A Guide to Your Benefits

5/1/2026 – 4/30/2027

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Welcome!

Your benefits are an important part of your overall compensation package. DSV is pleased to offer a comprehensive array of valuable benefit for you to choose from. This handbook acts as a guide to make the benefit elections best suited for you and your family.

Eligibility

You are eligible for benefits if you are a full-time employee working 30 or more hours per week. You may also enroll your eligible dependents. When enrolling with dependents, you must provide dependent documentation such as a marriage certificate or joint tax return for spouses; birth certificates or recent tax return for child(ren) and legal state filing for registered domestic partners. Eligible dependents include:

- Legal spouse
- Registered Domestic Partner and/or their children; where applicable by state law.
- Biological, adopted, stepchildren or children for whom you have legal custody up to the age of 26. Disabled children aged 26 or older who meet certain criteria may continue on your health coverage.
- Dependent children can be covered up to age 31 on your EyeMed Vision plan.

Required Information—When you enroll, you will be required to enter a Social Security number (SSN) for all covered dependents. The Affordable Care Act (ACA), otherwise known as health care reform, requires the company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential. Upon receipt of your Social Security card, please reach out to USbenefit.com for instructions as to how to submit a copy of your SS card.

Make an Election

Employees have the ability to enroll in the benefits that meet their needs. Meaning, if an employee only needs Dental coverage, they may do so without obligation to enrolling in any of the other plans.

Whether you are choosing to join coverages or waive coverages, it is important to make an election or submit your enrollment with a waiver so we have the most accurate enrollment information on for you.

Enrollment

Enroll in your benefits on the ADP Workforce Now platform either through mobile app or from your computer.

When enrolling, you can see the plans available to you. You can add or remove dependents, waive benefit coverages or make plan changes.

If you experience ADP registration or login issues, e-mail USPayroll@us.dsv.com for assistance.

Visit www.workforcenow.adp.com

GET IT ON Google Play

Download on the App Store

Our Benefits Program

DSV offers employees the opportunity to enroll in each benefit on a stand-alone basis, which means you can choose to enroll only in the plans that meet your needs. DSV also provides all employees life and disability insurance coverage at no cost in order to provide you and your dependents with protection. In addition, DSV makes a contribution to the cost of your medical and dental coverage.

Making Changes

Due to IRS regulations, you cannot change your elections outside of a New Hire Enrollment or the annual Open Enrollment period, unless you have a Qualifying Life Event (QLE) during the year. You have 30 days from the day of the QLE to make a changes (including newborns) to your benefits. Be prepared to submit documentation supporting your QLE and applicable dependent documentation.

Examples of the most common QLEs:

- Marriage or divorce
- Birth or adoption of a child
- Child reaching the maximum age limit
- Death of a spouse, RDP, or child
- You lose coverage under your spouse's/RDP's plan
- You gain access to state coverage under Medicaid or CHIP or federal ACA coverage

Required Information—When you enroll, you will be required to enter a Social Security number (SSN) for all covered dependents. The Affordable Care Act (ACA), otherwise known as health care reform, requires the company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential. Upon receipt of your Social Security card, please reach out to USbenefit.com for instructions as to how to submit a copy of your SS card.

Employer Sponsored benefit

DSV provides eligible full-time employees with employer-paid Life and AD&D insurance for you and your eligible dependents. In addition, DSV provides all eligible full-time employees with short and long-term disability.

Employee Contributions

Employees will be responsible to contribute to the cost of the elected coverages. Contributions for medical, dental and vision coverage will be made on a pre-tax basis which reduces the amount of payroll taxes.

Coverage Effective Dates

Benefits are effective on the 1st of the month following 30 days of continuous employment. Eligible employees who enroll in one or more of our coverage options must enroll within 30 days of their date of hire. If you fail to enroll on time, you will only have company-sponsored benefit

Example: If you were hired on March 15, 2026, your coverage would be effective on May 1, 2026.

This includes employer-sponsored coverages. All coverage ends at the end of the month following the last day worked. Employees are entitled to continue eligible coverage under COBRA.

If your coverage ends, you will receive a COBRA package from Inspira Financial, our COBRA Administrator.

Medical Plans

Health Reimbursement Account (HRA) & Copay Plans

Our Aetna Choice POS II PPO plans give you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and reduce your out-of-pocket costs if you choose a provider who participates in the Aetna network. The plans offer many resources to help you and your family maintain a healthy lifestyle.

Aetna Choice POS II HRA

HRA Plan Option 1: APCN $3,000 HRA Plan

HRA Plan Option 2: $1,500 90/70 HRA

Both plan options include an employer-paid "Health Reimbursement Account (HRA)" that funds the $500 toward the individual deductible or $1,000 toward the family deductible automatically. Employees do not contribute to the HRA. For the 2025 plan year, we introduced the APCN $2,500 80/60 HRA plan. APCN stands for Aetna Premier Care Network. With this plan you will receive the highest level of benefits and have the lowest out-of-pocket cost when you use providers in this network, and you will still have access to the broader network.

- The plans pay the full cost of eligible in-network preventive health care services.
- After the HRA funding is exhausted, you pay the balance of the deductible for non-preventive health care services until you meet the annual deductible.
- Once you meet the deductible, you pay a percentage of certain health care expenses (coinsurance) and the plan pays the rest. You may also have to pay a dollar amount (copay) for certain services, such as prescription drug coverage.
- Once your deductible, copays and coinsurance add up to the out-of-pocket maximum, the plan pays the full cost of all quality health care services for the rest of the year.

Aetna Choice POS II Copay

Plan Option 1: $30 / $50 $2000 Copay

Plan Option 2: $20 / $50 $750 Copay

Both plan options include a deductible and coinsurance that is applicable to certain benefits such as in-patient hospital admits, high-tech radiology and other services.

- Copays apply to services such as office visits and prescription drugs.
- The plan pays the full cost of eligible in-network preventive health care services.
- You pay a percentage of certain health care expenses (coinsurance) and the plan pays the rest.
- Once your deductible, copays and coinsurance add up to the out-of-pocket maximum, the plan pays the full cost of all qualified health care services for the rest of the year.

Benefits Advisement

It is recommended to elect a plan that meets the needs of yourself and your family members. To avoid under or over-insuring, take consideration to the amount of medical services and prescriptions you anticipate on continuing or establishing during the plan year.

