2026

Benefits Guide

Aeries®

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.

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.

Thank you for all that you do.

Welcome to Your 2026 Benefits Guide

Use this Benefits Guide to see what's new and to learn about your benefit plan options.

What's Inside

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 29 and 30 for more details.

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:

Changing Benefits After Enrollment

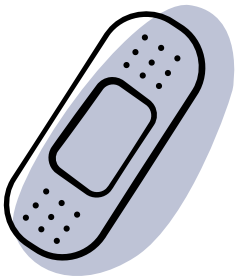
During the year, you cannot make changes to your benefits unless you have a Qualified Life Event. If you do not make changes to your benefits within 30 days of the Qualified Life Event, you will have to wait until the next annual Open Enrollment period to make changes (unless you experience another Qualified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

TERMS TO KNOW

Benefits can be confusing! Here's a quick reference to help you navigate commonly used terms:

- **Copay:** A flat dollar amount you pay the provider when you receive a service.
- **Deductible:** The amount you pay for services before the plan begins paying some of the cost. The deductible may not apply to all services, including preventive care.
- **Coinsurance:** The portion of covered expenses you and the plan share after you meet the deductible (listed as a percentage).
- **Out-Of-Pocket Maximum (OOP Max):** The maximum amount you pay out of your pocket for covered expenses in a year. Once you reach the out-of-pocket maximum, the medical plan pays for all covered services for the rest of the year.
- **Embedded Deductible or OOP Max:** A single family member does not need to meet the family deductible or OOP max before the benefit begins to pay for healthcare services.
- **Non-Embedded Deductible or OOP Max:** The total family deductible or OOP max must be met before health insurance starts paying for the healthcare services for any single family member.



Medical Benefits

When it comes to your health, it's important to care for your body and mind. The company offers a variety of benefits to help you focus on your whole well-being.

Aeries is rolling out a Medical Expense Reimbursement Plan (MERP) paired with your Cigna Healthcare plans.. A MERP is an employer-funded benefit that helps reduce your out-of-pocket healthcare costs. It works alongside your primary health insurance (Cigna) to reimburse certain eligible medical expenses—such as deductibles, copays, and coinsurance—up to a set limit.

HOW A MERP WORKS

- A Difference Card will be issued to both you and your spouse.
- You visit a provider and use your Cigna health plan as usual.
- You can swipe your Difference Card for any eligible charges specified in the plan summary.
- Pay your portion of the bill (deductible, copay, or coinsurance).
- Or you can submit eligible medical plan expenses for reimbursement, if necessary (e.g., your Difference Card wasn't available at point of service)
- Get reimbursed for eligible expenses—usually via direct deposit or check.

Key Features

- Employer-Funded: No cost to you for participating.
- Easy Claims Process: Submit receipts online or through the app.
- Tax-Free Benefit: Reimbursements are not considered taxable income.
- Works with Cigna: Designed to complement your existing coverage.

SAMPLE REIMBURSEMENT SCENARIO (High - DC OAP $3,000)

- Your MERP has a $5,500 first-dollar in-network benefit.
- You have a medical procedure costing $6,500.
- Difference Card Pays $5,500.
- You pay $1,000.
- You will pay the next $2,000 in eligible plan expenses for the year.
- After the MERP and you satisfy Cigna's $8,500 annual out-of-pocket maximum, your eligible in-network expenses will be covered at 100% for the remainder of the plan year.

THE PROVIDER LOOKUP MANAGER TOOL

PLUM, powered by The Difference Card, is a search tool that gives members visibility into the cost and quality of their healthcare.

PLUM is the ultimate Provider Lookup Manager for our members, leveraging a robust, unbiased database that matches quality and cost data to deliver the best options based on location and services provided.

Exclusive to The Difference Card, members can easily access the user-friendly database tool in the mobile app or in their member portal online.

Within PLUM, members can view top-tier providers, known as Plum Providers, who rank in the top 25% for both cost and quality.

PREVENTIVE CARE: YOUR KEY TO WELLNESS

Identifying potential problems before they become major issues is key to your physical health.

Both medical plans include free in-network preventive care that includes annual physicals, mammograms, well child visits, immunizations, and more. So, stay on top of your wellness and schedule your in-network preventive visit today.

