DSV US Employee Benefits Guide

May 1, 2025 - April 30, 2026

Global Transport and Logistics

BENEFIT INFORMATION

YOUR BENEFIT PLANS

DSV offers a variety of benefits allowing you the opportunity to customize a benefits package that meets your personal needs. In the following pages, you'll learn more about the benefits offered. You'll also see how choosing the right combination of benefits can help protect you and your family's health and finances – and your family's future.

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OUR VENDORS

Aetna

AllState

Brightline

CVS Health & Pharmacy

Delta Dental of New Jersey

EyeMed

Fidelity Investments

Hinge Health

Inspira Financial

Kaiser Permanente

LegalEase

The Hartford

ELIGIBILITY

All full-time regular employees working 30 or more hours per week are eligible to join DSV Benefits once the waiting period has been satisfied. Coverage will begin on the 1st day of the month following 30 days of employment. You may also enroll your dependents in your elected plans.

WHO'S AN ELIGIBLE DEPENDENT?

- Your legal spouse
- Biological, adopted, stepchildren or children whom you have legal custody up to age 26.
- Registered Domestic Partner and/or their children where applicable by state law (CA, OR, CO, IL, HI, WA, NV, WI, NJ, MD & DC)
- Disabled children age 26 and older may continue on your coverages if they meet specific criteria.

WHEN CAN YOU ENROLL?

Employees can enroll in benefits at the following times:

- As a new hire, at your initial eligibility date.
- During a change in work status that permits enrollment according to the Affordable Care Act
.
- During the annual open enrollment period.
- Within 30 days of a qualifying life event.
- Year-Round Enrollment for specific plans.

MAKING CHANGES

Generally, you can only change your benefit elections during the annual benefits enrollment period. However, you may be able to change your benefit elections during the plan year if you have a qualifying life event or are making updates through the Year-Round Enrollment.

QUALIFYING LIFE EVENTS

- Marriage or divorce.
- Birth or adoption of a child.
- Change in a dependent's coverage.
- Change in your coverage if not covered under the employer benefits.
- Death of a dependent.

YEAR-ROUND ENROLLMENT

- Updating your HSA contributions.
- Enrolling/updating the Dependent Care Account.
- Enrolling/updating the Commuter Benefit Account: Parking & Transit.
- Updating a beneficiary on your basic life insurance.

WHEN DOES COVERAGE END?

Coverage ends on the last day of the month from the employment termination date for medical, dental and vision plans. Employer sponsored plans and HSA/Reimbursement Accounts terminate on the last day worked. You may continue coverages through COBRA, which is administered by Inspira Financial.

OUR BENEFITS PROGRAM

ENROLLMENTS

All benefit enrollment events take place in ADP Workforce Now. Employees can submit New Hire, Qualifying life events, Open Enrollment and Year-Round enrollment elections from their ADP profiles either through desktop or mobile app. If an employee is adding a dependent to coverages, they must provide dependent documentation. Acceptable documentation includes a marriage certificate, legally filed registered domestic partnership document, birth certificates for children or a recent joint/single tax return with dependents claimed.

EMPLOYER SPONSORED BENEFITS

DSV provides eligible full-time employees with employer-paid Life and AD&D insurance, for employees and their eligible dependents. Additionally, eligible employees are provided short and long-term disability.

EMPLOYEE CONTRIBUTIONS

Employees are responsible to contribute to the cost of the elected coverages. Contributions are made on a pre-tax basis.

EFFECTIVE DATES

Benefits are effective on the 1st of the month following 30 days of continuous employment. Eligible employees must enroll within 30 days of their hire date. If enrollment is not completed within 30 days, employees will have company-sponsored benefits only.

MEDICAL INSURANCE

DSV offers six medical plans, including Aetna Choice POS II with in and out-of-network coverage, featuring HRA, HSA, and Copay plan options. For California residents, the Kaiser Permanente HMO plan is available, which only covers in-network services. Employees are encouraged to use participating providers to maximize benefits.

Aetna Choice POS II HRA

Option 1: APCN+ $2,500 HRA
Option 2: $1,500 100/70 HRA

Both plan options include an employer-paid Health Reimbursement Account (HRA) that covers the first $500 of the individual deductible and $1,000 for the family deductible. Starting in 2025, DSV is introducing the APCN+ $2,500 80/60 HRA plan, a tiered option that lowers out-of-pocket costs when using Aetna Premier Care Network providers and facilities.

Know Your HRA Plan

- Preventative healthcare services are fully covered by the plan.
- After HRA funding is exhausted, participants are responsible for the remainder of the deductible. Once deductible is met, participants will pay a coinsurance.
- Copayments are applicable to prescription drugs.
- Once the out-of-pocket maximum is reached, the plan pays the full cost of qualifying healthcare services.
- The APCN+ tier cross-accumulates with the standard $2,500 80/60 standard benefit on deductibles, out-of-pocket max and HRA.

Aetna Choice POS II Copay

Option 1: $30 / $50 $2,000 Copay Plan
Option 2: $20 / $50 $750 Copay Plan

Both plan options have applicable deductible and coinsurance for specific healthcare services. Copayments will apply to office visits to primary care, specialists and urgent care. Copay plans have more predictable billing when participants have frequent follow-ups with their providers for services due to the fixed dollar amount for office visits.

Know Your Copay Plan

- Preventative healthcare services are fully covered by the plan.
- Once deductible is met, participants will pay a coinsurance on qualifying healthcare services.
- Copayments are applicable to prescription drugs.
- Once the out-of-pocket maximum is reached, the plan pays the full cost of qualifying healthcare services.

MEDICAL INSURANCE - *Continued*

DSV offers six medical plans, including Aetna Choice POS II with in and out-of-network coverage, featuring HRA, HSA, and Copay plan options. For California residents, the Kaiser Permanente HMO plan is available, which only covers in-network services. Employees are encouraged to use participating providers to maximize benefits.

Aetna Choice POS II HSA

Option 1: HSA High-Deductible Health Plan

The High-Deductible Health Plan (HDHP) includes the opening of a Health Savings Account (HSA). Participants will receive employer contributions that funds $500 for individuals or $1,000 for participants with dependents. Employees may also contribute to the HSA on a pre-tax basis.

2025 HSA Contribution Limits

- **Employee Only: $4,300**
- **Employee + Family: $8,550**
- **Catch-up Contribution (Age 55+): $1,000**

Know Your HSA Plan

- Preventative healthcare services are fully covered by the plan.
- Participants pay the full cost of non-preventative services until the annual deductible is met. When enrolled with dependents, the full family deductible must be met before the plan pays for one covered individual.
- Copayments are applicable to prescription drugs.
- Once the out-of-pocket maximum is reached, the plan pays the full cost of qualifying healthcare services.

Kaiser Permanente HMO

Option 1: $500 80/20 HMO Plan

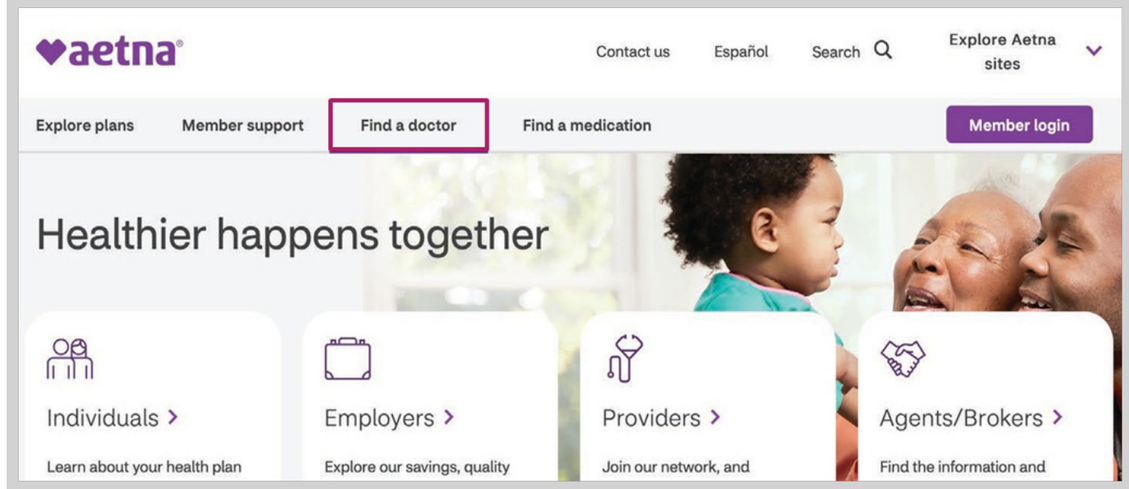
The Kaiser HMO plan option includes a deductible and coinsurance that is applicable to specific services. The plan resembles a copay plan, as there are also copayments for certain healthcare services. When covered by an HMO plan, there is no out-of-network coverage. Kaiser has a dedicated transition of care program to assist with transitioning to a participating provider in the event your current provider is out-of-network.