Medical Plans

Aetna Choice POS II
Health Reimbursement (HRA) Plans

	APCN 3000 HRA Plan		1500 90/70 HRA Plan	
	HRA Plan (FSA Compatible)		HRA Plan (FSA Compatible)	
Plan Coverage	**Individual**	**Family**	**Individual**	**Family**
APCN Deductible (Per Plan Year)	$1,500	$3,000		
APCN OOPM (Per Plan Year)	$4,000	$8,000		
APCN Coinsurance (Applicable after Deductible)	Plan: 90%	Member: 10%		
In-Network Deductible (Per Plan Year)	$3,000	$6,000	$1,500	$3,000
In-Network OOPM (Per Plan Year)	$6,000	$12,000	$6,000	$12,000
HRA Provided at Start of Plan Year	$500	$1,000	$500	$1,000
Coinsurance (Applicable after Deductible	Plan: 80%	Member: 20%	Plan: 90%	Member: 10%
Routine Preventative Care	Covered 100%		Covered 100%	
Office Visits (PCP/Specialist)	Deductible/Coinsurance		Deductible/Coinsurance	
CVS Virtual Care & CVS Minute Clinic Visits	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	$20 / $40 / $60		$20 / $40 / $60	
CVS Retail Supply & Mail Order (90-day Supply)	2x Retail Copay		2x Retail Copay	

Medical Plans

Aetna Choice POS II
Copay Plans

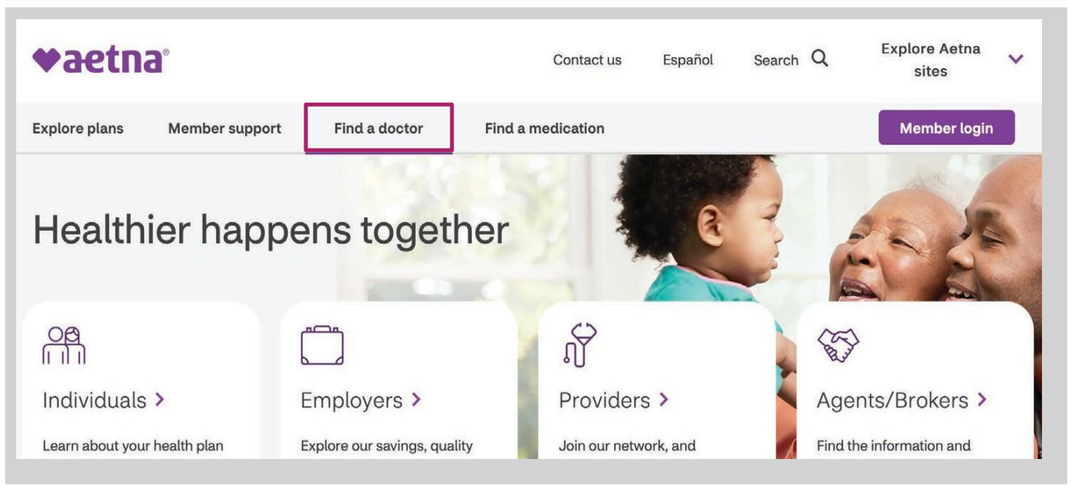
	20/50 750 Copay Plan		30/50 2000 Copay Plan	
	Copay Plan (FSA Compatible)		Copay Plan (FSA Compatible)	
Plan Coverage	**Individual**	**Family**	**Individual**	**Family**
In-Network Deductible (Per Plan Year)	$750	$1,500	$2,000	$4,000
In-Network OOPM (Per Plan Year)	$5,000	$10,000	$6,000	$12,000
Coinsurance (Applicable after Deductible	Plan: 80%	Member: 20%	Plan: 70%	Member: 30%
Routine Preventative Care	Covered 100%		Covered 100%	
Office Visits (PCP/Specialist)	$20 Copay / $50 Copay		$30 Copay / $50 Copay	
CVS Virtual Care & CVS Minute Clinic Visits	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	$250 Copay		$500 Copay	
Urgent Care Facility	$25 Copay		$50 Copay	
Inpatient Hospital	Deductible/Coinsurance		Deductible/Coinsurance	
Outpatient Surgery	Deductible/Coinsurance		Deductible/Coinsurance	
Prescription Coverage (Tiers: Generic/Preferred Brand/Non-Preferred Brand)				
Retail Pharmacy	$20 / $40 / $60		$20 / $40 / $60	
CVS Retail Supply & Mail Order (90-day Supply)	2x Retail Copay		2x Retail Copay	

Medical Plans

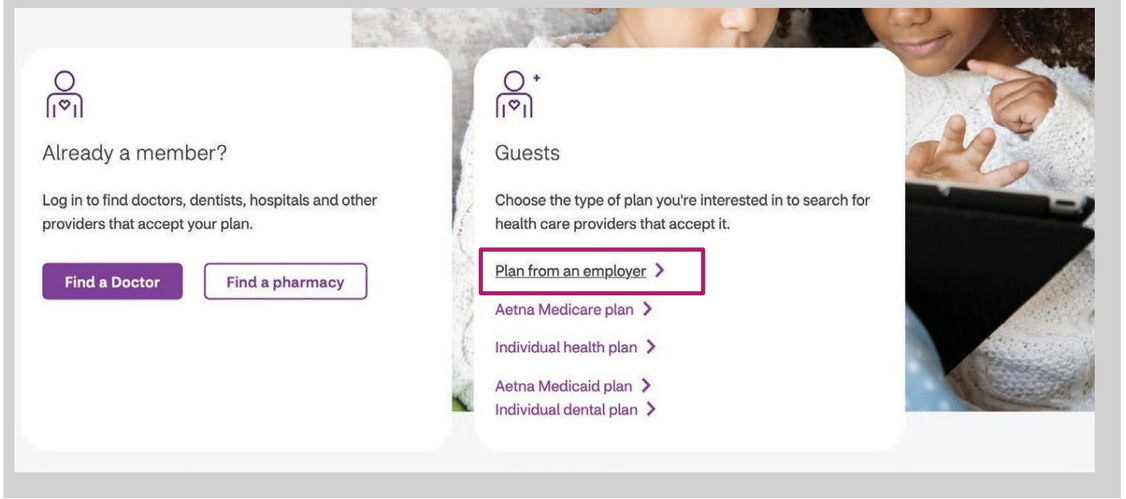
Finding a Provider for your APCN HRA Plan

Aetna Premier Care Network Plus Multi-Tier delivers the extensive provider access you want, and the quality and cost savings you deserve. The online provider directory at Aetna.com makes it easy to search and save.

