
CYIENT
2025 BENEFITS GUIDE

HERE'S WHERE TO FIND ...

Enrolling In Benefits 3
General Definitions 4
Your Cost For Coverage Per Pay 5
How The Medical Plans Compare 8
Voluntary Health Benefits 12
Virtual Primary Care 14
Virtual Visits 14
Additional Resources for UHC Members 18
Wellness Programs 19
Touchcare 22
Health Savings Account (HSA) 23
Flexible Spending Account (FSA) 26
Dental 27
Vision 28
Life & AD&D 29
Voluntary Life And AD&D 30
Disability 31
Employee Assistance Program for All Employees 32
Long Term Care 32
Identity Theft 32
401(k) Retirement Plan 33
Retirement Plan FAQs 34
Contacts 35

Cyient appreciates your commitment to our success. We are equally committed to providing you with competitive, affordable health and wellness benefits to help you take care of yourself and your family. This guide provides a summary of your plan options and helpful tips for getting the most value from your benefits, so please read the guide carefully.

In addition to the guide, you also have access to your HR Benefits Partner at **NAM.benefits@cyient.com** and detailed benefits descriptions under the summary plan description (SPD) at **my.cyient.com/sites/hr/benefits/Pages/default.aspx**.

For more information about your benefits, visit **mycyientbenefits.com** or scan the QR Code.

...and don't forget!

Text **CYIENT** to **(443) 748-1858** to stay up to date with your benefits

ENROLLING IN BENEFITS

ELIGIBILITY

EMPLOYEES

Employees classified as Regular Full or Part Time working a minimum of 16 hours are eligible for the benefits referenced in this guide. Benefits for newly hired employees are effective on their date of hire.

DEPENDENTS

In addition to enrolling yourself, you may also enroll any eligible dependents.

Eligible dependents include:

- Spouse: A person to whom you are legally married by ceremony under the laws of the state or jurisdiction in which the marriage was performed. Such person remains a spouse until a decree of divorce is issued.
- Children: Your biological, adopted or legal dependent children up to age 26 regardless of student, financial or marital status (even if coverage is available through their employers).

Dependent coverage terminates at the end of the month a child turns 26.

DOMESTIC PARTNERS

You may enroll a Domestic Partner in medical coverage beginning in 2025. Please note that you will need to complete and submit a notarized affidavit that can be found on **mycyientbenefits.com** in order to get approved to cover a Domestic Partner. Domestic partners can only be covered under the medical plans with UHC, not on the dental or vision plans. Domestic partners do not qualify for COBRA, HSA, OR FSA coverage.

Note: Upon separation from Cyient, your health coverage will end on the last day of your employment.

MAKING CHANGES

If you need to add or remove coverage for yourself or your dependents, you can do so during open enrollment. After open enrollment ends, you can only make changes to your elections if you've experienced a qualifying life event as defined by the IRS. If you qualify to make a change, you will have 30 days from the day of the event to notify your employer and make your benefit elections. Be sure to provide the required documentation.

Here are some examples of qualifying life events:

- Birth, legal adoption or placement for adoption.
- Marriage, divorce or legal separation.
- Dependent child reaches age 26.
- Spouse or dependent loses or gains coverage elsewhere.
- Death of your spouse or dependent child.
- Spouse or dependent becomes eligible or ineligible for Medicare/Medicaid or the state children's health insurance program.
- Change in residence that changes coverage eligibility.
- Court-ordered change.
- Spouse's open enrollment that occurs at a different time than yours.

GENERAL DEFINITIONS

COINSURANCE: Coinsurance is your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. Your coinsurance will begin after you have met your deductible. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health plan pays the rest of the allowed amount.

COPAY: A copay is a fixed dollar amount you pay for a healthcare service. The amount can vary by the type of service. Your copays will not count toward your deductible but will count toward your out-of-pocket maximum.

DEDUCTIBLE: The deductible is the amount you owe for covered healthcare services before your plan begins to pay benefits. For example, if your deductible is $4,500, your plan won't pay anything until you've met your $4,500 deductible for covered healthcare services subject to the deductible. Preventive care is not subject to the deductible as it is covered 100% by any medical plan option.

EXPLANATION OF BENEFITS (EOB): An EOB is a statement from the insurance company showing how claims were processed. The EOB tells you what portion of the claim was paid to the healthcare provider and what portion of the payment, if any, you are responsible for.

INDIVIDUAL MANDATE: Federal healthcare reform mandates most U.S. citizens have health insurance for themselves and their dependents. Cyient helps you stay insured by offering affordable healthcare for all employees who work at least 30 hours each week.

IN-NETWORK VS. OUT-OF-NETWORK: A network is composed of all contracted providers. Networks request providers to participate in their network, and in return, providers agree to offer discounted services to their patients. If you pick an out-of-network provider, your claims will be higher because you will not receive the discounts the in-network providers offer.

OUT-OF-POCKET MAXIMUM: The out-of-pocket maximum is designed to protect you in the event of a catastrophic illness or injury. Your out-of-pocket maximum includes your deductible, coinsurance and copays that come out of your pocket. After you have paid the specified out-of-pocket amount during a policy year, the plan pays the remaining covered services at 100%.

PREVENTIVE CARE: Routine healthcare services can minimize the risk of certain illnesses or chronic conditions. Examples of preventive care services include but are not limited to physical exams, mammograms, flu vaccines, prostate tests and smoking cessation.

REASONABLE AND CUSTOMARY: The amount of money a health plan determines is the normal or acceptable range of charges for a specific health-related service or medical procedure. If your healthcare provider submits higher charges than what the health plan considers normal or acceptable, you may have to pay the difference

YOUR COST FOR COVERAGE PER PAY

Note: Employees may be responsible for missed premiums back to their effective date.

MEDICAL

The health benefits available to you, as an employee, represent an important component of your compensation package. These benefits will allow you and your family access to health and wellness services through UnitedHealthcare. Eligible employees have the choice of three medical plans offered through UHC:

- Encore
- Accent
- Horizon

The Encore and Accent plans are qualified high deductible health plans (QHDHP) that allow for participation in an HSA, which helps you save money by allowing you to pay for healthcare expenses with tax-free dollars.

The Horizon plan is a copay plan, which does not allow for participation in an HSA. You can elect the FSA, which will allow you to pay healthcare expenses with tax-free dollars. Please keep in mind that FSA elections do not roll over year to year.

If you enroll in one of the health plans, you will also receive prescription drug coverage through UnitedHealthcare. The cost of the prescription drug plan is included in your medical plan payroll deduction.

Each medical plan allows you to choose which doctors you see. By choosing a Premium Designated Provider, you will save money and receive the highest-quality care.

EMPLOYEE PER PAY CONTRIBUTION

Note: Employees may be responsible for missed premiums back to their effective date.

FULL TIME EMPLOYEES			
Coverage tier	Accent	Encore	Horizon
Employee	$34.69	$69.13	$119.26
Employee + Spouse	$76.63	$148.54	$256.23
Employee + Child(ren)	$63.36	$124.44	$214.66
Family	$98.02	$186.33	$321.42

PART-TIME EMPLOYEES (30-39 HOURS)			
Coverage tier	Accent	Encore	Horizon
Employee	$84.21	$132.18	$228.04
Employee + Spouse	$235.10	$284.18	$490.21
Employee + Child(ren)	$194.37	$238.05	$410.64
Family	$300.72	$356.45	$614.88

PART-TIME EMPLOYEES (16-29 HOURS)			
Coverage tier	Accent	Encore	Horizon
Employee	$149.52	$170.05	$293.34
Employee + Spouse	$330.18	$365.56	$630.58
Employee + Child(ren)	$272.97	$306.23	$528.24
Family	$422.34	$458.53	$790.98

EMPLOYEE DOMESTIC PARTNER (DP) PER PAY CONTRIBUTION

Note: Employees may be responsible for missed premiums back to their effective date.

FULL TIME EMPLOYEES			
Coverage tier	Accent	Encore	Horizon
Employee + DP	$76.63	$148.53	$256.23
Employee + Employee Children + DP	$98.03	$186.32	$321.42
Employee + DP + DP 1 Child	$98.02	$186.33	$321.42
Employee + DP + DP Child(ren)	$98.02	$186.32	$321.42
Employee + Child(ren) + DP + DP 1 Child	$98.02	$186.33	$321.42
Employee + Child(ren) + DP + DP Child(ren)	$98.02	$186.32	$321.42

PART-TIME EMPLOYEES (30-39 HOURS)			
Coverage tier	Accent	Encore	Horizon
Employee + DP	$235.10	$284.17	$490.21
Employee + Employee Children + DP	$300.72	$356.44	$614.88
Employee + DP + DP 1 Child	$300.72	$356.45	$614.89
Employee + DP + DP Child(ren)	$300.72	$356.44	$614.88
Employee + Child(ren) + DP + DP 1 Child	$300.72	$356.45	$614.89
Employee + Child(ren) + DP + DP Child(ren)	$300.72	$356.44	$614.88

PART-TIME EMPLOYEES (16-29 HOURS)			
Coverage tier	Accent	Encore	Horizon
Employee + DP	$330.17	$365.56	$630.57
Employee + Employee Children + DP	$422.33	$458.53	$790.98
Employee + DP + DP 1 Child	$422.33	$458.54	$790.99
Employee + DP + DP Child(ren)	$422.33	$458.53	$790.98
Employee + Child(ren) + DP + DP 1 Child	$422.33	$458.54	$790.99
Employee + Child(ren) + DP + DP Child(ren)	$422.33	$458.53	$790.98

