BENEFITS GUIDE

2025

TD SYNNEX | hyve solutions

Explore Topics

At TD SYNNEX, we believe that our coworkers are our most important asset. Helping you and your families achieve and maintain well-being—physical, emotional, social, and financial—is one reason we offer this comprehensive benefits program. We embrace all coworkers by providing a variety of options for you to choose from. Our program combines innovative solutions with traditional benefits to provide you a safety net when and where it matters most. As you review this guide, consider how each of these benefits will support you and your loved ones. Then, enroll in the benefits that meet your needs.

This publication contains important information about your coworker benefit program. **Please read thoroughly.**

This document highlights some of the benefits offered through our benefits program. Please refer to the plan document(s) for a complete description. If there is a conflict between this document and the legal plan documents, the legal plan documents will prevail. The benefits and policies outlined in this document do not constitute the terms and conditions of an employment contract. Although the company maintains the benefits program on an ongoing basis, the company reserves the right to amend or terminate any plan at any time.

2025 Open Enrollment Overview

Important! Open Enrollment begins on November 1, 2024, and ends on November 15, 2024. You are selecting benefits for January 1, 2025-December 31, 2025. Open Enrollment this year will be an active enrollment. Your current benefits will not roll over into next year (except for any supplemental life and MetLife plans you are currently enrolled in; these will remain). **If you do not elect benefits, you will not have coverage for 2025.**

After Open Enrollment ends, you will not be allowed to change your benefit elections until the next Open Enrollment in late 2025, unless you experience a "qualifying life event" such as a change in your marital status or eligible dependents.

What is New for 2025?

- Starting 1/1/2025, the benefit plan year will run from 1/1-12/31 each year.
- Introducing Quantum Health, available to help with all your healthcare questions and needs at no additional cost. Consider them your personal advocate, offering a concierge level of service to help you and your family with your benefits. Please see additional information on page 6.
  - **Contact your Quantum Health Care Coordinators if you have any questions about Open Enrollment, healthcare or benefits in general starting November 1, 2024, at 866.871.0675 or by visiting TDSYNNEX.Quantum-Health.com.**
- We will be transitioning away from Cigna to a new medical provider. Beginning 1/1/25, you will have the Anthem BCBS provider network.
  - Locate providers at **https://www.anthem.com/find-care/**
  1. Select "Basic Search" as a guest
  2. Select "Medical Plan or Network"
  3. Select your state, then choose "Medical (Employer-Sponsored)"
  4. Most coworkers will select "National PPO (BlueCard PPO)". However, if you live in the following states, please select the applicable network:
     - FL: Choose "NetworkBlue (Select Network)"
     - GA: Choose "Blue Open Access POS (Select Network)"
     - NJ: Choose "Horizon Managed Care Network (Select Network)"
  - Keep in mind to look at the correct network for any dependents not living in the same state as you are. Do not forget that your Quantum Health Care Coordinators can help you find a provider or confirm your current provider is in-network.
  - While coverage levels will not be changing, the annual deductibles for the Anthem BCBS plans will be reduced for the 2025 plan year to help offset for the current short plan year. Keep in mind that the deductibles will reset for 2026, and return to $1,000, $2,000 and $3,250.
  - If you enroll in one of the Anthem BCBS medical plans, you will receive a new member ID card that will also include your prescription coverage under OptumRx, along with the phone number for Quantum. Make sure to present this card for your healthcare and pharmacy needs beginning 1/1/25.
- Small change to the Kaiser CA and CO HDHP annual out-of-pocket maximum limit.
- Dental carrier will be transitioning from Cigna to Delta Dental, providing greater network access with no change to coverage.
- Vision carrier will be transitioning from Cigna to VSP. There will be no changes to the plan design, but there will be broader network access nationally.
- Biometric screenings—save $300 on healthcare premiums for 2025 if completed by the communicated deadline. To be reflected beginning with your second paycheck in January on a bi-weekly basis.

Please review additional communications for Open Enrollment sessions dates/times along with other important open enrollment reminders at TDSYNNEX.Quantum-Health.com.

Opportunities to Enroll

As a TD SYNNEX coworker, you have three opportunities to enroll in benefits or change your elections as well as the dependents you cover.

New Hire Enrollment

Your medical, dental, vision, life and AD&D, Life Empowerment Assistance Program (LEAP), flexible spending accounts, and voluntary benefits are effective the first of the month following your date of hire or coinciding with your hire date if you are hired on the first of the month. The company sponsored disability plans are effective on the first of the month following your six-month anniversary of active employment. **You must enroll within 30 days of your hire date.** If you miss this deadline, you will not be able to enroll in benefits again until Open Enrollment or you experience a qualifying life event.

Open Enrollment

Open Enrollment will take place November 1-November 15. This is your yearly opportunity to review your benefits and dependents to make changes for the next plan year. This enrollment is active which means you must take action. Your current benefits will not rollover into next year. **If you do not elect benefits, you will not have coverage in 2025** (except for any Metlife or supplemental life plans you may be enrolled in, they will continue).

Changing Benefits During the Plan Year

You may change your benefits throughout the plan year if you experience a qualifying life event. You must change your benefits within 30 days of the event date. Examples of qualifying events include a change in:

- Legal marital status (e.g., marriage, divorce, death of spouse, legal separation)
- Change in domestic partnership status (e.g., partnership registration, termination of domestic partnership, death of domestic partner)
- Number of dependents (e.g., birth, adoption, death of dependent, ineligibility due to age)
- A dependent's eligibility status (e.g., a dependent child is no longer eligible)
- Employment or job status

Keep in mind, you will be required to provide documentation, such as a marriage or birth certificate, for the change to be completed. Except for birth, adoption or guardianship, approved benefit changes due to a qualifying life event will become effective on the first day of the month following the qualifying life event.

HOW TO CHANGE YOUR BENEFIT ELECTIONS

To submit a change to your benefits, please follow the below steps:

1. Log into **Workday** and click on the Menu, then the Pay and Benefits under Personal Information application
2. Click Change **Benefits** under **Tasks and Reports**
3. Select one of the listed reasons that best describes your change
4. Enter the Benefits Event Date
5. Under **Attachments**, upload a supporting document that confirms the reasons for the change. This is required in order for your change to be approved outside of Open Enrollment.
6. Click **Submit** and Click **Open**
7. The system will walk you through each benefit plan. Continue through each plan, making any desired changes, until you reach the Summary Page to review and submit your selections. You will need to accept the terms before you are able to submit your changes.

Be sure to print and save a copy of the confirmation page for your records.

Who is Eligible for Benefits?

You and your loved ones are eligible to enroll in benefits if you meet the following requirements.

COVERING YOURSELF

You are eligible for benefits if you are a regular full-time coworker regularly scheduled to work at least 30 hours per week.

COVERING A SPOUSE OR DOMESTIC PARTNER

You can enroll your legal spouse or domestic partner (same-sex or opposite-sex).

COVERING CHILDREN

You can enroll children under 26 years old, including:

- Natural
- Adopted
- Stepchildren
- Children of covered domestic partners

Please note: Disabled dependent children over the age of 26 may be eligible for coverage.