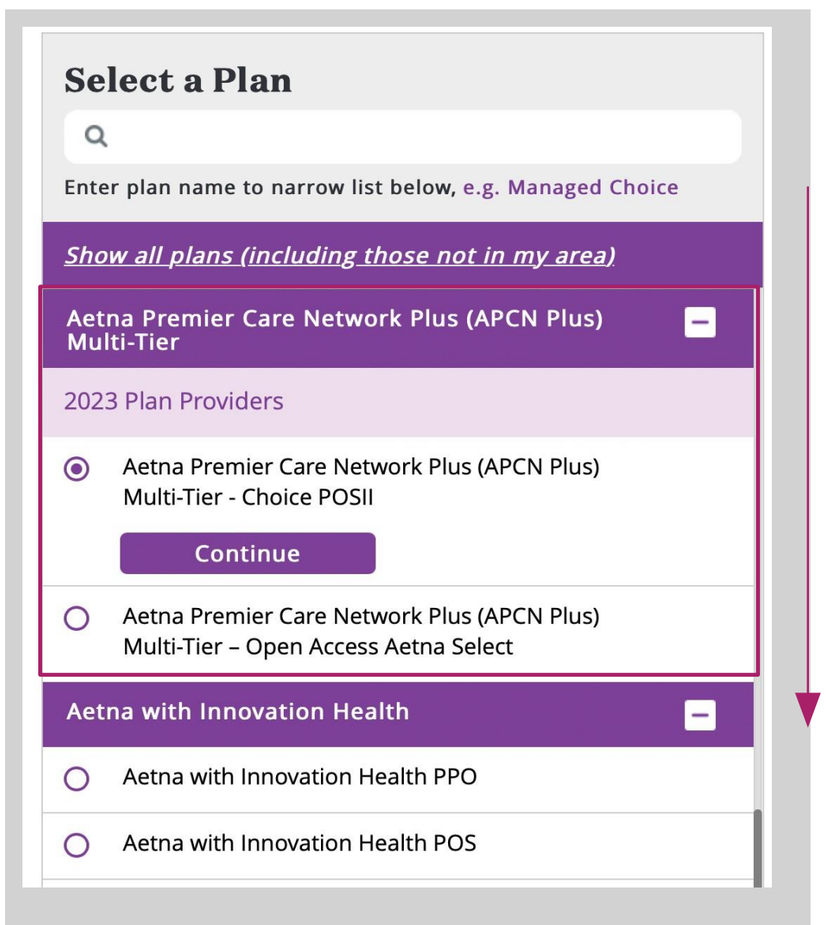
Step 1
Visit Aetna.com and click “Find a Doctor” at the top of the page.



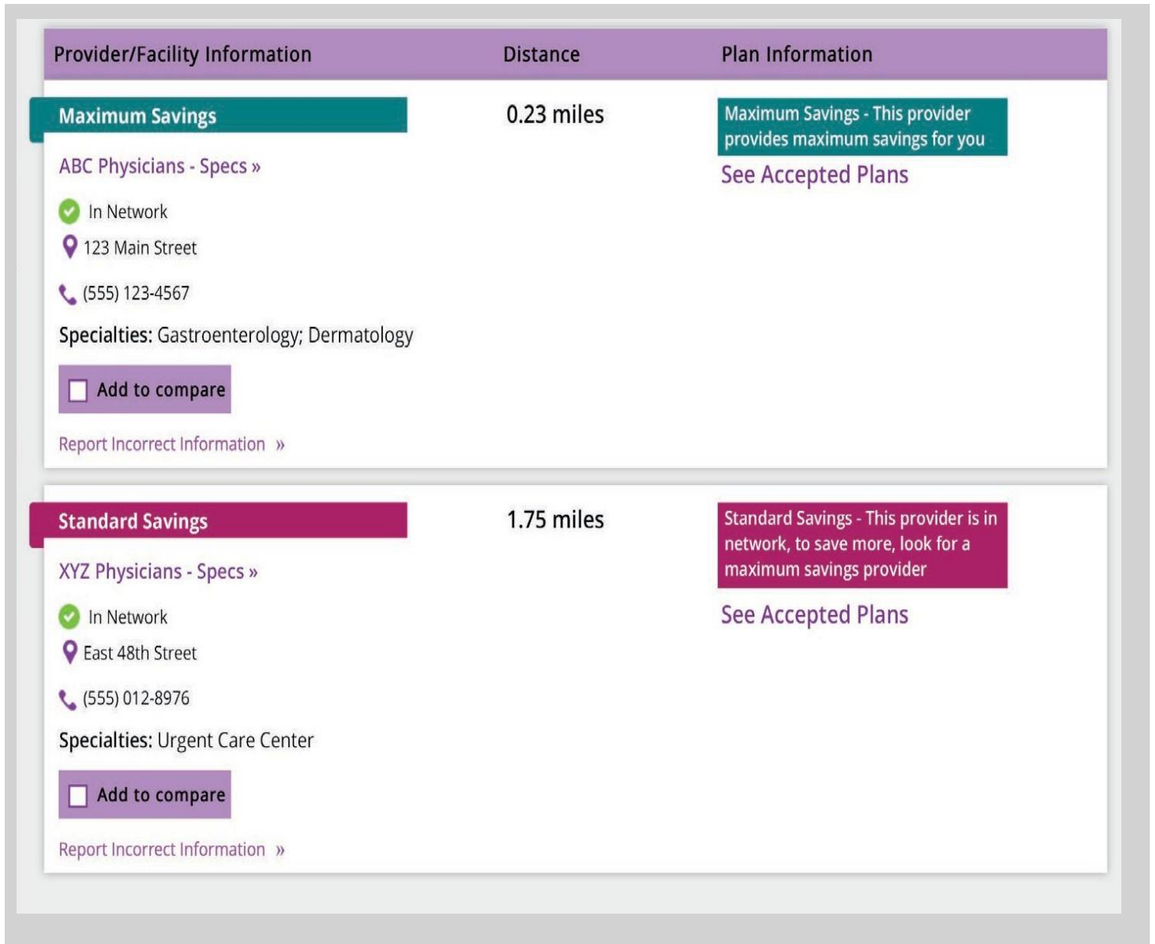
Step 2
Under “Guests” click “Plan from an employer” and enter your home ZIP code.



Step 3
Scroll down and select the Aetna Premier Care Network Plus (APCN Plus) Multi-Tier plan – either Choice POS II or Open Access Aetna Select based on the plan your employer is offering. Click “Continue.”



Step 4
Now you can search based on provider type or by provider name. Colorful labels will appear next to providers offering Maximum Savings and Standard Savings, so be sure to look for those.



Can’t find a provider in the search results? This could mean the provider is not participating in the network. Please check your plan design summary to see if you have out-of-network benefits. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage.

Medical Plans

Health Health Savings Account (HSA)

Our Aetna Choice POS II PPO plans give you the freedom to seek care from the provider of your choice. However, you will maximize your benefit and reduce your out-of-pocket costs if you choose a provider who participates in the Aetna network. The plans offer many resources to help you and your family maintain a healthy lifestyle.

Aetna Choice POS II HSA
Plan 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.