MEDICAL PLAN COMPARISON

	Accent		Encore		Horizon	
	Premium Designated Provider	Non-Premium Designated Provider	Premium Designated Provider	Non-Premium Designated Provider	Premium Designated Provider	Non-Premium Designated Provider
General Plan Coinsurance	100%		85%		70%	
Deductible Employee only Family	 $4,000 $8,000	 $4,000 $8,000	 $1,650 $3,300	 $1,650 $3,300	 $750 $1,500	 $750 $1,500
Out-of-pocket maximum (includes deductible) Employee only Family	 $4,000 $8,000	 $5,500 $11,000	 $3,200 $6,400	 $4,000 $8,000	 $7,000 $14,000	 $7,000 $14,000
Preventive care	100%	100%	100%	100%	100%	100%
Office visit (PCP and specialist)	100%	90%	90%	70%	$20	$30
Urgent care	100%	100%	85%	85%	$85	$85
Inpatient care	100%	100%	85%	85%	70%	70%
Outpatient care	100%	100%	85%	85%	70%	70%
Emergency room	100%	100%	85%	85%	$160	$160
Out-of-Network Services						
Coinsurance	80%	80%	60%	60%	50%	50%
Deductible Employee only Family	 $5,350 $10,700	 $5,350 $10,700	 $2,500 $5,000	 $2,500 $5,000	 $4,000 $8,000	 $4,000 $8,000
Out-of-pocket maximum (includes deductible) Employee only Family	 $10,000 $20,000	 $10,000 $20,000	 $10,000 $20,000	 $10,000 $20,000	 $14,000 $28,000	 $14,000 $28,000
Prescription drugs	Employee pays					
Retail (30-day supply)						
Tier 1 — generics	$0 Copay after Ded.		$5 Copay after Ded.		$15	
Tier 2 — preferred	$0 Copay after Ded.		$25 Copay after Ded.		$25	
Tier 3 — nonpreferred	$0 Copay after Ded.		$40 Copay after Ded.		$40	
Mail order (90-day supply)						
Tier 1 — generics	$0 Copay after Ded.		$10 Copay after Ded.		$30	
Tier 2 — preferred	$0 Copay after Ded.		$50 Copay after Ded.		$50	
Tier 3 — nonpreferred	$0 Copay after Ded.		$80 Copay after Ded.		$80	

Summary of Benefits and Coverage

Choosing a health coverage option is an important decision. To help you make an informed choice, a Summary of Benefits and Coverage (SBC) is available for each medical plan option. The SBC for each medical plan option is available on the MyCyient Benefits Hub, accessible by selecting **MyCyient > HR > Benefits**.

Additionally, you may obtain a copy by reaching out to **NAM.Benefits@cyient.com**

HOW THE MEDICAL PLANS COMPARE

Let's take a look at how the plans compare for three different employees:

ADRIAN

Adrian is 26 years old, unmarried with no children. He gets his physical exam every year and is generally pretty healthy. In the fall, he comes down with the flu and visits a doctor, who prescribes him a medication. Adrian has limited utilization of the medical/prescription drug program and does not approach either the deductible or out of pocket maximums in any of the plans available. Let's see how the plans work for Adrian.

			Accent	Encore	Horizon
Type of Care	Cost of Care	Number of Visits	Adrian Pays		
Preventive Physical Exam	$75	1	$0	$0	$0
Additional Doctor's Visit	$75	1	$75	$75	$20
Retail Generic Drug Purchase	$21	1	$21	$21	$15
Mail Order Generic Drug Purchase	$66	1	$66	$66	$30
Total OOP Cost			$162	$162	**$65***
Employer Contribution to HSA (Employees must contribute $900 to get the full $450 from Cyient)			$450	$450	$0**
Hospital Indemnity Benefit Reimbursement			$0	N/A	N/A
Adrian's OOP Expenses after Employer HSA Contribution			$0	$0	$65
Total Payroll Contributions			$902	$1,797	$3,101
Adrian's Total Payment Responsibility			**$902**	$1,797	$3,166

Adrian chooses the Accent plan because his total payment responsibilities are the least amount with that plan. Plus, he can use any funds he's contributed to his HSA to pay for his health care expenses on a before-tax basis.

*The Horizon plan is being offered to assist those who may experience high expenses at the beginning of the plan year or prefer to know they will have a set copay amount for office visits and prescriptions instead of utilizing a HSA with one of the high deductible plans.

** Employees enrolled in the Horizon plan will be able to use FSA funds for eligible expenses.

HOW THE MEDICAL PLANS COMPARE, CONTINUED

Let's take a look at how the plans compare for three different employees:

CARMEN

Carmen is 49 years old, unmarried with no children. Carmen is pretty active, so she generally doesn't see her doctor. However, Carmen falls off her bike in June and sustains some injuries. She sees a specialist who sends her to the emergency room for a cast. Carmen is a moderate utilizer of the medical/ prescription drug program. Let's see how the plans work for Carmen.

			Accent	Encore	Horizon
Type of Care	Cost of Care	Number of Visits	Carmen Pays		
Preventive Physical Exam	$75	1	$0	$0	$0
Additional Doctor's Visit	$75	3	$225	$225	$60
Specialist Visit	$130	1	$130	$130	$20
MRI Test	$2,250	1	$2,250	$1,438	$1,200
Emergency Room Visit	$542	1	$542	$81	$160
Retail Generic Drug Purchase	$21	2	$42	$10	$30
Mail Order Generic Drug Purchase	$66	6	$396	$60	$180
Total OOP Cost			$3,585	$1,945	**$1,650***
Employer Contribution to HSA (Employees must contribute $900 to get the full $450 from Cyient)			$450	$450	$0**
Hospital Indemnity Benefit Reimbursement	Carmen is sent to the ER via ground ambulance	Ambulance - $200	$200	N/A	N/A
Carmen's OOP Expenses after Employer HSA Contribution and Hospital Indemnity Reimbursement			$2,935	$1,495	$1,650
Total Payroll Contributions			$902	$1,797	$3,101
Carmen's Total Payment Responsibility			$3,837	**$3,292**	$4,751

The Encore Plan looks like the better option for Carmen. She'll save the most with this plan and she can use any funds she's contributed to her HSA to pay for her health care expenses pre-tax.

*The Horizon plan is being offered to assist those who may experience high expenses at the beginning of the plan year or prefer to know they will have a set copay amount for office visits and prescriptions instead of utilizing a HSA with one of the high deductible plans.

** Employees enrolled in the Horizon plan will be able to use FSA funds for eligible expenses.

HOW THE MEDICAL PLANS COMPARE, CONTINUED

Let's take a look at how the plans compare for three different employees:

GABRIEL

Gabriel is 38 years old, married with three children. Gabriel's family uses his health care like most families; they visit the pediatrician for ear infections and coughs a few times a year. However, in November, Gabriel and his daughter are involved in a car accident. Everyone is OK, but both Gabriel and his daughter sustain some injuries. Because of the unexpected car accident, both Gabriel and his daughter are higher utilizers of the medical/prescription drug program and both meet the plan deductible and out of pocket maximums in each plan. Let's see how the plans work for Gabriel.

			Accent	Encore	Horizon
Type of Care	Cost of Care	Number of Visits	Gabriel Pays		
Preventive Physical Exam	$75	1	$0	$0	$0
Additional Doctor's Visit	$75	10	$750	$750	$200
Specialist Visit	$130	4	$520	$520	$80
Hospital Visits	$22,850	2	$6,730	$5,130	$5,170
Retail Generic Drug Purchase	$21	8	$0	$0	$120
Mail Order Generic Drug Purchase	$66	8	$0	$0	$240
Total OOP Cost			$8,000	$6,400	**$5,810***
Employer Contribution to HSA Employees must contribute $1,550 to get the full $775 from Cyient)			$775	$775	$0**
Hospital Indemnity Benefit Reimbursement	Gabriel and his daughter were in the hospital for 3 days each, and were each in a ground ambulance	Ambulance - $200 Hospital Admission - $1,000 Hospital Confinement - $200 per day	$2,800	N/A	N/A
Gabriel's OOP Expenses after Employer HSA Contribution and Hospital Indemnity Reimbursement			$4,425	$5,625	$5,810
Total Payroll Contributions			$2,549	$4,845	$8,357
Gabriel's Total Payment Responsibility			**$6,974**	$10,470	$14,167

By choosing the Accent Plan, Gabriel will save significantly versus the other plans, due to the lower annual premium. He can use any funds he has contributed to their HSA to pay for his out of pocket costs.

*The Horizon plan is being offered to assist those who may experience high expenses at the beginning of the plan year or prefer to know they will have a set copay amount for office visits and prescriptions instead of utilizing a HSA with one of the high deductible plans.

** Employees enrolled in the Horizon plan will be able to use FSA funds for eligible expenses.

CHOOSING TIER 1 DOCTORS

WHERE YOU GO FOR CARE CAN MAKE A DIFFERENCE

When you choose a Tier 1 doctor, you may save money on routine and specialty care. That's because Tier 1 doctors are recognized for providing high value in health care delivery.

Tier 1 Primary Care Specialties

Your Tier 1 PCP may be selected from any of the following specialties:

Family Medicine

- Preventive Medicine
- Family Practice
- General Practice

Internal Medicine

- Internal Medicine
- Geriatric Medicine
- Pediatric Internal Medicine

Obstetrics & Gynecology

- Gynecology
- Obstetrics
- Obstetrics & Gynecology

Pediatrics

- Pediatrics
- Pediatric Adolescent
- Adolescent Medicine

Tier 1 Specialties

Allergy

- Allergy
- Allergy & Immunology

Cardiology

- Cardiology
- Cardiovascular Disease
- Cardiac Diagnostic
- Interventional Cardiology
- Clinical Cardiac Electrophysiology

Ear, Nose, and Throat (ENT)

- Otolaryngology
- Otology
- Pediatric Otolaryngology
- Head and Neck Surgery
- Laryngology
- Rhinology

Endocrinology

- Endocrinology, Diabetes and Metabolism
- Gastroenterology
- Digestive Diseases
- Gastroenterology

General Surgery

- Abdominal Surgery
- Proctology
- Colon & Rectal Surgery
- Surgery

Nephrology

- Nephrology

Neurology

- Neuromuscular Disease
- Neurology
- Neurology & Psychiatry

Neurosurgery, Orthopedics & Spine

- Orthopedic Surgery
- Neurology Surgery
- Shoulder Surgery
- Knee Surgery
- Hand Surgery
- Back & Spine Surgery
- Sports Medicine

Oncology

- Oncology

Pulmonology

- Pulmonary Medicine

Rheumatology

- Rheumatology

Urology

- Urology

Important Reminder:

Look for the Tier 1 blue dot when searching for a doctor on myuhc.com® or the UnitedHealthcare® app and you may be surprised by how much you can save.

Providers will have two blue hearts near their name if you are viewing as a Guest, and not signed in.

VOLUNTARY HEALTH BENEFITS

Voluntary benefits insurance can help protect you from significant or unexpected out-of-pocket expenses. Consider your anticipated medical needs along with the cost of the insurance plans available to you. Keep in mind, these plans are intended to supplement, not replace, a medical plan.