Medical Plans at a Glance

Cigna OAPIN $3,500 HSA Low Plan

TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	CIGNA BENEFIT
PHYSICIAN SERVICES			
Primary Care Office Visit Copay	Deductible	Remaining Deductible	Deductible
Specialist Office Visit Copay	Deductible	Remaining Deductible	Deductible
Preventive Care / Screening / Immunization	No Charge		
Urgent Care	Deductible	Remaining Deductible	Deductible
PHARMACY			
Prescription Deductible Application	Integrated with Medical Deductible		
Prescription Individual Deductible	Deductible	Remaining Deductible	Integrates w/ Medical Deductible
Prescription Family Deductible			
Retail Prescriptions			
Mail Order Prescriptions			
DIAGNOSTIC PROCEDURES			
Diagnostic Test- Lab Bloodwork	Deductible	Remaining Deductible	Deductible
Diagnostic Test X-Ray	Deductible	Remaining Deductible	Deductible
Complex Imaging (CT/Pet Scans, MRIs)	Deductible	Remaining Deductible	Deductible
HOSPITAL SERVICES			
Emergency Room Care	Deductible	Remaining Deductible	Deductible
Outpatient Surgery	Deductible	Remaining Deductible	Deductible
Inpatient Hospital	Deductible	Remaining Deductible	Deductible
IN NETWORK DEDUCTIBLE & COINSURANCE			
Qualified High Deductible Health Plan	Yes		Yes
Deductible Accumulation Period	Calendar year		
Family Deductible Accumulation Type	Individual Accumulation		Individual Accumulation
In-Network Individual Deductible	First $3,500	Last $5,000	$8,500
In-Network Family Deductible	First $7,000	Last $10,000	$17,000

Cigna OAPIN $4,500 Mid Plan

TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	CIGNA BENEFIT
PHYSICIAN SERVICES			
Primary Care Office Visit Copay	Remaining Costs	First $4,000/$8,000	Deductible
Specialist Office Visit Copay	Remaining Costs	First $4,000/$8,000	Deductible
Preventive Care / Screening / Immunization	No Charge		
Urgent Care	Remaining Costs	First $4,000/$8,000	Deductible
PHARMACY			
Prescription Deductible Application	Integrated with Medical Deductible		
Prescription Individual Deductible	Remaining Costs	First $4,000/$8,000	Integrates w/Medical Deductible
Prescription Family Deductible			
Retail Prescriptions			AD: $10/$30/$50/20%
Mail Order Prescriptions			$25/$75/$125/20%
DIAGNOSTIC PROCEDURES			
Diagnostic Test- Lab Bloodwork	Remaining Costs	First $4,000/$8,000	Deductible
Diagnostic Test X-Ray	Remaining Costs	First $4,000/$8,000	Deductible
Complex Imaging (CT/Pet Scans, MRIs)	Remaining Costs	First $4,000/$8,000	Deductible
HOSPITAL SERVICES			
Emergency Room Care	Remaining Costs	First $4,000/$8,000	Deductible
Outpatient Surgery	Remaining Costs	First $4,000/$8,000	Deductible
Inpatient Hospital	Remaining Costs	First $4,000/$8,000	Deductible
IN NETWORK DEDUCTIBLE & COINSURANCE			
Qualified High Deductible Health Plan	No		Yes
Deductible Accumulation Period	Calendar year		
Family Deductible Accumulation Type	Family Total Accumulation		Individual Accumulation
In-Network Individual Deductible	Last $4,500	First $4,000	$8,500
In-Network Family Deductible	Last $9,000	First $8,000	$17,000

Cigna OAP $3,000 High Plan

TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	CIGNA BENEFIT
PHYSICIAN SERVICES			
Primary Care Office Visit Copay	Remaining Costs	First $5,500/$11,000	Deductible
Specialist Office Visit Copay	Remaining Costs	First $5,500/$11,000	Deductible
Preventive Care / Screening / Immunization	No Charge		
Urgent Care	Remaining Costs	First $5,500/$11,000	Deductible
PHARMACY			
Prescription Deductible Application	Integrated with Medical Deductible		
Prescription Individual Deductible	Remaining Costs	First $5,500/$11,000	Integrates w/Medical Deductible
Prescription Family Deductible			
Retail Prescriptions			AD: $10/$30/$50/20%
Mail Order Prescriptions			$25/$75/$125/20%
DIAGNOSTIC PROCEDURES			
Diagnostic Test- Lab Bloodwork	Remaining Costs	First $5,500/$11,000	Deductible
Diagnostic Test X-Ray	Remaining Costs	First $5,500/$11,000	Deductible
Complex Imaging (CT/Pet Scans, MRIs)	Remaining Costs	First $5,500/$11,000	Deductible
HOSPITAL SERVICES			
Emergency Room Care	Remaining Costs	First $5,500/$11,000	Deductible
Outpatient Surgery	Remaining Costs	First $5,500/$11,000	Deductible
Inpatient Hospital	Remaining Costs	First $5,500/$11,000	Deductible
IN-NETWORK DEDUCTIBLE & COINSURANCE			
Qualified High Deductible Health Plan	No		Yes
Deductible Accumulation Period	Calendar year		
Family Deductible Accumulation Type	Family Total Accumulation		Individual Accumulation
In-Network Individual Deductible	Last $3,000	First $5,500	$8,500
In-Network Family Deductible	Last $6,000	First $11,000	$17,000
OUT-OF-NETWORK DEDUCTIBLE & COINSURANCE			
Out-of-Network Individual Deductible	First $10,500	Last $6,500	$17,000
Out-of-Network Family Deductible	First $21,000	Last $13,000	$34,000
Out-of-Network Individual Coinsurance Limit	$17,000	$0	50% to $17,000
Out-of-Network Family Coinsurance Limit	$34,000	$0	50% to $34,000