All dependents must reside within the United States. Coworkers cannot be covered both as a coworker and as a dependent under the plan. Dependent children can only be enrolled under one parent's plan if both parents are employed by TD SYNNEX and are eligible for benefits. Family members such as parents, grandparents, grandchildren, and siblings are not eligible for coverage.

DEPENDENT ELIGIBILITY DOCUMENTATION

Proof of eligibility is required when adding a dependent to benefits. Examples of accepted documentation include a marriage license, tax return, domestic partnership registration, birth certificate, or adoption orders.

Ready for a Simplified Healthcare and Benefits Experience?

One-of-a-Kind Support!

When dealing with healthcare and benefits, it can be hard to know where to start. Quantum Health will be your one place to turn to when you need assistance. Their Care Coordinators will help you with benefit questions, medical claims, prescriptions and so much more. You can expect expert guidance at no cost to you.

- **One number** to call with any benefits questions
- **One app** for self-service help (Coming 1/1/25)
- **One team** of experts dedicated to helping you

When your benefits begin, think of Quantum Health as your dedicated team of nurses, claims specialists and benefits experts ready to save you time and:

- Get answers to claims, billing, and benefits questions
- Find in-network providers
- Verify coverage and get prior approval if needed
- Contact providers to coordinate your treatment
- Review your care options
- Replace ID cards

When you don't know where to begin, start with Quantum. No request is too big or small for your Quantum Health Care Coordinators. When you need help, they'll be just a tap, click, chat, or call away. **Contact your Quantum Health Care Coordinators for healthcare and benefits help starting November 1, 2024, at 866.871.0675 or by visiting TDSYNNEX.Quantum-Health.com.**

Limited healthcare support provided to Kaiser Plan members.

Medical Benefits Comparison

Which Plan is Right for You?

	HSA-Qualified High Deductible Health Plan (HDHP)	Preferred Provider Organization (PPO)	Health Maintenance Organization (HMO)
Providers	Anthem and Kaiser (Kaiser only available in CA, CO)	Anthem	Kaiser (Only available in CA, CO, HI)
Accessing Care	You can choose between in-and out-of-network benefits each time and do not need referrals or Primary Care Physician (PCP) authorization for specialists.	You can choose between in-and out-of-network benefits each time and do not need referrals or Primary Care Physician (PCP) authorization for specialists.	Kaiser does not require a Primary Care Physician (PCP), but all services must be provided by Kaiser physicians at Kaiser facilities. Otherwise, you won't be covered, except in emergencies.
Restrictions	To receive in-network benefits, you must use the provider's network of doctors and facilities. The annual deductible must be met before plan benefits, including prescription drugs, are paid (except for preventive care).	To receive in-network benefits, you must use the provider's network of doctors and facilities.	You must use the HMO's network of doctors and facilities every time you receive care.
Out-of-Pocket Costs	The deductible is significantly higher than a traditional PPO. However, when this plan is paired with a Health Savings Account, it can be used to pay for all or part of the medical expenses you incur before you meet the deductible with tax-free dollars. Out-of-network benefits are reimbursed based on reasonable and customary charges (R&C) and you may be balanced billed for amounts above R&C.	There are annual deductibles, copays, and coinsurances. If you visit doctors and hospitals within the provider network, you will typically benefit from lower costs. Out-of-network benefits are reimbursed based on reasonable and customary charges (R&C) and you may be balanced billed for amounts above R&C.	Services are generally paid for with copays. There are generally no deductibles

PLANselect is a decision support tool to help you compare the medical benefit offerings on a side-by-side basis to identify which may work best to meet your needs. Visit the flimp website (**https://flimp.live/TDSynnex_FD2025OE**) to get started.

Explore resources including a provider search, plan details, and claims by visiting **TDSYNNEX.quantum-health.com** or by calling **866.871.0675**.

Medical Benefits Summary (Anthem BCBS)

	Anthem HDHP High Deductible		Anthem HDHP Low Deductible		Anthem PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Company HSA Contribution (employee only/family)—Lump sum funding is prorated for new hires and late enrollees						
	$250/$500		$500/$1,000		Not applicable	
Calendar Year Deductible						
Individual	$2,700	$6,500	$1,650	$4,000	$900	$2,000
Family	$5,400[1]	$13,000[1]	$3,300[1]	$8,000[1]	$1,800	$4,000
Out-of-Pocket Maximum (includes deductible)						
Individual	$6,500	$13,000	$4,000	$8,000	$4,000	$8,000
Family	$13,000[2]	$26,000[2]	$8,000[2]	$16,000[2]	$8,000[2]	$16,000[2]
Coinsurance (after you reach the deductible)						
Plan pays	75%	50%	80%	60%	80%	60%
Physician Office Visits—What You Pay						
Preventive Care	Covered 100%	Not covered	Covered 100%	Not covered	Covered 100%	Not covered
Virtual Visits	25% after deductible	50% after deductible	20% after deductible	40% after deductible	$30	40% after deductible
Primary Care Physician	25% after deductible	50% after deductible	20% after deductible	40% after deductible	$30	40% after deductible
Specialist	25% after deductible	50% after deductible	20% after deductible	40% after deductible	$60	40% after deductible
Chiropractic Care (up to 24 days per plan year)	25% after deductible	50% after deductible	20% after deductible	40% after deductible	$60	40% after deductible
Diagnostic Lab and X-Ray	25% after deductible	50% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Hospital Services—What You Pay						
Urgent Care	25% after deductible	50% after deductible	20% after deductible	40% after deductible	$60	40% after deductible
Emergency Room	25% after deductible	25% after deductible	20% after deductible	20% after deductible	$150	$150
Inpatient	25% after deductible	50% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient	25% after deductible	50% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible

To find an in-network provider, visit **https://www.anthem.com/find-care** and choose "Medical Employer Sponsored." The network will vary depending on which state you are in:

- For members residing in Florida, the network to choose will be "NetworkBlue (Select Network)"
- For members residing in Georgia, the network to choose will be "Blue Open Access POS (Select Network)"
- For members residing in New Jersey, the network to choose will be "Horizon Managed Care Network (Select Network)"
- For all other members, the network to choose will be "National PPO (BlueCard PPO)"
- Keep in mind to look at the correct network for any dependents not living in the same state as you are.
- **Don't forget that beginning Nov. 1, Quantum can also help you with finding a provider or to confirm your current provider is in-network. Just call 866.871.0675.**

Pharmacy Benefits Summary (OptumRx)

	Anthem HDHP High Deductible		Anthem HDHP Low Deductible		Anthem PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drug[3,4,5,6]						
Retail Prescription Copay (30-day supply)—What You Pay						
Generic	25% after deductible up to $50	Not covered	20% after deductible up to $50	Not covered	$15	Not covered
Formulary	25% after deductible up to $75	Not covered	20% after deductible up to $75	Not covered	$50	Not covered
Non-Formulary	25% after deductible up to $100	Not covered	20% after deductible up to $100	Not covered	$75	Not covered
Mail-Order Prescription Copay (90-day supply)—What You Pay						
Generic	25% after deductible up to $100	Not covered	20% after deductible up to $100	Not covered	$30	Not covered
Formulary	25% after deductible up to $150	Not covered	20% after deductible up to $150	Not covered	$100	Not covered
Non-Formulary	25% after deductible up to $200	Not covered	20% after deductible up to $200	Not covered	$150	Not covered

Annual deductibles and out-of-pocket maximums are per calendar year (1/1-12/31).

