2025

BENEFITS GUIDE

BEL FUSE

Here's where to find ...

Bel Fuse appreciates your commitment to our success. We're equally committed to providing you with competitive, affordable health and wellness benefits to help you take care of yourself and your family.

Please read this guide carefully. It has a summary of your plan options and helpful tips for getting the most value from your benefit plans. We understand that you may have questions about annual enrollment, and we'll do our best to help you understand your options and guide you through the process.

Bel Fuse offers a comprehensive suite of benefits to promote health and financial wellness for you and your family. This booklet provides a summary of your benefits. Please review it carefully so you can choose the coverage that's right for you.

For more information about your benefits, log in to your account at http://workforcenow.adp.com.

Benefit Basics

As a Bel Fuse associate, you are eligible for benefits if you work at least 30 hours per week. Most of your benefits are effective on the first day of the month following your date of hire.

You may enroll your eligible dependents for coverage once you are eligible. Your eligible dependents include:

- Your legal spouse
- Your domestic partner
- Your children up to age 26
- Your domestic partner's children up to age 26

Once your benefit elections become effective, they remain in effect until the end of the year. You may only change coverage within 30 days of a qualified life event.

At any point, Bel Fuse reserves the right to conduct an audit of our health plan's eligibility. During an audit, you may be asked to supply documents such as birth and marriage certificates and legal guardianship documentation. Any dependent determined to be ineligible or your noncompliance with the audit will result in removal of your dependent(s) from Bel Fuse's plans.

What is a Domestic Partner?

"Domestic Partner" means the person, regardless of gender, named in the Affidavit of Domestic Partnership that you have submitted to and has been approved by the Employer. Contact your local Human Resources Representative for questions.

Qualified Life Events

Generally, you may change your benefit elections only during the annual enrollment period. However, you may change your benefit elections during the year if you experience a qualified life event, including:

Questions about your benefits or enrollment? Contact Bel Benefits Department or your local HR Representative for assistance.

- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse, domestic partner or dependent child
- Adoption of or placement for adoption of your child
- Change in employment status of associate, spouse/domestic partner or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- Entitlement to Medicare or Medicaid

You must notify Human Resources within 30 days of the qualified life event. Depending on the type of event, you may be asked to provide proof of the event. If you do not contact Human Resources within 30 days of the qualified event, you will have to wait until the next annual enrollment period to make changes.

THE COST OF YOUR BENEFITS

Bel Fuse pays the full cost of many of your benefits; you share the cost for others. You pay the full cost for any voluntary benefits you elect.

Benefit	Who Pays	Tax Treatment
Medical Coverage	The Company & You	Pre-tax
Dental Coverage	The Company & You	Pre-tax
Vision Coverage	You	Pre-tax
Basic Life & AD&D	The Company	After-tax
Supplemental Life & AD&D	You	After-tax
Disability Coverage	The Company	After-tax
Critical Illness & Hospital Indemnity (HSA Plans only)	The Company	After-tax
Flexible Spending Accounts	You	Pre-tax
Health Spending Accounts	The Company & You	Pre-tax
AIG Benefits Travel Assist — Travel Guard	The Company	N/A
TELUS Health (EAP)	The Company	N/A
Pet Insurance	You	After-tax
Experian Financial Expert	You	After-tax
Legal Shield	You	After-tax

Medical Coverage

Bel Fuse offers a choice of two medical plan options through Cigna, so you can choose the plan that best meets your needs — and those of your family.

Plan Provisions	HSA Open Access		Silver Open Access	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Company Contribution to HSA (Individual/Family)	Associate $500 Associate +1 $650 Family $900		N/A	
Annual Deductible (Individual/Family)	$2,500/$5,000	$5,000/$10,000	$500/$1,000	$1,000/$2,000
	Non-embedded		Embedded	
Out-of-Pocket Max. (Individual/Family) (Includes Deductible)	$5,000/$10,000	$10,000/$20,000	$2,500/$5,000	$5,000/$10,000
Lifetime Maximum	Unlimited		Unlimited	
Preventive Care	100%	N/A	100%	60%*
Primary Physician Office Visit	80%*	60%*	$20 copay	60%*
Specialist Office Visit	80%*	60%*	$20 copay	60%*
Inpatient Hospital Services	80%*	60%*	90%*	60%*
Outpatient Hospital Services	80%*	60%*	90%*	60%*
Urgent Care	80%*	60%*	$50 copay	$50 copay
Emergency Room Care	80%*	80%*	$100 copay	
Retail Prescriptions (30-day supply) Generic Brand Preferred Brand Non-preferred	$10 copay* $30 copay* $70 copay*	50%*	$10 copay $30 copay $50 copay	50%*
Retail & Mail Order Prescriptions (90-day supply) Generic Brand Preferred Brand Non-preferred	$20 copay* $60 copay* $140 copay*	N/A	$20 copay $60 copay $100 copay	N/A
Supplemental Critical Illness Coverage**	Automatic enrollment for associate and child(ren)		Not eligible	
Supplemental Hospital Indemnity Coverage**	Automatic enrollment for associate and child(ren)		Not eligible	

