.

It's easy to create your account if you haven't already.

- Log on and select Register.
- Choose the I do not have a PIN tab.
- Follow the prompts to create your username and password.

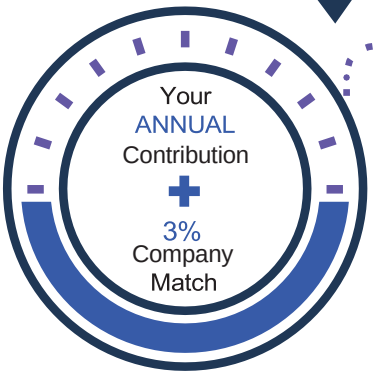
Click Español to view the website and receive your statements in Spanish.

For more help, call 800-338-4015.

Representatives are available weekdays from 6 a.m. to 8 p.m. Mountain time and Saturdays from 7 a.m. to 3:30 p.m. Mountain time.

Increase Your Retirement Savings With a 401(k)

Funded with PRE-TAX dollars



cannot exceed the IRS limit of

$23,000

If you are AGE 50+ you can make an additional contribution of $7,500

Employee Assistance Program

Our Employee Assistance Program is available at no cost to you — whether or not you elect other benefits coverage.

You can contact the EAP for help with the following:

LifeCare EAP Program through ADP
Call toll-free, 24 hours a day
1-866-338-5516 (1-800-873-1322 TTY). Please mention your affiliation with ADP.
Log into http://member.lifecare.com. Screen name: GROUPADPEAP and Password: login

Voluntary Benefits

Accident Insurance

Accident insurance pays out a lump sum if you become injured because of an accident — even if the injuries you incur do not keep you out of work. While health insurance companies pay your provider or facility, Accident insurance pays you directly.

How Does Accident Insurance Work?

Accident insurance policies can provide you with a lump sum paid directly to you that will help pay for a wide range of situations, including initial care, surgery, transportation and lodging, and follow-up care. Here's how it works:

- A set amount is payable based on the injury you suffer and the treatment you receive.
- Benefits are payable directly to you (unless you specify otherwise) and can be used as you see fit.
- Coverage is available for you, your spouse and eligible dependent children.
- You do not need to answer medical questions or have a physical exam to get basic coverage.
- Accident insurance covers injuries that happen on the job or off the job — unlike workers' compensation, which only covers on-the-job injuries.
- Benefit payments are not reduced by any other insurance you may have with other companies.

Examples of Covered Expenses

	Full-Time Employees - Monthly Premiums
Employee Only	$12.55
Employee + Spouse	$22.20
Employee + Child(ren)	$27.79
Employee + Family	$37.44

Critical Illness Insurance

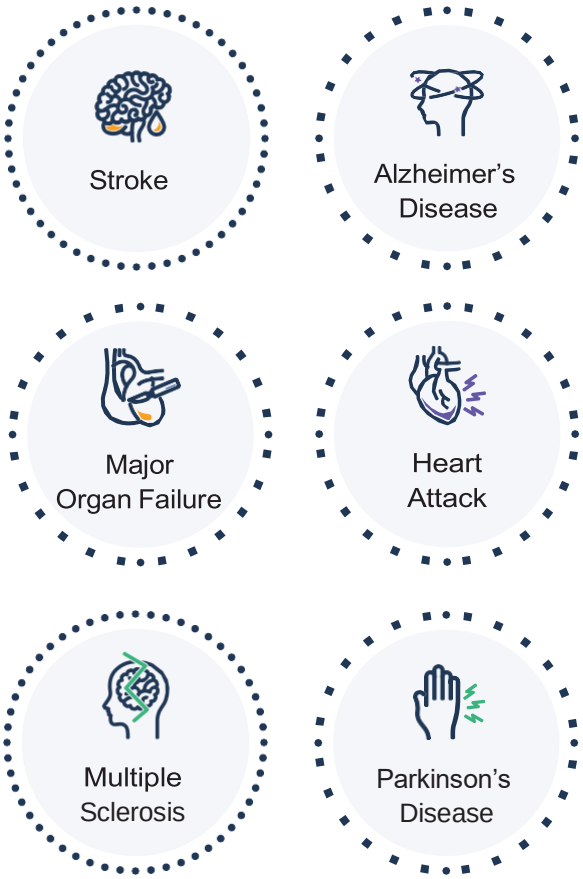
While medical insurance is vital, it doesn't cover everything. If you suffer from a serious illness, such as cancer, stroke or a heart attack, Medical insurance may not provide the coverage you need. Critical Illness insurance will ease the financial strain and help you focus on your recovery.