** The amount you pay for in-network expenses counts towards your in-network deductible and out-of-pocket maximum. The amount you pay for out-of-network expenses counts towards both your in-network and out-of-network deductible and out-of-pocket.

1 Under the HDHP plans, entire deductible must be met prior to benefits being paid for any family member other than preventive care. Deductible also applies to pharmacy benefits.

2 Under the HDHP and PPO plans, once an individual meets the individual out-of-pocket, the plan will pay 100% for covered expenses for that individual rather than having to meet the higher family out-of-pocket maximum.

3 Preventive medications are covered at no charge; deductible does not apply. Preventive medication list is subject to change at any time.

4 If you request a brand-name drug when there is a generic equivalent, you will pay the brand-name drug copay plus the cost difference between the brand-name and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW).

5 For specified maintenance medications, you must obtain a 90-day prescription (filled at either a 90-day network retail pharmacy or network home delivery pharmacy) for the medication to be covered by the plan. Otherwise, after three 30-day fill(s), you pay the entire cost of the prescription.

6 Before the deductible is met on the HDHP plans, you pay 100% of the cost. Once you meet your deductible, the cost decreases depending on the type of drug. The amount you pay is also capped, as outlined above.

To review the current formulary list and to find network pharmacies, please visit **optumrx.com** or call **844.265.1737**.

Medical and Pharmacy Benefits Summary (Kaiser)

	Kaiser HDHP CA Plan In-Network	Kaiser HMO CA Plan In-Network	Kaiser HDHP CO Plan In-Network	Kaiser HMO CO Plan In-Network
Company HSA Contribution (employee only/family)				
	$500/$1,000	Not applicable	$500/$1,000	Not applicable
Calendar Year Deductible				
Individual	$2,000	$0	$2,000	$0
Family	$4,000[1]	$0	$4,000[1]	$0
Out-of-Pocket Maximum (includes deductible)				
Individual	$3,600	$3,000	$3,600	$3,000
Family	$7,200[2]	$6,000[2]	$7,200[2]	$6,000[2]
Coinsurance (after you reach the out-of-pocket maximum)				
Plan pays	N/A	N/A	80%	N/A
Physician Office Visits				
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Virtual Visits	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Primary Care Physician	$30 after deductible	$25	20% after deductible	$25
Specialist	$50 after deductible	$50	20% after deductible	$50
Hospital Services				
Urgent Care	$30 after deductible	$25	20% after deductible	$25
Emergency Room	$200 after deductible	$150	20% after deductible	$150
Inpatient	$250 after deductible	$500 per day	20% after deductible	$500 per admission
Outpatient	$150 after deductible	$150	20% after deductible	$150
Prescription Drug				
Retail Prescription Copay (30-day supply)				
Generic	$10 after deductible	$15	$20 after deductible	$15
Formulary	$30 after deductible	$30	$40 after deductible	$30
Non-Formulary	$30 after deductible	$30	$60 after deductible	$30
Mail-Order Prescription Copay (90-day supply)				
Generic	$20 after deductible	$30	$40 after deductible	$30
Formulary	$60 after deductible	$60	$80 after deductible	$60
Non-Formulary	$60 after deductible	$60	$120 after deductible	$60

Kaiser annual deductibles and out-of-pocket maximums are per calendar year (1/1-12/31).

1 Under the HDHP with HSA plan, once an individual meets the individual deductible, the plan will begin to pay for covered expenses. For individuals within a family, a $3,300 individual deductible applies rather than the higher $4,000 family deductible.

2 Under the HDHP with HSA plan, once an individual meets the individual maximum out-of-pocket, the plan will begin to pay 100% for covered expenses for that individual rather than having to meet the higher family out-of-pocket maximum.

Coworker Bi-Weekly Cost of Medical Coverage

Costs shown are bi-weekly (deducted every 2 weeks). Medical premium tiers are based on your annualized Total Target Compensation (TTC) as of 10/1/2024, or date of hire whichever is later. TTC is defined as annual base salary plus any target variable (bonus, commission, etc.) opportunity, if applicable.

Most of your healthcare costs are deducted from your pay on a pre-tax basis so you pay less in taxes. Contributions toward domestic partner coverage are generally considered taxable, and we recommend you consult with your financial or tax advisor to confirm how that may impact you.

	Anthem HDHP High Deductible (With HSA)	Anthem HDHP Low Deductible (With HSA)	Anthem PPO	Kaiser HDHP with HSA CA Plan	Kaiser HMO CA Plan	Kaiser HDHP with HSA CO Plan	Kaiser HMO CO Plan
Less than $46,000 TTC							
Coworker	$13.84	$28.15	$111.69	$27.69	$87.69	$23.53	$80.76
Coworker + Spouse	$44.76	$100.15	$279.23	$121.38	$231.23	$102.46	$213.23
Coworker + Children	$37.84	$84.92	$237.23	$110.30	$210.00	$93.23	$193.84
Family	$64.61	$145.38	$404.76	$165.23	$315.23	$139.38	$290.76
$46,000-$64,999.99 TTC							
Coworker	$19.38	$31.38	$122.30	$32.76	$94.61	$28.15	$87.23
Coworker + Spouse	$55.84	$125.53	$292.61	$133.38	$270.00	$113.07	$248.76
Coworker + Children	$47.07	$106.61	$249.23	$121.38	$245.07	$102.46	$226.15
Family	$80.76	$181.84	$424.61	$181.38	$367.38	$153.69	$339.23
$65,000-$98,999.99 TTC							
Coworker	$22.15	$37.38	$132.46	$38.76	$98.30	$32.76	$90.46
Coworker + Spouse	$66.46	$150.46	$313.84	$150.92	$307.84	$127.84	$284.30
Coworker + Children	$56.76	$127.84	$266.76	$137.53	$280.15	$116.76	$258.46
Family	$96.46	$218.30	$455.07	$206.30	$420.00	$174.46	$387.69
Greater than $99,000 TTC							
Coworker	$27.69	$47.07	$143.07	$43.84	$104.76	$37.38	$96.92
Coworker + Spouse	$78.00	$175.84	$334.61	$169.38	$346.61	$143.07	$319.84
Coworker + Children	$66.00	$149.07	$284.30	$154.15	$315.23	$130.15	$290.76
Family	$112.61	$254.76	$485.53	$231.23	$473.07	$195.69	$436.15

Due to the division of monthly premiums into bi-weekly frequency, the actual premiums in the system of record could be +/- $0.01.

TD SYNNEX Bi-Weekly Cost of Medical Coverage

This page is informational to help you understand TD SYNNEX's contribution towards the cost of your healthcare. Employer costs shown are bi-weekly.