- The plan pays the full cost of qualified in-network preventive health care services and preventative medications.
- You pay the full cost of non-preventive health care services until you meet the annual deductible. **NOTE: When enrolled with dependents, participants must meet the full FAMILY deductible before the plan starts to pay expenses for any one individual**.
- Once you meet the deductible, you pay a percentage of your health care expenses (coinsurance) and the plan pays the rest.
- Once your deductible and coinsurance add up to the out-of-pocket maximum, the plan pays the full cost of all qualified health care services for the rest of the year. **NOTE: When enrolled with dependents,you must meet the full FAMILY out-of-pocket maximum before the plan starts to pay covered services at a hundred percent for any one individual.**

Your Health Savings Account

Managed through Inspira Financial, your contributions, in addition to the company's contributions, may not exceed the annual IRS limits. Please see the 2026-2027 HSA Contribution Limits below.

- You can use HSA funds tax-free to pay for current qualified health care expenses, or save them for the future, also tax-free. Unused funds roll over each year and are yours to keep, even if you change medical plans or leave your employer.
- You must meet certain eligibility requirements to have an HSA: You must a) be at least 18 years old, b) be covered under a qualified HDHP, c) must not be enrolled in Medicare Part A or Part B or TRICARE d) cannot be claimed as a dependent on another person's tax return. For more information, please refer to IRS Publication 969.
- For a complete list of qualified health care expenses, refer to IRS Publication 502.
- Adult children must be claimed as dependents on your tax return for their medical expenses to qualify for payment or reimbursement from your HSA.

HSA Contribution Limits 2026-2027

- Employee Only: **$4,400**
- Employee + Dependents: **$8,750**
- Catch-Up (Age 55+): **$1,000**

Medical Plans

Health Health Savings Account (HSA)

	1700 80/60 HSA Plan	
	H.S.A Plan (FSA Incompatible)	
Plan Coverage	**Individual**	**Family**
In-Network Deductible (Per Plan Year)	$1,700	$3,400
In-Network OOPM (Per Plan Year)	$6,000	$12,000
DSV H.S.A Contribution (Front Loaded Quarterly)	$500	$1,000
Coinsurance (Applicable after Deductible	Plan: 80%	Member: 20%
Routine Preventative Care	Covered 100%	
Office Visits (PCP/Specialist)	Deductible/Coinsurance	
CVS Virtual Care & CVS Minute Clinic Visits	Deductible first; Covered 100%	
Outpatient Diagnostic (Lab/X-ray)	Deductible/Coinsurance	
Complex Imaging (CT/MRI/PET)	Deductible/Coinsurance	
Ambulance	Deductible/Coinsurance	
Emergency Room	Deductible/Coinsurance	
Urgent Care Facility	Deductible/Coinsurance	
Inpatient Hospital	Deductible/Coinsurance	
Outpatient Surgery	Deductible/Coinsurance	
Prescription Coverage (Tiers: Generic/Preferred Brand/Non-Preferred Brand)		
Retail Pharmacy	Deductible first; $20 / $40 / $60	
CVS Retail Supply & Mail Order (90-day Supply)	Deductible first; 2x Retail Copay	

Rx Savings Solutions

For Aetna members

RxSS is a prescription service created and run by pharmacists—that can help you take control of your prescription drug costs

RxSS will find all the medication options for your conditions. You and your doctor decide what's best for your health and budget.

How it Works:

- RxSS pharmacists find equally effective, affordable medications covered by your insurance
- Your online account shows any lower-cost prescriptions available and lets you compare prices
- Switch to a more affordable option with ease
- **RxSS will get your doctor's approval and work with your pharmacy to get it done for you**
- **RxSS will contact you** anytime you can save on prescriptions

RxSS can assist you in finding:

- Generic forms of name-brand drugs
- Better prices through different pharmacies or mail-order
- Equally effective medications that cost less than your current prescription

Medical Plans

Kaiser Permanente (HMO) - CA Only

In addition to the Aetna plans, California residents will have the option of enrolling in the Kaiser Permanente HMO Plan. The Kaiser Permanente plan provides high quality and affordable healthcare services to members. Participants will maximize benefit coverage by utilizing participating providers and facilities in the Kaiser Permanente network.

Kaiser Permanente HMO Plan

Option 1: $500 80/20 HMO

The Kaiser HMO plan option includes a deductible and coinsurance that is applicable to certain benefits such as in-patient hospital admits, high-tech radiology and other services.

- Copays apply to services such as office visits and prescription drugs.
- The plan pays the full cost of eligible in-network preventive health care services.
- You pay a percentage of certain health care expenses (coinsurance) and the plan pays the rest.
- Once your deductible, copays and coinsurance add up to the out-of-pocket maximum, the plan pays the full cost of all qualified health care services for the rest of the year.
- **NEW: As of May 1, 2026, the plan will accumulate deductible and out-of-pocket on a plan year basis (May 1 – April 30) each year.**

Benefits Advisement

If you need help with Kaiser's transition of care program, a benefits team member can assist you and your family with making the change. We will connect you with the appropriate Kaiser Care Management Program team for guidance.

Understanding Kaiser's HMO Coverage

When enrolling in an HMO plan, participants must use providers within the network for coverages. HMO plans do not have out-of-network coverage. It is important to note that if you seek out-of-network care, you risk full responsiblity for services rendered.

Before enrolling or making a switch to the Kaiser Permanente Plan, check if your current providers are participating in the Kaiser Permanente network. If not, prepare ahead of time to transition your healthcare service providers.

If you are switching to Kaiser and your current providers are not in-network, Kaiser offers a transition of care program for participants and their family members who have signi medical needs.

With the transition of care program, Kaiser will work with your current providers in obtaining current and historical clinical information to connect you with a participating Kaiser provider for ongoing care.

Participants have seven days from plan enrollment to submit a transition of care request.

Medical Plans

Kaiser Permanente (HMO) - CA Only

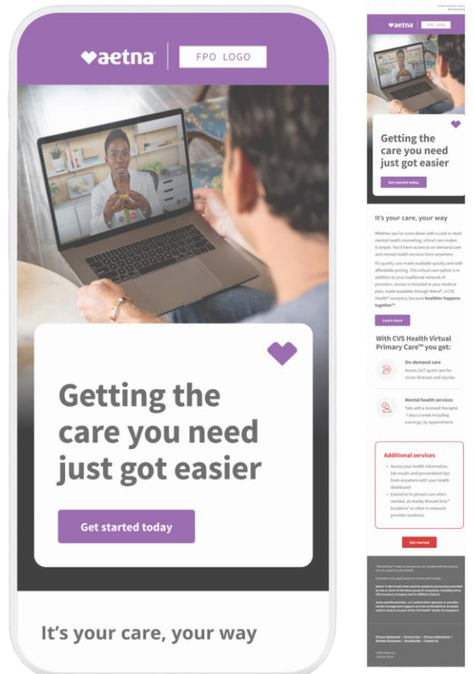
	Kaiser HMO Plan	
Kaiser Medical Benefits Overview	**Copay Plan (FSA Compatible)**	
Plan Coverage	**Individual**	**Family**
In-Network Deductible* (Per Plan Year)	$500	$1,000
In-Network OOPM* (Per Plan Year)	$3,000	$6,000
Coinsurance (Applicable after Deductible	Plan: 80%	Member: 20%
Routine Preventative Care	Covered 100%	
Office Visits (PCP/Specialist)	$30 Copay	
Outpatient Diagnostic (Lab/X-ray)	$10 Copay; after deductible	
Complex Imaging (CT/MRI/PET)	Deductible/Coinsurance	
Ambulance	$150 Copay; after deductible	
Emergency Room	Deductible/Coinsurance	
Urgent Care Facility	Deductible/Coinsurance	
Inpatient Hospital	Deductible/Coinsurance	
Outpatient Surgery	Deductible/Coinsurance	
Prescription Coverage (Tiers: Generic/Preferred Brand/Non-Preferred Brand)		
Retail Pharmacy	$10 - $30 Copay	
Retail Supply & Mail Order (90-day Supply)	2x Retail Copay	

