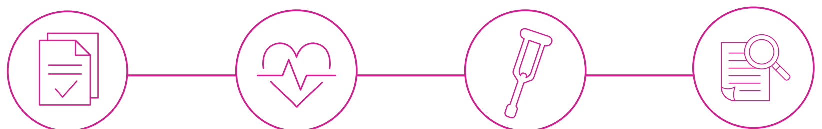
Employee Benefits Guide 2024

exela TECHNOLOGIES



Open Enrollment is November 6 – November 17, 2023

View the new options ahead of Open Enrollment and make elections in **two enrollment websites**.

Exela will continue to offer medical and prescription drug benefits on the Aon Active Health Exchange™ for 2024. In 2024 you'll have a new PPO medical option. The new Bronze Plus coverage option will be a traditional PPO with prescription drug copays rather than a Bronze Plus HDHP like it was in 2023. This will be significantly different from the current option, so you will need to consider all of your options carefully before enrolling.

You must take action during the Open Enrollment window **or you will not have medical or prescription drug coverage through Exela in 2024.** You'll have the opportunity to participate in a Health Savings Account (if eligible) or Flexible Spending Account during this time.

Exela will be offering new voluntary supplemental Accident, Hospital Indemnity, and Critical Illness policies through Lincoln Financial. A new Group Whole Life Insurance policy with a Long-Term Care rider will be offered through Allstate Benefits. Each plan offers benefit enhancements that provide you with more robust coverage than is currently available. **Be sure to enroll in these new benefits as the current coverages through Aflac will not carry forward into 2024.**

Assistance Online

Visit "Make It Yours" at **exela.makeityoursource.com** beginning October 23, 2023 to learn more about all your benefit options and find instructions on how to enroll in medical and other health benefits beginning November 6.

Assistance by Phone

Call the Exela Benefits Call Center at **1-877-772-7266** (Monday – Friday, 10 a.m. – 7 p.m. CST).

Important – If you do not enroll or make changes to your benefits plan, you must wait until the next annual Open Enrollment period, unless you experience a qualified life event and enroll or make changes within 30 days of the event.

Take Action!

You must make new medical elections (includes prescription drugs) or you will have no coverage in 2024.

All Flexible Spending Account (FSA) and Health Savings Account (HSA) elections must be made every year.

You must make new elections for Accident, Hospital Indemnity, Critical Illness, and Group Whole Life Insurance.

Review your beneficiaries and make sure the information is still current!

Remember, Open Enrollment is the only opportunity for you and your eligible dependents to enroll or make changes to your existing enrollment in Exela's health and welfare benefits. If you do not enroll or make changes during the annual Open Enrollment period, you cannot later enroll or make changes for 2024 coverage unless you experience a qualified life event and enroll or make changes within 30 days of the qualified event.

If you are adding a new dependent, in order for your benefits to be updated accordingly, you will be required to provide the applicable necessary documentation to support your dependent relationship (i.e.: birth/ marriage certificate, domestic partner affidavit, etc.) by uploading to your Dependent Tab within the Spring Benefits portal within 30 days of your benefits eligibility date.

Visit Spring

Elections and any changes to Life and Disability Insurance, Voluntary Supplemental Benefits, Legal, and Commuter/Parking benefits will need to be made through Spring. **If you do not make changes to these benefits, your current Life, Supplemental Life, and Legal plans will roll over to 2024. New elections must be made for Voluntary Supplemental Benefits (i.e.: Accident, Hospital Indemnity, Critical Illness, and Whole Life Insurance with a Long-Term Care Rider). Current Voluntary Supplemental Benefits through Aflac will not roll forward.**

Below are two ways to access Spring.

1. Log into Exela HCM at **https://hcm.exelatech.com**. Click on the "Spring Benefits" icon.

    Username: Enter HCM Login ID.

    Password: Enter HCM Password.

    One-time code: Enter authentication code received on your mobile or other device.

2. Log into Spring at **https://exela.springapp.io**. Click on the "Registered User Sign In" button.

    Username: Enter HCM Login ID.

    Password: Enter HCM Password.

    One-time code: Enter authentication code received on your mobile or other device.

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The Medicare Part D Creditable Coverage Notice can be found on page 18.

This benefits guide is not a substitute for the official health and welfare plan document(s). Copies of the plan documents including SPDs can be accessed at https://exela.springapp.io. You may also request a paper copy by contacting the Benefits Plan Administrator, 2701 E. Grauwyler Road, Irving, TX 75061.

Eligibility & Enrolling

Eligibility

Employees
If you are a full-time regular employee working 30 or more hours per week, you are eligible to participate in the benefit program on the first of the month following date of hire. Employees moving from temporary or part-time status to full-time status are eligible the first of the month following the effective date of the status change.

Dependents
You may also cover your eligible dependents under many of our benefit plans. Your eligible dependents include:

- Legal spouse and domestic partner. If spouse or domestic partner is eligible for employer-sponsored medical coverage elsewhere, he or she is not eligible.
- Children up to age 26, whether natural, adopted, stepchildren, or those for whom you have legal custody by court decree.
- If you cover your domestic partner, you may also cover your domestic partner's children.
- Your children of any age who are incapable of self-sustaining employment due to a behavioral or physical disability, as long as the incapacity started when the child was eligible for coverage.

When you enroll new dependents for the first time, you will be required to provide the applicable necessary documentation to support your dependent relationship (i.e.: birth/marriage certificate, domestic partner affidavit, etc.) by uploading to your Dependent Tab within the Spring Benefits portal during enrollment. As required by the Affordable Care Act, you will need to provide a full name, Social Security number, and date of birth for all eligible family members to complete the enrollment process.