	Anthem HDHP High Deductible (With HSA)	Anthem HDHP Low Deductible (With HSA)	Anthem PPO	Kaiser HDHP with HSA CA Plan	Kaiser HMO CA Plan	Kaiser HDHP with HSA CO Plan	Kaiser HMO CO Plan
Less than $46,000 TTC							
Coworker	$263.24	$313.13	$235.81	$267.39	$289.42	$196.94	$225.50
Coworker + Spouse	$509.41	$582.42	$415.74	$527.79	$598.43	$382.61	$460.55
Coworker + Children	$433.21	$495.26	$353.52	$479.86	$544.24	$347.72	$418.69
Family	$738.94	$844.34	$602.97	$720.00	$816.13	$522.07	$628.03
$46,000-$64,999.99 TTC							
Coworker	$257.70	$309.90	$225.20	$262.32	$282.50	$192.32	$219.03
Coworker + Spouse	$498.33	$557.04	$402.36	$515.79	$559.66	$372.00	$425.02
Coworker + Children	$423.98	$473.57	$341.52	$468.78	$509.17	$338.49	$386.38
Family	$722.79	$807.88	$583.12	$703.85	$763.98	$507.76	$579.56
$65,000-$98,999.99 TTC							
Coworker	$254.93	$303.90	$215.04	$256.32	$278.81	$187.71	$215.80
Coworker + Spouse	$487.71	$532.11	$381.13	$498.25	$521.82	$357.23	$389.48
Coworker + Children	$414.29	$452.34	$323.99	$452.63	$474.09	$324.19	$354.07
Family	$707.09	$771.42	$552.66	$678.93	$711.36	$486.99	$531.10
Greater than $99,000 TTC							
Coworker	$249.39	$294.21	$204.43	$251.24	$272.35	$183.09	$209.34
Coworker + Spouse	$476.17	$506.73	$360.36	$479.79	$483.05	$342.00	$353.94
Coworker + Children	$405.05	$431.11	$306.45	$436.01	$439.01	$310.80	$321.77
Family	$690.94	$734.96	$522.20	$654.00	$658.29	$465.76	$482.64

Due to the division of monthly premiums into bi-weekly frequency, the actual premiums in the system of record could be +/- $0.01.

Get care from anywhere

Video visits on LiveHealth Online are an included benefit for Anthem medical plan members

Get the care you need, virtually.

Looking for a quick and easy way to get care? With LiveHealth Online, you can access video visits from anywhere. All you need is a smartphone, tablet, or computer!

Care options available to you through LiveHealth Online:

Urgent Care. Get care 24/7 for common health issues, including allergies, COVID-19 symptoms, the flu, sinus infections, and UTIs. Doctors assess your symptoms, provide a treatment plan, and send prescriptions to the pharmacy of your choice when needed.

Therapy and Psychiatry. See a licensed therapist online from the comfort of your couch to get help for anxiety, depression, panic attacks, stress relief, and more. Board-certified psychiatrists are also available by appointment and can prescribe medication when talk therapy isn't enough.

Dermatology. Our board-certified dermatologists can provide a diagnosis and treatment plan in under 24 hours. No appointment or video visit needed. Just upload pictures of your skin, hair, or nail concern. Dermatologists can write a prescription, if necessary.

SCAN ME

Get started today! LiveHealth Online is available through LiveHealth Online app, or and LiveHealthOnline.com

LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

LGBTQ+ Benefits and Preventive Care

The LGBTQ+ community can face unjust barriers to accessing healthcare. Discrimination, a lack of proper training, and an insufficient understanding of LGBTQ+ needs contribute to all the other challenges this community faces to live healthy lives. TD SYNNEX wants to ensure we provide continued support; this includes access to healthcare.

At TD SYNNEX, we are committed to providing comprehensive benefits coverage for all. The TD SYNNEX medical plans include gender affirming care. In this guide you will find a highlight of our benefits services and resources for LGBTQ+ individuals. If additional information is needed, please reach out to Quantum Health for a full list of services covered under our medical plans.

TD SYNNEX offers a supportive and safe work environment for transgender coworkers. Benefits offered through TD SYNNEX's medical plans are designed to meet the criteria for "More Comprehensive Coverage" as established by the Human Rights Campaign through their Corporate Equity Index survey. Gender Affirming Care resources can be found on the Quantum and Kaiser webpages.

Gay and Lesbian Medical Association (GLMA) Provider Directory

It's not easy to find a health care provider who knows best practices when treating LGBTQ+ individuals. The GLMA's online Provider Directory can help. Check the Gay and Lesbian Medical Association (GLMA) website to find providers who are educated in LGBTQ+ health needs.

Make sure to find out which providers are in your plan's network. Even if you find a great healthcare provider, your elected benefit plan may not pay for treatment. Please check with your medical provider to ensure you are covered for treatment or it may have significant out-of-pocket costs. Ask your healthcare provider if the cost of your services will be covered. If they won't, ask if your portion of the cost can be reduced, or if payment plans are available. Search for primary care providers, specialists, therapists, and other health professionals in your area. The service is free, and you do not need to register. Search the GLMA provider directory here: **https://www.glma.org/**.

How to Find an LGBTQ+ Network and Resources

If you already have a trusted provider but need to see a new doctor or specialist, you can ask them for a referral. Many LGBTQ+ friendly doctors have a recommended network of providers for patient referral. If you don't have a network of individuals in the queer community you can talk to, search for "queer exchange [name of your city]" on Facebook and request to join. Here, queer people can post questions to their local queer community members and ask for recommendations for LGBTQ+ friendly doctors in the area.

Local clinics and LGBTQ+ centers: Local clinics are a great resource to find care. Find one near you by Googling "clinic near me + LGBTQ+" or similar search terms. You can also visit your local Planned Parenthood, which offers affordable care and LGBTQ+ services in all 50 states.

Please PrEP me: This is a community-based service that curates providers who prescribe PrEP based on ZIP code. Simply go to their webpage and enter your ZIP code.

The Trevor Project: The Trevor Project is geared specifically toward providing crisis intervention and suicide prevention services to the LGBTQ+ community. While their goal is to provide mental health support, they can also refer individuals to resources that meet their other health needs.

Health and Well-Being Resources

Maven Benefits

Family Planning

Not all paths to parenting look the same and we want to support your journey of growing your family. This comprehensive benefit covers coworkers and their eligible partners who want to have a child or preserve their fertility, including single parents and members of the LGBTQ+ community.

Eligibility: You and your partner, if applicable, must be enrolled in medical coverage through TD SYNNEX to take advantage of the benefit.

Benefit: $10,000 lifetime maximum reimbursement toward fertility, adoption, and surrogacy costs (lifetime maximum applies to each program separately). **HDHP participants must first meet the medical plan deductible before qualifying expenses can be reimbursed.** Some benefits may be considered taxable, including fertility services that are not related to a medical diagnosis of infertility, and adoption assistance. For additional tax details, please review the "Important Tax Information" section of the Maven Wallet Program Overview, which is available on the Maven website, or contact Maven directly.

Navigation/Support: Through Maven, you have access to concierge support and education as you explore your options. You can work directly with a care advocate or reference their library of resources on your own. Maven has a large network of fertility specialists with negotiated discounts and priority scheduling, as well as networks of vetted adoption and surrogacy agencies that are ethical and inclusive.