Prescriptions

All medical plans include prescription drug coverage.

YOU PAY	Cigna OAPIN $3,500 HSA Low	Cigna OAPIN $4,500 Mid	Cigna OAP $3,000 High
IN-NETWORK RETAIL PHARMACIES (UP TO A 30-DAY SUPPLY)			
Pharmacy Deductible	Integrated w/ Medical Ded	$0	Integrated w/ Medical Ded
Pharmacy Copay	Member Pays $3,500, then DC Pays $5,000	DC Pays $4,000, then Member Pays $4,500	DC Pays $5,500, then Member Pays $3,000

MAINTENANCE DRUGS

If you take maintenance drugs (like those used to treat chronic conditions such as high blood pressure or high cholesterol) on a regular basis, be sure to have your physician write a 90-day prescription instead of a 30-day prescription. You can:

- **Have your medication delivered** straight to your door by using CVS's convenient mail order service.
- **Pick up your prescriptions** at any in-network pharmacy.

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.

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. Pick up your prescriptions at any in-network pharmacy.
- 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.

MemberChoice - Pharmacy Network Options

You and each covered family member can choose between two networks: CVS and Walgreens. Both Networks Offer Over 55,000 Pharmacies, including local independent pharmacies, grocery stores, retail chains, and wholesale warehouse stores. Your chosen pharmacy network can be changed once per plan year. Please note, CVS is the default pharmacy.

CVS Pharmacy Network

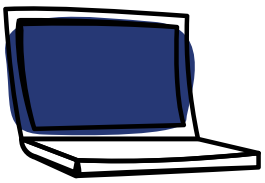
- 30-day supplies can be filled at any in-network retail pharmacy, including CVS.
- 90-day supplies are available at select in-network pharmacies, including CVS.
- Walgreens is not in this network. Prescriptions at Walgreens may not be covered.

Walgreens Pharmacy Network

- 30-day supplies can be filled at any in-network retail pharmacy, including Walgreens.
- 90-day supplies are available at select in-network pharmacies, including Walgreens.
- CVS is not in this network. Prescriptions at CVS may not be covered.

CHANGING YOUR PHARMACY NETWORK

- By Phone: Call customer service using the toll-free number on your Cigna HealthcareSM ID card.
- Online: Log in to myCigna® App or **myCigna.com**®, go to profile, and follow the instructions to change networks.



Telemedicine: MDLive

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.

Common non-acute, non-emergency illnesses

Examples of illnesses a virtual visit can diagnose (but not limited to): Allergies, Bronchitis, Eye Infections, Flu, Headaches/Migraines, Rashes, Sore Throats, Stomachaches

MDLive lets you and your covered family members see and speak to a board-certified doctor 24/7 using their mobile device or computer, wherever they are.

You can receive a diagnosis and if needed, a prescription can be sent to your local pharmacy.

No appointment is necessary–and it usually takes less than 20 minutes.

Using Telemedicine is as easy as 1, 2, 3

1

Access MDLIVE

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

2

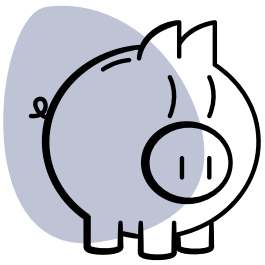
Select Care Needed

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

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 High Deductible Health Plan.

CONTRIBUTIONS

The company contributes: Employee Only (EE): $1,000; Employee + Spouse (ES): $1,500; Employee + Child(ren) (EC): $1,500; Employee + Family (EF): $1,750.