ACCENT HOSPITAL INDEMNITY INSURANCE

If you choose the Accent plan, you also receive a Hospital Indemnity Benefit. This benefit provides financial protection if you have a hospital admission. Hospital indemnity plan benefits do not apply against your plan deductibles or out-of-pocket maximums.

Example: With this plan, if you sprain your foot and are admitted to the hospital by ground ambulance, you will receive:

- $1,000 for the Hospital Admission
- $100 for each day of Hospital Confinement
- $200 for Ground Ambulance

That's a total up to $1,300

You also have a Wellness Benefit Rider which will reimburse $50 for an annual wellness exam.

Event	Plan Benefits
Hospital Admission (1 day / plan year)	$1,000
Hospital Confinement (up to 364 days / plan year)	$100
ICU Confinement (up to 364 days / plan year)	$200
Ground Ambulance (up to 3 days / plan year)	$200
Air Ambulance (up to 3 days / plan year)	$800
ICU Admission (1 day / plan year)	$1,000
Wellness Benefit Rider	$50

ACCIDENTAL INJURY INSURANCE

The accidental injury insurance through Cigna is designed to supplement major medical coverage by paying specific benefit amounts for expenses resulting from injuries or accidents. Hospitalization, physical therapy, intensive care, transportation and lodging are some of the out-of-pocket expenses that this accidental injury insurance could cover. Coverage is available for you, your spouse and/or your child(ren).

Biweekly Rates	
Employee	$2.91
Employee + Spouse	$4.38
Employee + Child(ren)	$5.10
Employee + Family	$6.57

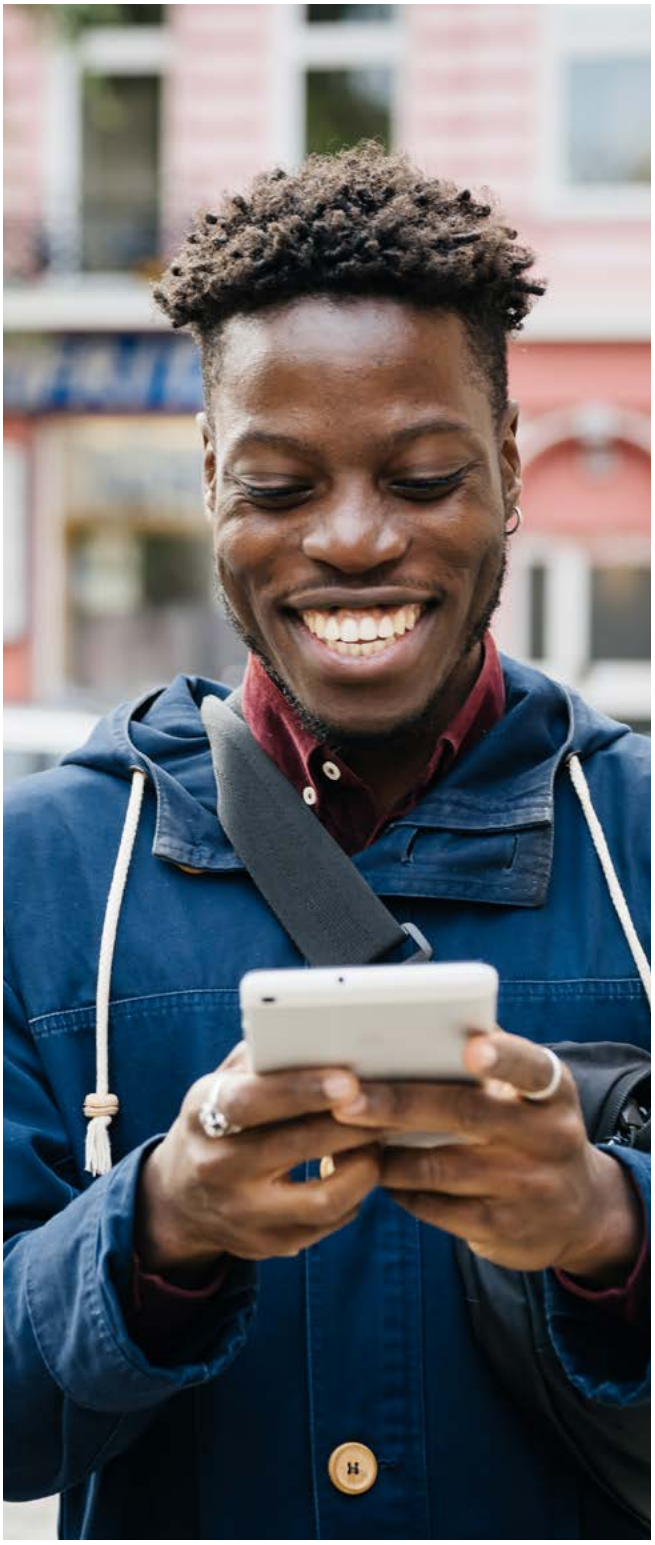
CRITICAL ILLNESS

Cigna's Critical Illness insurance provides employees and their families with additional financial protection to help cover unexpected expenses. A lump sum benefit of $10,000 is paid to the employee upon diagnosis. A benefit of $5,000 is paid for spouse or child coverage.

Critical Illness insurance typically covers the following conditions: invasive cancer, heart attack, stroke, end-stage renal disease, ALS, major organ failure.

Rates are based on attained age. Please contact Cigna for more information.

Biweekly Rates				
Age	Employee	Employee + Spouse	Employee + Children	Employee + Family
Under 25	$2.59	$5.45	$4.78	$7.63
25-29	$2.72	$5.71	$4.90	$7.89
30-34	$3.06	$6.42	$5.24	$8.61
35-39	$3.81	$7.73	$6.00	$9.91
40-44	$4.66	$9.08	$6.84	$11.26
45-49	$6.20	$11.67	$8.39	$13.85
50-54	$8.81	$15.37	$10.99	$17.55
55-59	$12.11	$20.14	$14.29	$22.32
60-64	$15.23	$24.58	$17.22	$26.76
65-69	$17.71	$28.75	$19.89	$30.94
70-74	$23.64	$38.18	$25.82	$40.37
75 to 79	$32.36	$49.56	$34.55	$51.75
80 +	$40.20	$60.40	$42.38	$62.58



VIRTUAL PRIMARY CARE

WHAT IS VIRTUAL CARE?

Schedule primary care just like an office visit with a PCP – over video instead. You choose an Optum Virtual Care network PCP and will meet with that same provider each visit.

SEE A VIRTUAL PRIMARY CARE PROVIDER FOR:

- Annual wellness visits
- Regular follow-ups for chronic conditions
- Referrals for screening tests
- Prescriptions*
- Lab tests
- Referrals to quality network specialists

*Certain prescriptions may not be available, and other restrictions may apply.

VIRTUAL VISITS

WHAT ARE VIRTUAL VISITS?

When you're sick and need care quickly, a Virtual Visit is a convenient way to start feeling better faster.

With a Virtual Visit, you can see and talk to a doctor via mobile device or computer — 24/7, no appointment needed. The doctor can give you a diagnosis and write you a prescription, if needed.

To get started with a Virtual Visit, go to **uhc.com/virtualvisits**.

Virtual visits are available to UHC members at no cost!

PREPARE FOR YOUR VIRTUAL VISIT

Have these three items ready to register and complete your Virtual Visit:

- Health plan ID card
- Credit card
- Pharmacy location

GET CARE IN 20 MINUTES OR LESS

Use a Virtual Visit for these minor medical needs:

- Bladder infection/urinary tract infection
- Bronchitis
- Cold/ flu
- Fever
- Pinkeye
- Rash
- Sinus problems
- Sore throat
- Stomach-ache

ONLINE HEALTH ASSESSMENT

Taking a health assessment is a quick and easy way to determine the current state of your overall health, and to figure out what steps you need to take now to improve your health in the future. After all, when you're healthy, you have the strength and confidence to be your true self.

Rally is designed to help you make changes to your daily routine, set smart goals and track your progress. You'll get personalized recommendations to help you move more, eat better and improve your health — and have fun doing it.

Start with the quick Health Survey and get your Rally Age℠, a measure to help you assess your overall health. Rally will then recommend missions for you, and activities designed to help improve your diet, fitness and mood. Start easy, and level up when you're ready. Plus, on Rally there are lots of ways to earn Rally Coins, which you can use for chances to win rewards. Rack up Rally Coins for taking healthy actions, like joining missions, completing healthy activities, or pushing yourself in a Challenge.

TO START:

1. Log in or register on **myuhc.com**
2. Click the **'Health Resources'** tab
3. Click **'Visit Rally Now'**
4. Click on **'Health Survey'**

UNITED HEALTHCARE TOOLS

Cyient cares about your health and wellbeing. Our medical carrier, UnitedHealthcare, provides access to a variety of programs to help you live well. The best part is that they are available to all enrolled members and don't cost you anything to use.

ACTIVATE YOUR MYUHC.COM ACCOUNT

When it comes to managing your health plan, **myuhc.com**® lets you see what's covered, manage costs and so much more. To help everyone get the most from their plan, it's important that each member age 18 and over create their own account. Use **myuhc.com** to:

- FInd and estimate the cost of care
- See what's covered
- View claim details
- Check your plan balances
- Find network doctors

SET UP YOUR ACCOUNT TODAY:

- Go to **myuhc.com** > **Register Now**
- Follow the step-by-step instructions

DOWNLOAD THE UNITED HEALTHCARE APP

The UnitedHealthcare app puts your health plan at your fingertips. Download it to:

- Find nearby care options in your network
- See your claim details and view progress toward your deductible
- View and share your health plan ID card with your doctor's office
- Video chat with a doctor 24/7

HOW TO FIND A PREMIUM DESIGNATED PROVIDER

Take an active part in your health by seeking out and choosing physicians with the help of the UnitedHealth Premium program.

The Premium designation makes it easy for you to find doctors who meet national standards for quality and local market benchmarks for cost efficiency.

To find a UnitedHealthcare Premium Care Physician, just go to myuhc.com® > Find a Provider. Premium Designated Providers will have two blue hearts near their name when you are viewing as a Guest.

GET AN ANNUAL PREVENTIVE PHYSICAL IN 2025

Cyient provides the high-quality benefits you need in the event of an illness or injury. Preventive care is an incredibly powerful and valuable component of your benefits. The plans are designed to provide the care you need to stay healthy year-round and hopefully not to be used just in the event of an emergency or illness.