Know Your Kaiser Plan

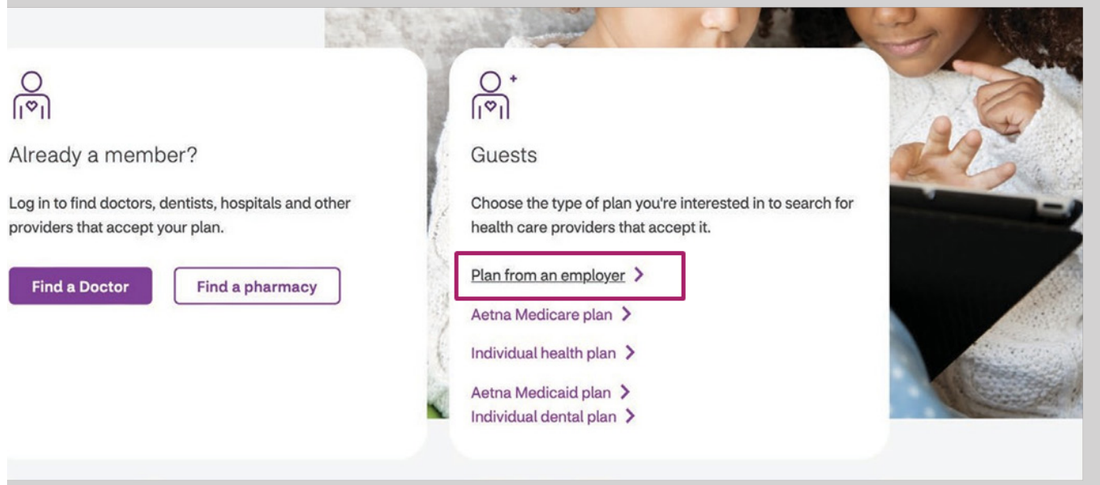
- Preventative healthcare services are fully covered by the plan.
- Once deductible is met, participants will pay a coinsurance on qualifying healthcare services.
- Copayments are applicable to prescription drugs.
- Once the out-of-pocket maximum is reached, the plan pays the full cost of qualifying healthcare services.

APCN+ HRA PROVIDER LOCATOR

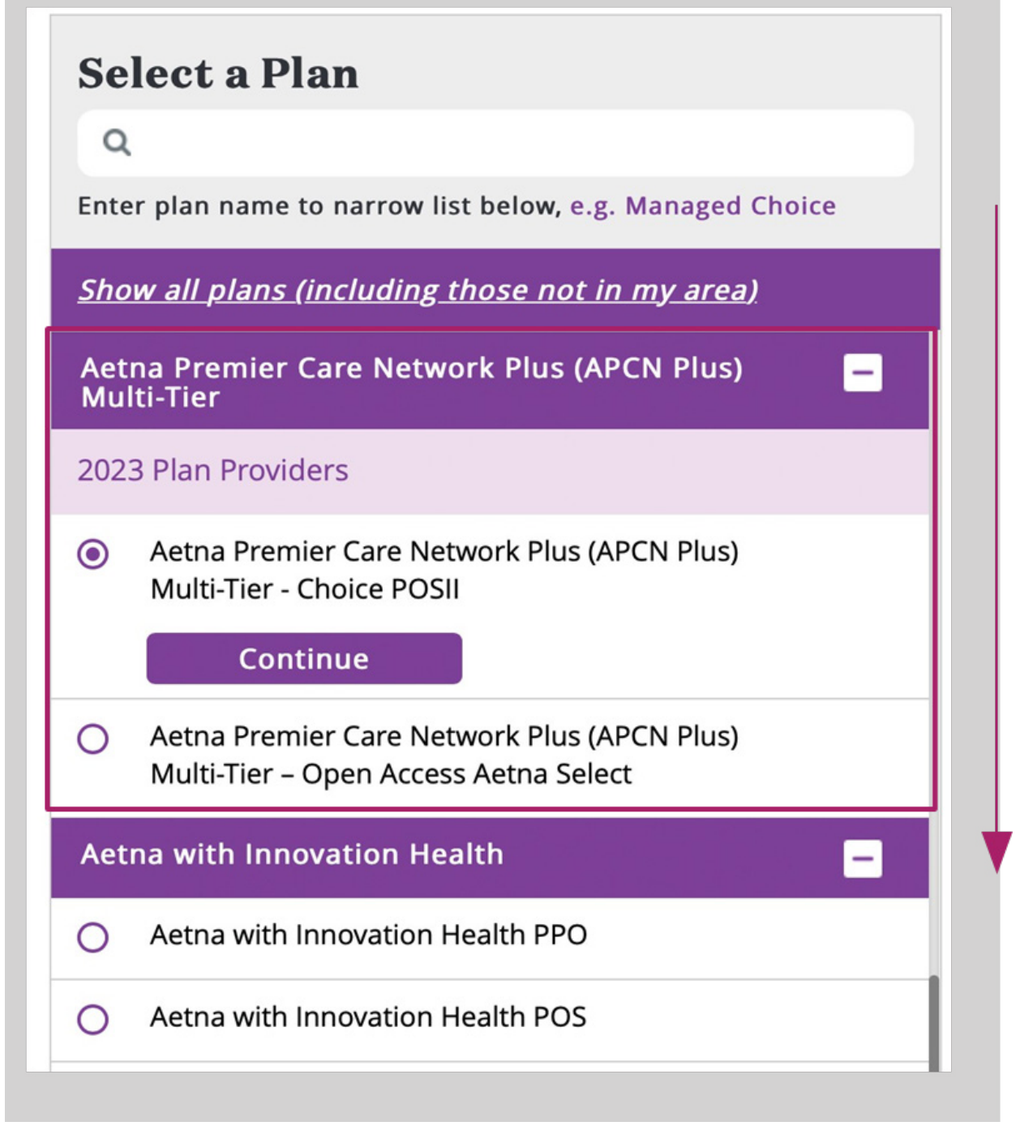
Participants in the APCN+ HRA plan will have the ability to locate providers within the network for maximum savings. Participants' Aetna member portal will highlight providers who offer maximum savings in APCN+ Network or Standard Savings (In-Network, no APCN+ benefit).