*Plan Deductible and OOPM reset 5/1

CVS Health

Virtual Primary Care & Minute Clinic

Aetna plan participants have access to telehealth and in-person medical services through CVS Health Virtual Primary Care and CVS Minute Clinics. Participants in HRA or Copay plans have 100% general medicine visits. HSA plan participants meet the deductible before visits are covered 100%. Dermatology and Mental Health services have a cost-share regardless of the enrolled health plan.



CVS Health Virtual Primary Care

CVS Health Virtual Primary Care is the telehealth platform for Aetna participants. Members can schedule appointments with a virtual Primary Care Physician and receieve 24/7 Urgent Care services.

Members can address ailments such as sinus infection, allergies, rash, sore throat and more with a licensed provider virtually. Prescriptions as a result of virtual visits will apply to the applicable health plan deductible or copay.

CVS Minute Clinic

CVS Minute Clinics are locations where Aetna members can see a licensed provider for medical services. Members can locate their nearest CVS Minute Clinic and schedule appointments online or walk-in to be seen same-day.

Schedule Your Appointment

Members can schedule a telehealth appointment with CVS Health Virtual Primary Care, or a CVS Minute Clinic n the Aetna member portal, mobile app or CVS site.

Aetna Member Site
www.aetna.com

CVS Health Virtual Primary Care
www.cvs.com/virtual-care

Download the Aetna App!

GET IT ON Google Play

Download on the App Store

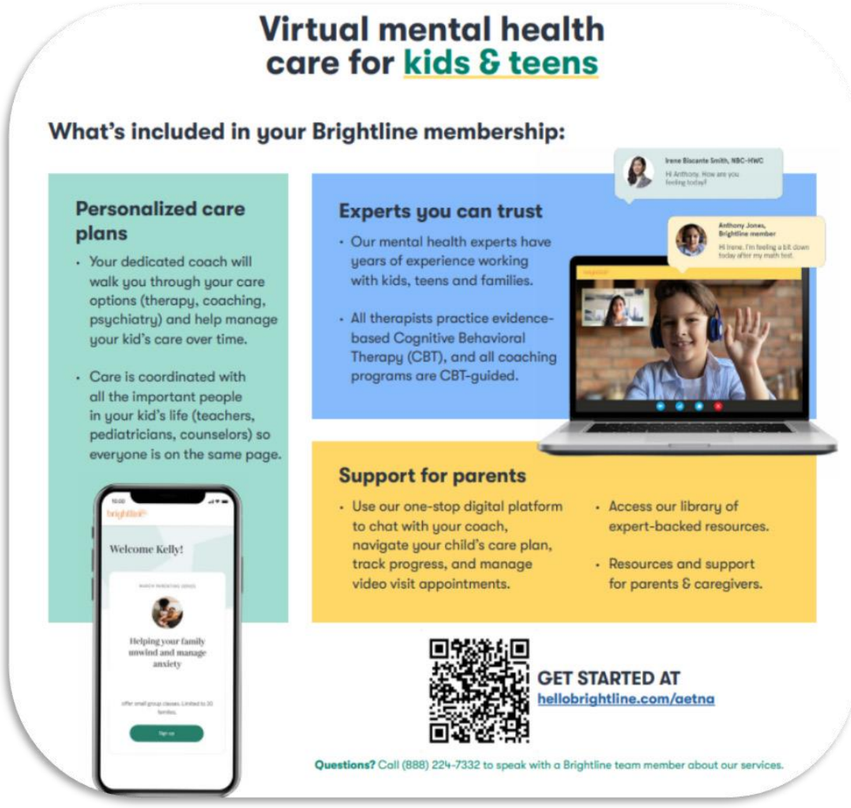
Benefits Advisement

By using CVS Health Virtual Primary Care and Minute Clinic services for non-emergent healthcare needs, you can save money on visits that would go towards deductible, copay or co-insurance.

Brightline

Virtual Mental Healthcare for Kids & Teens

Through your health plan, you now have access to virtual mental health support for your kids & teens with Brightline. Brightline provides personalized therapy, psychiatry, & coaching for your kids, and a one-stop digital platform to track progress, see appointments, & check out expert-backed resources. Plus, support and resources for parents & caregivers too!



Get Started today!

Step 1: Visit hellobrightline.com/aetna to create your account.

- Brightline will confirm your kid's health plan information, and what services are covered.

Step 2: Consult with Brightline about your family.

- Based on your answers to the short questionnaire, Brightline will recommend therapy or coaching.

Step 3: Book your kid's session

- Your dedicated mental health expert will help guide next steps.

Questions? For questions about insurance coverage or the cost of services, call (888) 224-7332 to speak with a Brightline team member (M-F, 8am - 9pm local time).

Dental Plans

Delta Dental of NJ

Delta Dental DPPO Network with Premier Dentist: This plan offers you the freedom and to use the dentist of your choice. However, you will maximize your benefit and reduce your out-of-pocket costs if you choose a dentist who participates in the Delta Dental PPO network as a contracted provider or a designated Premier Dentist.

Delta Dental Core Plan

The Delta Dental Core plan is a basic-level plan that covers preventative and basic dental services. Major services and Orthodontia is not a covered benefit under this plan. It is recommended for those with minimal dental needs such as routine or deep cleanings and simple fill-ins.

Delta Dental Buy-Up 1 Plan

The Delta Dental Buy-Up 1 plan is a mid-level coverage plan that covers basic and major dental services. Orthodontia for adults and children, however, is not a covered benefit. It is recommended for those who need a broader range of coverage for simple and complex dental services such as routine cleanings and crowns for root canals.