Menopause Support

Eligibility: You are eligible for benefits if you are a full-time regular coworker regularly scheduled to work at least 30 hours per week.

You have 24/7 virtual access to menopause educational resources and specialists, including OB-GYN's, nutritionists, and physical therapists. They can help identify menopausal symptoms and manage care. The virtual care team can provide support for issues such as mood fluctuations, hot flashes, sleep issues, balancing work, and preventing chronic conditions.

To get started, visit **mavenclinic.com/join/tdsynnex** or search Maven Clinic in the App Store or Google Play. For additional questions, contact the Maven Care Team at **support@mavenclinic.com**.

Well-Being Matters

Being well involves more than just using your health care plans. The TD SYNNEX Well-Being Program focuses on 4 dimensions of well-being (financial, mental, physical, and social well-being) which are critical to thriving and living a happy and healthy life. To learn more about the many opportunities, follow "Well-Being Matters" on Current or visit Events and Happenings (**https://tdworldwide.sharepoint.com/sites/Well-BeingTDSYNNEX**).

Interested in contributing to our culture of well-being? We have a group of well-being champions that we'd love for you to join! Email **wellbeing@tdsynnex.com** to get started.

Life Empowerment Assistance Program (LEAP)

There are times when everyone needs a little help or advice. Maybe you need support for something fun, like finding a pet for you and your family to love. Other times, life may have thrown you an unexpected curve ball that you're not certain how to manage. LEAP can help you with tools, resources, and counseling services to support life's ups and downs. Best of all, it's completely confidential, free, and available to any member of your immediate family.

- Unlimited phone access 24/7 at **888.851.7032** or set an appointment at your convenience using WPO's online scheduler
- In-person help for short-term issues tailored to your needs, up to 6 sessions, per issue per year
- Life coaching, Aware mindfulness sessions and work/life consultations are available at no cost
- Unlimited web access to helpful articles, resources, and self-assessment tools

Scan the QR code to access the Workplace Options' Life Empowerment Assistance Program (LEAP) on your mobile phone or visit **global.helpwhereyouare.com**.

Company Code: TD SYNNEX

Dental Coverage

We partner with Delta Dental to offer you and your family members affordable dental insurance. Visit an in-network provider to make the most of your dental coverage and to avoid balance billing. Regular visits to your dentist can protect your health. Dentists can screen for oral symptoms of many diseases including cancer, diabetes, and heart disease. Visit **deltadentalins.com** to find an in-network provider.

Please note: Delta Dental has two networks—PPO and Premier. The main difference between the two is the discount. You may save more when you visit a PPO dentist, but both are in-network options.

	Delta Dental PPO Plan	
	In-Network (PPO and Premier)	**Out-of-Network***
Calendar Year Deductible		
Individual	$50	$50
Family	$150	$150
Calendar Year Maximum Benefit		
Preventive, Basic, and Major Services	$1,750 per person	
Coinsurance		
Preventive/Diagnostic		
Examples: Exams, Cleaning, Fluoride Treatment, X-Rays, and Space Maintainers	100% no deductible	
Basic Services		
Examples: Fillings, Extractions, Periodontal Scaling and Root Planning, and Oral Surgery	90% after deductible	80% after deductible
Major Services		
Examples: Crown, Inlays, Fixed Bridgework, and Dentures	60% after deductible	50% after deductible
Orthodontia		
Coinsurance	50%	
Lifetime Maximum	$1,750	
Benefit Applies to	Adults and dependent children	

* If you choose to visit an out-of-network provider, you may be balance billed.

Coworker Bi-Weekly Cost of Dental Coverage

	Delta Dental PPO Plan
Coworker	$10.19
Coworker + Spouse	$20.39
Coworker + Children	$22.94
Family	$30.59

TD SYNNEX Bi-Weekly Cost of Dental Coverage

	Delta Dental PPO Plan
Coworker	$10.20
Coworker + Spouse	$20.39
Coworker + Children	$22.94
Family	$30.58

WHAT IS BALANCE BILLING?

In-network providers are contracted with the plans at negotiated rates. If you see an out-of-network provider, you may be balance billed by that provider. This means you may receive unplanned charges which you will be responsible for paying out-of-pocket.

Vision Coverage

We partner with VSP Vision to offer you and your family members affordable vision care, including generous allowances for glasses and contact lenses. Even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol and thyroid disease. Visit **vsp.com** to find an in-network provider.

	VSP Vision Plan	
	In-Network	**Out-of-Network**
Exam (Once per Calendar Year)		
	$10 copay, then plan pays 100%	$45
Prescription Glasses Lenses (Once per Calendar Year)		
Single Vision	100%	$30
Lined Bifocal	100%	$50
Lined Trifocal	100%	$65
Lenticular	100%	$100
Frames (Once per Calendar Year)		
	$150 allowance	Up to $70
Contacts (Once per Calendar Year, In Lieu of Glasses)		
Contact Lens Exam	Covered in full after copay; will never exceed $60	N/A
Contact Lens Allowance	$150 allowance	Up to $105

Benefit frequency resets each plan year on January 1st.

Coworker Bi-Weekly Cost of Vision Coverage

	VSP Vision Plan
Coworker	$1.59
Coworker + Spouse	$3.19
Coworker + Children	$3.59
Family	$4.79

TD SYNNEX Bi-Weekly Cost of Vision Coverage

	VSP Vision Plan
Coworker	$1.60
Coworker + Spouse	$3.19
Coworker + Children	$3.59
Family	$4.79

EXTRA DISCOUNTS AND SAVINGS

LASER VISION CORRECTION DISCOUNTS THROUGH CONTRACTED FACILITIES

- Average 15% off the regular price or 5% off the promotional price
- Visit **www.vsp.com** for more information and to find contracted locations

HEARING AID DISCOUNT PROGRAM THROUGH TRUHEARING

- Save up to 60% on a pair of hearing aids with TruHearing
- Visit **truhearing.com/vsp** or call **877.396.7194** with questions. Be sure to mention VSP if you call.

Health Savings Account (HSA)

A Health Savings Account (HSA) is a tax-favored personal savings account that works with your High Deductible Health Plan (HDHP). You can use it to pay qualified medical expenses such as deductibles, copays, dental, and vision care. For a complete list of qualified expenses, see **IRS Publication 502**.

HSA Major Benefits

- Your account always belongs to you; you can take it with you when you leave or retire
- Your balance rolls over from year-to-year
- Contributing lowers your taxable income
- The account helps you build a healthcare nest egg for emergencies or retirement

Triple Tax Savings

- Tax deduction when you contribute to your account
- Tax-free earnings through investment
- Tax-free withdrawal for qualified expenses

* Any Medicare enrollment is considered disqualifying coverage for HSA contributions. To avoid potential tax implications, TD SYNNEX will not deposit employer funds for those age 65+. If you are age 65 or older and not enrolled in Medicare (including Part A), contact **usbenefits@tdsynnex.com**.

HSA contributions are tax-free at the federal level. Note, however, that CA and NJ do not exclude HSA contributions from state income taxes.