How Will a Critical Illness Claim Get Paid?

After purchasing Critical Illness insurance, if you suffer from one of the serious illnesses covered by your policy, you'll be paid in a lump sum. The payment will go directly to you instead of to a medical provider. The payment you receive can be used for many things including:

- Child care costs
- Medical and living expenses
- Travel expenses for you and your family
- Lost wages from missed time at work

Examples of Covered Expenses



	Full-time Employees - Monthly Critical Illness Attained Age Rates per $1,000	
Age	Employee & Child(ren) Rate	Spouse Rate
Under 25	$0.42	$0.42
25–29	$0.50	$0.50
30–34	$0.57	$0.57
35–39	$0.66	$0.66
40–44	$0.82	$0.82
45-49	$1.10	$1.10
50-54	$1.41	$1.41
55-59	$1.86	$1.86
60-64	$2.68	$2.68
65-69	$3.60	$3.60
70-74	$5.14	$5.14
75-79	$7.00	$7.00
80-84	$9.14	$9.14
85+	$12.54	$12.54

	Full-time Employees - Monthly Critical Illness Attained Age Costs $10,000 Employee and $10,000 Spouse, $50 Be Well Benefit	
Age	Employee & Child(ren) Rate	Spouse Rate
Under 25	$4.20	$4.20
25–29	$5.00	$5.00
30–34	$5.70	$5.70
35–39	$6.60	$6.60
40–44	$8.20	$8.20
45-49	$11.00	$11.00
50-54	$14.10	$14.10
55-59	$18.60	$18.60
60-64	$26.80	$26.80
65-69	$36.00	$36.00
70-74	$51.40	$51.40
75-79	$70.00	$70.00
80-84	$91.40	$91.40
85+	$125.40	$125.40

	Full-time Employees - Monthly Critical Illness Attained Age Costs $20,000 Employee and $20,000 Spouse, $50 Be Well Benefit	
Age	Employee & Child(ren) Rate	Spouse Rate
Under 25	$8.40	$8.40
25–29	$10.00	$10.00
30–34	$11.40	$11.40
35–39	$13.20	$13.20
40–44	$16.40	$16.40
45-49	$22.00	$22.00
50-54	$28.20	$28.20
55-59	$37.20	$37.20
60-64	$53.60	$53.60
65-69	$72.00	$72.00
70-74	$102.80	$102.80
75-79	$140.00	$140.00
80-84	$182.80	$182.80
85+	$250.80	$250.80