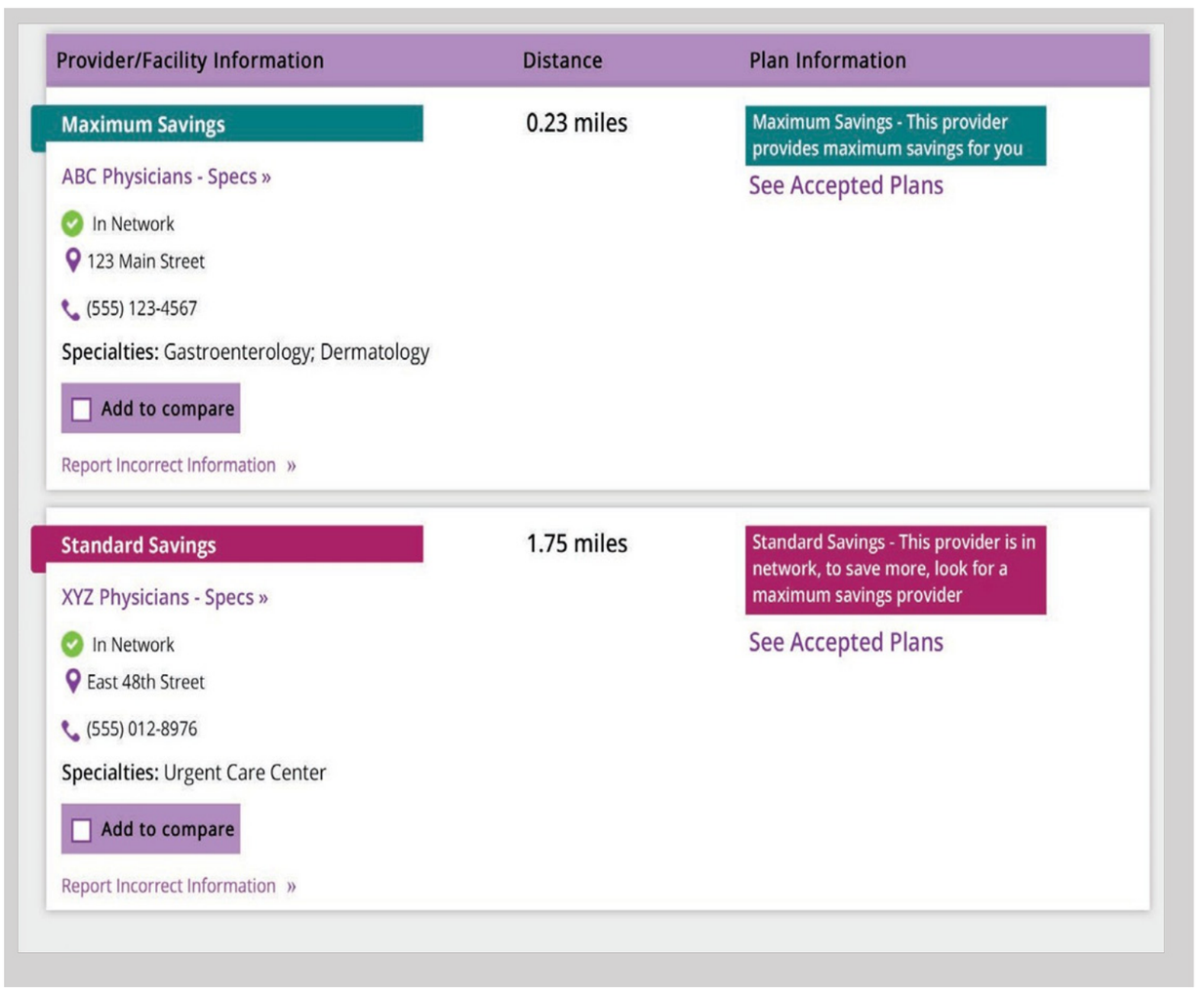
Step 1: Visit Aetna.com and select "Find a Provider" at the top of the page.



Step 2: Under "Guests" select "Plan from an employer" and enter your home zip code.



Step 3: Scroll down to select the Aetna Premier Care Network Plus (APCN+) Multi-Tier plan - Choice POS II. Click continue.



Step 4: Search based on provider type or by provider name. The portal will highlight the providers offering Maximum Savings and Standard Savings.

AETNA APCN+ $2,500 HRA COVERAGE

APCN+ Multi-Tier Choice POS II	APCN+ 2500 HRA Plan (FSA Compatible)	
Plan Coverage	APCN+ Tier 1	In-Network Tier 2
Individual/Family Deductible (Per Plan Year)	$1,500 / $3,000	$2,500 / $5,000
HRA (Provided at start of plan year)	$500 / $1,000	$500 / $1,000
Co-insurance (Applies after Deductible)	Plan: 90% / Member: 10%	Plan: 80% / Member: 20%
Individual / Family Out-of-Pocket Maximum (Per Plan Year)	$4,000 / $8,000	$6,000 / $12,000
Medical Coverage		
Routine Preventative Care	Covered 100%	Covered 100%
Office Visits (PCP/Specialist)	Deductible/Coinsurance	Deductible/Coinsurance
CVS Virtual Care & CVS Minute Clinic	Covered 100%	Covered 100%
Outpatient Diagnostic (Lab/X-ray)	Deductible/Coinsurance	Deductible/Coinsurance
Complex Imaging (CT/MRI/PET)	Deductible/Coinsurance	Deductible/Coinsurance
Ambulance	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Room	Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care Facility	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Surgery	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Coverage (Tiers: Generic / Preferred Brand / Non-Preferred Brand)		
Retail Pharmacy	$15 / $35 / $50	$15 / $35 / $50
CVS Retail Pharmacy & Mail Order (90-day Supply)	2x Retail Copay	2x Retail Copay

AETNA MEDICAL COVERAGE

Choice POS II	1500 100/70 HRA Plan (FSA Compatible)	HSA HDHP (FSA Incompatible)
Plan Coverage	In-Network	In-Network
Individual/Family Deductible (Per Plan Year)	$1,500 / $3,000	$1,650 / $3,300
HRA (Provided at start of plan year)	$500 / $1,000	Not Applicable
DSV HSA Contribution (Deposited Monthly)	Not Applicable	$500 / $1,000
Co-insurance (Applies after Deductible)	Plan: 100% / Member: 0%	Plan: 80% / Member: 20%
Individual / Family Out-of-Pocket Maximum (Per Plan Year)	$6,000 / $12,000	$6,000 / $12,000
Medical Coverage		
Routine Preventative Care	Covered 100%	Covered 100%
Office Visits (PCP/Specialist)	Deductible/Coinsurance	Deductible/Coinsurance
CVS Virtual Care & CVS Minute Clinic	Covered 100%	Deductible first; Covered 100%
Outpatient Diagnostic (Lab/X-ray)	Deductible/Coinsurance	Deductible/Coinsurance
Complex Imaging (CT/MRI/PET)	Deductible/Coinsurance	Deductible/Coinsurance
Ambulance	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Room	Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care Facility	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Surgery	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Coverage (Tiers: Generic / Preferred Brand / Non-Preferred Brand)		
Retail Pharmacy	$15 / $35 / $50	Deductible first; $15 / $35 / $50
CVS Retail Pharmacy & Mail Order (90-day Supply)	2x Retail Copay	Deductible first; 2x Retail Copay

AETNA MEDICAL COVERAGE

Choice POS II Plan Coverage	30/50 2000 Copay Plan (FSA Compatible) In-Network	20/50 750 Copay Plan (FSA Compatible) In-Network
Individual/Family Deductible (Per Plan Year)	$2,000 / $4,000	$750 / $1,500
Co-insurance (Applies after Deductible)	Plan: 80% / Member: 20%	Plan: 80% / Member: 20%
Individual / Family Out-of-Pocket Maximum (Per Plan Year)	$6,000 / $12,000	$6,000 / $12,000
Medical Coverage		
Routine Preventative Care	Covered 100%	Covered 100%
Office Visits (PCP/Specialist)	$30 Copay / $50 Copay	$20 Copay / $50 Copay
CVS Virtual Care & CVS Minute Clinic	Covered 100%	Covered 100%
Outpatient Diagnostic (Lab/X-ray)	Deductible/Coinsurance	Deductible/Coinsurance
Complex Imaging (CT/MRI/PET)	Deductible/Coinsurance	Deductible/Coinsurance
Ambulance	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Room	Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care Facility	$50 Copay	$25 Copay
Inpatient Hospital	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Surgery	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Coverage (Tiers: Generic / Preferred Brand / Non-Preferred Brand)		
Retail Pharmacy	$15 / $35 / $50	$15 / $35 / $50
CVS Retail Pharmacy & Mail Order (90-day Supply)	2x Retail Copay	2x Retail Copay

KAISER DHMO MEDICAL COVERAGE

DHMO Southern & Northern	Kaiser Permanente DHMO Plan (FSA Compatible)
Plan Coverage	In-Network
Individual/Family Deductible (Per Plan Year)	$500 / $1,000
Co-insurance (Applies after Deductible)	Plan: 80% / Member: 20%
Individual / Family Out-of-Pocket Maximum (Per Plan Year)	$3,000 / $6,000
Medical Coverage	
Routine Preventative Care	Covered 100%
Office Visits (PCP/Specialist)	$30 Copay / $40 Copay
Telehealth	Covered 100%
Outpatient Diagnostic (Lab/X-ray)	$10 Copay; after Deductible
Complex Imaging (CT/MRI/PET)	Deductible/Coinsurance; Up to $150
Ambulance	$150 Copay; after Deductible
Emergency Room	Deductible/Coinsurance
Urgent Care Facility	$30 Copay
Inpatient Hospital	Deductible/Coinsurance
Outpatient Surgery	Deductible/Coinsurance
Prescription Coverage (Tiers: Generic / Preferred Brand / Non-Preferred Brand)	
Retail Pharmacy	$10 - $30 Copay
Retail Pharmacy & Mail Order Up to 100-day Supply)	2x Retail Copay

CVS HEALTH

CVS VIRTUAL PRIMARY CARE & CVS MINUTE CLINIC

As an Aetna member, participants have access to CVS Virtual Primary Care and CVS Minute Clinics for on-demand care for non-emergent illnesses and conditions. This partnership allows members to consult with a provider virtually for primary care and 24/7 urgent care visits, or receive in-person care at a local Minute Clinic.