Opening an HSA

If you enroll in the Anthem HDHP High Deductible, Anthem HDHP Low Deductible or the Kaiser HDHP Plan and elect the HSA, an account will be created for you through Fidelity. However, you will need to ensure your HSA is open and ready for funding by 1/1/25. New HSA accounts will receive an HSA debit card and instructions to access your account. If you already have an HSA with Fidelity, you will continue to use your current debit card.

HSA Eligibility

You may open and contribute to an HSA if you're enrolled in the Anthem Low Deductible, Anthem High Deductible, or Kaiser HDHP plan and you:

- Are not enrolled in a traditional PPO plan through your spouse or other employer-sponsored plan
- Are not enrolled in a Medicare plan*
- Are not claimed as a dependent on someone else's tax return
- Do not have a healthcare FSA

HSA Funding Limits

Anthem HDHP Low Deductible and Kaiser HDHP Plans

Coverage Level	2024 IRS Limits	2025 IRS Limits	Company Contribution (Lump sum funding; prorated for new hires and late enrollees)	Your Total Possible Contribution
Coworker only Coverage	$4,150	$4,300	$500	$3,800
Family Coverage	$8,300	$8,550	$1,000	$7,550
Age 55+ Catch-Up Contribution	$1,000	$1,000	$0	$1,000

Anthem HDHP High Deductible Plan

Coverage Level	2024 IRS Limits	2025 IRS Limits	Company Contribution (Lump sum funding; prorated for new hires and late enrollees)	Your Total Possible Contribution
Coworker only Coverage	$4,150	$4,300	$250	$4,050
Family Coverage	$8,300	$8,550	$500	$8,050
Age 55+ Catch-Up Contribution	$1,000	$1,000	$0	$1,000

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax dollars from your paycheck to cover qualified expenses. We offer four types of FSAs through TRI-AD.

Healthcare FSA

The Healthcare FSA helps you pay IRS-approved medical expenses. Funds you contribute to the Healthcare FSA are available in full on the first day of the plan year. This plan is available to coworkers not covered under a HDHP/HSA plan.

Limited Purpose FSA

The Limited Purpose FSA is similar to the Healthcare FSA, but it only covers dental and vision expenses. You can choose this FSA if you are enrolled in an HDHP plan.

Dependent Care FSA

The Dependent Care FSA helps you pay for daycare-related expenses. This account works like a debit card; you need to accumulate the funds before you can use them. Highly Compensated Coworkers (as defined by the IRS) will be limited to $2,000 annually due to regulatory compliance.

Use It or Lose It

Carefully consider your FSA contribution amounts for the plan year. At the end of the year, you lose any money left in your FSA over the eligible rollover amount.

FSA Funding Limits

FSA Type	2025 IRS Limits
Healthcare FSA	$3,300
Limited Healthcare FSA	$3,300
Dependent Care FSA	$5,000*

* $2,500 if married and filing separately.

Claim Deadlines and Rollovers

You can roll over up to $660 if you have leftover funds in your account at the end of the plan year. This rollover does not count against the FSA limit for the following plan year. You also have until 90 days after the plan year ends to submit expenses incurred in the previous plan year. For example, you will have until 3/31/2026 to submit expenses for claims incurred in 2025. Please note the rollover is not applicable to the Dependent Care FSA and you can submit claims for reimbursement within 90 days of term date.

Commuter FSA

Do you have out-of-pocket commuting expenses for public transportation, van pooling, or for worksite parking? If so, you can save on taxes by enrolling in our transportation savings account, administered by TRI-AD. The account lets you set aside money—before it's taxed—through payroll deduction. You may enroll in or stop this program at any time. Money in the account can be used in future months or plan years.

Set aside up to $325 per month for work-related parking expenses and up to $325 per month for work-related commute expenses. To get started, reach out to TRI-AD administrators at **commute@tri-ad.com**.

ELIGIBLE EXPENSES

The funds in each FSA must be used for qualified expenses such as the examples listed below. For a more comprehensive list of eligible expenses, see IRS Publication 502.

HEALTHCARE FSA

- Doctor's visits
- Prescription drugs
- Medical and dental deductibles
- Over-the-counter items
- Hearing aids
- Eyeglasses

LIMITED PURPOSE FSA

- Braces
- Dental services
- Eyeglasses
- Eye exams

DEPENDENT CARE FSA

- Child or adult daycare*
- Nursery school
- Preschool (excluding kindergarten)

* An eligible dependent is a tax dependent child under age 13 or a tax dependent spouse, parent, or child unable to care for themselves.

* In general, you cannot claim both the Dependent Care FSA and the childcare tax credit. We recommend that you consult with your tax advisor to determine which makes the most sense for you.

Life and AD&D Coverage

Protect yourself and your loved ones when the unexpected occurs. Life and Accidental Death and Dismemberment (AD&D) insurance is provided in partnership with Lincoln Financial.

Don't forget! It's important to designate a beneficiary or ensure your current beneficiary information is up to date by logging into Workday.

Basic Life and AD&D

TD SYNNEX automatically provides you with basic life and AD&D coverage of 1 times your annual salary, from a minimum of $50,000 and up to a maximum of $250,000. This benefit is provided at no cost to you*.

Coworker Optional Life

You're eligible to purchase additional coverage in increments of $25,000 up to the lesser of 8 times your annual salary or $1,500,000. The guaranteed issue amount is $600,000.

Spouse/Domestic Partner Optional Life

If you elect optional life coverage for yourself, you can also elect voluntary life coverage for your spouse/domestic partner in increments of $25,000 up to the coworker election or $500,000 (whichever is less). The guaranteed issue amount is $50,000.

Child(ren) Optional Life

You may elect coverage for your eligible dependent child(ren) in the amount of $10,000. The cost of coverage is the same regardless of how many children you enroll.

* Please note the IRS requires that any employer-paid life insurance over $50,000 is treated as taxable income to you.

WHAT IS EOI?

Evidence of Insurability (EOI), sometimes known as proof of good health, is health information the insurance company requires to approve you for coverage. You may be required to submit EOI if you elect coverage outside new hire enrollment or if you elect above the guaranteed issue amount.

WHAT IS GUARANTEED ISSUE?

This is the amount of coverage available without having to provide information about your health.

COST OF COVERAGE

Your cost for coworker Optional Life coverage will depend on your age and how much coverage you buy. Rates will be calculated when you enroll online.

Age reduction: supplemental life benefits are reduced according to the following schedule:

- Age 70: 65% of original benefit amount
- Age 75: 50% of original benefit amount

Coverage is discontinued on your date of termination of employment or retirement. If you leave TD SYNNEX, you may be able to port or convert your group coverage to an individual policy.

Disability Coverage

Disability insurance protects your income by financially supporting you and your family when you are unable to work. We partner with Lincoln Financial to provide this coverage.

Basic Short Term Disability

TD SYNNEX automatically provides Short Term Disability (STD) insurance to replace a portion of your base salary during the initial weeks of an eligible disability, such as pregnancy and childbirth recovery, prolonged illness or injury and surgery and recovery time. Once you are approved, you will receive benefits on the 8th day of disability. The plan provides 60% of your pre-disability weekly base earnings, up to a $2,889 weekly benefit, for up to 26 weeks. The short-term benefits payable under the TD SYNNEX benefit plan may be reduced by any state-disability benefits to which you are entitled.