Aeries' contribution will be added in one lump sum at the time of enrollment in the plan. It will be pro-rated by the number of missed payroll cycles. You contribute on a pretax basis and can change how much you contribute from each paycheck up to the 2026 annual IRS maximum of $4,400 if you enroll only yourself or $8,750 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.

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. Your dental plan is administered through Unum.

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible	$25 individual Max 3 per family	$50 individual Max 3 per family
Annual Benefit Maximum	$2,500 per individual (Basic and Major Services combined)	
	YOU PAY	
Preventive services	$0	$0
Basic services **(fillings, simple tooth extractions, root canals, gum treatment)**	20% after deductible	20% after deductible
Major services **(crowns, inlays, bridges, dentures)**	50% after deductible	50% after deductible
Orthodontia **(child - lifetime limit of $2,000)**	50% after deductible	50% after deductible

IN-NETWORK DENTIST

You can see any dentist you choose, but in-network dentists have agreed to provide services at discounted rates. Use the **Find a Provider** tool at **unum.com** to locate an in-network dentist.

Out-of-network benefits are based on reasonable and customary (R&C) limits. You will be responsible for any charges over that amount. These charges won't apply to your deductible.

Vision

The Vision Plan is administered by Unum powered by EyeMed and includes eye exams, lenses, and contacts every 12 months and frames every 24 months. 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.

PLAN FEATURE	IN-NETWORK YOU PAY	OUT-OF-NETWORK REIMBURSEMENTS
Eye Exam (one every 12 months)	$10 co-pay	Up to $40
Single Vision Lenses	$25 co-pay	Up to $30
Bifocal Lenses	$25 co-pay	Up to $50
Trifocal Lenses	$25 co-pay	Up to $70
Lenticular Lenses	$25 co-pay	Up to $70
Standard Progressive Lenses	$90 co-pay	Up to $50
Frames (1 per 24 months)	$130 allowance	Up to $91
Contact Lenses Elective	$130 allowance	Up to $130
Contact Lenses Non-Elective	Covered	Up to $210

EYEMED PROVIDERS

You can use any eye doctor you choose, but using in-network providers will save you money. Use the **Find a Provider** tool at **https://eyedoclocator.eyemedvisioncare.com/unum/en-us** to locate an in-network eye doctor.

Employee Assistance Program (EAP)

Available to all employees, our EAP partner LifeCare through ADP helps you and your family manage life's challenges with in-person, phone, and video counseling sessions, all at no cost to you. You can also get referrals to household services related to child/elder care, financial and legal help, and much more.

MENTAL WELL-BEING

You can receive up to six counseling sessions per issue per year. The sessions are a free and confidential service and are available face to face, online with televideo, or by phone.

Licensed counselors can help with issues such as:

- Mental health concerns
- Emotional difficulties
- Domestic abuse
- Substance abuse
- Financial worries
- Grief and loss
- Relationship support
- Self-esteem and personal development
- Stress management
- Work-life balance

When you need in-the-moment emotional well-being support, counselors are here to help 24/7. You can call **1-866-338-5516** . Log into **http://member.lifecare.com**. Screen name: GROUPADPEAP and Password: login.

WORK-LIFE ASSISTANCE

LifeCare also provides a wide variety of work-life support, with some services at no cost. A few of the services include:

- **Daily life assistance:** Resources for child, elder, or pet care, and household services
- **Legal support:** Wills and estate planning, family, civil, criminal, and real estate
- **Financial services:** Budgeting, mortgages, college funding, and issues
- **Identity theft services:** Fraud resolution and credit restoration coaching