COVERAGE

Participants enrolled in an HRA or Copay plan have 100% coverage for CVS Virtual Primary Care or CVS Minute clinic visits. HSA plan participants need to meet the plan deductible before visits are covered at 100%.

GET CONNECTED

Members can schedule appointments by visiting the CVS Virtual Care & Minute Clinic websites.

CVS Virtual Care

www.cvs.com/virtual-care

CVS Minute Clinic

www.cvs.com/minuteclinic

EXCLUSIONS

Members enrolled in the APCN+ 2500 80/60 HRA will not have access to the Virtual Primary Care feature, but will have access to the virtual urgent care and CVS Minute clinic services.

Louisiana
Alexandria/Shreveport/Monroe
North Carolina
Charlotte/Raleigh/Durham/Winston-Salem
Tennessee
Chattanooga/Memphis/Nashville
Oklahoma
Oklahoma City
Texas
Austin/El Paso/Houston/Rio Grande Valley
San Antonio

CVS CAREMARK

CVS CAREMARK OVERVIEW

Employees have access to CVS Caremark to manage their prescription medications, access a nationwide network of pharmacies, and take advantage of cost-saving programs available through their Aetna medical plans.

DIGITAL ACCESS

When you register for an online account or download the mobile app, there is access to manage medications from a desktop or mobile device — anytime, anywhere. Here's how the CVS Caremark digital tools can help you and your family members:

- Locate participating pharmacies
- Check drug costs
- Manage refills
- Receive alerts and updates on your medications.

RX MAIL DELIVERY

CVS Caremark Mail Service Pharmacy can deliver 90-day supplies of medications directly to your home and you can set automatic refills from your account.

CVS SPECIALITY

For those managing complex conditions, CVS Speciality provides specialized medications when managing these conditions. The CVS Specialty Care Team that you can connect with from your account to assist with medication management.

AETNA SUPPLEMENTAL

AETNA SUPPLEMENTAL PLANS

Aetna Supplemental Plans provide additional financial protection for employees and their eligible dependents during unexpected life events. These plans offer cash benefits paid directly to covered individuals after an approved claim, which can be used to cover healthcare expenses or personal needs. Additionally, the Wellness Rider on Accident and Critical Illness plans provides a $50 benefit per covered individual for submitting proof of a routine health screening completed within the plan year. Employees do not need to be enrolled in any of DSV's medical plans to enroll in an Aetna Supplemental Plan.

ACCIDENT INSURANCE

Covers employees and eligible dependents for accidental injuries resulting in broken bones, sports injuries or needing to take an ambulance. Cash benefits are determined based on the injury type, severity and treatment required for the injury.

CRITICAL ILLNESS

Covers employees and eligible dependents for newly diagnosed critical illness and conditions such as Cancer, Stroke or Heart Attack. The plan does not cover pre-existing conditions. Enrolled employees and their spouses receive a $15,000 cash benefit and enrolled child dependents receive $7,500.

HOSPITAL INDEMNITY

Covers planned and unplanned overnight hospital admissions at two coverage levels. The plan is not eligible for the Wellness rider. Employees have the following coverage options:

- **$500 Plan:** Pays $500 for the first night admitted; $100 any subsequent nights admitted.
- **$1,000 Plan:** Pays $1,000 for the first night admitted; $50 any subsequent nights admitted.

BRIGHTLINE

Brightline is a virtual mental healthcare platform available to children and teens of Aetna members. It offers therapy, coaching, and medication management for individuals aged 2 to 17, providing accessible and specialized support for mental health needs.

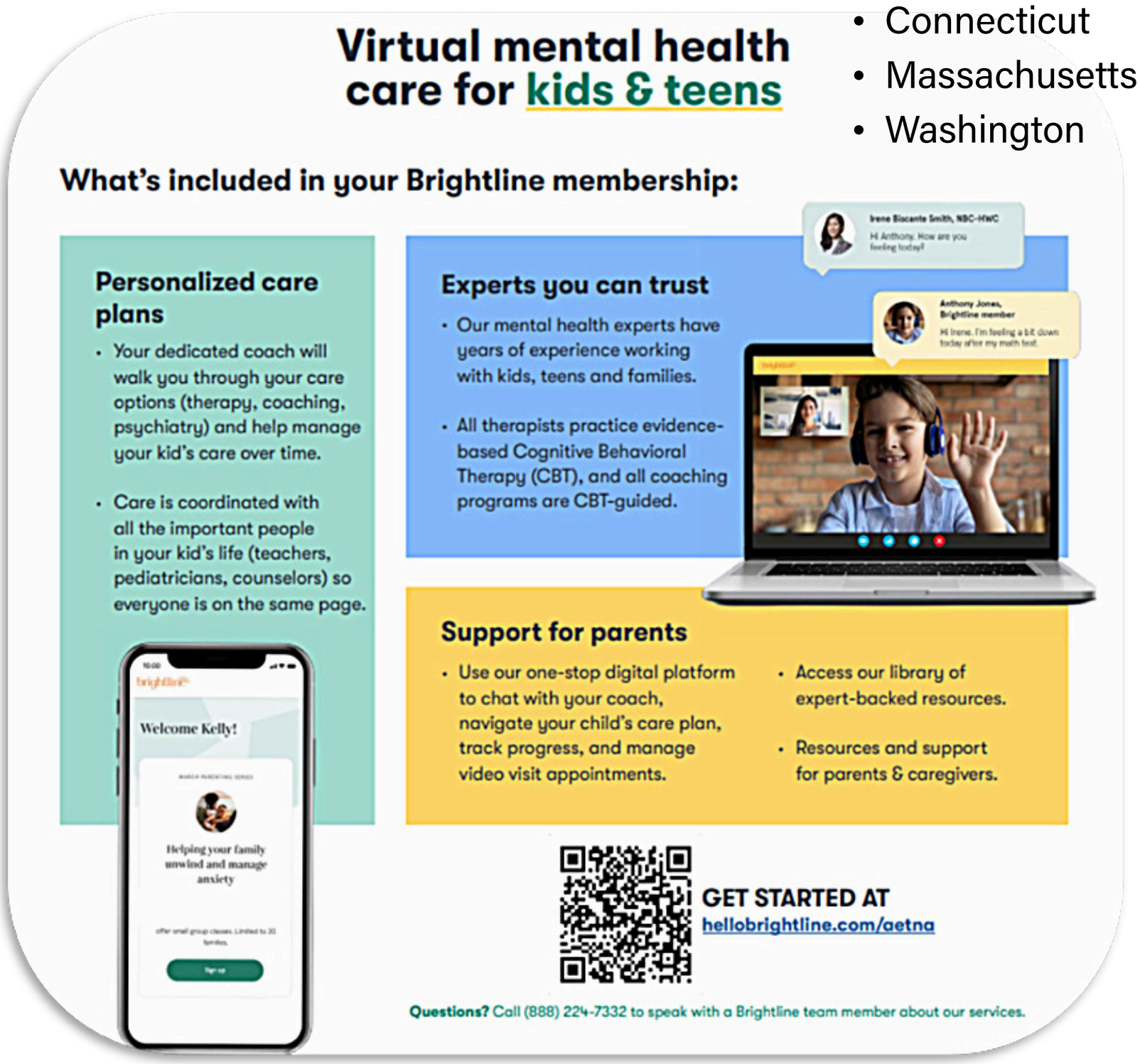
REGISTRATION

- Visit www.hellobrightline.com
- Complete an assessment and get matched with a provider.
- Schedule your child's first appointment.