Enrolling or Making Changes

Enrolling as a New Employee
If you are enrolling for the first time and are a new employee, you're eligible for benefits on the first day of the month following your date of hire. Your deadline to enroll is 30 days from your hire date with benefits effective the 1st of month following your hire date. If you don't take action, you'll automatically be enrolled in Basic Life and AD&D coverage. The next opportunity to enroll will be during Open Enrollment for the following year or if you experience an eligible qualified life event.

Benefits Enrollment
Any elections you make during your Benefits Enrollment will remain in effect for the rest of the plan year, unless you experience an eligible qualified life event. The deadline is 30 days from the qualifying event to make a change and submit supporting documentation.

Rehires
Employees rehired within 91 days of terminating employment with Exela are eligible for benefits immediately. You must review and make any changes to your reinstated benefit elections within 30 days of your rehired date. Employees rehired after 91 days of terminating employment with Exela will follow New Hire rules. Refer to the section, Enrolling as a New Employee.

Qualified Life Event (QLE) Changes
You can change your benefit elections during the plan year if you have a qualifying life event as defined by the IRS. QLEs include, but are not limited to:

- Marriage or divorce
- Birth, death, or legal adoption
- Gain or loss of coverage eligibility

If you experience a qualified life event, you must report the change within 30 days of the event if you want to change your coverage. You can enroll online at **digital.alight.com/exela** or by calling the Exela Benefits Call Center at **1-877-772-7266, Push #2**. Supporting documentation must be loaded to **https://exela.springapp.io** before a qualified life event can be approved and deductions updated within the payroll system. Please review the "Dependent Eligibility Verification Process" found in the Spring Resource Library under Dependent Eligibility Verification. **Be sure to complete your enrollment in both the Alight and Spring portals.**

If You are Eligible for Medicaid
Depending on your income, you may be eligible for free or low-cost medical care through Medicaid. Each state has different guidelines about what income levels qualify. Note that Medicaid eligibility is based on household size and total household income. You can also visit **www.medicaid.gov** for information about Medicaid eligibility in your state.

Domestic Partner Requirements
In order to qualify a domestic partner for coverage, you and your domestic partner must complete the Exela Domestic Partner Affidavit and supply the required documentation as outlined in the affidavit.

Note: Enrolling a domestic partner will result in imputed income and/or after-tax contributions to certain benefits.

Medical Plans

Aon Active Health Exchange

The Aon Active Health Exchange creates a dynamic health coverage market for Exela employees. The exchange offers a menu of standardized plans with multiple insurance carriers that compete at the consumer level. This innovative structure provides employees with a broad choice of health coverage options.

The medical plans on the exchange ensure access to the Nation's top providers and are integrated with clinical programs that address acute and chronic needs. Telehealth and independent expert medical opinions deliver convenience and improved care quality.

Decision-support tools are available to help employees make confident decisions to protect those they care about the most. Employees can truly personalize their benefit choices.

The Aon Exchange will provide our Exela employees with some unique advantages:

- **Lots of choices.** Each employee can shop and choose from several coverage levels, a variety of insurance carriers, and a range of costs. Options can vary based on where you live.
- **Carrier choices.** The insurance carriers are competing for business, so it's in their best interests to offer their best prices. Plus, Exela will provide an employer contribution (credit) for employees to use toward the cost of coverage.
- **Helpful resources.** In addition to hosting employee webinars, there will be great resources to help before, during, and after enrollment:
  - **Make It Yours website:** The Make It Yours website is a year-round resource for information about the available medical options, things to consider before enrolling, and practical tips for employees to get the most out of their benefits. This is also where employees can get "The Inside Scoop" on how to work the health care system and make the most of their health care dollars.
  - **Insurance carrier "preview" websites:** These sites are available through the Make It Yours website so employees can get up to speed on each medical carrier's provider networks, prescription drug information, and other programs.

Visit **"Make it Yours"** at **exela.makeityoursource.com** to learn more about your medical (including prescription drug coverage) benefit options.

Health Savings Account (HSA)

When you enroll in the High Deductible Health Plan (HDHP), you may also be eligible to open a Health Savings Account (HSA). An HSA is a tax-advantaged account that you can use to pay for qualified health care expenses now or in the future.

You fund your account through pre-tax payroll deductions up to IRS limits. You can use the money throughout the year to pay for qualified healthcare expenses until you meet your deductible and out-of-pocket maximum, or you can leave the money in the account and allow it to accumulate for future qualified expenses.

There is no time limit to spend your HSA funds. Whatever you don't use remains in the account and can be invested in mutual funds. Subject to market conditions, any growth in your account can grow tax-free over time and you can have more funds available in retirement when you may have increased medical expenses.

2024 IRS Limits for HSA Contributions	
Individual Coverage	$0 to $4,150*
Family Coverage	$0 to $8,300*

**If you are age 55 or older, you can also make catch-up contributions of up to $1,000 per year.*

You can use your HSA to pay for a wide range of IRS-qualified medical expenses including coinsurance, dental and vision copays, prescription drugs, orthodontia, eyeglasses, contact lenses, and more.

Things to Know

- You must be enrolled in a high deductible health plan to be eligible for the HSA.
- If you are enrolled in Medicare, you may not contribute to an HSA or receive employer HSA contributions.
- The HSA provides a triple-tax advantage:
  1. Contributions are tax-deductible,
  2. Balances grow tax-free, and
  3. Withdrawals for qualified expenses are tax-free.
- You can withdraw money at any time to pay for qualified medical expenses. However, you will only have access to the funds that have been deposited in your account to-date. Your money rolls over if you don't use it.
- If you have an HSA elsewhere, you can transfer the balance to your new one.
- You can open an investment account once your HSA balance reaches $1,000.