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 - 100% paid by Aeries

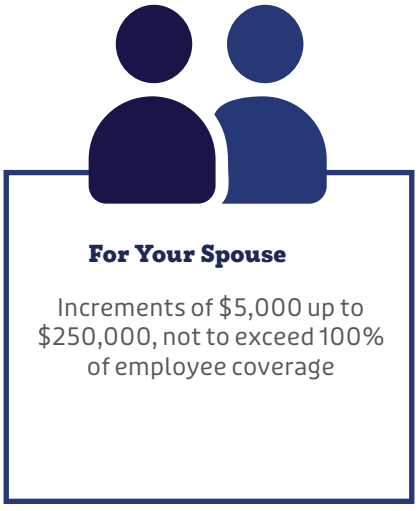
For You

$50,000 employer-paid

Voluntary Life and AD&D

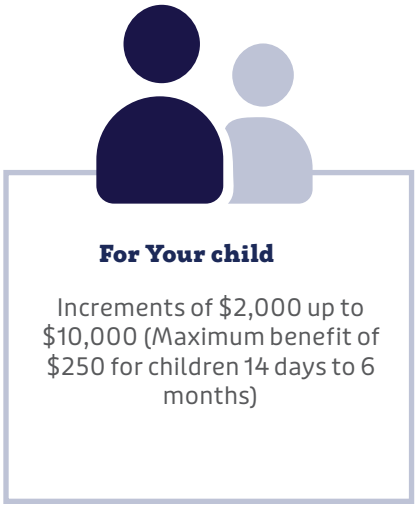
For You

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

Short-Term Disability

Aeries pays for Short-Term Disability (STD) through Unum coverage for all eligible associates. The STD benefit pays a percentage of your total weekly earnings (less other income benefits) if you can't work due to a disability.

WHAT IS SHORT-TERM DISABILITY INSURANCE (STD)?

STD is a type of disability insurance coverage that can help you remain financially stable should you become injured or ill and cannot work. Aeries' STD coverage begins on the 8th day after the event causing your disability and continues for the next 12 weeks. The coverage allows you to continue to receive pay at a fixed weekly amount or a set percentage of your income. If you are still disabled when this STD coverage ends, Long-Term Disability (LTD) coverage typically takes effect.

Voluntary Long-Term Disability

Aeries offers voluntary Long-Term Disability (LTD) coverage through Unum for all eligible associates. The LTD benefit pays a percentage of your total monthly earnings (less other income benefits) if you can't work due to a total disability.

Benefits become payable on a monthly basis once you have been disabled for 90 days. Benefits may continue while you are disabled up to Social Security Normal Retirement Age. In some cases, benefit payments may extend past age 65, depending on the age you become disabled.

The Plan will not cover any disability caused by, or resulting from, a preexisting condition. A preexisting condition means a condition for which you received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed medicines in the **3 months prior** to your effective date of coverage, and the disability begins in the **first 12 months after your effective date** of coverage.

Disability Benefits at a Glance

First 17 Days	Next 12 Weeks	After 90 Days
Elimination Period: 7 days PTO replaces 100% of your pay.	Approved STD replaces 60% of your earnings to a $3,400 maximum for 12 weeks. Benefit begins after 7 days of disability.	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.

AGE BAND	VOLUNTARY LTD RATE PER $10 OF MONTHLY BENEFIT	AGE BAND	VOLUNTARY LTD RATE PER $10 OF MONTHLY BENEFIT
15-24	$0.030	50-54	$0.810
25-29	$0.080	55-59	$0.900
30-34	$0.160	60-64	$0.950
35-39	$0.210	65-69	$0.710
40-44	$0.320	70+	$0.510
45-49	$0.550		

Accident, Critical Illness, and Hospital Indemnity Insurance

These benefits, administered by Unum, offer an extra layer of protection for you and your family. The payment these benefits provide is in addition to any other insurance you may have and is yours to spend as you wish—to help cover bills or for everyday living expenses. These plans do not provide health insurance coverage and do not replace the medical plans.

PERKS OF THE PLANS

- **Guaranteed Issue:** There are no medical questions or tests required for coverage.
- **Flexible:** You can use the benefit payments for any purpose you choose.
- **Payroll Deductions:** Premiums are paid via convenient payroll deductions.
- **Wellness Incentives:** Each covered person who completes a preventive care visit, health screening, or wellness treatment can receive a $50 Wellness Incentive.
- **Portable:** If you leave the company, you can take the coverage with you.

ACCIDENT COVERAGE

Accident insurance pays a cash benefit directly to you when you are injured and require medical services due to a covered off-the-job accident that occurs on or after your coverage date. The benefit amount depends on the type of injury and care received. If you elect coverage for yourself, you may also purchase coverage for your spouse and/or children equal to your own coverage.

	MONTHLY PREMIUMS
Employee Only	$12.55
Employee + Spouse	$22.20
Employee + Child(ren)	$27.79
Employee + Family	$37.44

HOSPITAL INDEMNITY INSURANCE

Hospital indemnity insurance pays a daily benefit if you have a covered stay in a hospital, critical care unit, or rehabilitation facility that occurs on or after your coverage date. The benefit amount is determined based on the type of facility and the number of days you stay. If you elect coverage for yourself, you may also purchase coverage for your spouse and/or children equal to your own coverage.

	MONTHLY PREMIUMS
Employee Only	$17.44
Employee + Spouse	$35.39
Employee + Child(ren)	$24.82
Employee + Family	$42.77

Critical Illness

Critical illness insurance pays a lump-sum cash benefit directly to you if you are diagnosed with a covered illness or condition on or after your coverage effective date. You can choose the amounts of $10,000, $20,000, or $30,000 for yourself. If you purchase coverage for your spouse and/or children, their coverage is equal to half of your own coverage.