Preventive care can help identify and treat minor, or even asymptomatic, health conditions well before they turn serious. Following the preventive care guidelines for medical, dental and vision health increases your chance of catching a health condition early and starting treatment before the condition becomes a major health issue.

Annual physicals and screenings are a great first step. Be sure to schedule preventive care visits with a health care provider to learn about what is needed to maintain your good health. You must schedule a physical and complete the online health assessment at **myuhc.com** to earn a $125 deposit to your HSA account! (incentives are paid out quarterly.)

REGISTER ONCE TO ACCESS BOTH TOOLS

Start by downloading the UnitedHealthcare app or going to myuhc.com and then:

Tap **Register Now** on the app, or select **Register** on the website

- Fill in the required fields and create your username and password
- Enter your contact information and select SMS text or phone call for two-factor authentication — then, agree to the terms and conditions
- Opt in to paperless delivery from your communication preferences

Now you're registered for — and connected to — the app and the website.

Get Connected

Scan this code to download the app and register, or visit **myuhc.com**

MANAGE YOUR MEDICATIONS

To help you stay healthy and manage the prescription medications you or your family may need.

You'll enjoy:

- Convenient access to thousands of in-network pharmacies
- Free standard shipping delivery of your prescriptions anywhere within the U.S with OptumRx Home Delivery
- Online resources to:
  - review your pharmacy coverage
  - see the list of brand and generic medications available under your plan
  - track expenses
  - research medications
  - compare prescription drug prices
  - refill your prescription drugs online and check order status with OptumRx
- Talk with a licensed pharmacist anytime, day or night

HEALTH AND WELLNESS DISCOUNTS

UnitedHealthcare has a discount program through Rally Marketplace. Rally Marketplace gives members the ability to redeem Rally Coins for discounts on goods and services from brands like Fitbit, Garmin, Under Amour, and more!

MATERNITY SUPPORT PROGRAM

Education, support and case management.

Employees enrolled in the Maternity Support Program can receive:

Maternity education materials — Upon enrollment, employees receive important educational materials covering a wide range of topics. In addition, employees receive a complimentary choice of a pregnancy or newborn care book.

Dedicated maternity nurses — Each employee, regardless of risk level, is supported before, during and after pregnancy by an experienced maternity nurse. Nurses provide assistance, guidance, answers and education via phone consultation.

These consultations focus on wellness and health risk screenings at different points throughout the pregnancy. Topics may include breastfeeding/lactation support, preparing to return to work, family planning and more. Ideally, consultations begin with preconception planning and continue after birth to screen for postpartum depression and provide information about newborn care.

Support of special care needs — Nurses experienced in high-risk pregnancies and pre- term births help provide specialized support services throughout the pregnancy.

ADDITIONAL RESOURCES
FOR UHC MEMBERS

United Healthcare

SELF CARE FROM CALM HEALTH APP

The Calm Health app provides programs and tools to help support your mental health and well-being — all at your own pace.

As a UnitedHealthcare member, Calm Health is included in your health plan and available at no additional cost.

Tap into tools and support

The Calm Health app brings you a library of support — including mindfulness content and programs created by psychologists — for a variety of health experiences and life stages. This information is designed to help you:

- Learn techniques to improve well-being – Find tools, music and sounds to help you meditate, improve focus, move mindfully and feel calm
- Work toward goals – Join self-guided self-care programs, and track your progress along the way
- Support your mind and body – Access mental health information and support to help you strengthen the mind-body connection

Scan this code to get started:

You'll first need to sign in to your account on myuhc.com® or the UnitedHealthcare® app.

TALKSPACE

Talkspace is a convenient, safe, and secure online therapy service that connects you to a dedicated, licensed therapist in your state of residence via private messaging (text, voice, video) or live video.

Talkspace treats a wide range of behavioral conditions including depression, anxiety, relationships, PTSD, addiction, eating disorders and more. You can regularly contact your dedicated therapist as life happens – anytime, anywhere. Therapists engage daily, 5 days per week.

This service is available through your United Healthcare medical plan's behavioral health benefits. Keep in mind that engaging with a Talkspace therapist is subject to the same co-pay or co-insurance (after deductible) that would apply to an in-person visit. Talkspace is available to you, your spouse/domestic partner and your dependent children (13+).

To get started, simply register (first visit only) and choose a provider at **talkspace.com/connect**. Download the app (iOS and Android) for easy future access.

WELLNESS PROGRAMS

QUIT FOR LIFE - TOBACCO CESSATION PROGRAM

Use of tobacco products is one of the leading preventable health risks in the United States. If you are a tobacco or e-cigarette user and enrolled in a Cyient medical plan, you will pay a $75 monthly surcharge in addition to your medical plan premium in 2025. During Open Enrollment, you will need to attest to being tobacco free for 60 days.

Quitting today is easier than ever with support from Quit For Life® on Rally Coach™. Quit For Life offers an eight-week program with the support of experienced Quit Coach Staff.

If you successfully complete the tobacco cessation program by June 1, 2025, you will be eligible for a reimbursement of the surcharge, retroactive to January 1. If you complete a tobacco cessation program after June 1, you will not be eligible for reimbursement, but the tobacco surcharge deductions will stop.

Get Started

Go to Myuhc.com > Coverage & Benefits >My Coverage & Benefits > Additional Benefits > View all additional benefits

Please note that failure to provide accurate information could result in discipline, including termination of employment. By completing the enrollment process, you attest that the information provided is accurate to the best of your knowledge.

WEIGHT LOSS PROGRAM

Real Appeal takes an evidence-based approach to support weight loss. The program helps participants make small changes necessary for larger long-term health results. Real Appeal uses a highly interactive internet show, videos and live online coaching to drive small behavior changes. In order to participate you must have a BMI of 23 or more.

Each member who participates in the Real Appeal program gets a Success Kit sent to them after their first group-coaching session with tools to help kick-start their weight loss. The Success Kit will include a weight and food scales, a portion plate and more.

Join today at **enroll.realappeal.com** or scan this code:

ONEPASS MEMBERSHIP PROGRAM

Only available for employees enrolled in the medical plans

Cyient is pleased to partner with OnePass for 2025. With OnePass, you can access fitness and wellbeing resources through OnePass Select, UnitedHealthcare's subscription-based program. It provides flexible access to thousands of gyms and online classes nationwide, with no long-term contracts or annual fees.

This convenient, digital program aims to increase engagement and productivity through healthier living. With competitive pricing and flexibility, One Pass Select lets you choose the health options that fit your lifestyle goals and budget.

Enroll Today:

1. Scan QR code below or visit: member.uhc.com/coverage/additional
2. Sign in or register
3. Select the One Pass Select tile

DIABETES MANAGEMENT PROGRAM

Livongo is a free health program to help you and your enrolled dependents manage diabetes and hypertension. The Livongo program includes vital health benefits, all included at no cost to you!

Here what you get with the Livongo Program:

Free strips and lancets, plus a new blood glucose meter.

While enrolled in this program, Livongo will ship the strips and lancets directly to you with no hidden costs. You can order your refills from Livongo online or by using your meter.

Better diabetes monitoring.

Livongo's smart meter comes with a cellular chip that automatically uploads readings - no more logbooks! The meter also provides real-time tips and, if desired, it can notify your family if your reading is out of range.

Answers to your questions 24/7

Certified Diabetes Educators are available to provide nutrition and lifestyle tips. Coaches are also available for support.

Sign up and receive

- A connected blood pressure monitor
- Step-by-step action plans based on your goals
- Tips on nutrition, activity and more
- One-on-one support from expert coaches

Learn More

To learn more about this program, visit the Livongo website or call Livongo Member Support and mention registration code **CYIENT**

Livongo by Teladoc Health

HYPERTENSION MANAGEMENT

Modern blood pressure management at no cost to you.

An advanced blood pressure monitor and the support you need 100% paid for by Cyient.

It's all for you and all on the house:

- **A connected** blood pressure monitor
- **Summary reports** you can send to your doctor
- **Reminders** you can set to check your blood pressure
- **Automatic uploads** mean no more writing down numbers
- **Support** from coaches when you need it
- **Advice** on what to eat and how to live healthier

Unlimited support. Unlimited inspiration. It's all free.

Get Started:

To learn more about this program, visit **Ready.Livongo.com/CYIENT/register** or call 800-945-4355 and mention registration code **CYIENT**

TOUCHCARE

Visit or log into the member portal at touchcare.com or call 866.486.8242 (M-F, 8am - 9pm EST)

TouchCare is a healthcare concierge service that helps you make better-informed healthcare decisions. They take care of things like billing mistakes, finding and coordinating with providers, selecting a health insurance plan, and more at no additional cost to you! With TouchCare, you have access to personal, expert healthcare service to help you navigate the complexities of the healthcare system.

WE'RE HERE TO HELP

TouchCare services were designed to make your life easier.

NEVER PAY MORE THAN YOU HAVE TO.