Keys to Growing Your HSA

- Try not to use your Health Savings Account for routine expenses. If you can pay out-of-pocket, leave your HSA funds alone so that they can grow for when you need them in the future. Remember, the money in your HSA is yours. You keep it if you don't spend it.
- Consider having supplemental medical coverage such as Critical Illness, Accident, or Hospital Indemnity Insurance so that unexpected serious illnesses or injuries don't wipe away the money in your HSA.
- Monitor your fund's growth. Like a 401(k), your HSA funds earn interest through investments. Make sure your money is growing at an acceptable and safe pace.

Please note that investments are not FDIC-insured, are not guaranteed, and may lose value.

Dental & Vision Plans

Dental Plans

Exela offers two dental plans, both administered by Delta Dental. The PPO plan provides in-network benefits and out-of-network benefits. The DHMO only provides benefits through participating providers according to a fixed fee schedule and is only available as an option to employees who live in certain zip codes.

To find a provider, visit **www.deltadentalins.com**. Locate "Find a Dentist" on the right side of the page. Enter your address, select the network (PPO: Delta Dental PPO or Delta Dental Premier; DHMO: DeltaCare USA), then follow the easy steps to search. Note: for the DHMO only – enter the 6-digit facility number on your dental enrollment under PCP Provider.

Dental Plans		
What You Pay	PPO In-Network	DHMO In-Network
Annual Deductible (waived for Diagnostic & Preventive Services and Orthodontics) Per Person / Per Family	$50 / $150	N/A
Maximums Per Person Annual Maximum / Per Person Lifetime Orthodontic Maximum	$2,000 / $1,500	N/A
Diagnostic and Preventive Services Routine Exams, X-rays, Fluoride, Preventive Services, and Cleanings	$0	$0
Basic Restorative Services Fillings and Extractions	20%	$5 – $85
Major Restorative Services Crowns, Inlays and Onlays, Dentures and Bridges	50%	$160 – $380
Orthodontics Children and Adults	50%	$1,150 – $2,100

Vision Plan

The EyeMed vision plan can help cover the cost of an eye exam, glasses, and contacts for you and your family. In-network benefits are shown below, but the plan also provides reimbursement for some services received out-of-network. To find a provider, visit **www.eyemedvisioncare.com**. Click on the Members tab, then navigate to Find an Eye Doctor. Once in the search tool, enter your zip code, choose the "Select" network, then choose "What else is important?" if you want to narrow your search.

Vision Plan	
What You Pay	In-Network
Exam (Once every calendar year)	$20 copay
Lenses (Once every calendar year) Single, bifocal, trifocal Basic progressive lens	 $10 copay $70 copay
Frames (Once every other calendar year) Retail frame equivalent	Plan covers up to $135 plus 20% off remaining balance
Contacts (Once every calendar year) Necessary Elective	 Covered in full Plan covers up to $135 (discount available on remaining balance for conventional contact lenses)

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) allow you to set aside money for out-of-pocket expenses and reduce your income taxes at the same time. You must enroll each year if you wish to participate. Your prior elections do not automatically roll over. Smart Choice is the plan administrator for the FSAs.

Health Care FSA

You may contribute $100 to $3,200 per year through pre-tax payroll deductions to cover qualified medical, pharmacy, dental, and vision expenses not covered by the plan (i.e.: copays, deductibles, coinsurance). Employees may roll over up to $610 in unused Health Care FSA or Limited Purpose FSA funds to the next year only if they re-elect a Health Care FSA or a Limited Purpose FSA and contribute at least $100 per year.

Note: If you are enrolled in a Health Savings Account (HSA), you are not eligible for the Health Care FSA.

Limited Purpose FSA

The Limited Purpose FSA is restricted to qualified dental and vision expenses and can be used in conjunction with the Health Savings Account. You can contribute $100 to $3,200 per year through pre-tax payroll deductions to cover expenses such as dental and vision copays, orthodontics, eyeglasses, or contact lenses.

Items you might not realize are Health Care FSA-eligible:

- Sunscreen
- Heating and cooling pads
- First aid kits
- Shoe inserts and other foot grooming treatments
- Travel pillows
- Motion sickness bands

Dependent Care FSA

You may contribute $100 to $5,000 per year ($2,500 per parent per year if you are married and filing separate tax returns) through pre-tax payroll deductions. The money can be used to pay for eligible dependent care while you or your spouse work or attend school full-time.*

Plan	Maximum Contribution Amounts	Examples of Covered Expenses**	Claims Period
Health Care FSA	$3,200 per year	Copays, deductibles, orthodontia, prescription medications, etc.	Expenses must be incurred from your coverage effective date through 12/31/24. Claims incurred against your 2024 election need to be submitted by 3/31/25. Up to $610 in remaining funds will roll over.***
Limited Purpose FSA	$3,200 per year	Dental and vision copays, orthodontia, eyeglasses, contact lenses, etc. Once you meet the medical deductible, then you can utilize your Limited Purpose FSA toward qualified medical expenses.	Expenses must be incurred from your coverage effective date through 12/31/24. Claims incurred against your 2024 election need to be submitted by 3/31/25. Up to $610 in remaining funds will roll over.***
Dependent Care FSA	$5,000 per year ($2,500 per parent per year if married and filing separate tax returns)*	Day care, nursery school, elder care expenses, etc.	Expenses must be incurred from your coverage effective date through 12/31/24. Claims against your 2024 election need to be submitted by 3/31/25. Dependent Care FSA cannot be rolled over.

**Highly compensated employees may contribute only up to a capped amount to their Dependent Care FSA. The capped amount is determined annually and is subject to change.*

***See IRS Publications 502 and 503 for a complete list of covered expenses.*

****Employees may carry over up to $610 in unused Health Care FSA or Limited Purpose FSA funds to the next year only if they re-elect the Health Care FSA or Limited Purpose FSA and contribute at least $100 per year.*

Life and AD&D Insurance

Basic Life and AD&D Insurance

Exela provides Basic Life and Accidental Death and Dismemberment (AD&D) Insurance through Lincoln Financial Group at no cost to you. If you pass away while employed by Exela, it pays a benefit equal to one times your annual base salary as of November 1, 2023 (or hire date if later) up to a maximum of $500,000.