SERVICE AREAS

Brightline services are available in the following states:

- New York
- New Jersey
- Connecticut
- Massachusetts
- Washington



HINGE HEALTH

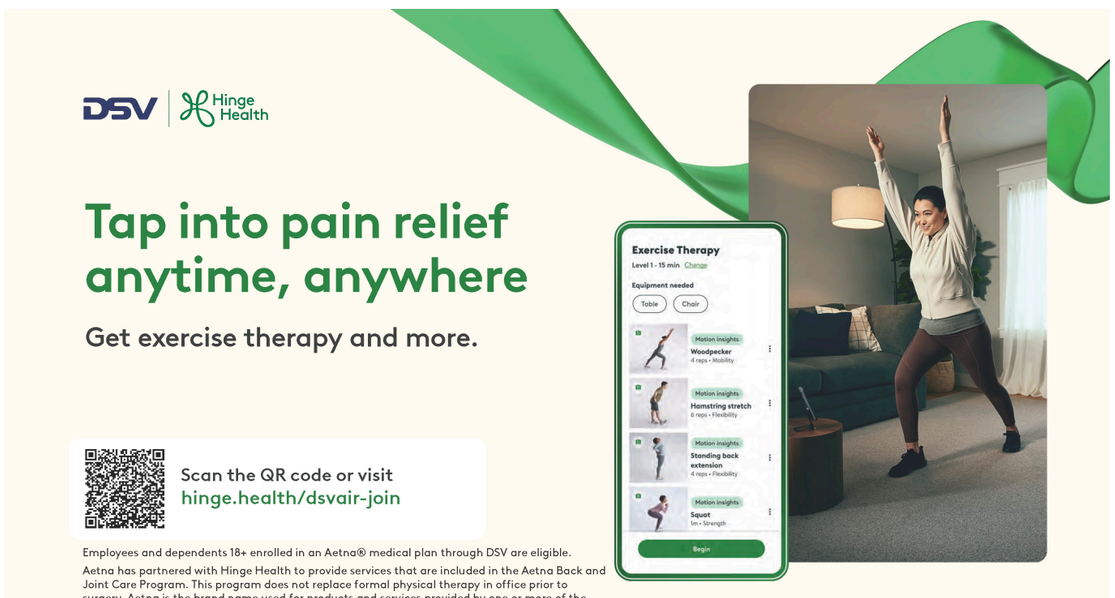
Hinge Health is a virtual physical therapy platform available to Aetna members and dependents. At no additional cost or impact on the health plan allotment, members can receive personalized care for musculoskeletal conditions, including back, neck, and shoulder pain. New in 2025, Hinge Health has introduced the Women's Pelvic Health Program, specifically designed to address pelvic floor concerns.

GET STARTED WITH HINGE HEALTH

Use the QR codes below to begin care with Hinge Health. Members will complete a health assessment and get matched with their care team. Then schedule your first appointment to establish a care plan and begin treatment. Members are able to treat multiple areas of concern at the same time. Your Physical Therapist will update your exercises to address these issues.

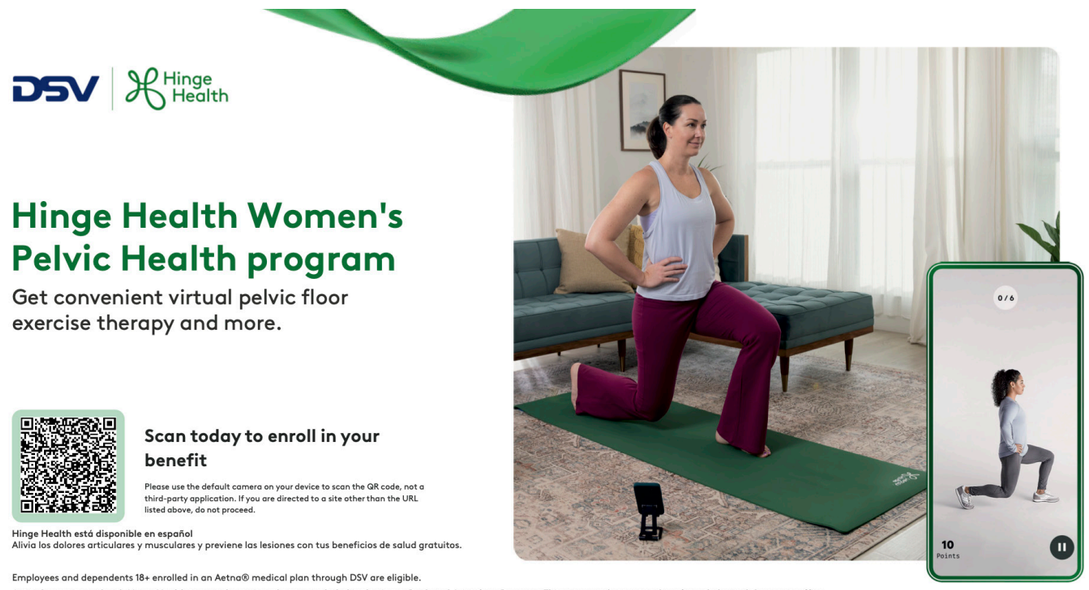
How Hinge Health Supports You

Once members are established with their care team, they can expect to meet with their Physical Therapist and Health Coach regularly to track progress, make care plan revisions as needed or discuss additional problem areas. Hinge Health will send members any necessary equipment to complete exercises for their care. Hinge Health will also work with your providers regarding conditions you are treating.



Employees and dependents 18+ enrolled in an Aetna® medical plan through DSV are eligible.

Aetna has partnered with Hinge Health to provide services that are included in the Aetna Back and Joint Care Program. This program does not replace formal physical therapy in office prior to surgery. Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).



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DENTAL PLANS

Delta Dental of New Jersey administers DSV's dental plans under the DPPO Plus Premier Network. These plans provide both in-network and out-of-network coverage; however, staying in-network is highly recommended to minimize out-of-pocket costs. Employees can choose from three plan options to best meet their needs and those of their dependents.

Delta Dental Core Plan

The Core plan is a basic level plan that covers preventative and basic dental services. Major services such as non-prefabricated crowns and implants are not a covered benefit. The Core plan does not have an Orthodontia benefit. This plan is ideal for those with minimal dental care needs.

Delta Dental Buy-Up 1 Plan

The Buy-Up 1 plan provides well rounded coverage for preventative, basic and major dental services. The Buy-up 1 plan does not have an Orthodontia benefit. This plan is ideal for those who need a range of coverage for simple and complex dental services from simple fill-ins to root canals.

Delta Dental Buy-Up 2 Plan

The Buy-Up 2 Plan is the highest level of coverage offered. The plan covers preventative, basic and major services including dental implants and crowns. The Buy-Up 2 plan has an Orthodontic benefit applicable to both adults and children.

Delta Dental Carryover MaxSM

The Carryover MaxSM is an automated benefit as a Delta Dental member. This program allows members to carryover a portion of their unused standard annual maximum benefit limit into the next plan year and accrue beyond. To qualify for the carryover max, members must have one oral exam or cleaning during the plan year. If a member fails to do so, the carryover will not apply and any accrual will be lost.

- A covered person is eligible if less than half of the standard annual max is used in the prior benefit year.
- Carryover MaxSM allows members to carry over up to 25% of the unused portion of the standard annual maximum up to a maximum of $500.
- Standard annual maximum dollars are used first. Carryover MaxSM dollars are used secondarily.