Basic Long Term Disability

TD SYNNEX automatically provides Long Term Disability (LTD) insurance to replace a portion of your base salary if you're unable to work for an extended period. Benefits begin after 180 days. The plan covers 60% of your pre-disability earnings, up to a $12,500 monthly benefit. For Directors and above, the definition of disability is own occupation, and the coverage duration is to Social Security Normal Retirement Age. For all other coworkers, the definition of disability is own occupation for 2 years and then any occupation, and coverage duration is to Social Security Normal Retirement Age. Please note: Payments may be reduced by state or federal disability benefits you receive while disabled. This is an employer-paid benefit meaning you will be responsible for any federal or state taxes required.

Voluntary Benefits

When life throws you a curve ball, our voluntary benefits administered by MetLife create an added layer of financial protection for you and your family. These plans make cash payments directly to you, and you can use the benefit however you wish. These benefits are intended to supplement (not replace) the core benefits.

Accident Insurance

Accidents can happen when you least expect them. This plan is designed to pay a tax-free cash benefit directly to you when an injury occurs off the job.

Examples of Covered Accidents and Payments

Hospital Admission Benefit (Once per Year)	$1,500
Daily Hospital Confinement (Up to 365 Days per Confinement)	$300
Daily ICU Supplemental Confinement (Up to 30 Days per Confinement)	$300
Burns	Up to $15,000
Ambulance (Ground/Air)	$400/$1,250
Concussion	$500

Bi-Weekly Cost of Coverage

Coworker	$4.56
Coworker + Spouse	$7.99
Coworker + Children	$6.86
Family	$10.29

HEALTH SCREENING BENEFIT

Each person covered under the accident or critical illness plan is eligible to receive a $50 wellness benefit per calendar year for keeping up with your preventive care.

FILING A CLAIM

To file a claim under one of the voluntary benefits plans:

- Call **800.438.6388**
- Visit **mybenefits.metlife.com**
- Policy Number: 241035

Critical Illness Insurance

There can be a lot of expenses associated with a critical illness, and a major medical plan may not cover them all. Critical illness insurance provides you a lump sum payment so you can focus on what matters most—getting better. You can purchase coverage of $10,000, $20,000, or $30,000. Spouse coverage is available at 100% of your elected amount and children are automatically included at 50% for no additional cost.

Covered critical illnesses include:

- Cancer
- Heart attack
- Stroke
- Alzheimer's disease
- Major organ transplant

How the Plan Works

A TD SYNNEX coworker's life is turned upside down after suffering a heart attack followed by a stroke a week later. This coworker and their spouse missed work to help in recovery. Not only was their income affected, but medical bills started piling up while the need for childcare increased.

Example Amount Paid to Coworker*	
Heart Attack	$20,000
Stroke	$20,000
Total Direct Benefit Payment	$40,000

* Amount will depend on elected coverage

Rates for the critical illness plan vary by coverage amount and age. Refer to your Workday benefit enrollment screen for costs.

Hospital Indemnity Insurance

Hospital costs can add up fast, and medical coverage typically doesn't cover the entire stay. This plan provides a flat payment directly to you to use however best meets your needs in the event of a hospital confinement. Benefits are paid directly to you, regardless of the cost of treatment. Please note: These benefits are intended to supplement (not replace) the core benefits.

Covered Benefits and Payment Amounts

Hospital Admission Benefit	$1,500
Daily Hospital Confinement (up to 31 days per confinement)	$200
Daily ICU Confinement (pays in addition to hospital admission and up to 10 days)	$200
Rehabilitation Facility Benefit (up to 31 days per year)	$150
Newborn Routine Care (up to 2 days)	$25

Bi-Weekly Cost of Coverage

Coworker	$8.23
Coworker + Spouse	$12.21
Coworker + Children	$15.11
Family	$19.09

Identity Protection Plan

Identity Protection proactively safeguards your identity, credit, and finances, while also providing full-service remediation with a 5-million-dollar insurance policy and resources to restore your identity to pre-theft status. Opportunities for identity theft and fraud are more prevalent than ever in today's rapidly changing technology landscape. Having Identity Protection can bring you peace of mind knowing you have the protection in place and the resources available in case you do experience any form of identity theft.

Bi-Weekly Cost of Coverage

- Coworker Only: $3.90
- Family: $6.44

Legal Plan

A Legal plan provides you with an easy to use, cost effective way to access legal services. The plan provides support through all of life's stages. Whether you are creating a will or estate, getting married or divorced, need contracts reviewed, or experience a traffic violation – having a Legal plan in place helps you protect what's important without hurting your finances or causing you hours of work and research.

Bi-Weekly Cost of Coverage

- Coworker + Family: $8.54

For more information on our MetLife voluntary benefits, visit **metlife.com/info/TD-SYNNEX/**.

Pet Insurance

Pet Insurance offsets the cost of a vet visit with reimbursement to cover unexpected accidents, injuries, and illnesses. You can also buy-up your coverage to include wellness benefits to help cover the costs of routine exams, immunizations, and more. Pets are family too, and having affordable access to their care is important!

Pets are individually underwritten according to age, breed, and ZIP code. Visit **metlife.com/getpetquote** to get a quote or to enroll. Enrollment is direct bill (not payroll deducted).

401(k) Plan

TD SYNNEX wants you to feel secure and prepared for life after your career. In partnership with Fidelity, the TD SYNNEX 401(k) Retirement Plan is designed to help you feel prepared for retirement.

Eligibility

You are eligible as a full-time and part-time regular coworker for the TD SYNNEX 401(k) Retirement Plan on the first of the month following 30 days of employment, or any time after meeting the initial eligibility qualifications. You will automatically be enrolled in the 401(k) for a 3% pre-tax contribution that will be invested in a qualified default investment alternative (QDIA) target-dated funds should you take no action to enroll.

Coworker Contributions

Through convenient payroll deductions, you may elect to contribute to traditional 401(k) pre-tax, Roth 401(k) after-tax, or a combination. For 2024, you may save up to $23,000 to your 401(k). If you are age 50 or older, you may elect to save an additional catch-up contribution of $7,500. These amounts are evaluated annually by the IRS and are subject to change.

Company Match

TD SYNNEX will deposit a discretionary employer match of 50% on the first 6% of your contributions. You are eligible for the employer match on the first of the month following six (6) months of service.

Employer match does not count toward your IRS pre-tax contribution limit.

* Upon termination, 401(k) deferrals may be updated to $0 within Workday as soon as administratively feasible. Updates impact the deferrals within the current payroll period and any future payroll periods

Vesting Schedule

Year	Percent
0-1	0%
1-2	30%
2-3	60%
3+	100%

Your 401(k) in Action

Manage your 401(k) account at any time online at **netbenefits.com**, on the Fidelity NetBenefits app, or by calling the Fidelity Retirement Benefits Line at **800.890.4015**. By logging in, you can:

- Adjust or stop your contributions
- Change how your funds are invested
- Request a loan and withdrawal
- Designate and update your beneficiary

The beneficiary you designate will receive your 401(k) balance in the event of your death. It's important to ensure you designate and keep your beneficiary information up to date.