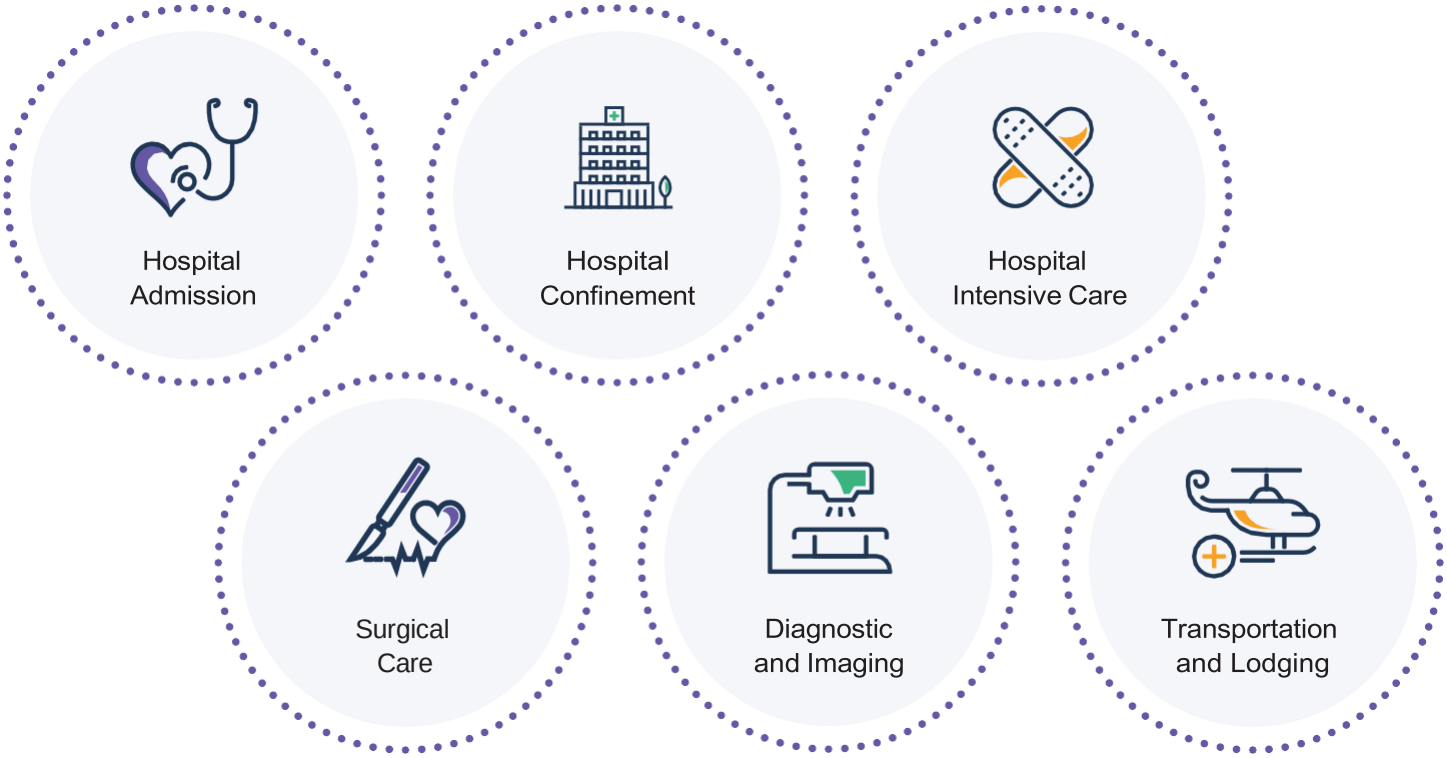
Hospital Indemnity Insurance

Hospital Indemnity insurance is a plan designed to pay for the costs of a hospital admission that may not be covered by other insurance. The plan covers employees who are admitted to a hospital or ICU for a covered sickness or injury. Even if your Medical insurance covers most of your hospitalization, you can still receive payments from your Hospital Indemnity insurance plan to cover extra expenses while you recover.

How Does Hospital Indemnity Insurance Work?

You pay monthly premiums for your Hospital Indemnity insurance plan. If you are admitted to the hospital for an injury or illness, your Hospital Indemnity plan makes cash payments to you. And with the payments going directly to you, you can use these emergency funds to pay for costs not covered by your Medical insurance, Medical insurance deductibles, copays and coinsurance, child care expenses while you are in the hospital or cost-of-living expenses as you recover.

Examples of Covered Expenses



	Full-Time Employees - Monthly Premiums
Employee Only	$17.44
Employee + Spouse	$35.39
Employee + Child(ren)	$24.82
Employee + Family	$42.77

Short-Term Disability

The loss of income due to illness or injury can cause serious financial hardship for your family. Disability insurance replaces a portion of your income to help you continue paying your bills and meeting your financial obligations during this difficult time.

How Does Short-Term Disability Insurance Work?

- You are eligible to receive STD benefits after you have been disabled for seven days due to a non-work-related illness or injury, or pregnancy.
- Replaces up to 60% of your eligible income, up to a maximum of $2,000 per week.
- Benefits end after 12 weeks.

Group Voluntary Short-Term Disability Insurance

Coverage Effective Date: January 1, 2025
Rate Guarantee: 2 Years

	Full-time Employees
Age Band	Rates per $10 of Weekly Benefit
Under 25	$0.041
25–29	$0.103
30–34	$0.231
35–39	$0.157
40–44	$0.072
45-49	$0.055
50-54	$0.071
55-59	$0.086
60-64	$0.118
65+	$0.142

Additional Benefits

Legal Services - Unum

Navigating legal matters can be complex and costly. With Unum's Legal Services, you have access to a network of experienced attorneys to assist with a variety of personal legal issues, such as estate planning, real estate transactions, family law matters, and more. Whether you need legal advice, document preparation, or representation, this service helps ensure you receive the support you need without the high cost of typical attorney fees. Protect your peace of mind by taking advantage of this valuable benefit. Call 800-854-1446 or visit www.unum.com/lifebalance.