IRS Rules About Basic Life Insurance Coverage
If the Basic Life Insurance coverage that Exela provides you is more than $50,000, your income taxes could be affected. IRS regulations require that the value of life insurance benefits over $50,000 be reported as "imputed income" – non-cash income that you receive from an employer-provided benefit. The value of your Basic Life Insurance coverage that exceeds $50,000 (if any) will be reported to the IRS as imputed income.

Supplemental Life and AD&D Insurance

If you wish to purchase greater protection, you may elect Supplemental Life and AD&D Insurance through Lincoln Financial Group for yourself and your dependents. You must be enrolled in coverage in order to have Supplemental Life and AD&D coverage for your dependents. If you were previously eligible and waived coverage, you will be subject to Evidence of Insurability (proof of good health).* Your coverage will remain in a pending status until Lincoln Financial makes a determination, approving or denying coverage. This process can involve completing health screenings or having a physical exam with a physician.

Supplemental Life and AD&D	
Employee	$10,000 increments up to 5x your salary or $500,000 (Guaranteed Issue up to $300,000)
Spouse	$5,000 increments up to $250,000 (Guaranteed Issue up to $30,000)
Children	$10,000 or $20,000

* *Supplemental Employee Life can be increased by $30,000 without Evidence of Insurability (EOI) as long as election is not over the guaranteed issue amount.*

* *Supplemental Spouse Life can be increased by $5,000 without Evidence of Insurability (EOI) as long as election is not over the guaranteed issue amount.*

The amount of Basic and Supplemental Life and AD&D coverage will reduce at age 65 or older as follows:

Ages 65-69: to 75% Ages 70-74: to 50%

Ages 75-79: to 15% Age 80 & up: to 10%

How Much Life Insurance Do You Need?

Many financial experts recommend you have at least five to eight times your household income in life insurance. To calculate the level sufficient to cover your needs, you should consider your current income and how much it costs to maintain your family's standard of living. You should also consider your current expenses and your family's future financial needs such as the following:

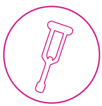
Current Expenses

- Home Mortgage
- Car Payments
- Credit Card Debt
- Other Debt

Future Needs

- Child Care
- College Tuition
- Spouse's Retirement
- Routine Household Expenses

After you add your financial responsibilities, how does the sum compare with your current coverage?



Disability Insurance

When you're healthy, it's hard to imagine not being able to work because of a serious illness or injury. But a disability that keeps you out of work could have a major impact on your finances. Disability insurance protects your finances by offering partial income replacement while you are not able to work.

Supplemental Short-Term Disability Insurance

Short-Term Disability (STD) will continue to be provided by Lincoln Financial Group. Although proof of good health is not required, pre-existing condition provisions may apply to this and future enrollments, changes, or increases in benefits.

The STD plan provides a source of income if you are unable to work due to a covered injury or illness. For most employees, STD benefits pay 60% of your gross weekly covered income up to $1,846 per week. For employees in California, STD benefits pay 20% of your gross weekly covered income up to $1,846 per week. Benefits begin after a 14-day elimination period. You are eligible for STD payments for up to 26 weeks (24 weeks after the 14-day elimination period), if approved. After 26 weeks, either your coverage ends or your Long-Term Disability Insurance begins, provided you've enrolled in this coverage.

Your gross weekly earnings are based off of your rate of pay as of November 1. You can file a claim at **www.MyLincolnPortal.com**. First time users must register using company code **Exela** or you can call **1-800-213-6231** and speak with an Intake Specialist to report your claim.

Voluntary Long-Term Disability Insurance

The Lincoln Financial Long-Term Disability (LTD) Insurance plan is helpful if your disability continues beyond the period covered by the Short-Term Disability benefit. LTD Insurance replaces 60% of your monthly income up to $15,000 per month if you are unable to work for a long period of time due to a covered illness or injury. Benefits begin after 26 weeks of disability.

It's estimated that **1 in 4** 20-year-olds will experience a disability for 90 days or more before they reach age 67.

Social Security Administration, Disability Insurance, Facts 2021

How STD and LTD Benefits Work

26 Weeks After Injury or Illness	26 Weeks to Retirement
Supplemental Short-Term Disability Insurance	Voluntary Long-Term Disability Insurance
60% of your weekly earnings (20% for employees in California) up to $1,846 per week	60% of your monthly earnings up to $15,000 per month

Your earnings are defined as your annual base salary. Because you pay premiums for this coverage with after-tax dollars through payroll deductions, STD and LTD benefits are free from most income taxes.

Supplemental Medical Benefits

Have you ever known someone who was diagnosed with a critical illness, experienced an accident, or was hospitalized? Events like these happen unexpectedly. Don't go another day unprotected. Enroll in Accident, Critical Illness, and Hospital Indemnity Insurance and be prepared for whatever tomorrow brings.

We are pleased to announce that, effective January 1, 2024, our voluntary Accident, Critical Illness, and Hospital Indemnity plans will be offered through Lincoln Financial Group. You must actively enroll in these plans if you wish to receive coverage in 2024. Any existing Aflac policies will no longer be offered through Exela.