- **RXCARE** Get assistance finding the lowest cost options for all of your prescriptions.
- **ANCILLARY BENEFITS** We will help you leverage the right benefit, at the right time, to save you time and money

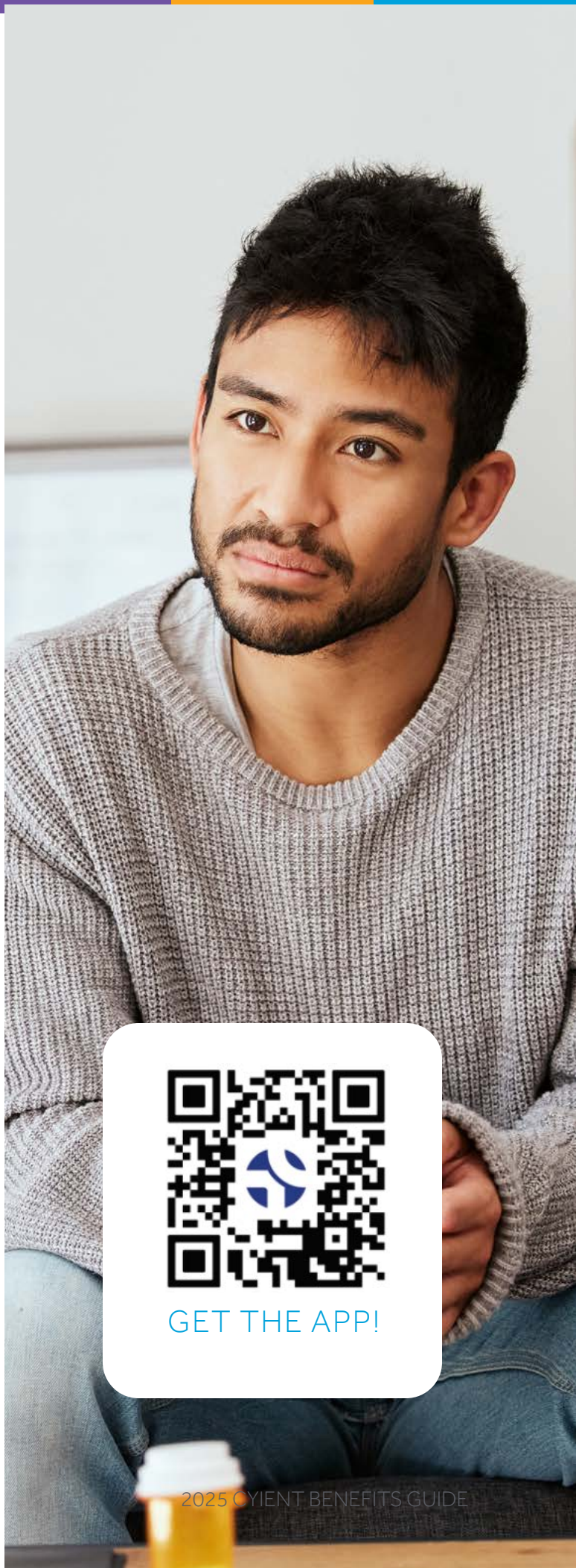
KEEP IN TOUCH WITH ALL OF YOUR BENEFITS

- **BENEFIT REFRESHER** Consult with an expert regarding your benefits anytime throughout the year.
- **QUESTIONS** You have questions; we have expertly researched answers. Your Health Assistant (HA) is always there to help.
- **OPEN ENROLLMENT SUPPORT:** With Touchcare, you have an expert Health Assistant in your corner who can help you select the best plan for yourself and your family. Schedule a 1 on 1 session today.

WE'RE HERE TO CONNECT

Our Health Assistants aren't just available on our app! You can also open a case via email, our online portal, or by phone.

Call 866.486.8242 (M-F, 8am - 9pm EST)
or visit touchcare.com



GET THE APP!

Fidelity

HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account (HSA) can help you save money by allowing you to pay for healthcare expenses with tax-free dollars. An HSA allows you to use the funds to pay for qualified medical expenses such as deductibles, copayments, coinsurance and more. Your HSA can be used to pay for eligible medical expenses of any family member who qualifies as a dependent on your tax return.

HSA ELIGIBILITY

To open an HSA, you must meet the following eligibility criteria:

- You must be covered by an HSA-compatible health plan, such as one of the Cyient high deductible health plans, and you cannot be covered by any other medical plan that is not an HSA-compatible health plan. This would include being enrolled in your spouse's plan as secondary coverage, an executive medical plan, or your spouse's Health Care Flexible Spending Account (FSA). Note: The IRS does not allow participation in an HSA if you have a Health Care FSA.
- You must be enrolled in the HSA-compatible health plan on the first day of the month (otherwise, your eligibility to make contributions to your HSA begins the first day of the following month). You may make the maximum annual HSA contribution for the year regardless of the month you become eligible.
- You must not be enrolled in Medicare.
- You must not be eligible to be claimed as a dependent on another individual's tax return.

HSA SET-UP

When you enroll in one of the Accent or Encore plans and elect to contribute dollars to your HSA, you will have the option to enroll in an HSA through Fidelity. During the enrollment process in Workday, you will be asked to acknowledge the terms and conditions of the Fidelity HSA. Once acknowledged, you will be issued a debit card that makes it easy for you to pay for qualified medical expenses.

Cyient employer contributions count toward the annual HSA contribution limits, so you need to carefully plan how much you'll contribute annually to avoid excess contributions. These limits apply even for participants entering the plan midyear.* Prior-year contributions may be made through April 15 of the following year.

** Employees currently enrolled in Medicare will not be eligible for HSA contributions in 2025; employees planning to enroll in Medicare in 2025 may not be eligible for HSA contributions (Employee and Cyient) for all or part of the year in 2025. Please consult with your tax advisor for further guidance.

FUNDING YOUR HSA

Make elections in Workday

To fund your HSA, you can make deposits using one of the following:

- pre-tax payroll deductions from your pay
- tax-deductible contributions
- rollover funds from another HSA
- one-time transfer from your IRA

Remember, you can change your HSA contribution at any time throughout the year. Making a contribution to a Health Savings Account is a smart investment. For 2025, Cyient is offering two opportunities for you to earn Company contributions to your HSA:

- **HSA Match**—Cyient will contribute up to an annual Company maximum of $450 for single coverage and $775 for family coverage. To receive Cyient's contribution, you must make contributions to your account. For every dollar that you contribute, Cyient will put in $.50, up to a maximum of $450 for single coverage and $775 for family coverage.
- **Get to Know Your Doctor**—You must have an annual physical in 2025 and complete UnitedHealthcare's online health assessment in order to receive a deposit of $125 into your HSA account.
- **Please note:** this amount will be deducted from your maximum contribution limit for 2025.

  This amount is a Wellness Incentive. The $125 is processed quarterly.

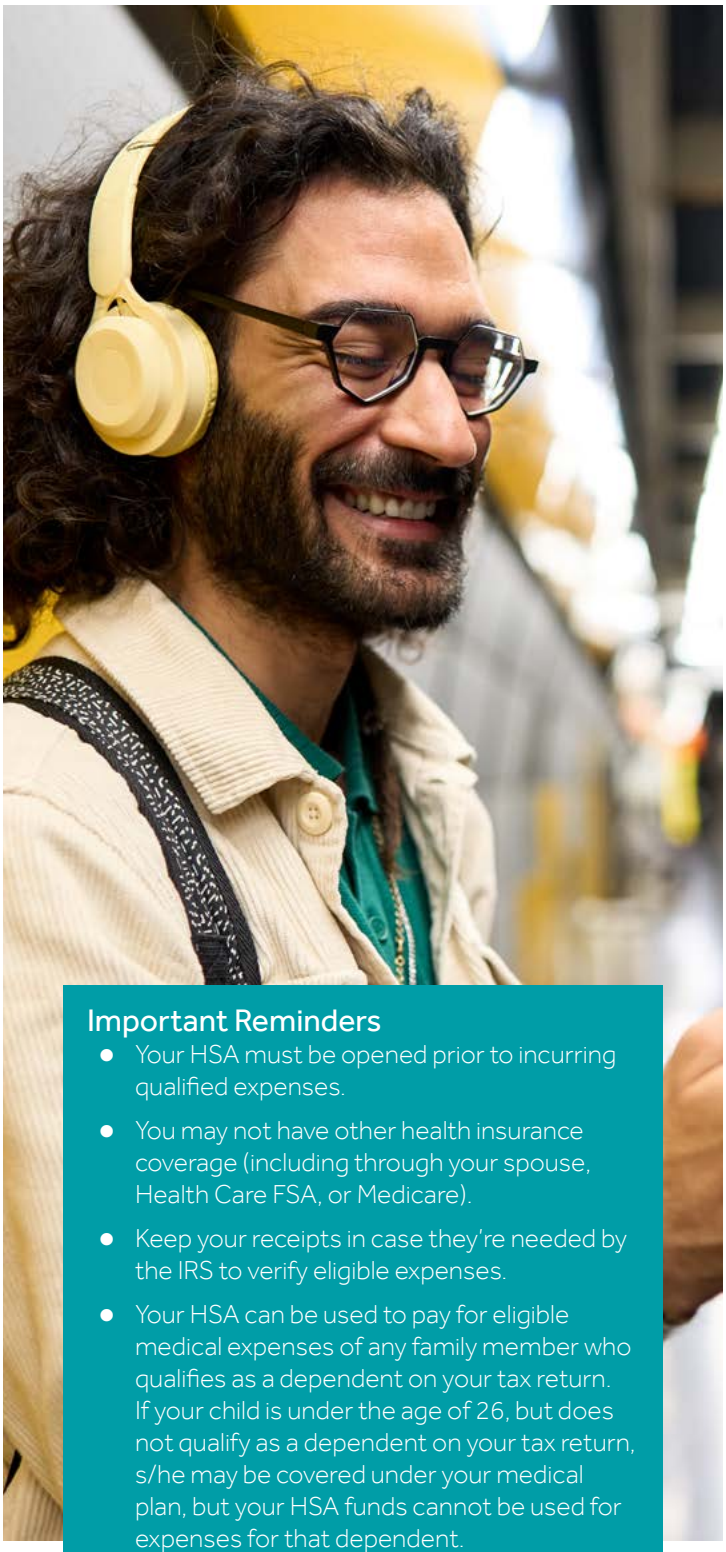
  The chart below details the limits below but does not include the $125 in the Maximum Contribution Limit.

Look at the chart to see how our new HSA Match offering impacts the annual contribution limits set forth by the IRS: You are not enrolled in any other non-HSA qualified health insurance plan.