Travel Assistance Program - Unum

If you're looking for peace of mind while traveling, consider the travel assistance program. It offers toll-free emergency assistance to you, your spouse and your dependents 24 hours a day, seven days a week when you're traveling 100 miles or more from your primary home for 90 days or less. Services provided by Assist America, Inc. through your Unum group life and disability insurance plans. Call 800-872-1414 within the U.S., +01 609-986-1234 outside the U.S., or email mailto:medservices@assistamerica.com. You may also download the mobile app from the Apple® App Store or Google Play™. Reference No. 01-AA-UN-762490

Tuition Reimbursement - Aeries

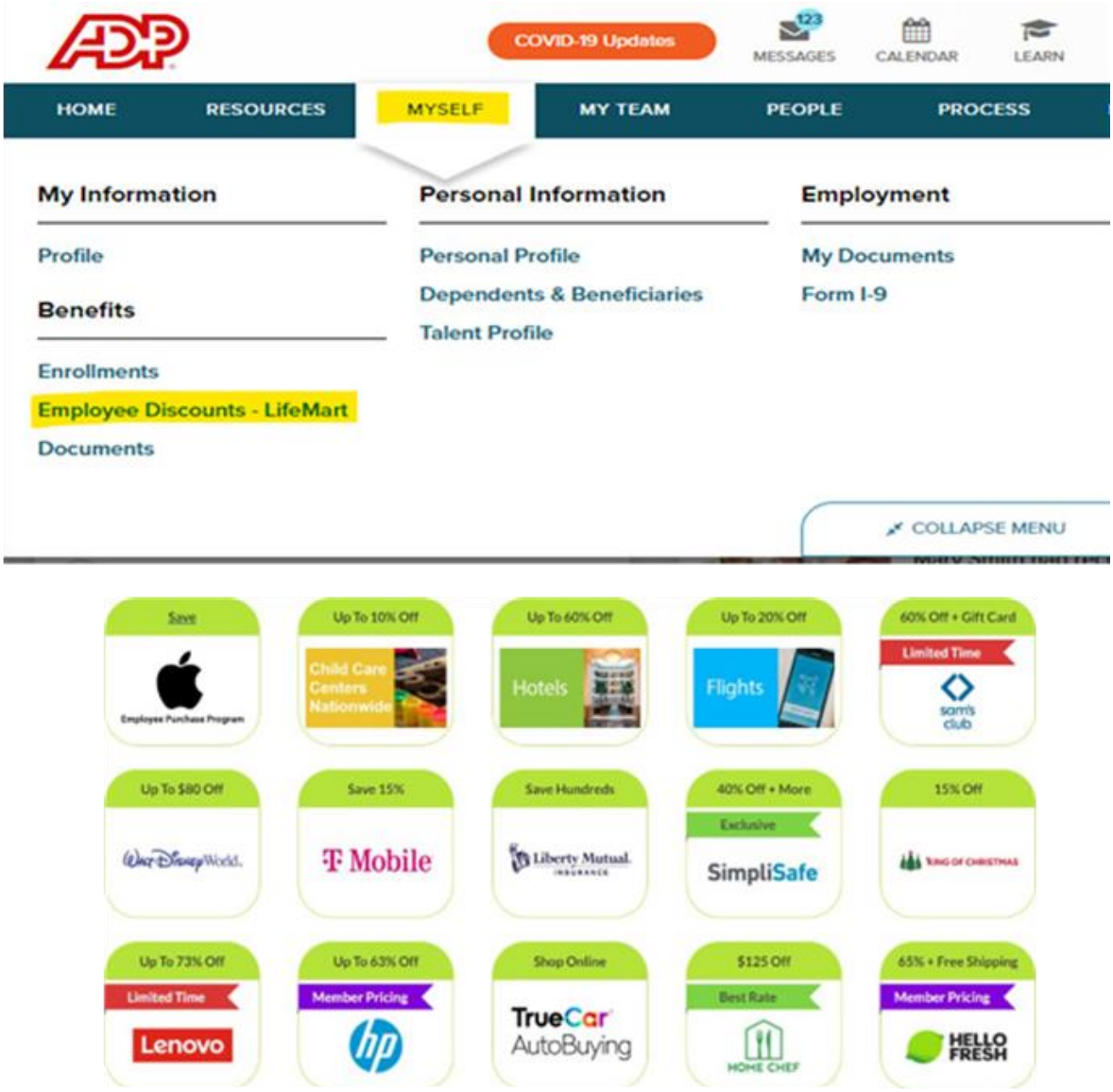
Through the Tuition Reimbursement benefit, full-time employees are eligible to receive reimbursement for a portion of the tuition costs for study or training programs pursued outside of working hours.