Full-time Employees - Monthly Critical Illness Attained Age Rates per $1,000		
Age	Employee & Child(ren) Rate	Spouse Rate
<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

Financial

Your well-being extends beyond the physical and emotional—it applies to your financial health too. Aeries Software offers a variety of benefits designed to help you save and grow your money.

401(k) Plan

To help plan for your future, Aeries Software sponsors a 401(k) plan administered by Empower. The 401(k) plan is a great way to plan for your future, as you control how much you save and how you invest your funds.

ELIGIBILITY

If you are an employee, you are eligible to join on the first of the month following 30 days of employment.

HOW IT WORKS

- **100% of Salary Deferrals up to the first 3% of Plan Compensation**
  If you contribute up to 3% of your salary, Aeries will match dollar-for-dollar.
  Example: If your salary is $50,000 and you contribute 3% ($1,500), your employer adds $1,500.
- **Plus 50% of Salary Deferrals up to the next 2% of Plan Compensation**
  If you contribute an additional 2% of your salary (bringing your total contribution to 5%), your employer will match half of that extra amount.
- **To get the full 4% match - you must contribute 5% or more each pay period**

ENROLL AND MANAGE YOUR 401(K)

Enrolling in the 401(k) is a separate process and is not part of the annual benefits enrollment. Enroll or make changes at any time by logging in to **www.empowermyretirement.com or by calling 855-756-4838. Our contract number is 530649-01.**

ADDITIONAL RESOURCES

Aeries provides access to a dedicated financial advisor to help you with retirement planning and investment questions. **Please reach out to Ben Julianel by calling 949-359-6495 or emailing ben@navigatorsadvisory.com.**

DISCRETIONARY AERIES CONTRIBUTIONS

In addition to the standard matching contributions, Aeries may choose to make extra contributions to your account through profit sharing or an additional discretionary match.

5-YEAR GRADED VESTING SCHEDULE

Aeries' Discretionary Profit Sharing & Discretionary Matching contributions become yours over time according to the following vesting schedule:

After 1 year: 20% vested
After 2 years: 40% vested
After 3 years: 60% vested
After 4 years: 80% vested
After 5 years: 100% vested

You are always 100% vested in the safe harbor contribution and any Salary Deferrals you make to the Plan.

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 **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 - ADP

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 and grocery, home and auto insurance and much more!

Rates

Paycheck Deductions

The following chart contain the biweekly paycheck deductions for benefits beginning January 1, 2026.

MEDICAL

COVERAGE LEVEL	Cigna OAPIN $3,500 HSA Low	Cigna OAPIN $4,500 Mid	Cigna OAP $3,000 High
Employee Only	$16.70	$110.18	$132.70
Employee + Spouse	$61.24	$242.40	$291.93
Employee + Child(ren)	$55.67	$220.37	$265.38
Employee + Family	$83.51	$330.55	$398.08

DENTAL

COVERAGE LEVEL	RATES
Employee Only	$0
Employee + 1	$8.28
Employee + Family	$13.18

VISION

COVERAGE LEVEL	RATES
Employee Only	$0
Employee + 1	$0.79
Employee + Family	$1.34

SUPPLEMENTAL LIFE AND AD&D INSURANCE

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

Contacts

PLAN	CARRIER	WEBSITE	PHONE
Medical	Cigna	**www.cigna.com**	800-997-1654
Medical Expense Reimbursement Plan	The Difference Card	**www.differencecard.com**	866-494-2111
Dental	Unum	**www.unum.com**	888-400-9304
Vision	Unum	**www.unum.com**	888-400-9304
Basic Life, AD&D, LTD	Unum	**www.unum.com**	800-445-0402 (Life) 866-779-1054 (DI)
Voluntary Benefits (STD, Accident, Critical Illness, Hospital Indemnity)	Unum	**www.unum.com**	800-635-5597
Health Savings Account (HSA)	The Difference Card	**www.differencecard.com**	800-635-5597
401(k)	Empower	**www.empowermyretirement.com**	800-338-4015
HR Contact	**hr@aeries.com**	**www.aeriesbenefits.com**	714-575-3685

REQUIRED NOTICES

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 "onestop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other outofpocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employmentbased health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain costsharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employmentbased health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowestcost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1 2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employmentbased coverage. Also, this employer contribution as well as your employee contribution to employmentbased coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an aftertax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is **offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage**. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility.
To learn more, visit HealthCare.gov or call the Marketplace Call Center at 18003182596. TTY users can call 18558894325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employmentbased health plan (such as an employersponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employmentbased health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employmentbased health plan through September 8, 2023. Confirm the deadline with your employer or your employmentbased health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit healthcare.gov/medicaidchip/gettingmedicaidchip for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources. 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.