Coverage Level	2025 IRS Limit	Cyient's Contribution	Max. Employee Contribution
Individual	$4,300	$450	$3,850
Family	$8,550	$775	$7,775

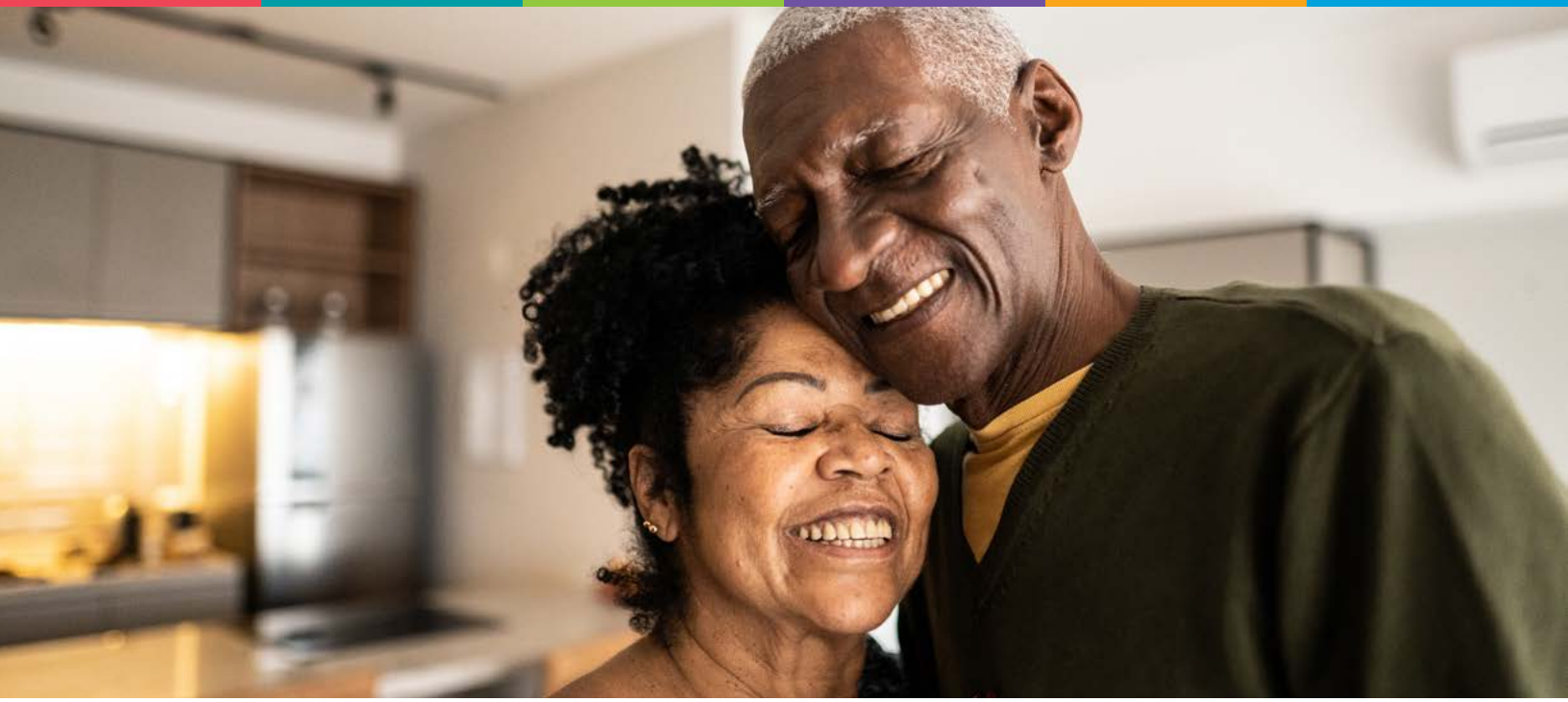
Individuals age 55 or older may make an additional catch-up contribution of $1,000 per year.

*Does not factor in wellness contribution



Important Reminders

- Your HSA must be opened prior to incurring qualified expenses.
- You may not have other health insurance coverage (including through your spouse, Health Care FSA, or Medicare).
- Keep your receipts in case they're needed by the IRS to verify eligible expenses.
- Your HSA can be used to pay for eligible medical expenses of any family member who qualifies as a dependent on your tax return. If your child is under the age of 26, but does not qualify as a dependent on your tax return, s/he may be covered under your medical plan, but your HSA funds cannot be used for expenses for that dependent.



REASONS TO LOVE AN HSA

- Triple Tax Savings
  - You can contribute to your HSA using tax-free dollars.
  - You can use the money in your HSA to pay for healthcare expenses with tax free money.
- Whatever you don't use in a year rolls over to the next year, and earns interest that is tax-free!
- You decide how and when to use the funds in your account—you can use the funds to pay for your healthcare expenses or save them for future healthcare costs.
- The account may be used to build funds for retirement. Once you reach age 65, you can withdraw the money for non-medical reasons without a penalty

ALLOWABLE EXPENSES

The following is a partial list of allowable expenses for an HSA, according to IRS guidelines:

- Prescription drugs or insulin, prescribed birth control
- Medical equipment, such as wheelchair, crutches, artificial limbs, wigs (where prescribed by a physician for mental health or due to hair loss because of disease)
- Treatments and therapies, such as treatment for alcoholism or drug addiction, acupuncture to treat a medical condition, physical therapy, smoking cessation programs
- Dental and Orthodontic care, such as x-rays, braces, dentures
- Vision care expenses, including eye exams, eyeglasses and contacts
- Hearing aids
- Assistance for the handicapped, such as a guide dog, braille book, home or car equipment for a handicapped person's needs
- Mental health institute treatment
- Other fees and services, such as hospital services, home care services, laboratory fees, surgical fees, x-rays, chiropractic fees

Please consult your tax advisor should you require specific tax advice. This list is subject to change. For a complete list of eligible expenses, please visit **netbenefits.com**.

FLEXIBLE SPENDING ACCOUNT (FSA)

Flexible Spending Accounts (FSA) allow you to set aside pre-tax dollars to pay yourself back for eligible health care and dependent care expenses. The FSA is administered through Flores and Associates.

There are two types of FSAs: Health Care FSA and Dependent Care FSA.

Please note: If you are age 65 and older and enrolled in any of the Medicare plans, you are not eligible for the Health Savings Account, but you are eligible for the Health Care FSA.

HOW IT WORKS

- Deductions are divided equally between pay periods and are automatically deducted from each paycheck and placed into your account.
- As you incur expenses, you simply use your Benny Card to pay for eligible expenses at the time of service. The Benny Card is a pre-paid benefits card that you can use to pay for eligible expenses that can be reimbursed from your health Flexible Spending Account (FSA). However, If you pay out-of-pocket for the eligible expense, you can submit a claim for reimbursement through the mobile app or logon to **flores247.com**. The reimbursement you receive is tax-free and is deducted from your FSA account.
- Eligible expenses must be incurred during the plan year (January 1 through December 31) and while you are making contributions to the plan.
- The annual contribution amount you elect cannot be changed throughout the year unless you have a qualified change-in-status event.

REMINDER: In order to participate in the Health Care FSA or Dependent Care FSA you must enroll or re-enroll each plan year during Open Enrollment.

HEALTH CARE FSA

- You may set aside up to $3,300 annually in pre-tax dollars.
- You may use your Health Care FSA to pay for qualified health expenses that are not covered by your medical, dental or vision plans, such as deductibles, copays, dental expenses, glasses, and chiropractic treatments.
- Funds can be used for yourself, your spouse and your dependent children.
- Your annual contribution amount is deposited into your account and is available to you at the beginning of the plan year.

DEPENDENT CARE FSA

- You may set aside up to $5,000 annually in pre-tax dollars or $2,500 if you are married and file taxes separately from your spouse. This dollar amount is further limited by salaries of plan participants and subject to annual non- discrimination testing. Despite the IRS limit, it is possible if the Plan fails to meet non- discrimination requirements, a portion of your contribution will be returned and subject to applicable taxes.
- Contributing to a Dependent Care FSA allows you to pay dependent care expenses so that you and your spouse can work or attend school full-time.
- Eligible expenses include care at a licensed daycare, before/after school care, summer day camp and elder care.
- When submitting a claim, you can only be reimbursed up to the amount you have contributed to date, less any previous reimbursements.

DENTAL

Cyient offers you a choice of two dental plans to allow you and your family the opportunity to select the plan that best suits your needs. You can choose from the PPO Plan option or the DHMO Plan option. Both plans are offered through Cigna.

PPO Plan

If you elect the PPO Plan option, you can visit any dentist of your choice. Each time you seek care, you have the option to utilize the DPPO Advantage network, the DPPO network or go out of the network to receive services. If you choose to use an out-of-network dentist, these providers may charge you according to their own fee schedule. To avoid this so-called balance billing, always ask your dentist if they are a participating Cigna Dental PPO provider.

DHMO Plan

If you elect the DHMO Plan option, you must select a Primary Care dentist, and coordinate all dental care through a network of dental providers. Keep in mind that your dental benefits are only covered when you utilize an in-network dental provider.

DHMOs are not available in all areas. When selecting the DHMO plan, you must confirm there is a participating dentist in your area. To search for a participating provider, visit **cigna.com**, and click on 'Find a Doctor, Dentist or Facility' at the top of the screen. Then select the box that reads 'employer or school'.

Enter your search location, choose Dentist, and choose Cigna Dental Care Access Plus

PPO	DPPO Advantage In-network	DPPO (no balance billing)	Out-of-network
Calendar Deductible			
Employee only	$50		
Family	$150		
Calendar Year Maximum	Increase your benefit maximum with annual preventive visits! Year 1: $1,000 Year 2: $1,100 Year 3: $1,200 Year 4: $1,300		
Diagnostic and preventive	Oral exams, X-rays, cleanings, fluoride, space maintainers, sealants		
	100%	90%	90%
Basic	Oral surgery, fillings, endodontic treatment, periodontic treatment, repairs of dentures and crowns		
	80%	70%	70%
Major	Crowns, jackets, dentures, bridge implants		
	60%	50%	50%
Orthodontia	Adults and Children		
	Covered at 50%; $1,000 lifetime maximum benefit		

DHMO	In-Network Only
Calendar Year Deductible	None
Calendar Year Maximum	None
Preventive Care	Covered at 100%
Basic Care	See Schedule of Benefits
Major Care	See Schedule of Benefits
Orthodontia	See Schedule of Benefits

This table is intended for comparison purposes only. If there are any discrepancies, the plan document will govern. Limitations or exclusions may apply.

EMPLOYEE PER PAY CONTRIBUTION

Coverage tier	Cigna PPO	Cigna DHMO
Employee	$13.81	$10.89
Employee + Spouse	$26.08	$22.04
Employee + Child(ren)	$28.53	$28.52
Family	$41.33	$39.29

VISION

Your vision coverage provides a full range of vision care services provided through the EyeMed network. You may receive care from any provider you choose, but your benefits are greater when you see a participating, in-network provider. If you visit an out-of-network provider, you will be responsible for all payments up front, and then must file a claim with EyeMed for reimbursement.

	In-network	Out-of-network
Eye exam with dilation as necessary (once every 12 months)	$10 copay	Reimbursed up to $30
Frames (once every 24 months)	$150 Allowance 20% off balance over $150	Reimbursed up to $75
Standard lenses (once every 12 months)		
Single vision	$25 copay	Reimbursed up to $25
Bifocal	$25 copay	Reimbursed up to $40
Trifocal	$25 copay	Reimbursed up to $60
Lenticular	$25 copay	Reimbursed up to $60
Contact lenses in lieu of glasses		
Elective	$150 allowance	Reimbursed up to $120
Medically Necessary	Covered at 100% no copay	Reimbursed up to $200

When you call an EyeMed provider to make an appointment, be prepared to provide your Social Security number for identification.