Delta Dental Buy-Up 2 Plan

The Delta Dental Buy-Up 2 plan is a high-level coverage plan that covers basic, dental implants and major dental services. Orthodontia for adults and children, is a covered benefit. It is recommended for those who need a broader range of coverage for simple and complex dental services such as routine cleanings and crowns for root canals; also for adults and children needing, braces, Invisalign or maintenance for retainers.

Delta Dental Carryover MaxSM

This valuable benefit feature allows you to carry over a portion of your unused standard annual maximum benefit limit into the next year, and beyond. You can accumulate part of your unused benefit dollars from a healthy year and use it for services such as bridges, crowns, and root canals. Carryover Max SM is easy and automatic.

To qualify for Carryover MaxSM, you must receive at least one cleaning or one oral exam during the plan year. If you don’t receive a cleaning or exam, you won’t be eligible to carry over any of your benefit dollars to the following year. If you fail to do so, any accumulated carryover will be lost.

- A covered person is eligible for the Carryover MaxSM benefit if less than half of the standard annual maximum is used in the prior benefit year.
- Carryover MaxSM allows you to carry over up to 25% of the unused portion of your standard annual maximum up to a maximum of $500. For example, if your standard annual maximum is $1,000, and you use $200, you can carry over $200 ($800 x 25% = $200).
- Standard annual maximum dollars are used first. Carryover MaxSM dollars are available after the standard annual maximum is met.

Dental Plans

Delta Dental of NJ

	Delta Dental PPO & Premier Core Plan		Delta Dental PPO & Premier Core Plan Buy-Up 1 Plan		Delta Dental PPO & Premier Core Plan 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)	$50 / $150		$50 / $150		$50 / $150	
Benefit Maximum (Per Plan Year / Covered Individual)	$1,000		$1,500		$2,000	
Preventative & Diagnostic Services (Deductible Not Applicable)	100% Covered		100% Covered		100% Covered	
Basic Services (Co-insurance)	80% / 20%		80% / 20%		80% / 20%	
Major Services (Co-insurance)	Not Covered		50% / 50%		50% / 50%	
Orthodontia (Adults & Children)	Not Covered		Not Covered		50% up to $2,000 Lifetime Max Benefit	

Vision Plan

EyeMed Insight

The EyeMed vision plan gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefit and reduce your out-of-pocket costs if you choose a provider who participates in the EyeMed provider network.

EyeMed Insight Network Vision Plan

The EyeMed network includes some of the most preferred, recognized names, including LensCrafters, Pearle Vision and Target Optical.

Dependent children can be covered up to age 31. On the next page, you will find an outline of the EyeMed Vision Coverage.

Vision Plan Highlights

ONE-STOP SHOPPING: Members can easily get an eye exam and materials in the same location since nearly 100% of our locations offer both eye care and eyewear.

HIGH-END FASHION: Lots of frame options from brands like Oakley, Ray-Ban, Coach, Tory Burch, Tiffany & Co. and so many more.

BUDGET-SAVVY OPTIONS: All in-network locations have at least 100 frames priced $130 or lower so that members can minimize (or eliminate) their out-of-pocket cost.

DISCOUNTS!

- 20% off your remaining balance beyond plan coverage
- 20% off non-prescription sunglasses
- 40% off complete pair of prescription eyeglasses
- 15% off the retail price or 5% off the promotional price for Lasik or PRK treatment through the U.S. Laser Network
- 40% off hearing exams through Amplifon Hearing Network

Benefits Advisement

With EyeMed's Reimbursement Program, members can receive reimbursement for prescription eyeglasses or contacts purchased through an out-of-network retailer or online vendor. Submit your invoice to EyeMed directly from your member portal to create an out-of-network claim!

Vision Plan

EyeMed Insight

Key Benefits	In-Network	Out-of-Network Reimbursement
Routine Eye Exam (Once every 12 months)	$0 Copay	Up to $40
Retinal Imaging	Up to $39	Not Covered
Frames (Once every 12 months)	Covered up to $130	Up to $65
Standard Lenses (Once every 12 months)		
Single Vision	$0 Copay	Up to $40
Bifocal	$0 Copay	Up to $50
Trifocal	$0 Copay	Up to $75
Standard Progressive Lenses	$65 Copay	Up to $75
Contact Lenses (Once every 12 months)		
Standard Contact Lenses	$150 allowance	Up to $150
Disposable Contact Lenses	$150 allowance	Up to $150
Contact Lens Fit & Follow-Up		
Standard Contact Lens Fit & Follow-Up	Up to $40	Not Covered
Premium Contact Lens Fit & Follow-Up	10% off Retail	Not Covered

Reimbursement Accounts

Inspira Financial

We provide you with an opportunity to participate in three different spending accounts (FSAs) administered by Inspira Financial. FSAs allow you to set aside a portion of your income, before taxes, to pay for qualified health care and/or dependent care expenses. Because that portion of your income is not taxed, you pay less in Federal Income, Social Security and Medicare taxes.

Healthcare Flexible Spending Account (FSA)

For the 2026-2027 plan year, you may contribute up to $3,400 to cover qualified healthcare expenses incurred by yourself, spouse or children up to age 26. Some qualified expenses include:

- Deductibles, Co-insurances and Copayments
- Prescriptions
- Dental treatment and Orthodontia
- Eye exams/Eyeglasses

For the 2026-2027 plan year, up to $680 in unused funds will carry over into the next plan year. These carryover funds will not count against or offset the amount that you can contribute annually. Unused funds over $680 will not be returned to you or carried over to the next plan year.

Dependent Care Account (DCA)

For the 2026-2027 plan year, you may contribute up to
$7,500 per family or
$3,750 per individual/separate tax spouses to cover eligible dependent care expenses. Some qualified expenses include:

- Care of a child under the age of 13 through pre-school, daycare, or a babysitter.
- Care of a household member who is physically or mentally disabled and a qualified federal tax dependent.

Unused funds are not returned to you or carried over to the next plan year. It is recommended to calculate your estimated dependent care costs as accurately as possible to take advantage of reimbursement and avoid losing funds.

Commuter Transit & Parking benefit

For the 2026-2027 plan year, you may contribute up to $340/month for either Transit or Parking expenses. The commuter benefit can only be used for expenses for traveling or parking to and from work. Some qualified expenses include:

- Taking the Train or Bus to and from work
- Parking in a vendor lot or garage associated with your commute to and from work

Commuter Transit & Parking benefits do not have a carryover limit and carryover year after year. Carryover funds do not limit the amount that you can contribute monthly per plan year.

Managing Your Reimbursement Account

Use your issued Inspira Financial Card for eligible expenses. If you make an eligible purchase on your personal credit/debit card, you can submit an invoice to reimburse yourself with your FSA dollars.

Download the Inspira Financial mobile app to view your balance and manage your balance.