Please note that reimbursement is only for educational courses in areas that will improve your present job performance. You must have advance written approval. Contact Human Resources for more information.

LifeMart

Through our partnership with ADP, you have access to thousands of discounts. If you are in the market for something, please check LifeMart first before making a purchase online.

These discounts vary and can change throughout the year. The link can be found on the homepage of ADP. Discounts include, pet insurance, Apple products, electronics, cell phones, food & grocery, home and auto insurance and much more!



Employee Contributions

Medical

Rates are per pay period

	Cigna HDHP OAPin Low	Cigna OAPin Mid	Cigna OAP High
Employee Only	$9.38	$29.06	$47.26
Employee + Spouse	$20.63	$63.93	$103.96
Employee + Child(ren)	$18.75	$58.11	$94.51
Employee + Family	$28.13	$87.17	$141.77

Dental

Rates are per pay period

	DPPO Plan
Employee Only	$0.00
Employee + Spouse	$6.44
Employee + Child(ren)	$6.44
Employee + Family	$10.25

Vision

Rates are per pay period

	Vision Plan
Employee Only	$0.00
Employee + Spouse	$0.99
Employee + Child(ren)	$0.99
Employee + Family	$1.58

Voluntary Life

Age	Monthly Rates per $1,000	Age	Monthly Rates per $1,000
Child Rate	$0.200*	50–54	$0.350
15-24	$0.060	55–59	$0.560
25–29	$0.070	60–64	$0.780
30–34	$0.090	65–69	$1.290
35–39	$0.100	70–74	$2.510
40–44	$0.140	75+	$4.850
45–49	$0.220		

*Note: The premium paid for child coverage is based on the cost of coverage for one child, regardless of how many children you have. Children are eligible up to age 26.

Important Contacts

Coverage	Contact	Phone	Website
Medical	Cigna	866-494-2111	www.mycigna.com
Dental	MetLife	800-438-6388	www.metlife.com/insurance/dental-insurance
Vision	MetLife	800-438-6388	www.metlife.com/insurance/vision-insurance
Basic Life, AD&D, LTD	Unum	800-445-0402 (Life) 866-779-1054 (DI)	www.unum.com
Voluntary Benefits (STD, Accident, Critical Illness, Hospital Indemnity)	Unum	800-635-5597	www.unum.com
HSA	Optum	866-234-8913	www.optumbank.com
401(k)	Empower	800-338-4015	www.empowermyretirement.com
HR Contact	Nica Tahsequah	714-575-3685	N/A

Required Notices

HEALTH COVERAGE NOTICES

FOR YOUR FILES

This guide contains legal notices for participants in group health plan(s) sponsored by Aeries Software Inc. The notices included in this guide are:

- Health Insurance Marketplace Coverage Options and Your Health Coverage that describes the Health Insurance Marketplace and eligibility and tax credit information.
- Notice of Privacy Practices that explains how the health care plan(s) protect your personal medical information.
- Medicare Part D Notice that provides information about how your current prescription drug coverage under the health care plan(s) is affected—and your options for coverage—when you become eligible for Medicare.
- COBRA Rights Notice that explains when you and your family may be able to temporarily continue coverage under the health care plan(s) if coverage would otherwise end for you.
- Newborn & Mothers Health Protection Notice that describes federal laws that govern benefits for hospital stays for mothers following the birth of child.
- Women's Health and Cancer Rights Act that summarizes the benefits available under your medical plan if you have had or are going to have a mastectomy.
- Notice of Special Enrollment Rights that explains when you can enroll in the health care plan(s) due to special circumstances.
- 60-Day Special Enrollment Period that describes a special 60-day timeframe to elect or discontinue coverage.