DENTAL COVERAGE

PPO Plus Premier	Delta Dental Core Plan	Delta Dental Buy-Up 1 Plan	Delta Dental Buy-Up 2 Plan
Plan Coverage	In-Network & Out-of-Network	In-Network & Out-of-Network	In-Network & Out-of-Network
Individual/Family Deductible (Per Plan Year/Covered Individual)	$50 / $150	$50 / $150	$50 / $150
Benefit Maximum (Per Plan Year/Covered Individual)	$1,000	$1,500	$2,000
Preventative & Diagnostic Services (No deductible)	100% Covered	100% Covered	100% Covered
Basic Services (Co-insurance)	80% / 20%	80% / 20%	80% / 20%
Major Services (Co-insurance)	Not Covered	50% / 50%	80% / 20%
Orthodontia (Adults & Children)	Not Covered	Not Covered	50% up to a $2,000 Lifetime Max

Preventative & Diagnostic

Routine Exams
Routine Cleanings
X-rays
Sealants

Major Services

Non-Prefabricated Crowns
Bridgework, Full & Partial Dentures
Impants, Prothesis over Impant
Impacted Extractions

Basic Services

Fillings (Composite Fillings on all teeth
Simple Extractions
Non-Surgical Periodontics
Denture Repair, Occlusal Guards

Orthodontia

Tooth & Jaw Correction

VISION PLAN

EyeMed administers DSV's Vision plan through the Insight Network. Employees are able to see contracted providers through LensCrafters, Target Optical, PearleVision and more. The plan has an out-of-network reimbursement program for employees to submit for reimbursement when seen by or obtaining eyeglasses and contacts through an out-of-network provider.

Vision Benefits Online

EyeMed is contracted with online providers that will apply your Vision benefit when purchasing glasses or contacts online. Employees can visit online retailers such as glasses.com, rayban.com and contactsdirect.com to order.

EyeMed Virtual Benefit Fair

Get detailed information on the Vision benefit by accessing the Virtual Benefit Fair!
EyeMed Virtual Benefit Fair Site
Access Code: VR85W4J6

Member Discounts

As a member of EyeMed, you will have access to various discounts:

- 40% off an additional pair of glasses.
- 20% off any item not covered by the plan.
- 15% off the retail price or 5% off the promotional price for Lasik or PRK treatment from the US Laser Network.

Vision Coverage	In-Network Member Cost	Out-of-Network Member Reimbursement
Routine Exam (Once every 12 months)	$0 Copay	Up to $40
Frame (Once every 12 months)	$0 Copay; 20% off balance over $150 allowance	Up to $75
Standard Plastic Lenses (In lieu of contacts once every 12 months)		
Single Vision/Bifocal/Trifocal/Lenticular	$0 Copay	Up to $40
Progressive - Standard	$65 Copay	Up to $75
Contact Lenses (In lieu of lenses once every 12 months)		
Contacts - Conventional	$0 Copay; 15% off balance over $150 allowance	Up to $150
Contacts - Disposable	$0 Copay; 100% of balance over $150 allowance	Up to $150
Contacts Fit & Follow Up - Standard	Up to $40	Not Covered

HSA & REIMBURSEMENT ACCOUNTS

Inspira Financial

DSV partners with Inspira Financial to administer Health Savings Accounts (HSA), Flexible Spending Accounts (FSA), Dependent Care Accounts (DCA), and Commuter Benefits (Parking & Transit). Employees can contribute pre-tax dollars to cover eligible healthcare, dependent care, and commuting expenses.

Employees enrolled in the Aetna High-Deductible Health Plan (HDHP) are eligible to contribute to an HSA. Enrollment in the corresponding medical plan is required to make HSA contributions. Additionally, employees cannot contribute to both an HSA and an FSA simultaneously.

Health Savings Account (HSA)

Employees enrolled in the Aetna High-Deductible Health Plan are eligible to contribute pre-tax dollars for eligible medical, dental, vision expenses and HSA approved goods. DSV makes monthly contributions to employee Health Savings Accounts for total amounts of $500 individual / $1,000 family per plan year.

Employees will receive DSV contributions regardless if they contribute or not. Employees are able to reimburse themselves for eligible HSA approved transactions directly from their Inspira Financial member portal. Inspira Financial administers a debit Mastercard to utilize HSA funds. HSA funds rollover without limit.

2025 HSA Contribution Limits

- **Employee Only: $4,300**
- **Employee + Family: $8,550**
- **Catch-up Contribution (Age 55+): $1,000**

Flexible Spending Account (FSA)

Employees can contribute pre-tax dollars to the Flexible Spending Account (FSA) for eligible medical, dental, vision and FSA approved expenses. The FSA is not funded by the employer. FSA funds are a "Use it or Lose it" structure. If there is a balance greater than the allowed rollover limit by April 30, 2025, excess funds will be lost.

Employees are able to reimburse themselves for eligible FSA approved transactions directly from their Inspira Financial member portal. Employees may also reimburse themselves during the 90-day runout period at the conclusion of the plan year if their balance exceeds the rollover amount. Inspira Financial administers a debit Mastercard to utilize FSA funds.

2025 FSA Contribution Limit

- **Employee: $3,300**

2025 FSA Rollover Limit

- **$660**

Visit Inspira Financial's website for a list of eligible expenses and using your HSA or Reimbursement Account.

www.inspirafinancial.com

HSA & REIMBURSEMENT ACCOUNTS

Inspira Financial

DSV partners with Inspira Financial to administer Health Savings Accounts (HSA), Flexible Spending Accounts (FSA), Dependent Care Accounts (DCA), and Commuter Benefits (Parking & Transit). Employees can contribute pre-tax dollars to cover eligible healthcare, dependent care, and commuting expenses.

Employees enrolled in the Aetna High-Deductible Health Plan (HDHP) are eligible to contribute to an HSA. Enrollment in the corresponding medical plan is required to make HSA contributions. Additionally, employees cannot contribute to both an HSA and an FSA simultaneously.

Dependent Care Account (DCA)

Employees can contribute pre-tax dollars to the Dependent Care Account (DCA) for eligible dependent expenses, including:

- Babysitter costs
- Daycare
- Summer Camp
- Care related to an eligible family member who is a federal tax dependent.

Employees will submit for reimbursement on their dependent costs directly from their Inspira Financial member portal. Inspira Financial does not issue a card for this account type. Dependent care funds are "Use it or Lose it" and does not have a rollover. If there are unused funds at the conclusion of the plan year, April 30, 2025, they are forfeited.

Commuter : Parking & Transit

Employees who use public transportation or park in a vendor lot or garage when traveling to work can use their pre-tax dollars to pay for monthly passes or public garage expenses. Employees are eligible to enroll in either the Parking or Transit, but not both. Inspira Financial administers a debit Mastercard to utilize for eligible Commuter transactions. Commuter funds rollover each plan year without limit.

2025 Commuter Benefit Contribution Limit
Parking & Transit: $325/month

2025 DCA Contribution Limits

- **Individual or Separate tax filing spouses: $2,500**
- **Family: $5,000**

Visit Inspira Financial's website for a list of eligible expenses and using your HSA or Reimbursement Account.

www.inspirafinancial.com

LIFE & AD&D

DSV offers Basic life and AD&D coverage at no cost through The Hartford for eligible full-time employees, their spouses and dependent children. Employees can also purchase supplemental life insurance at affordable group rates for added family protection. Designating a beneficiary is required when enrolling, as failure to do so may create estate issues

Basic life insurance provides a benefit to your named beneficiary(ies) in the event of your death. Accidental Death and Dismemberment (AD&D) Insurance offers specific benefits if you suffer a covered accidental injury resulting in dismemberment, such as the loss of a hand, foot, or eye. If your death is due to a covered accident, both Life and AD&D benefits will be paid.

Basic Life & AD&D Insurance Coverage

Coverage Level	Benefit Assignment
Employee Life	1x base salary up to a $300,000 minimum
Spouse Life	$2,000 amount
Child Life	Child(ren) from birth to 14 days. - $500 Child(ren) from 14 days - age 26 - $1,000

Supplemental Life & AD&D Insurance Coverage

If you determine you need more than the basic coverage, you may purchase supplemental Life & AD&D coverage through The Hartford for yourself and your eligible family members.