To review eligible FSA, DCA and Commuter expenses, visit www.inspirafinancial.com

For the FSA and Commuter Transit & Parking benefit participants must receive their issued Inspira Financial Card to register in the member portal.

Spend Down Your Funds

If you know that you are approaching the end of the plan year with a balance greater than the allowed carryover amount; you may spend down your FSA funds at www.FSAstore.com or www.amazon.com/FSA.

401(k) Retirement Plan

Fidelity Investments

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% you contribute and a 50% match on the next 2% you contribute to a maximum of 5%. All contributions, employee and employer, are fully vested. New Hires are automatically enrolled at a 3% contribution after 30 days of employment.

401(k) Contribution Limits

2026 Employee Contributions

Employees can contribute a maximum of **$24,500**;

- Those aged 50 or older are entitled to an additional catch-up contribution of **$8,000**.
- Super Catch-Up Contribution (ages 60-63) **$11,250**
- NEW: Starting January 1st, 2026 employees who earn more than $150, 000 in the prior year are required to contribute after-tax Roth instead of pretax for catch-up contributions. If your 2025 FICA wages (Box 3 on your W-2)1 exceed $150,000*, any catch-up contributions you make in 2026 must be Roth.

401(k) Enrollment

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. New Hires will receive an e-mail prompt from Fidelity's NetBenefits to register their 401(k) account and manage contributions and add beneficiaries.

Existing employees can login to their Fidelity account to manage contributions, add beneficiaries or enroll in 401(k).

DSV Company Match

See the guide below to determine how much company match you will receive based on your contributions. As a reminder, employees are eligible for company match after one year of service.

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

Life & AD&D

The Hartford

DSV provides eligible full-time employees with life and AD&D coverage at no charge via The Hartford. We provide coverage for our employees, their spouses and dependent children. Employees have the option of purchasing supplemental life insurance at affordable group rates to provide additional protection for their families. You must designate a beneficiary when you enroll in any of our life insurance options. Failure to designate a beneficiary can cause issues with your estate.

Life & AD&D Insurance

Life Insurance provides your named beneficiary(ies) with a benefit in the event of your death. Accidental Death and Dismemberment (AD&D) Insurance provides specific benefits to you in the event of a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot, or eye). In the event that your death occurs due to a covered accident, both the Life and the AD&D benefit would be payable.

Supplemental Life (Employee-Paid)

If you determine you need more than the basic coverage, you may purchase additional coverage for yourself and your eligible family members.

***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.**

Basic Life benefit

This benefit is provided at no cost to employees through The Hartford.

Employee Benefit Amount

1x base salary up to a $300,000 maximum

Dependent Benefit Amount

Spouse Life - $2,000 amount

Child Life - $500 for child(ren) from birth to 14 days. $1,000 amount from 14 days to age 26

Supplemental Life Benefit

Employee Benefit Amount

$10,000 increments; minimum of $10,000 up to $600,000

Employee Guaranteed Issue*: $250,000

Spouse Benefit Amount

$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 Benefit Amount (Birth to 14 days)

$500

Child Benefit Amount (14 days to age 26)

$2,500 increments; minimum of $2,500 up to $25,000

Child Guaranteed Issue: N/A

Income Protection

The Hartford

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 first 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)

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 earning. This results in a tax-free LTD benefit if applied for and approved.

Employer Sponsored Short-Term Disability Benefit

Benefit Percentage: 60%
Weekly benefit Maximum: $2,000
Benefits Begin: After the 7th day of disability
Maximum Benefit Duration: 26 weeks

Employer Sponsored Long-Term Disability benefit

Benefit Percentage: 60%
Monthly benefit Maximum: $12,000
Benefits Begin: After the 180th day of disability
Maximum Benefit Duration: Social Security Retirement Age

Benefits Advisement

You can apply for disability benefits on The Hartford's website at by visiting www.abilityadvantage.thehartford.com or by calling 1-888-301-5615.

You may view a detailed disclosure/summary document for our disability plans by visiting the **US Benefits Toolkit**.

Family & Medical Leave

The Hartford

If you are suddenly unable to work due to an illness or accident incurred by an eligible family member, you may need to take time off to assist them in their day to day functions. You may be entitled to use up to 12 weeks of unpaid Family & Medical Leave benefits to assist eligible family members. Additionally, if you work in a State that provides Paid Family Leave benefits you can apply for these benefits as well. Under both FMLA and PFL, your job is protected while you are out on approved leave. DSV provides disability coverage at no cost to you. You will be eligible for disability coverage the first of the month following 30 days from your date of hire.

Family & Medical Leave Act (FMLA)

DSV understands that sometimes a leave of absence for your own medical condition, maternity, to care for a family member or other reasons is sometimes needed. For information on taking a leave of absence and/or how to apply, please contact USBenefits@us.dsv.com or The Hartford at 1-888-301-5615 or online at www.abilityadvantage.thehartford.com. Download the "The Employee Guide to the Family and Medical Leave Act" for more information.

The FMLA provides eligible employees of covered employers with job-protected leave for qualifying family and medical reasons and requires continuation of their group health benefits under the same conditions as if they had not taken leave. FMLA leave may be unpaid or used at the same time as employer-provided paid leave.

Eligible employees: Employees are eligible if they work for a covered employer for at least 12 months, have at least 1,250 hours of service with the employer during the 12 months before their FMLA leave starts and works at a location where the employer has at least 50 employees within 75 miles.

The FMLA offers job-protective leave for:

- The birth of a child or placement of a child with the employee for adoption or foster care
- The care for a child, spouse, or parent who has a serious health condition
- A serious health condition that makes the employee unable to work
- Reasons related to a family member's service in the military, including:

Qualifying exigency leave - Leave for certain reasons related to a family member's foreign deployment

Military caregiver leave – Leave when a family member is a current servicemember or recent veteran with a serious injury or illness

Paid Family Leave

Several states have enacted Paid Family Leave benefits. These plans are administered by the respective state. You would be covered by a PFL plan if you work in a state that has such benefits in effect.

If you have any questions, please contact USBenefits@us.dsv.com or assistance.

The Hartford's Value Added Benefits

The Hartford offers these additional value added benefits:

- Beneficiary Assistance to help loved ones with life insurance
- Funeral Concierge Services to assist with funeral plans
- Estate Guidance with access to will prep services
- HealthChampion

Employee Assistance Program

Life is full of challenges, and sometimes balancing it is difficult. We are proud to provide a 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.

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 Con
- Child and Eldercare
- Substance Abuse
- Grief and Loss
- Legal or Financial matters

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.

Accessing the EAP Platform

You 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.