IMPORTANT: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Prescription Drug program gives you more choices about your prescription drug coverage. Please see pages 30 and 31 for more details.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

Since key parts of the health care law took effect in 2014, there is another way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace's annual Open Enrollment period or if you experience a qualifying life event.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 8.39 in 2024 and 9.02% in 2025 of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Nica Tahsequah at (888) 487-7555.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Aeries Software Inc.	4. 33-0427993	
5. 770 The City Drive South, Suite 6500	6. (888) 487-7555	
7. Orange	8. CA	9. 92868
10. Nica Tahsequah		
11. (888) 487-7555	12. hr@aeries.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to some employees.

  Eligible employees are:

  - Regular full-time
  - Hourly and salaried
  - Working 30 or more hours per week

- With respect to dependents, coverage is offered to

  Eligible dependents are:

  - Your lawful spouse or domestic partner
  - Your dependent children, under age 26
  - Your unmarried children, age 26 and older, who are mentally or physically disabled and unable to support themselves

; If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, www.healthcare.gov will guide you through the process.

AERIES SOFTWARE INC. BENEFIT PLAN NOTICE OF PRIVACY PRACTICES

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

OUR COMPANY'S PLEDGE TO YOU

This notice is intended to inform you of the privacy practices followed by the Aeries Software Inc. Benefit Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on 12/1/2024.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Aeries requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or Required by Law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of Aeries for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Nica Tahsequah
Aeries Software Inc.
770 The City Drive South, Suite 6500
Orange, CA 92868
(888) 487-7555 & hr@aeries.com

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

IMPORTANT NOTICE FROM AERIES SOFTWARE INC. ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Aeries coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Aeries coverage, be aware that you and your dependents may not be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with Aeries and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Aeries changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare Prescription drug coverage:

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

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

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

Name of Entity/Sender: Aeries Software Inc.
Contact/Office: Nica Tahsequah
Address: 77O The City Drive South, Suite 6500,
Orange, CA 92868
Phone Number: (888) 487-7555

Since you are losing creditable prescription drug coverage under the Aeries Software Inc. Benefit Plan, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

COBRA RIGHTS NOTICE

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: PrimePay.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before

the 60th day of COBRA continuation coverage and must
last at least until the end of the 18-month period of COBRA continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

Date: 12/1/2024
Name of Entity/Sender: Aeries Software Inc. Contact/Office: Nica Tahsequah
Address: 770 The City Drive South, Suite 6500, Orange, CA 92868
Phone Number: (888) 487-7555

OTHER NOTICES

60-DAY SPECIAL ENROLLMENT PERIOD

In addition to the qualifying events listed in the enrollment guide, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in medical coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in Aeries Software Inc. medical coverage if you or your dependents lose eligibility for that
other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no more than 30 days after your or your dependent's other coverage ends (or after the employer stops contributing to the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll yourself and your dependents in Aeries medical coverage as long as you request enrollment by contacting the benefits manager no more than 30 days after the marriage, birth, adoption or placement for adoption. For more information, contact Aeries, Nica Tahsequah at (888) 487-7555.

NEWBORN & MOTHERS HEALTH PROTECTION NOTICE

For maternity hospital stays, in accordance with federal law, the Plan does not 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 delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact Cigna Healthcare or your medical plan administrator.