Accident Insurance

Re-enrollment required for 2024

Lincoln Financial Group Accident Insurance pays a lump sum benefit directly to you, unless otherwise assigned, if you suffer a covered injury such as a fracture, burn, torn ligament, or concussion. Benefits are paid even if you have other coverage. The benefit amount is calculated based on the type of injury, its severity, and the medical services required in treatment and recovery. The plan covers a wide variety of injuries and accident-related expenses, including but not limited to:

- Injury Treatment (Fractures, Dislocations, Concussions, Burns, Lacerations, etc.)
- Hospitalization
- Emergency Room
- Transportation
- Physical Therapy

New and Improved Plan Features

- **Improved Benefits:** Emergency Room benefits are increased to $250 and Hospital Confinement benefits are increased to $300 per day under the new plan.
- **New! Child Sports Injury Benefit:** Benefits increase by 25% for children age 18 and younger who are covered on your Accident plan and who are injured in a sanctioned school sport or competitive sport requiring registration.
- **Guaranteed-Issue:** Coverage is not dependent on answering health questions or getting a physical exam.
- **Family Coverage:** Coverage options are available for your eligible dependents.
- **24-Hour Coverage:** Benefits are paid for accidents that happen on and off the job.
- **Portability:** You can take your plan with you if you change jobs or retire (upon contacting Lincoln Financial Group directly to discuss your options and any certain stipulations).
- **Health Screening Benefit:** The plan pays a $75 benefit per covered person per calendar year if a covered health screening test is taken.

How Accident Insurance Works

Joe's son trips while playing in a youth basketball league. He suffers a concussion and fractured wrist, which require a trip to the emergency room and two physician follow-up visits. Fortunately, Joe has family Accident Insurance coverage. He receives a lump sum payment to help cover out-of-pocket costs, including copays and deductibles.

How Joe's Accident Benefit Was Calculated:

Medical Service	Sample Benefit
Emergency Care Treatment	$250
Concussion Benefit	$400
Wrist Fracture Benefit	$2,000
Physician Follow-Up Visit Benefit (2)	$200 ($100 per visit)
Child Sports Injury Benefit (additional 25%)	$712.50
TOTAL SAMPLE BENEFIT	**$3,562.50***

**This scenario does not reflect the benefits of a specific Accident Insurance plan schedule. The benefits are generic for the purposes of this example to show how the benefit total of an Accident Insurance plan is calculated. The plan offered to you may provide different benefit amounts and may not cover all services. See the plan details for the benefit schedule for the plan offered to you.*

Critical Illness Insurance

Re-enrollment required for 2024

Even the most generous medical plan does not cover all of the expenses of a serious medical condition like a heart attack or cancer. Lincoln Financial Group Critical Illness Insurance pays a lump sum benefit directly to you, unless otherwise assigned, if you are diagnosed with a covered condition. The benefit is paid in addition to any other insurance coverage you may have.

Covered illnesses include:

- Heart Attack
- Stroke
- Cancer
- Major Organ Failure
- End Stage Renal (Kidney) Failure
- Coronary Artery Bypass Surgery

New and Improved Plan Features

- **Additional Covered Conditions:** Multiple Sclerosis and Occupational HIV/AIDS are covered at 100%. Arterial/Vascular Disease is covered at 25% under the new plan.
- **Childhood Conditions Included:** Type 1 Diabetes, Cerebral Palsy, Cleft Lip/Palate, Cystic Fibrosis, Down Syndrome, Muscular Dystrophy, and Spina Bifida are covered at 100% under the new plan.
- **Guaranteed-Issue:** Coverage is not dependent on answering health questions or getting a physical exam unless you apply for coverage above the Guaranteed-Issue amount.

Guaranteed-Issue Amounts:

• Employee:	Up to $40,000
• Spouse/Domestic Partner:	Up to $40,000 - *increased amount for 2024*
• Children:	Up to $20,000

- **Family Coverage:** Coverage options are available for your eligible dependents.
- **Health Screening Benefit:** The plan pays a $75 benefit per covered person per calendar year if a covered health screening test is taken.
- **Portability:** You can take your plan with you if you change jobs or retire (upon contacting Lincoln Financial Group directly to discuss your options and any certain stipulations).

Rates for you (and your spouse if enrolled) are based on your individual ages and tobacco statuses as of January 1st each year. Costs vary by age bracket and amount of coverage as well. Your deductions will be recalculated annually based on your current age each January 1st, your coverage amount, and your tobacco status.

How Critical Illness Insurance Works

When Sam had a stroke, she was grateful her doctors were able to stabilize her condition, but she learned there was some permanent damage to her vision. She began to see her out-of-pocket costs adding up quickly. The good news is she received a lump sum payment of $10,000* to help cover these expenses from the Critical Illness coverage she elected during Open Enrollment.

**This scenario does not reflect the benefits of a specific Critical Illness Insurance plan. The benefits are generic for the purposes of this example to show how the benefit total of an Critical Illness Insurance plan is calculated. The plan offered to you may provide different benefit amounts and may not cover all services. See the plan details for the benefit schedule for the plan offered to you./*

Hospital Indemnity Insurance

Re-enrollment required for 2024

If you are admitted into a hospital, it doesn't take long for the out-of-pocket costs to pile up. Lincoln Financial Group Hospital Indemnity Insurance pays benefits directly to you, unless otherwise assigned, if you are admitted into a hospital for care due to a covered sickness or accident. Benefits are paid even if you have other coverage.

You receive a benefit as soon as you are admitted and then an additional benefit based on the number of days you are confined to the hospital. There is an additional benefit if you are admitted and confined to an intensive care unit.

New and Improved Plan Features

New and Improved Benefits:

- Additional Confinement Benefits – Rehab Facility, Mental Disorder and Substance Abuse Treatment, and Inpatient and Outpatient Surgery
- Hospital Admission Benefit – Increased to 2 admissions per year
- NICU Newborn Benefit – Admission and Confinement increased by 25%

Guaranteed-Issue: Coverage is not dependent on answering health questions or getting a physical exam.

Family Coverage: Coverage options are available for your eligible dependents.