1. Indexed annually; see **irs.gov/pub/irsdrop/rp2234.pdf** for 2023.
2. An employersponsored or other employmentbased health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Special Enrollment Notice

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

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact:

Aeries Software Inc.

Nica Tahsequah

77O The City Drive South, Suite 6500, Orange, CA 92868

Phone Number: (888) 4877555

Your Information. Your Rights. Our Responsibilities.

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.**

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, costbased fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 18776966775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.

- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Important Notice from Aeries Software 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 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 Software has determined that the prescription drug coverage offered by the Aeries Software, LLC Benefit 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 15 to December 7.

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 coverage will not be affected. If you decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will 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 Software 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 Software changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

- **Visit** www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1800MEDICARE (18006334227). TTY users should call 18774862048.

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 18007721213 (TTY 18003250778).

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) 4877555

Continuation Coverage Rights Under COBRA

INTRODUCTION

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 outofpocket costs. Additionally, you may qualify for a 30day 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 parentemployee dies;
- The parentemployee's hours of employment are reduced;
- The parentemployee's employment ends for any reason other than his or her gross misconduct;
- The parentemployee 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 continuation 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; or
- 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 Human Resources.

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 18month period of COBRA continuation coverage can be extended:

Disability Extension of 18month Period of COBRA 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 18month period of COBRA continuation coverage.

Second Qualifying Event Extension of 18month 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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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

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

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

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicareandyou.

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

Aeries Software, LLC Benefit Plan, Nica Tahsequah, Aeries Software Inc., 770 The City Drive South, Suite 6500 Orange, CA 92868, (888) 4877555 & hr@aeries.com

1. https://www.medicare.gov/basics/getstartedwithmedicare/signup/whendoesmedicarecoveragestart.

Women's Health and Cancer Rights Act

ENROLLMENT NOTICE

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 mastectomyrelated benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: Low ($3,500/$7,000 single/family deductible and 0% coinsurance); Mid ($4,000/$8,000 single/family deductible and 30% coinsurance); and High ($3,000/$6,000 single/family deductible and 30% coinsurance). If you would like more information on WHCRA benefits, call your plan administrator at .

ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomyrelated services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 8664942111 for more information.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48hour (or 96hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "selfinsured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "selfinsured.")

The Newborns' Act provisions always apply to coverage that is selfinsured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

For more information, see the Frequently Asked Questions (FAQs) About the Newborns' and Mothers' Health Protection Act.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an outofnetwork provider at an innetwork hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain outofpocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an innetwork facility but are unexpectedly treated by an outofnetwork provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

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

Certain services at an innetwork hospital or ambulatory surgical center

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

If you get other services at these innetwork facilities, outofnetwork providers can't balance bill you, unless you give written consent and give up your protections.

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

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

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

If you believe you've been wrongly billed, you may contact Cigna Healthcare at 8664942111.

Visit **www.mycigna.com** for more information about your rights under federal law.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1877KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employ-ersponsored 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 **1866444EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