Insurance Terms You Should Know

Insurance can be confusing. Understanding these common insurance terms will help you make the most of your benefits.

BALANCE BILLING

This is a bill out-of-network providers can you send you for a portion of the bill insurance does not cover.

COINSURANCE

This is a percentage of what you will pay for covered services after you reach any applicable deductible or copays. Typically, your percentage is lower than the plan's.

COPAY

This is a set fee you pay for certain services and expenses, such as doctor visits and prescriptions.

DEDUCTIBLE

This is the amount you pay out of your pocket before the plan begins to help pay for covered expenses.

EXPLANATION OF BENEFITS (EOB)

This is not a bill; it is a document sent by the insurance company to list the services you receive and what the insurance plan will cover.

FORMULARY

The list of medications covered under your health plan; they typically have different tiers, such as generic and brand name.

NETWORK

A group of doctors and facilities contracted with the plan at negotiated rates.

OUT-OF-POCKET MAXIMUM

This is the most you'll pay for eligible healthcare services during the plan year.

PREAUTHORIZATION

Is a process giving the insurance company a chance to review needed services and/or medication and determine if it will be covered.

PREMIUM

This is the cost you must pay to be covered by the plan.

Important Contacts

HEALTH

Medical—Anthem	Anthem BCBS Contact Quantum Health at **866.871.0675** for any healthcare needs!
Medical—Kaiser	Kaiser **800.464.4000** **kp.org** Policy Number: 030191 (N. CA), 229255 (S. CA), 47007 (CO)
Prescription	OptumRx **844.265.1737** **optumrx.com** Policy Number: CTTDS
Dental	Delta Dental **888.335.8227** **deltadentalins.com** Policy Number: 23010
Vision	VSP **800.877.7195** **www.vsp.com** Policy Number: 40161064
Life and AD&D Coverage	Lincoln Financial **888.787.2129** **lfg.com**
Disability and Leave Coverage	Lincoln Financial **877.722.8777** **lfg.com**
Voluntary Benefits	MetLife **800.438.6388** **mybenefits.metlife.com** Policy Number: 241035

MONEY

Health Savings Account (HSA)	Fidelity **800.890.4015** **netbenefits.com** Policy Number: 86516
Flexible Spending Accounts (FSAs)	TRI-AD **888.844.1372** **tri-ad.com**
401(k) Plan	Fidelity **800.890.4015** **netbenefits.com** Policy Number: 55966
Financial Well-Being	LearnLux **tdsynnex.learnlux.com** Benefit is available through June 30, 2025.

SUPPORT

Navigation and Advocacy	Quantum Health **866.871.0675** **www.tdsynnex.quantum-health.com**
Planselect Decision Support Tool	Flimp **https://flimp.live/TDSynnex_FD2025OE**
Life Empowerment Assistance Program (LEAP)	Workplace Options **888.851.7032** and **919.706.4551** **global.helpwhereyouare.com**
Pet Insurance	MetLife **800.438.6388** **metlife.com/getpetquote** Policy Number: 241035
Legal Insurance	MetLife **800.821.6400** **members.legalplans.com** Policy Number: 241035
Identity Theft and Fraud Protection	MetLife **844.931.2872** **my.aura.com/start** Policy Number: 241035

FOR ALL YOUR BENEFITS QUESTIONS

Quantum Health is here to help answer your benefits questions and support you throughout enrollment. For assistance, call **866.871.0675**.

TD SYNNEX Corporation

HEALTH PLAN NOTICES

TABLE OF CONTENTS

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 TD SYNNEX Corporation About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE
IMPORTANT NOTICE FROM TD SYNNEX CORPORATION 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 TD SYNNEX Corporation 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. TD SYNNEX Corporation has determined that the prescription drug coverage offered by the TD SYNNEX Corporation Health and Welfare 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 TD SYNNEX Corporation 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 TD SYNNEX Corporation Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the TD SYNNEX Corporation 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 TD SYNNEX Corporation 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. **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 TD SYNNEX Corporation 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:	TD SYNNEX Corporation, Benefits Team
Contact—Position/Office:	US Benefits
Email:	USbenefits@tdsynnex.com
Phone:	800-237-8931
Address:	44201 Nobel Dr. Fremont, CA 94538

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

TD SYNNEX CORPORATION
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:

TD SYNNEX Corporation Health and Welfare Plan*

* This notice pertains only to healthcare coverage provided under the plan.

For the remainder of this notice, TD SYNNEX Corporation 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:

Patty Zanghi
Sr. Director, Global Benefits & Well-Being
800-237-8931

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

TD SYNNEX CORPORATION 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 *30 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 *30 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

TD SYNNEX Corporation, Benefits Team
US Benefits
USbenefits@tdsynnex.com
800-237-8931

**** 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:

TD SYNNEX Corporation, Benefits Team
US Benefits
USbenefits@tdsynnex.com
800-237-8931
44201 Nobel Dr.
Fremont, CA 94538

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

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

TD SYNNEX Corporation Health and Welfare 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 TD SYNNEX Corporation Health and Welfare 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:

ANTHEM PLANS

Anthem HDHP - Low Deductible	In-Network	Out-of-Network
Individual Deductible	$1,650	$4,000
Family Deductible	$3,300	$8,000
Coinsurance	20%	40%
Anthem HDHP - High Deductible	In-Network	Out-of-Network
Individual Deductible	$2,700	$6,500
Family Deductible	$5,400	$13,000
Coinsurance	25%	50%

Anthem PPO	In-Network	Out-of-Network
Individual Deductible	$900	$2,000
Family Deductible	$1,800	$4,000
Coinsurance	20%	40%

KAISER PLANS

Kaiser HMO - California	In-Network	Out-of-Network
Individual Deductible	$0	N/A
Family Deductible	$0	N/A
Coinsurance	N/A	N/A
Kaiser HMO - Colorado	In-Network	Out-of-Network
Individual Deductible	$0	N/A
Family Deductible	$0	N/A
Coinsurance	N/A	N/A

Kaiser HDHP - California	In-Network	Out-of-Network
Individual Deductible	$2,000	N/A
Family Deductible	$4,000	N/A
Coinsurance	N/A	N/A
Kaiser HDHP - Colorado	In-Network	Out-of-Network
Individual Deductible	$2,000	N/A
Family Deductible	$4,000	N/A
Coinsurance	20%	N/A

Kaiser HMO - Hawaii	In-Network	Out-of-Network
Individual Deductible	$0	N/A
Family Deductible	$0	N/A
Coinsurance	20%	N/A

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

TD SYNNEX Corporation, Benefits Team
US Benefits
USbenefits@tdsynnex.com
800-237-8931

MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact TD SYNNEX Corporation, Benefits Team at USbenefits@tdsynnex.com or 800-237-8931.

NOTICE TO PROSPECTIVE HOSPITAL INDEMNITY ENROLLEES

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your state Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

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)

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