Health Screening Benefit: The plan pays a $75 benefit per covered person per calendar year if a covered health screening test is taken.

Portable Coverage: You can take your plan with you if you change jobs or retire (upon contacting Lincoln Financial Group directly to discuss your options and any certain stipulations).

How Hospital Indemnity Insurance Works

Taylor is injured in a car accident and is in the hospital for four days. He is then moved to a rehabilitation unit for three additional days. Taylor has Hospital Indemnity Insurance. He receives a benefit for being admitted into the hospital and a benefit for each day of his inpatient and rehab stays.

How Taylor's Hospital Indemnity Benefit Was Calculated:

Medical Service	Sample Benefit	Total
Hospital Admission	$1,000 per admission	$1,000
Hospital Confinement	$200 per day (4 days)	$800
Inpatient Rehabilitation Facility	$200 per day (3 days)	$600
TOTAL SAMPLE BENEFIT		**$2,400***

**This scenario does not reflect the benefits of a specific Hospital Indemnity Insurance plan schedule. The benefits are generic benefits for the purposes of this example to show how the benefit total of a Hospital Indemnity plan is calculated. The plan offered to you may provide different benefit amounts and may not cover all services. See the plan details for the benefit schedule for the plan offered to you.*

Accident, Critical Illness, and Hospital Indemnity Insurance are underwritten by Lincoln National Life Insurance Company. The plans have limitations and exclusions that may affect benefits payable. Refer to the plans for complete details, limitations and exclusions.

Whole Life Insurance

Re-enrollment required for 2024

We are pleased to announce that, effective January 1, 2024, voluntary Group Whole Life Insurance will be offered through Allstate Benefits. You must actively enroll in this plan if you wish to receive coverage in 2024. Any existing Aflac policies will no longer be offered through Exela.

Allstate Benefits Group Whole Life Insurance completes your life insurance protection, providing a cost-effective benefit for final expenses that would otherwise defray the term insurance benefit. Final expenses include funeral costs, unpaid credit card debt and medical bills. This plan never expires, so the premium always remains the same as long as you maintain the payments.

New and Improved Plan Features

Guaranteed-Issue: No physical exams are required to apply for coverage (although health questions may be asked).

Guaranteed Issue Amounts:
- Employee: Up to $150,000
- Spouse/Domestic Partner: Up to $50,000
- Child: $10,000

Child Term Rider covers all children for one premium price.

Family Coverage: You can purchase coverage for yourself, your spouse, your children and/or your grandchildren.

New! Long-Term Care Benefit: The benefit provides a payout of up to 6% of the death benefit for up to 17 months should you need long-term care services.

Plan Builds Cash Value: This plan builds cash value, which you can eventually use to buy a paid-in-full plan with no more premiums due, or you can take out a loan against the cash value on the plan.

One-Time Election: **Once you enroll, you will not be able to increase or change your benefit amount.** In order for children to be covered, you must elect the Child Term Rider during your initial enrollment. You may add a spouse or domestic partner coverage during annual enrollment or upon a qualified life event.

Life Insurance Plan Comparison			
	Basic Life	**Supplemental Life**	**Group Whole Life**
Will the premiums go up?	N/A - The premium is fully company paid	The premiums increase as you age	The premiums stay the same
What's it for?	Replacing your income so your family can maintain their dreams and lifestyle	Replacing your income so your family can maintain their dreams and lifestyle	Paying for final expenses, such as funeral costs and nuisance debt such as credit cards
What if I leave the organization?	You may have the option to change to an individual policy that you can continue	You may have the option to change to an individual policy that you can continue	This is a plan that you can continue

Group Whole Life Insurance benefits are provided under form GWLP, or state variations thereof. Rider benefits are provided under the following forms, or state variations thereof: Accelerated Death Benefit for Terminal Illness (GWPTI); Children's Term (GWPCT); and Accelerated Death Benefit for Long-Term Care with Restoration of Benefits (GWCLTCR, GWCLTCR1).

This is a brief overview of the benefits available under the group voluntary policy underwritten by American Heritage Life Insurance Company. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation.

Commuter Benefits & Legal Plan

Commuter Benefits

You may contribute up to $300 per month through pre-tax payroll deductions to cover eligible transportation and up to $300 per month to cover eligible parking expenses while commuting to and from work.

Note: You can increase or decrease your Commuter Benefits at any time during the year. If you want to stop the deduction, zero out your election to read $0.00. Call Spring Benefits Call Center at **1-877-772-7266, Push #1** for assistance.

Plan	Maximum Contribution Amounts	Examples of Covered Expenses	Claims Period
Commuter Benefits	$300 per month for transit and $300 per month for parking	Employment-related transportation and commuter parking expenses	Any unused funds remain in the account and roll over into the next year as long as you remain actively employed by Exela and enrolled in the plan.

Legal Plan

Legal matters, both planned and unplanned, are part of life. The MetLife Legal Plan gives you the financial and emotional peace of mind to know you will be covered for expected and unexpected legal events.

The MetLife Legal Plan provides you, your spouse, and dependents with legal advice and services for a variety of legal matters. You'll have a nationwide network of more than 15,000 participating plan attorneys from which to choose. There are no deductibles, copays, claim forms, or usage limits when using a plan attorney. You can also use a non-plan attorney and get reimbursed for covered services according to a set fee schedule. You can consult with your attorney on the phone or in person.

For more information, visit **info.legalplans.com** and enter access code: 9390010 or call **1-800-821-6400**.