CHIP NOTICE

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from

E.J. Brooks, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since July 31, 2024 or for more information on special enrollment rights, contact either:

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

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

State	Website/E-mail	Phone
Alabama (Medicaid)	http://www.myalhipp.com/	1-855-692-5447
Alaska (Medicaid)	Premium Payment Program: http://myakhipp.com/ Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx E-mail: CustomerService@MyAKHIPP.com	1-866-251-4861
Arkansas (Medicaid)	http://myarhipp.com/	1-855-692-7447
California (Medicaid)	http://dhcs.ca.gov/hipp hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado (Medicaid and CHIP)	Medicaid: https://www.healthfirstcolorado.com/ CHIP: https://hcpf.colorado.gov/child-health-plan-plus HIBI: https://www.mycohibi.com/	1-800-221-3943 1-800-359-1991 1-855-692-6442 State Relay 711
Florida (Medicaid)	**https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**	1-877-357-3268
Georgia (Medicaid)	HIPP: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hip** CHIPRA: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**	678-564-1162, press 1 678-564-1162, press 2
Indiana (Medicaid)	Healthy Indiana Plan for low-income adults 19-64: http://www.in.gov/fssa/hip/ All other Medicaid: https://www.in.gov/medicaid	1-877-438-4479 1-800-457-4584
Iowa (Medicaid and CHIP)	Medicaid: https://dhs.iowa.gov/ime/members CHIP: http://dhs.iowa.gov/Hawki CHIP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	1-800-338-8366 1-800-257-8563 1-888-346-9562
Kansas (Medicaid)	https://www.kancare.ks.gov/	1-800-967-4660
Kentucky (Medicaid and CHIP)	Medicaid: https://chfs.ky.gov/agencies/dms KI-HIPP: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.apsx KI-HIPP E-mail: KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx	1-855-459-6328 1-877-524-4718
Louisiana (Medicaid)	www.medicaid.la.gov www.ldh.la.gov/lahipp	1-888-342-6207 1-855-618-5488
Maine (Medicaid)	https://www.maine.gov/dhhs/ofi/applications-forms https://www.mymaineconnection.gov/benefits/s/?language=en_US	Enroll: 1-800-442-6003 Private HIP: 1-800-977-6740 TTY: Maine relay 711
Massachusetts (Medicaid and CHIP)	https://www.mass.gov/masshealth/pa Email: masspremassistance@accenture.com	1-800-862-4840 TTY: 711
Minnesota (Medicaid)	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp	1-800-657-3739
Missouri (Medicaid)	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana (Medicaid)	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HHSHIPPProgram@mt.gov	1-800-694-3084
Nebraska (Medicaid)	http://www.ACCESSNebraska.ne.gov	1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada (Medicaid)	http://dhcfp.nv.gov/	1-800-992-0900

State	Website/E-mail	Phone
New Hampshire (Medicaid)	**https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**	603-271-5218 or 1-800-852-3345, ext. 5218
New Jersey (Medicaid and CHIP)	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP: http://www.njfamilycare.org/index.html	Medicaid: 609-631-2392 CHIP: 1-800-701-0710
New York (Medicaid)	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina (Medicaid)	https://medicaid.ncdhhs.gov/	919-855-4100
North Dakota (Medicaid)	https://www.hhs.nd.gov/healthcare	1-844-854-4825
Oklahoma (Medicaid and CHIP)	http://www.insureoklahoma.org	1-888-365-3742
Oregon (Medicaid)	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html	1-800-699-9075
Pennsylvania (Medicaid and CHIP)	Medicaid: **https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx** CHIP: https://www.dhs.pa.gov/chip/pages/chip.aspx	Medicaid: 1-800-692-7462 CHIP: 1-800-986-KIDS (5437)
Rhode Island (Medicaid and CHIP)	http://www.eohhs.ri.gov/	1-855-697-4347 or 401-462-0311 (Direct Rite)
South Carolina (Medicaid)	https://www.scdhhs.gov	1-888-549-0820
South Dakota (Medicaid)	http://dss.sd.gov	1-888-828-0059
Texas (Medicaid)	**https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program**	1-800-440-0493
Utah (Medicaid and CHIP)	Medicaid: https://medicaid.utah.gov/ CHIP: http://health.utah.gov/chip	1-877-543-7669
Vermont (Medicaid)	https://dvha.vermont.gov/members/medicaid/hipp-program	1-800-250-8427
Virginia (Medicaid and CHIP)	**https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs**	1-800-432-5924
Washington (Medicaid)	https://www.hca.wa.gov/	1-800-562-3022
West Virginia (Medicaid)	https://dhhr.wv.gov/bms/ http://mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 1-855-699-8447
Wisconsin (Medicaid and CHIP)	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
Wyoming (Medicaid)	**https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/**	1-800-251-1269

Aeries®