STATE	WEBSITE/EMAIL	PHONE
Alabama Medicaid	myalhipp.com	8556925447
Alaska Medicaid	Premium Payment Program: myakhipp.com Medicaid Eligibility: health.alaska.gov/dpa Email: customerservice@myakhipp.com	8662514861
Arkansas Medicaid	http://myarhipp.com/	855MyARHIPP (8556927447)
California Medicaid	dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	9164458322 9164405676 (fax)
Colorado Medicaid and CHIP	Medicaid: healthfirstcolorado.com CHIP: hcpf.colorado.gov/childhealthplanplus HIBI: mycohibi.com	8002213943 Relay 711 8003591991 Relay 711 8556926442
Florida Medicaid	flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	8773573268
Georgia Medicaid	HIPP: medicaid.georgia.gov/healthinsurancepremiumpayment- programhipp CHIPRA: medicaid.georgia.gov/programs/thirdpartyliability/childrenshealthinsuranceprogramreau-thorizationact2009chipra	6785641162, press 1 6785641162, press 2
Indiana Medicaid	HIPP: https://www.in.gov/fssa/dfr/ All other Medicaid: in.gov/medicaid	8004030864 8004574584
Iowa Medicaid and CHIP	Medicaid: hhs.iowa.gov/programs/welcomeiowamedicaid CHIP: hhs.iowa.gov/programs/welcomeiowamedicaid/iowahealthlink/hawki HIPP: hhs.iowa.gov/programs/welcomeio-wamedicaid/feeservice/hipp	8003388366 8002578563 8883469562
Kansas Medicaid	kancare.ks.gov	8007924884 HIPP: 8009674660
Kentucky Medicaid and CHIP	KIHIPP: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KIHIPP Email: KI-HIPP.PROGRAM@ky.gov KCHIP: kynect.ky.gov Medicaid: chfs.ky.gov/agencies/dms	KIHIPP: 8554596328 KCHIP: 8775244718
Louisiana Medicaid	ldh.la.gov/healthylouisiana or www.ldh.la.gov/lahipp	Medicaid: 8883426207 LaHIPP: 8556185488
Maine Medicaid	Enrollment: mymaineconnection.gov/benefits Private health insurance premium: maine.gov/dhhs/ofi/applicationsforms	Enroll: 8004426003 Private HIP: 8009776740

STATE	WEBSITE/EMAIL	PHONE
		TTY/Relay: 711
Massachusetts Medicaid and CHIP	mass.gov/masshealth/pa Email: masspremassistance@accenture.com	8008624840 TTY/Relay: 711
Minnesota Medicaid	mn.gov/dhs/healthcarecoverage	8006573672
Missouri Medicaid	dss.mo.gov/mhd/participants/pages/hipp.htm	5737512005
Montana Medicaid	HIPP: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HIPP Email: HHSHIPPProgram@mt.gov	8006943084
Nebraska Medicaid	ACCESSNebraska.ne.gov	8556327633 Lincoln: 4024737000 Omaha: 4025951178
Nevada Medicaid	Medicaid: dhcfp.nv.gov	8009920900
New Hampshire Medicaid	dhhs.nh.gov/programsservices/medicaid/healthinsurancepremiumprogram Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	6032715218 or 8008523345, ext. 15218
New Jersey Medicaid and CHIP	Medicaid: state.nj.gov/humanservices/dmahs/clients/medicaid CHIP: njfamilycare.org/index.html	Medicaid: 8003561561 CHIP Premium Assist: 6096312392 CHIP: 8007010710 TTY/Relay: 711
New York Medicaid	health.ny.gov/health_care/medicaid	8005412831
North Carolina Medicaid	medicaid.ncdhhs.gov	9198554100
North Dakota Medicaid	hhs.nd.gov/healthcare	8448544825
Oklahoma Medicaid and CHIP	insureoklahoma.org	8883653742
Oregon Medicaid	healthcare.oregon.gov/Pages/index.aspx	8006999075
Pennsylvania Medicaid and CHIP	Medicaid: pa.gov/en/services/dhs/applyformedicaidhealthinsurancepremiumpayment-programhipp.html CHIP: dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 8006927462 CHIP: 800986KIDS (5437)
Rhode Island Medicaid and CHIP	eohhs.ri.gov	8556974347 or 4014620311 (Direct RIte)
South Carolina Medicaid	scdhhs.gov	8885490820
South Dakota Medicaid	dss.sd.gov	8888280059
Texas Medicaid	hhs.texas.gov/services/financial/healthinsurancepremiumpaymenthippprogram	8004400493
Utah Medicaid and CHIP	UPP: medicaid.utah.gov/upp/ UPP Email: upp@utah.gov Adult Expansion: medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: medicaid.utah.gov/buyoutprogram/ CHIP: chip.utah.gov	UPP: 8772222542
Vermont Medicaid	dvha.vermont.gov/members/medicaid/hippprogram	8002508427
Virginia Medicaid and CHIP	coverva.dmas.virginia.gov/learn/premiumassistance/famisselect coverva.dmas.virginia.gov/learn/premiumassistance/healthinsurancepremiumpaymenthippprograms	Medicaid/CHIP: 8004325924
Washington Medicaid	hca.wa.gov	8005623022

STATE	WEBSITE/EMAIL	PHONE
West Virginia Medicaid and CHIP	dhhr.wv.gov/bms/ mywvhipp.com/	Medicaid: 3045581700 CHIP: 8556998447
Wisconsin Medicaid and CHIP	dhs.wisconsin.gov/badgercareplus/p10095.htm	8003623002
Wyoming Medicaid	health.wyo.gov/healthcarefin/medicaid/programsandeligibility	8002511269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Notes

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