Covered Services

- Administrative Hearings
- Adoption
- Affidavits, Deeds
- Boundary or Title Disputes
- Civil Litigation Defense
- Consumer Protection Matters
- Debt Collection Defense
- Demand Letters
- Document Review
- Domestic Violence Protection
- Elder Law Matters
- Eviction and Tenant
- Guardianship
- Home Equity Loans
- Identity Theft Defense
- Immigration Assistance
- Incompetency Defense
- Juvenile Court Defense
- Living Wills
- Mortgages
- Name Change
- Personal Bankruptcy
- Personal Property Protection
- Powers of Attorney
- Prenuptial Agreement
- Promissory Notes
- Property Tax Assessment
- Restoration of Driving Privileges
- Sale, Purchase, or Refinancing
- Security Deposit Assistance (for tenants)
- Small Claims Assistance
- Tax Audits
- Traffic Ticket Defense (excludes DUI)
- Trusts

Other Benefits

Employee Assistance Program (EAP)

Because Exela cares about your total health, we offer a confidential Employee Assistance Program at no cost to you and your dependents. This is especially important with the impact of the added stress of COVID-19 on your physical and mental wellbeing. You can receive up to five in-person counseling sessions per person per issue per year and/or unlimited counseling by phone. The EAP can help with issues, such as:

- Depression
- Substance abuse
- Financial concerns
- Marital or family difficulties
- Stress management and anxiety
- Child or elder care

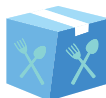
To access EmployeeConnect EAP, visit **www.GuidanceResources.com** (Username: LFGsupport / Password: LFGsupport1) or call **1-888-628-4824**.

Employee Discount Program

Employees have access to thousands of exclusive discounts through the Exela Employee Discount Program. This is your one-stop shop for savings on products, services, and experiences, with new deals added weekly. It's cost-free and simple to enroll. Shop smart and save big on:

- **TV & Laptops**

- **Meal Kit Services**



- **Hotel & Travel**

- **Theme Park & Event Tickets**

- **Automotive**

- **Camping & Outdoor Gear**

Auto & Home Insurance Discounts

Exela continues to offer access to auto and home insurance discounts through multiple carriers.

Nationwide Pet Insurance

Protect your precious pets. Nationwide Insurance helps provide your pets with the best care possible by reimbursing eligible vet bills and offering coverage for accidents and injuries. Review the pet insurance FAQs in the resource library on the Spring Benefits website. Visit **https://exela.savings.beneplace.com** to register using your email address and/or get a quote, or call **1-800-683-2886** to start saving.

2024 Employee Contributions

Delta Dental Plans* - Bi-weekly Contributions (Pre-tax)		
	PPO	DHMO
Employee Only	$17.45	$8.94
Employee + Spouse/DP	$34.89	$17.88
Employee + Child(ren)	$38.38	$19.52
Employee + Family	$55.82	$29.10

EyeMed Vision Plan - Bi-weekly Contributions (Pre-tax)	
Employee Only	$2.58
Employee + Spouse/DP	$4.89
Employee + Child(ren)	$5.16
Employee + Family	$7.57

Lincoln Financial Group Accident Insurance - Bi-weekly Contributions (Post-tax)	
Employee Only	$4.20
Employee + Spouse/DP	$6.80
Employee + Child(ren)	$8.00
Employee + Family	$10.60

Lincoln Financial Group Hospital Indemnity Insurance - Bi-weekly Contributions (Post-tax)	
Employee Only	$12.66
Employee + Spouse/DP	$25.41
Employee + Child(ren)	$20.16
Employee + Family	$32.90

Rates for all other benefit plan options including medical will be presented at the time of enrollment.

**Note: Enrolling a domestic partner will result in imputed income and/or after-tax contributions to certain benefits.*

Notices

ABOUT THIS GUIDE

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan descriptions (SPDs), plan document, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail. Exela reserves the right to make changes at any time to the benefits, costs, and other provisions relative to benefits.

REMINDER OF AVAILABILITY OF PRIVACY NOTICE

This is to remind plan participants and beneficiaries of the Exela Health and Welfare Plan (the "Plan") that the Plan has issued a Health Plan Privacy Notice that describes how the Plan uses and disclosed protected health information (PHI). You can obtain a copy of 0the Exela Health and Welfare Plan Privacy Notice upon your written request to the Human Resources Department, at the following address:

Exela, Human Resources

You may access a copy at https://exela.springapp.io. You may also request a paper copy by contacting Exela, Benefits Plan Administrator, 2701 E. Grauwyler Road, Irving, TX 75061

NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which the mastectomy was performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(3) prostheses; and

(4) treatment of physical complications of all stages of the mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions, about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card. For more information, you can visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/whcra.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT DISCLOSURE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted and you will continue to pay the same amount as if you were not absent. If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. Contact 1-877-772-7266 for more information.

Also, if you elect not to continue your health plan coverage during your military service, you have the right to be reinstated in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service connected illnesses or injuries, as applicable.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Your Options

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Exela 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. Exela has determined that the prescription drug coverage offered by the Express Scripts Medical Plan through United Healthcare 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 through 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 Exela coverage WILL be affected. If you do decide to join a Medicare drug plan and drop your current Express Scripts prescription drug 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 Exela 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 19 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.

Notices

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 Exela 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 for personalized help. See the inside back cover of your copy of the "Medicare & You" handbook for their telephone number.

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: 1-800-772-1213 (TTY: 1-800-325-0778)
Name of Entity/Sender: Exela
Contact: Exela, Benefits Plan Administrator
Address: 2701 E. Grauwyler Road, Irving, TX 75061

Phone Number: 1-877-772-7266

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).

YOUR ERISA RIGHTS

As a participant in the Exela benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants shall be entitled to receive information about their plan and benefits, continue group health plan coverage, and enforce their rights. ERISA also requires that plan fiduciaries act in a prudent manner.