Coverage Level	Benefit Assignment
Employee Life	$10,000 increments; minimum of $10,000 up to $600,000 **Employee Guaranteed Issue*:** $250,000
Spouse Life	$5,000 increments; minimum of $5,000 up to $250,000 (cannot exceed 50% of the employee's supplemental life coverage) **Spouse Guaranteed Issue*:** $50,000
Child Life	Child(ren) from birth to 14 days - $500 Child(ren) from 14 days - age 26 - $2,500 increments; minimum of $2,500 up to $25,000

*During your initial eligibility period only, you can receive life coverage up to the Guaranteed Issue amounts without having to provide Evidence of Insurability (EOI) or information about your health. Coverage amounts that require EOI will not be effective unless approved by the insurance carrier.

INCOME PROTECTION

If you're suddenly unable to work due to an illness or accident, disability insurance can help cover expenses such as your mortgage, tuition, car payments, food, clothing, utilities, etc. Disability insurance provides income protection until you're able to return to work. DSV provides disability coverage at no cost to you. You will be automatically enrolled for disability coverage on the 1st of the month following 30 days from your date of hire.

Short-Term Disability (STD)

STD covers 60% of your pre-disability weekly earnings up to a maximum benefit of $2,000 per week. Benefits begin on the 8th day of injury or illness up to the earlier of recovery or 180 days. Employees have the option to utilize sick and/or accrued vacation to cover the one week elimination period.

The Hartford administers the NY Disability Benefits Law (NY DBL), New York Paid Family Leave (NY PFL), Colorado Family and Medical Leave (COFAMLI), Oregon Paid Leave, (OPL) and Massachusetts Paid Family & Medical Leave (MA PFML) on behalf of DSV.

Note: If you work in one of the following states with state-mandated disability coverage (California, Hawaii, New Jersey and Rhode Island) you will need to apply directly to the State for the benefit.

Long-Term Disability

LTD covers 60% of your pre-disability monthly earnings up to a maximum benefit of $12,000. Benefits begin after 180 days of disability and payments last as long as you meet the definition of disability (or until you reach your Social Security Normal Retirement Age, whichever is sooner). Certain exclusions and pre-existing condition limitations may apply. A small tax will apply on employees' paychecks for Long-Term Disability. The premium DSV pays for your LTD benefit is added to your gross income and taxed along with your earnings. This results in a tax-free LTD benefit if applied for and approved.

Short-Term Disability Benefit	Benefit Assignment
Benefit Percentage	60% of eligible earnings
Weekly Benefit Maximum	$2,000
Benefits Begin	On the 8th day of disability
Maximum Benefit Duration	26 weeks
Long-Term Disability Benefit	**Benefit Assignment**
Benefit Percentage	60%
Monthly Benefit Maximum	$12,000
Benefits Begin	After the 180th day of disability
Maximum Benefit Duration	Social Security Retirement Age

RETIREMENT PLAN

DSV offers eligible full-time employees the opportunity to put money aside for retirement on a pre-tax (traditional 401k) and after-tax (Roth 401k) basis. After you have been employed for one year and have worked a minimum of 1,000 hours, you will be eligible for a company match on your own contributions at 100% of the first 4% and a 50% match on the next 2% you contribute to a maximum of 5% match. All contributions, employee and employer, are fully vested. New Hires are automatically enrolled at a 3% contribution after 30 days of employment.

Enrolling in 401(k)

To enroll in the 401(k) plan, you must register by visiting www.401k.com. Once you have set up your user ID and password, you can set up your account and preferences.

You can make changes to your 401(k) contribution any time during the year and defer eligible bonus earnings to reach your savings goals.

New hires will receive a letter from Fidelity's NetBenefits to register their 401(k) account and manage contributions and add beneficiaries.

Company Match

Employee Contribution	DSV Match
1%	1%
2%	2%
3%	3%
4%	4%
5%	4.5%
6% & Up	5%

Helpful Resources

Stay educated on your investing and savings by utilizing the Plan & Learn feature in your NetBenefits profile. You will have access to On-Demand and can attend scheduled live workshops on various financial topics. These resources can assist those of all levels - from the advanced to those just starting to invest in their retirement fund.

Mobile Access

You can manage your 401(k) account directly from your smartphone or device by downloading the NetBenefits mobile app. Keep track of your investments and update information on the go!

EMPLOYEE ASSISTANCE PROGRAM

Life is full of challenges, and sometimes balancing it is difficult. We are proud to provide a convenient program dedicated to supporting the emotional health and well-being of our employees and their families. The employee assistance program (EAP) is provided at no cost to you through The Hartford & ComPsych.

SERVICES

Through the Employee Assistance Program, employees and their family members will have access to counseling and consultation services related to the following:

- Mental Health
- Relationship or Marital Concerns
- Child and Eldercare
- Substance Abuse
- Grief and Loss
- Legal or Financial matters

EAP ACCESS

The Employee Assistance Program offers 24/7 telephonic counseling, 365 days per year. Assistance for employees and their families. Three face-to-face emotional counseling sessions per occurrence, per year. Unlimited toll-free phone access and online resources.

Employees can access the EAP by visiting www.guidanceresources.com or contacting ComPsych at 1-800-964-3577.

First-time users will need to enter the following information when registering:

- Organizational Web Field: **HLF902**
- Company Name Field: **ABILI**

VALUE-ADDED BENEFITS

EMPATHY SERVICES

Employees have access to valuable benefits through Empathy & The Hartford, offering support for a wide range of needs—from travel assistance to navigating life's more challenging moments. These services are available to ensure employees have the resources and guidance they need whenever necessary.

FUNERAL PLANNING

Expert team members will help with funeral pre-planning, funeral preparation and burial arrangements.

WILL PREP

Create a will, protect your assets and secure your family's future by utilizing the Will Prep services. Licensed attorneys are available to secure your will and provide online support.

BEREAVEMENT

Bereavement Services assist with families dealing with loss and provide grief support, estate and probate services as well as planning tools.

TRAVEL ASSISTANCE & IDENTITY THEFT PROTECTION

Get travel assistance when traveling more than 100 miles from home and for 90 days or less. Services include medical assistance, emergency transport, lost luggage assistance and document assistance.

Get 24/7/365 assistance through the Identity Theft Support Services and education on protecting your identity.

HEALTH CHAMPION

Health Champion provides Health Care Navigation support if you are diagnosed with a critical illnessor become disabled. You can review care options and assistance with resolving Health Care issues.

Register at join.empathy.com/hartford

VOLUNTARY EXTRAS

LEGALEASE & ALLSTATE

DSV offers additional benefits for employees to take advantage of, which are fully voluntary plans designed to extend coverage for various daily life circumstances. These plans allow employees to enhance their protection and support beyond the standard offerings,

Allstate
IDENTITY PROTECTION

ALLSTATE IDENTITY THEFT & CYBER CRIME PROTECTION

AllState Identity Theft and cybercrime protection offers 24/7 monitoring of financial accounts, ensuring comprehensive protection for employees and their family members. In the event of an identity breach, such as through email phishing scams or personal information being compromised from a personal electronic device, AllState provides full services to help recover the stolen identity. This service is designed to offer peace of mind by safeguarding personal information and assisting in resolving any identity theft-related issues. Visit www.myaip.com.

LegalEASE

LEGALEASE

LegalEase is available to employees and their family members, offering legal consultation with a licensed attorney at reduced rates. This service is designed to assist with a wide range of legal matters, including estate planning, divorce, immigration, case consulting, and document preparation. LegalEase provides access to professional legal advice and support, helping employees navigate complex legal issues at an affordable cost. Visit www.legaleaseplan.com/dsv.

EMPLOYEE DISCOUNTS

DSV employees have access to a variety of exclusive employee discount programs, offering savings on a wide range of products and services. These discounts include special offers on travel accommodations, theater performances, and tickets to sporting events. Additionally, employees can enjoy savings on meal delivery services, electronics, fitness memberships, retail shopping, and more. These benefits are designed to provide employees with valuable savings and enhance their overall experience, both at work and in their personal lives. Be sure to explore the available discount platforms to take advantage of these great deals!

BenefitHub™

Access DSV's BenefitHub platform to take advantage of various discount offers.

dsv.benefithub.com
Referral Code: YGH8NM

plumbenefits™ POWERED BY TicketsatWork®

Get discounts for theme parks, movie tickets, Broadway shows and more on the PlumBenefits site.

www.plumbenefits.com
Company Code: **AC0825422**

LifeMart®

Accessible in your ADP WFN in the Benefits section, LifeMart offers discounts on gym membership, food subscription services and much more.