In the Organizational Web ID Field, enter:

HLF902

In the Company Name Field, enter:

ABILI

Wellness Program

At DSV, we recognize the importance of investing in our employees' health and well-being. We believe that a healthy workforce is a more productive and engaged workforce, and we are committed to delivering on resources that help to support our employees in achieving their wellness goals. Our program is focused on a range of services, initiatives and programs aligned to cultivate physical, emotional, environmental, and social well-being. Through these services, our program is designed to meet the diverse needs and interests of our employees.

Below are some examples of what you can expect to see from our program, and following is an example of one of our recent initiatives.

As part of DSV's Wellness Program, DSV employess have access to Monthly Newsletters, Virtual Event Invites, Fitness Challenges and more!

We encourage employees to join our Wellness Movement to cultivate a happier, healthier and more productive workplace.

Interested in becoming a Wellness Ambassador? Ambassadors serve as advocates by helping to push wellness education and facilitate initiatives with colleagues at their locations. To join, contact USWellness@dsv.com for more information.

Voluntary Benefits

Aetna Accident Insurance

The Aetna accident insurance is supplemental to your major medical. You and your eligible dependents will receive a cash benefit for accidental injuries such as broken limbs, sports injuries, falls and more.

Aetna Critical Illness Plan

The Aetna Critical Illness plan is supplemental to your major medical. You and your eligible dependents will receive a cash benefit for newly diagnosed critical illnesses and conditions such as Cancer, Stroke or Heart Attack. Pre-existing conditions are not covered. An insured employee and spouse will receive $15,000, insured child(ren) will receive $7,500 on an approved claim.

Aetna Hospital Indemnity $500/$1,000

The Aetna Hospital Indemnity Plans are supplemental to your major medical. You and your eligible dependents will receive a cash benefit for planned or unplanned in-patient hospital admissions.

Hinge Health

Aetna plan participants and dependents have access to Hinge Health's Virtual Physical Therapy program at no additional cost! Hinge Health will connect you with a licensed Physical Therapist and health coach to resolve pain in areas such as back, knee or shoulder. There are no limits to your visits and all exercises are performed at home.

LegalEase

LegalEase offers an affordable way to protect yourself and your family for legal matters related to traffic offenses, real estate, divorce, bankruptcy and more.

AllState Identity Theft Protection

AllState will protect you and your family members' identities from being compromised. Either through account hacking or stolen electronic devices, AllState will be available 24/7 to assist you in recovering your identity.

Valuable Extras

Travel Assistance (Company-Paid)

The Hartford provides Travel Assistance through International Medical Group (IMG) for use when you are traveling away from home.

- Travel Emergency Transport Services
- Travel Medical Assistance
- Lost Luggage Assistance

Plumbenefits

Get discounts for theme parks, movie tickets, Broadway shows and more on the Plumbenefits site. Visit www.plumbenefits.com and enter company code **AC0825422**

BenefitHub

BenefitHub is an employer discount platform offering discounts for services such as entertainment, pet insurance, restaurants, sporting events and more. Visit https://dsv.benefithub.com/Welcome and enter referral code **YGH8NM** for access.

LifeMart via ADP

Accessible in your ADP pro under Benefits LifeMart offers discounts on gym memberships, food subscription services, travel and more. Login to your ADP profile to explore.

Contact Information

Leave & Disability

State Disability Contact Information

California State Disability Insurance
P: (800) 480-3287
W: www.edd.ca.gov

New Jersey Temporary Disability Insurance
P: (609)-292-7060
W: www.nj.gov/labor/myleavebenefit

New York Disability Benefits Law
P: (866) 750-5157
W: www.wcb.ny.gov

Rhode Island Temporary Disability Insurance
P: (401) 462-8420
W: www.dlt.ri.gov

States with Pending PFL Benefits

Delaware: January 1, 2026

Maryland: January 1, 2025

Paid Family Leave Contact Information

California Paid Family Leave
P: (877) 238-4373
W: www.edd.ca.gov

Connecticut Paid Family Leave
P: (877)-499-8505
W: www.ctpaidleave.org

Colorado FAMLI
P: (866)-263-2654
W: www.famli.colorado.gov

District of Columbia PFML
P: (202) 899-3700
W: www.dcpaidfamilyleave.dc.gov

Massachusettes PFML
P: (202) 899-3700
W: www.mass.gov

New Jersey FLI
P: (609) 292-7060
W: www.nj.gov/labor/myleavebenefit

New York PFL
P: (844) 337-6303
W: www.paidfamilyleave.ny.gov

Oregon PFL
P: (833) 854-1122
W: www.paidleave.oregon.gov

Rhode Island TCI
P: (401) 462-8420
W: www.dlt.ri.gov

Washington PFML
P: (360) 902-9500
W: www.paidleave.wa.gov

Contact Information

Aetna - Medical
P: (866) 393-0002 W: www.aetna.com

Aetna - Voluntary (Accident, Critical Illness & Hospital Indemnity)
P: (800) 607-3366 W: www.myaetnasupplemental.com

AllState - Identity Theft
P: (800) 789-2720 W: www.myaip.com

CVS/Caremark - Prescriptions
P: (800) 756-7182 W: www.caremark.com

Delta Dental of NJ - Dental
P: (877) 305-9485 W: www.deltadentalnj.com

EyeMed - Vision
P: (866) 939-3633 W: www.eyemed.com

Fidelity Investments - 401(k)
P: (800) 835-5095 W: www.401k.com

Inspira Financial - FSA, HSA, DCA & Commuter
P: (844) 729-3539 W: www.inspira

Kaiser Permanente - Medical
P: (800) 464-4000 W: www.kaiserpermanente.org

LegalEase - Legal Insurance
P: (800) 248-9000 W: www.legaleaseplan.com/dsv

Rx Savings Solutions – Pharmacy Consult Service
P: (800) 248-9000 W:www.rxss.com

Benefit Contact Information

Benefits Department
P: (732) 850-8000
E: USbenefits@us.dsv.com

Benefits Department After-Hours Hotline
P: (732) 956-4861
Available Mon. - Thur.
5pm - 8pm EST / 2pm - 5pm PST

Access the US Benefits Toolkit
Click Here for Access

Please use the provided contact information to reach a benefit team member for questions regarding your benefits, the plans we offer or to troubleshoot enrollment issues.

DISCLAIMER: The material in this benefit brochure is for informational purposes only and is neither an offer of coverage or medical or legal advice. It contains only a partial description of plan or program benefit and does not constitute a contract. Please refer to the Summary Plan Description (SPD) for complete plan details. In case of a conflict between your plan documents and this information, the plan documents will always govern.

Annual Notices: ERISA and various other state and federal laws require that employers provide disclosure and annual notices to their plan participants. The company will distribute all required notices annually.

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).

CMS Form 10182-CC Updated April 1, 2011

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 2026
Name of Entity/Sender: DSV Air & Sea Inc.
Contact/Position: Benefits Manager
Resources Address: 200 Wood Ave, 3rd Floor, Iselin NJ 08830