EMPLOYEE PER PAY CONTRIBUTION

Coverage tier	EyeMed Vision
Employee	$2.68
Employee + Spouse	$5.09
Employee + Child(ren)	$5.36
Family	$7.88

To locate a participating provider, call EyeMed at 1-866-939-3633 or visit **EyeMed.com**.

Participating providers will contact EyeMed to verify your eligibility and plan coverage and to obtain authorization for services and materials.

LIFE & AD&D

Life insurance helps protect your family from financial risk and sudden loss of income in the event of your death. Accidental Death & Dismemberment (AD&D) insurance provides additional benefits if you lose your life, sight, hearing, speech or one or more limbs in an accident.

The Company provides you with Basic Life insurance from Cigna in the amount of $50,000— at no cost to you. If you die as a result of an accident, your beneficiary will receive an additional benefit. For other covered losses, the amount of the benefit is a percentage of the AD&D insurance coverage amount. Evidence of good health is not required.

Group Term Life and AD&D	100% paid by the employer
Employee	$50,000

AGE REDUCTION SCHEDULE

- Ages 65 to 69: Benefit decrease to 35% of original benefit.
- Ages 70-74: Benefits will reduce an additional 25% of the original amount.
- Ages 75+: Benefits will reduce an additional 15% of the original amount
- Benefits will terminate when you retire.

HERE ARE SOME HELPFUL TERMS

AGE REDUCTION: The group term basic life and AD&D insurance coverage are subject to a reduction in benefit amount as you age.

PORTABILITY AND CONVERSION: Portability and conversion are available if your employment with Cyient ends. Portability allows you to continue your term life coverage, while the conversion option allows you to convert your term life policy into an individual whole life policy.

VOLUNTARY LIFE AND AD&D

You may purchase additional Life and/or AD&D coverage for yourself, your spouse and/or dependent children. Voluntary Life and Voluntary AD&D are separate elections, and you do not have to elect one to get the other.

Coverage	Available benefit	Guaranteed amount
Employee $10,000 increments	$10,000 to $500,000	$150,000
Spouse $5,000 increments	$5,000 to $250,000 (cannot exceed 50% of employee coverage)	$25,000
Dependent child(ren) $10,000	Birth to 15 days — No coverage 15 days to 6 months — $250 6 months to 26 years — $10,000	N/A

Spouse rates will be determined by the employee age. Voluntary spouse life coverage is not available for employees age 70 or more.

AGE BASED REDUCTIONS: When you are age 65 or older, your life insurance benefit will reduce by the following percentage: 35% at age 70, 25% at age 75, 15% at age 80

Voluntary life employee rates per $1,000 of coverage			
Under 25	$0.050	50-54	$0.170
25-29	$0.050	55-59	$0.330
30-34	$0.060	60-64	$0.510
35-39	$0.070	65-69	$0.980
40-44	$0.075	70-74	$1.580
45-49	$0.110	75+	$1.580

Voluntary AD&D employee and spouse rate per $1,000 of coverage
Employee: $0.035 Spouse: $0.020 Child: $0.015

Voluntary life child rate per $1,000 of coverage*
$0.020

*Rate is for all children, regardless of number of children covered.

IMPORTANT NOTE ABOUT EVIDENCE OF INSURABILITY

If you do not elect Employee or Spousal Supplemental Life Insurance when you are first eligible, any amount elected later will be subject to Evidence of Insurability (EOIO). For new hires, EOI will be required if you elect an amount over $150,000 for yourself or $25,000 for your spouse. EOI is not required for child Life coverage. Voluntary AD&D does not require EOI approval.

Increase Your Coverage During Open Enrollment Without EOI

Whether or not you are already enrolled, you can increase your coverage during annual Open Enrollment by two increments ($20,000 for employees / $10,000 for spouses) without providing evidence of insurability (EOI).

Example

Employee A is age 29. Based on the above chart, the rate is $0.050 per $1,000 of coverage.
Employee A elects $20,000 in voluntary life coverage. The monthly premium will be $1.00.

$0.050	x	20	=	$1.00
Plan rate (determined by age)		Coverage per $1,000		Monthly premium

DISABILITY

To protect your income in case you are unable to work because of an illness or injury, Cyient provides disability coverage at no cost to you. The plan is administered by New York Life Group Benefit Solutions.

SHORT-TERM DISABILITY (STD) PLAN

Once you have been disabled for seven days, the STD plan pays you 60% of your weekly base salary up to a maximum benefit amount of $2,000 for up to 26 weeks while you are unable to work because of to a non-work-related illness (no waiting period for injury). Once your claim is approved, you will receive the benefit payment through your normal payroll, with normal deductions and taxes withheld.

Short-term disability eligibility — full-time employees	100% paid by the employer
Weekly benefit amount	60%
Weekly benefit maximum	$2,000
Benefits duration	26 weeks

If you live in a state that provides paid leave, you must first file with the state and Cyient would pay any balance owed.

Coordination of disability benefits

Your benefit may be reduced if you receive disability benefits from retirement, Social Security, workers' compensation, state disability insurance, no-fault benefits or return-to-work earnings. Refer to your certificate of coverage for more details.

LONG-TERM DISABILITY (LTD) PLAN

The LTD plan provides income protection in the event of an extended illness or injury. The plan pays 50% of your monthly base salary up to a maximum benefit amount of $5,000 for each month you are unable to work because of a disabling condition. Benefits begin after 180 days of disability and may be reduced by income you receive from other sources, such as workers' compensation, Social Security and other disability coverage. LTD benefits will continue for two years if you are unable to perform the duties of your own occupation. If after two years, you are disabled from performing any and all occupations, benefits will be paid while you are totally and permanently disabled up to age 65, or according to ADEA rules.

Long-term disability eligibility — full-time employees	Claims are processed and paid through New York Life Group Benefit Solution
Monthly benefit amount	50%
Monthly benefit maximum	$5,000
Benefits begin	180 days
Benefits duration	up to SSRNA

LTD benefits received are tax-free, provided the premium has become a taxable benefit.

Cyient pays the premium and you pay the tax on the premium amount. The cost of the LTD premium is added to your taxable income on your W-2 at the end of each year. This results in a tax-free disability benefit to you!

EMPLOYEE ASSISTANCE PROGRAM
FOR ALL EMPLOYEES

COMPSYCH

As a Cyient employee, you and your family have access to 3 EAP sessions per issue per year.

Issues include:

- Legal
- Financial
- Work-life balance assistance
- Family
- Relationships

To connect with the ComPsych EAP through NYL,
please visit **guidanceresources.com**
or call 1-800-344-9752
Company Code: NYLGBS

LIFEWORKS

As a Cyient employee, you and your family have access to 3 EAP session per issue per year.

EAP Services

- EAP is designed to provide local expert support and consultation
- Assistance in meeting challenges and resolving work/life issues
- Short-term, solution-focused counselling and consulting services
- Services offered away from the workplace, in confidentiality
- Caring advisor who can help you choose a support option thatbest suits your needs and learning style

To connect with the EAP,
please visit login.lifeworks.com
or call 1-844-880-9137
Company Code: CYIENT-US

LONG TERM CARE

TRUSTMARK

Universal Life Insurance combines the benefits of life insurance with living benefits which can be utilized for long-term care, home healthcare, adult day care or assisted living. For employees, protecting their families' future with end-of-life benefits is a common occurrence. Adding to these concerns is the likelihood that they will need long term care services. This life insurance, with living benefits, provides an answer to both of those worries.

Advantages to considering coverage now:

- **Set Rates** – streamlined application; rates do not increase due to age
- **Portable** – coverage will continue even if you move to a different state or change jobs.

Long-Term Care services can be expensive. For example, a home health aide can cost over $4,000 a month. Enroll with Trustmark and be better prepared for costs like these. Plus, you get life insurance benefits as well. Access to Trustmark Universal Life is brought to you via the YourCare360 program.

Access to Trustmark Universal Life is brought to you via the YourCare360 program.

IDENTITY THEFT

NORTON LIFELOCK

No one intends to be unsafe online. That's why Norton LifeLock Benefit plans were created to help members feel protected and confident in our connected world.

The Norton LifeLock plans provide members with the tools to help protect their devices, connection, and identity. Each plan offers credit alerts, social security number alerts, dark web monitoring, social media monitoring, and much more!

Biweekly Rates	Benefit Essential	Benefit Premier
Employee	$3.23	$4.38
Employee + Spouse	$6.45	$8.30

401(K) RETIREMENT PLAN

There are many great benefits to being a participant in the Cyient, Inc. 401(k) Retirement Plan. Among those benefits is exceptional customer service— online or by phone. In fact, you can count on your company and Fidelity to help support you every step of the way.

BEST PRACTICES TO CONSIDER:

- **THE IMPACT OF AN EARLY START.** Your decision to start today could give you quite a bit more at retirement than starting five years from now.
- **CONTRIBUTE AS MUCH AS YOU CAN.** That amount can take you a long way toward reaching your financial goals.
- **DO WHAT YOU CAN AFFORD.** Start at a number that feels comfortable to you. You can always change it later. The important thing is to invest what you can afford and start right away.
- **INVEST MORE IN YOUR PLAN, PAY LESS IN TAXES.** Your pretax contributions come out of your pay before income taxes are taken out. You can actually lower your current taxes by investing in the plan today

ENROLL IN THE RETIREMENT PLAN

If you haven't already, enrolling in your plan is the right step towards a more secure retirement.

It's easy to join your plan and make that next great investment in yourself.

Here's how:

- First, go to Fidelity NetBenefits® at **401k.com**.
- Next, set up your password. If you're already a Fidelity customer, you can use your existing password.
  Please note, you will be prompted to enter your email address.
- Finally, click on the link to enroll.
- If you have questions or need help before getting started, visit **401k.com** or call Fidelity at 1-800-835-5097.
- Your plan has an **automatic enrollment** feature. If the automatic enrollment feature applies to you and you do not take action, you will be automatically enrolled. You will receive a separate notification explaining when the automatic enrollment will occur.