CONTACT INFORMATION

VENDORS

Vendor	Service	Website	Phone
Aetna	Medical	www.aetna.com	1-866-393-0002
Kaiser Permanente - CA	Medical	www.myaetnasupplemental.com	1-800-777-7902
Delta Dental of NJ	Dental	www.deltadentalnj.com	1-877-305-9485
EyeMed	Vision	www.eyemed.com	1-866-800-5457
CVS Caremark	Pharmacy	www.caremark.com	1-800-756-7182
CVS Virtual Care	Telehealth	www.cvs.com/virtual-care	1-877-993-4321
CVS Minute Clinic	Health Clinic	www.cvs.com/minuteclinic	1-866-389-2727
Inspira Financial	HSA, Reimbursement Accounts	www.inspirafinancial.com	1-844-729-3539
The Hartford	Life Insurance & AD&D	www.thehartford.com	1-888-301-5615
The Hartford	Disability & Leave	www.abilityadvantage.thehartford.com	1-888-301-5615
ComPsych	Employee Assistance Program	www.guidanceresources.com	1-800-964-3577
Fidelity Investments	Retirement Plan (401k)	www.401k.com	1-800-835-5095
AllState	Identity Theft Protection	www.myaip.com	1-800-789-2720
LegalEase	Legal Insurance	www.legaleaseplan.com/dsv	1-800-248-9000

BENEFITS DEPARTMENT

Benefits Department	E-mail	Phone
General Inquiries	Benefits@us.dsv.com	(732) 850-8000

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOU MAY OBTAIN A COPY OF THE PLAN'S NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES THE WAYS THAT THE PLAN USES AND DISCLOSES YOUR PROTECTED HEALTH INFORMATION.

DVS's medical plan (the "Plan") provides health benefits to eligible employees of DSV (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information. To receive a copy of the Plan's Notice of Privacy Practices you should contact Aisha Nurse, who has been designated as the Plan's contact person for all issues regarding the Plan's privacy practices and covered individuals' privacy rights. You can reach this contact person at:

- Aisha.Nurse@us.dsv.com
- (732) 850-8000 ext. 2379

HIPAA Special Enrollment Notice

If you are declining enrollment 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 or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as result of 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, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 60-day period applies to most special enrollments.

To request special enrollment or obtain more information, contact Aisha Nurse, Manager, Benefits, Iselin NJ, Air & Sea US.

- Aisha.Nurse@us.dsv.com
- (732) 850-8000 ext. 2379

Patient Protection Model Disclosure

Aetna generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact DSV Benefits at benefits@us.dsv.com

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact DSV Benefits at Aisha.Nurse@us.dsv.com

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. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Programhttp://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	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-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442

ARKANSAS-Medicaid	FLORIDA-Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery. com/hipp/index.html Phone: 1-877-357-3268
GEORGIA-Medicaid	**MAINE-Medicaid**
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
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	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
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-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	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

LOUISIANA-Medicaid	NEBRASKA-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)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA-Medicaid	**SOUTH CAROLINA-Medicaid**
Medicaid Website: http://dhcfp.nv.govMedicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://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	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	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)

PENNSYLVANIA-Medicaid	WISCONSIN-Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	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 October 15, 2022, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Women's Health and Cancer Rights Act Notice

Our Plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in 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. If you would like more information on WHCRA, call your Plan Administrator at (732) 850-8000 ext. 2379 for more information.

General Notice of COBRA Continuation Coverage Rights

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 out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA 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;
- 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:

- Aisha.Nurse@us.dsv.com
- (732) 850-8000 ext. 2379

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

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

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

Disability extension of 18-month period of 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 18-month period of COBRA continuation coverage.

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

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, 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 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 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

- Aisha.Nurse@us.dsv.com
- (732) 850-8000 ext. 2379

Notice of Privacy Practices

DSV

Health Information Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

DSV's medical plan (the "Plan") provides health benefits to eligible employees of DSV (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

The Plan is required by law to provide notice to you of the Plan's duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice according to the Plan's distribution process. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan is distributing this notice, and will distribute any revisions, only to participating employees and COBRA-qualified beneficiaries, if any. If you have coverage under the Plan as a dependent of an employee or COBRA-qualified beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor's or other health care provider's privacy practices with respect to your PHI that they maintain.

Receipt of Your PHI by the Company and Business Associates

The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, the Company and Business Associates, and any of their subcontractors without obtaining your authorization.

Plan Sponsor: The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice.

The Plan may disclose your PHI to the Company for plan administration functions performed by the Company on behalf of the Plan, if the Company certifies to the Plan that it will protect your PHI against inappropriate use and disclosure.

> **Example:** The Company reviews and decides appeals of claim denials under the Plan. The Claims Administrator provides PHI regarding an appealed claim to the Company for that review, and the Company uses PHI to make the decision on appeal.

Business Associates: The Plan and the Company hire third parties, such as a third party administrator (the "Claims Administrator"), to help the Plan provide health benefits. These third parties are known as the Plan's "Business Associates." The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or the Company to assist or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of the Company and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. So, when this Notice refers to the Plan taking various actions with respect to health information, those actions may be taken by the Company or a Business Associate on behalf of the Plan.

How the Plan May Use or Disclose Your PHI

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization. And, with only limited exceptions, we will send all mail to you, the employee. This includes mail relating to your spouse and other family members who are covered under the Plan. If a person covered under the Plan has requested Restrictions or Confidential Communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

Your Health Care Treatment: The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider.

Example: If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.

Example: The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist's reference in determining whether a new prescription may be harmful to you.

Making or Obtaining Payment for Health Care or Coverage: The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

Example: The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a bill.

Example: The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost-sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related healthcare data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Health Care Operations: The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

Example: If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.

Example: If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes.

- Quality assessment and improvement activities
- Disease management, case management and carecoordination
- Activities designed to improve health or reduce health carecosts
- Contacting health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs

The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

- The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.
- Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan
- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions
- Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above.

Limited Data Set: The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.

Legally Required: The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

Health or Safety: When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others. The Plan 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

Law Enforcement: The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

Lawsuits and Disputes: In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

Workers' Compensation: The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

Personal Representatives: The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: 1) you have been or may be a victim of domestic abuse by your personal representative; or 2) recognizing such person as your personal representative may result in harm to you; or 3) it is not in your best interest to treat such person as your personal representative.

Public Health: To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

Health Oversight Activities: The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

Coroner, Medical Examiner, or Funeral Director: The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.

Organ Donation. The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

Specified Government Functions: In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Research: The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

Disclosures to You: When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

Authorization to Use or Disclose Your PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

Furthermore, we will not: (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations); (2) sell your confidential information (unless under strict legal restrictions) (to sell means to receive direct or indirect remuneration); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law.

Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone.

The Plan May Contact You

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail.

You should note that the Plan may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

Your Rights With Respect to Your PHI

Confidential Communication by Alternative Means: If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information
for the treatment, payment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

Right to Be Notified of a Breach: You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.

Electronic Health Records: You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after
(1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Paper Copy of This Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

Right to Access Your PHI: You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about

you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request. However, if you or a third party requests a copy of your PHI, the fee limitations set out in the rules will apply only to your individual request for access to your own records but these fee limitations will not apply to an individual's request to transmit records to a third party.

Right to Amend: You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred more than six years before the date of your request, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice.
Your request must state a time period which may not include dates more than six years before the date of your request. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Personal Representatives: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

Complaints: If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Information: The Plan has designated **DSV Benefits** as its contact person for all issues regarding the Plan's privacy practices and your privacy rights. You can reach this contact person at:
Aisha.Nurse@us.dsv.com

Important Notice from DSV 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 DSV 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 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.

   DSV has determined that the prescription drug coverage offered by DSV is, on average for all plan participants, is 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.

2.

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current DSV coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current DSV coverage, be aware that you and your dependents will 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 DSV 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.

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 DSV 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 DSV 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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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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).

Date: February 2025
Name of Entity/Sender: DSV Air & Sea Inc.
Contact/Position: Benefits Manager
Resources Address: 200 Wood Ave, 3rd Floor, Iselin NJ 08830