Receive Information About Your Plan and Benefits

You are entitled to:

- Examine, without charge, at the plan administrator's office, all plan documents—including pertinent insurance contracts, trust agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the plan's administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary report of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continued Group Health Plan Coverage

You are entitled to:

- Continued health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have credible coverage from another plan. You should be provided a certificate of credible coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the plan;
  - You become entitled to elect COBRA continuation coverage;
  - You request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to:

- Know why this was done;
- Obtain copies of documents relating to the decision without charge; and
- Appeal any denial.

All of these actions must occur within certain time schedules. Under ERISA, there are steps you can take to enforce your rights. For instance, you may file suit in a federal court if:

- You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator;
- You have followed all the procedures for filing and appealing a claim (as outlined earlier in this summary) and your claim for benefits is denied or ignored, in whole or in part. You may also file suit in a state court.
- You disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order; or
- The plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. This should occur if the court finds your claim frivolous.

Assistance with Your Questions

If you have questions about how your plan works, contact the Human Resources Department. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office listed on EBSA's website: https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/regional-offices

Or you may write to the:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee and Employer Hotline of the Employee Benefits Security Administration at: 1-866-444-3272. You may also visit the EBSA's web site on the Internet at: https://www.dol.gov/agencies/ebsa.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 when you would otherwise lose your group health coverage.

It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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 (www.healthcare.gov). 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 coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

•Your hours of employment are reduced, or

•Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

•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 any of the following qualifying events happen:

•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. When the qualifying event is 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), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the 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: Exela Human Resources or COBRA Administrator.

How is COBRA 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. Any qualified beneficiary who does not elect COBRA within the 60-day election period specified in the election notice will lose his or her right to elect COBRA.

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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two 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 the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of the date of the Social Security Administration's disability determination; the date of the covered employee's termination of employment or reduction in hours; and the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction in hours. You must also provide this notice within 18 months after the covered employee's termination or reduction in hours in

order to be entitled to this extension.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Other Coverage Options

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.

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 8-month 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/medicare-and-you.

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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at https://www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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

For further information regarding the plan and COBRA continuation, please contact:

Exela Benefits Plan Administrator
2701 E. Grauwyler Road, Irving, TX 75061

1-877-772-7266

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

Notices

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

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

CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-healthplan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

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

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-partyliability/childrens-health-insurance-program-reauthorizationact-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-766-9012

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

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

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

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programsservices/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: https://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

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

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://www.healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPPProgram.aspx
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: https://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

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

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid/CHIP Phone: 1-800-432-5924

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

WEST VIRGINIA-Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

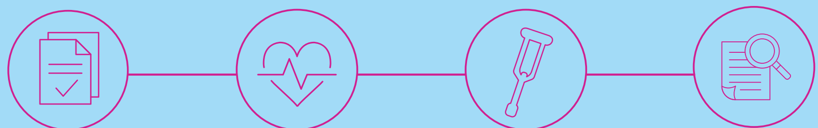
To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

Important Contacts

Important Contacts				
Benefit	**Provider**	**Network / Group Number**	**Phone**	**Web**
Enrollment Platform & Call Center	Exela Spring	N/A	1-877-772-7266, option 1	https://exela.springapp.io
	Exela Health Benefits	N/A	1-877-772-7266, option 2	https://exela.makeityoursource.com
Medical	Refer to the back of your medical card for Group Number and Customer Service contact number, or refer to your carrier contacts listed on the Exela Health Benefit website.			
Dental PPO	Delta Dental	Network: Delta Dental PPO & Premier Group #: 19106	1-800-521-2651	www.deltadentalins.com
Dental HMO	Delta Dental	Network: DeltaCare USA Group #: 78941	1-800-422-4234	www.deltadentalins.com
Vision	EyeMed	Group #: 9889924	1-866-939-3633	www.eyemedvisioncare.com/member
Life and AD&D	Lincoln Financial	Group #: 02-094796	Active Life Claims: 1-888-787-2129 Conversion: 1-800-423-2765, option 1 Portability: 1-888-786-2688 EOI: 1-888-287-8494, option 2	www.MyLincolnPortal.com
FMLA/Long-Term Disability	Lincoln Financial	Group #: 02-094796	Active Leaves: 1-866-630-9320 Reporting a New Leave: 1-800-213-6231 Active LTD Claims: 1-800-291-0112	www.MyLincolnPortal.com
Accident, Critical Illness, and Hospital Indemnity	Lincoln Financial Group	Group ID #: 1027625	1-800-423-2765	www.lincolnfinancial.com
Group Whole Life	Allstate Benefits	Group #: 82962	1-800-521-3535	https://mybenefits.allstate.com/#/login
Short-Term Disability	Lincoln Financial	Group #: 02-094796	1-800-213-6231	www.MyLincolnPortal.com First-time users must register using company code: Exela
Health Savings Account	Smart Choice	N/A	1-877-772-7266, option 2	digital.alight.com/exela
Flexible Spending Accounts	Smart Choice	N/A	1-877-772-7266, option 2	digital.alight.com/exela
Commuter Benefits	American Benefits Group	N/A	1-800-499-3539, option 2	www.amben.com/wealthcare
COBRA	Alight	N/A	1-833-938-4025	digital.alight.com/exela
Legal Assistance	MetLife Legal	N/A	1-800-821-6400	info.legalplans.com Access code: 9390010
Employee Assistance Program	EmployeeConnect	N/A	1-888-628-4824	www.GuidanceResources.com Username: LFGsupport Password: LFGsupport1
Discount Program	Beneplace	N/A	1-800-683-2886	https://exela.savings.beneplace.com



NOTE: This statement is intended to summarize the benefits you receive from Exela Technologies. The actual determination of your benefits is based solely on the plan documents provided by the carrier of each plan. This summary is not legally binding, is not a contract, and does not alter any original plan documents. For additional information, please contact the Human Resources department.