Please Note: 401k eligibility is limited to associates that are a citizen of the United States or have received their permanent residency in the United States. Associates working on a visa are not eligible for the 401k but may enroll in the National Pension Scheme (NPS). Additional details regarding NPS can be found on the MyCyient > HR > Benefits Hub.

RETIREMENT PLAN FAQs

When am I eligible to enroll?	All contributions	Attain Age 21 401k eligibility is limited to associates that are a citizen of the United States or have received their permanent residency in the United States.
When can I enroll in the plan?		First day of each month Your plan offers an Automatic Enrollment feature. Refer to Enrollment Information on previous page.
How much can I contribute?	Employee Contributions	1% to 90% of eligible compensation, inclusive of pretax and/or Roth deferrals (IRS limit of $23,500 for 2025) EGTRRA Catch Up Provision
	Contribution Change Frequency	Beginning of Payroll Period
	Discretionary Match	Cyient's match will be paid at 50% on the first 4% of eligible compensation
	Discretionary Profit Sharing	Refer to the Summary Plan Description for further information regarding profit sharing contributions.
Can I make a catch up contribution?	If you are age 50 or over by the end of the taxable year and have reached the annual IRS limit or Plan's maximum contribution limit for the year, you may make additional salary deferral, pretax contributions to the Plan up to the IRS Catch-Up Contribution Limit (2025 = $7,500). Beginning in 2025, those between 60-63 will be eligible to contribute up to $11,250 as a catch-up contribution.	
When am I vested?	Employee Contributions	100% immediate
	Discretionary Match	Years of Service for Vesting / Percentage less than 1 / 0 2 / 33 3 / 66 3 / 100
Can I take a loan?	Although your plan account is intended for the future, you may take a loan from your account.	
Can I take a withdrawal?	Withdrawals from the Plan are generally permitted in the event of termination of employment, retirement, disability, or death.Hardship Withdrawals are permitted in accordance with the IRS regulations.	
Where can I go for more information?	Please consult the 401k Summary Plan Description found on the MyCyient > HR > Benefits Hub, or you may contact **NAM.Benefits@cyient.com** .	

CONTACTS

Stay in the loop!

Text **CYIENT** to **(443) 748-1858** to stay up to date with your benefits.

Benefit	Contact	Phone Number	Website or Email
Medical and Prescription	UnitedHealthcare	1-833-894-5447	For general information: uhc.com Enrolled members can also check coverage, get claims statuses, search for a provider, and more at: myuhc.com
Dental	Cigna	1-800-CIGNA24 1-800-244-6224	mycigna.com
Health Savings Account (HSA)	Fidelity	1-800-835-5095	netbenefits.com
Vision	EyeMed	1-866-939-3633	EyeMed.com
Life and AD&D	New York Life Group Benefit Solutions	1-800-362-4462	newyorklife.com
Disability	New York Life Group Benefit Solutions	1-800-362-4462	newyorklife.com
Diabetes Management Program **Hypertension Benefit**	Livongo	1-800-945-4355	welcome.livongo.com/cyient Registration Code: CYIENT
Flexible Spending Account (FSA)	Flores and Associates	1-800-532-3327	flores247.com
Accidental Injury Insurance	Cigna	**Enrollment Support:** 1-800-351-9214 **Claims Support post enrollment:** 1-800-754-3207	mycigna.com
Critical Illness Insurance	Cigna	**Enrollment Support:** 1-800-351-9214 **Claims Support post enrollment:** 1-800-754-3207	mycigna.com
Long-Term Care Benefits	Trustmark	1-855-425-7670	cyient.yourcare360.com
Identity Theft	Norton LifeLock	800-607-9174	my.norton.com
401(k)	Fidelity	1-800-835-5097	401k.com
EAP	LifeWorks	1-844-880-9137	login.lifeworks.com Company Code: CYIENT-US
	New York Life ComPsych	1-800-344-9752	guidanceresources.com Company Code: NYLGBS
Advocacy and Navigation Support	Touchcare	866-486-8242	assist@touchcare.com

Cyient, Inc.

HEALTH PLAN NOTICES

TABLE OF CONTENTS

1. Medicare Part D Creditable Coverage Notice
2. HIPAA Comprehensive Notice of Privacy Policy and Procedures
3. Notice of Special Enrollment Rights
4. General COBRA Notice
5. Women's Health and Cancer Rights Notice

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Cyient, Inc. About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE FROM CYIENT, INC. ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Cyient, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Cyient, Inc. has determined that the prescription drug coverage offered by the Cyient, Inc. Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of

the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
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. See the Cyient, Inc. Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the Cyient, Inc. Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Cyient, Inc. Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Cyient, Inc. prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call 860-726-4432. **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 Cyient, Inc. changes. You also may request a copy.

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).

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 whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2025
Name of Entity/Sender:	Mihaela Popescu
Contact—Position/Office:	Manager | Benefits Administration
Address:	99 East River Drive East Hartford, CT 06108
Phone Number:	860-726-4432

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

CYIENT, INC.
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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.

This notice is provided to you on behalf of:

These plans comprise what is called an "Affiliated Covered Entity," and are treated as a single plan for purposes of this notice and the privacy rules that require it. For purposes of this notice, we will refer to these plans as a single "Plan."

For the remainder of this notice, Cyient, Inc. is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

If protected health information is properly disclosed under the HIPAA Privacy Practices, such information may be subject to redisclosure by the recipient and no longer protected under the HIPAA Privacy Practices.

5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities (subject to certain limitation described in paragraph 20 below);
- When required for judicial or administrative proceedings (subject to certain limitation described in paragraph 20 below);
- When required for law enforcement purposes (subject to certain limitation described in paragraph 20 below);
- When required to be given to a coroner or medical examiner or funeral director (subject to certain limitation described in paragraph 20 below);
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not

objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years

prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. Reproductive Health Care Privacy: Effective December 23, 2024, a group health plan may not disclose protected health information to: (i) conduct a criminal, civil, or administrative investigation into a person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; (ii) impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; or (iii) identify any person for the purposes described in (i) and (ii).

Reproductive health care means care, services, or supplies related to the reproductive health of the individual.

This prohibition only applies if the reproductive health care is lawful under the law of the state in which the health care was provided and under the circumstances in which it was provided, or if the reproductive health care was protected, required, or authorized by Federal law, including the United States Constitution, regardless of the state in which it is provided. For example, if you receive reproductive health care in a state where such care is lawful even though it is not lawful in the state where you reside, the plan may not disclose this information to conduct an investigation.

A group health plan may not use or disclose protected health information potentially related to reproductive health care for the purposes of uses and disclosures of 1) public health oversight activities, 2) judicial and administrative proceedings, 3) law enforcement purposes, and 4) coroners and medical examiners without obtaining a valid attestation from the person requesting the use or disclosure of such information. A valid attestation under this section must include the following elements:

(i) A description of the information requested that identifies the information in a specific fashion, including one of the following: (A) the name of any individual(s) whose protected health information is sought, if practicable; and (B) if including the name(s) of any individual(s) whose protected health information is sought is not practicable, a description of the class of individuals whose protected health information is sought.

(ii) The name or other specific identification of the person(s), or class of persons, who are requested to make the use or disclosure.

(iii) The name or other specific identification of the person(s), or class of persons, to whom the covered entity is to make the requested use or disclosure.

(iv) A clear statement that the use or disclosure is not for a purpose prohibited by the reproductive health care regulation.

(v) A statement that a person may be subject to criminal penalties if that person knowingly and in violation of HIPAA obtains individually identifiable health information relating to an individual or discloses individually identifiable health information to another person.

(vi) Signature of the person requesting the protected health information, which may be an electronic signature, and date. If the attestation is signed by a representative of the person requesting the information, a description of such representative's authority to act for the person must also be provided.

For example, if you lawfully obtain an abortion and an investigation into the provider is conducted, law enforcement would need to submit an attestation in order to try and obtain the information. The plan would deny the request per HIPAA's prohibition on the disclosure of reproductive health care because such care was lawful.

21. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 24).

22. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

23. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

24. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Mihaela Popescu
Manager | Benefits Administration
860-726-4432

Organized Health Care Arrangement Designation

The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.
The members of the Organized Health Care Arrangement are:

Effective Date

The effective date of this notice is: January 1, 2025.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

CYIENT, INC. EMPLOYEE HEALTH CARE PLAN

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 later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *60 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a 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 *60 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Mihaela Popescu
Manager | Benefits Administration
860-726-4432

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

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 in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

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. If you believe you are eligible for this extension, contact the Plan Administrator.

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[1] 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

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Mihaela Popescu
Manager | Benefits Administration
99 East River Drive
East Hartford, CT 06108
860-726-4432

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Cyient, Inc. Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The Cyient, Inc. Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

Horizon	In-Network	Out-of-Network
Individual Deductible	$750	$4,000
Family Deductible	$1,500	$8,000
Coinsurance	30%	50%
Encore	In-Network	Out-of-Network
Individual Deductible	$1,650	$2,500
Family Deductible	$3,300	$5,000
Coinsurance	20%	40%

Accent	In-Network	Out-of-Network
Individual Deductible	$4,500	$5,350
Family Deductible	$9,000	$10,700
Coinsurance	0%	0%

If you would like more information on WHCRA benefits, please refer to your or contact your Plan Administrator at:

Mihaela Popescu
Manager | Benefits Administration
860-726-4432

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

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

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

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

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

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA 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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

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.

OMB Control Number 1210-0137 (expires 1/31/2026)

Employer Name:	Cyient, Inc.
Employer State of Situs:	Connecticut
Name of Issuer:	UnitedHealthcare
Plan Marketing Name:	Accent, Encore, Horizon
Plan Year:	1/1/2025-12/31/2025

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2024 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	No
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	No
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	No
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes

23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	No
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	No
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

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

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

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

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

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

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

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

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

_____.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Cyient Inc.	4. Employer Identification Number (EIN) 66-0867496
5. Employer address 99 East River Drive 5th Floor	6. Employer phone number 860-726-4432
7. City East Hartford	8. State CT / 9. ZIP code 06108
10. Who can we contact about employee health coverage at this job? Mihaela Popescu -Benefits Manager	
11. Phone number (if different from above)	12. Email address: mihaela.popescu@cyient.com

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    Full time, Part-time 30-39 hours/week; Part-time 16-29 hours/week
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:

    Children, Spouse, Domestic Partner + Domestic Partner child(ren);Family
  - ☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? Hire date (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $ 34.69
b. How often? ☐ Weekly ☐ X Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

CYIENT

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.