*After deductible is met

**See page 15 for additional details

Preventive Prescriptions For Those Enrolled in the HSA Open Access Plan

If you are enrolled in the HSA Open Access Plan, the deductible and generic copay will be waived for certain generic preventive prescriptions. Contact Human Resources for a list of eligible prescriptions. Log in to the myCigna app or mycigna.com to check your plan materials to see which medications your plan includes and to see how much your medication costs.

NON-EMBEDDED DEDUCTIBLE

One or more family member(s) must satisfy the entire family deductible before the coinsurance applies for the HSA plan.

EMBEDDED DEDUCTIBLE

After one family member meets his or her individual deductible on the Silver Plan, the coinsurance will then apply.

HSA OPEN ACCESS

- Must be enrolled in IRS qualified HDHP. (Bel's HSA Open Access Plan meets the IRS qualified HDHP criteria.)
- Underlying medical benefits and an HSA partially funded by the employer.
- Funds are used to pay for eligible medical expenses to help offset the higher deductible and out-of-pocket costs.
- Any unused HSA funds will roll over from year to year.
- Money contributed to your HSA is owned by you.

DIGITAL ID CARDS

Cigna Healthcare will provide digital ID cards and you will not receive physical cards in the mail. Digital ID cards will allow easier access to plan coverage information.

- Members will still have the option to request physical medical ID cards via mycigna.com.

PHARMACY UPDATE

Bel Fuse will continue offering Cigna's 90-day Member Choice Program for 2025. You can visit mycigna.com to choose your preferred anchor chain for 2025, either CVS or Walgreens for your 30-day and 90-day prescription fills. If you made a selection in 2024, your preferred anchor chain will automatically roll over for 2025. Every covered member in your household may choose the pharmacy network that works best for them. Members can only change their network one time in a calendar year. If you wish to change your anchor chain before 01/01/2025, please call the customer service number on your Cigna digital ID card 24/7/365. After 01/01/2025, you can make the change by calling the customer service number on your Cigna digital ID card or chat online using the myCigna website, Monday-Friday, 9:00 a.m.-8:00 p.m. EST. For members that do not make a selection, Cigna Healthcare will review six months of utilization and assign members to the network they use most often. If there is no utilization, the members will be placed in Bel Fuse's assigned network (CVS).

2025 Contributions	Premium	Associate Monthly Contribution	Associate Annual Contribution
Medical Plan — Silver Plan			
Associate Only	$1,283.43	$256.68	$3,080.16
Associate + Spouse	$2,566.86	$538.65	$6,463.80
Associate + Child(ren)	$2,477.02	$495.40	$5,944.80
Associate + Family	$3,991.46	$837.60	$10,051.20
Medical Plan — HSA Plan			
Associate Only	$1,115.40	$111.51	$1,338.12
Associate + Spouse	$2,230.79	$223.01	$2,676.12
Associate + Child(ren)	$2,152.71	$215.20	$2,582.40
Associate + Family	$3,468.88	$346.78	$4,161.36

Health Savings Account (HSA)

A health savings account (HSA) will be available for all associates enrolled in the HSA high deductible health plan (HDHP). An HSA is a personal healthcare bank account that you can use to pay out-of-pocket medical expenses with pre-tax dollars. You own and administer your HSA. You determine how much you will contribute to your account, when to use your money to pay for qualified medical expenses, and when to reimburse yourself. HSAs allow you to save and roll over money if you do not spend it in the calendar year. This is your personal bank account; you must have money in the account before you can spend it. If you change health plans or jobs, the money in the account is yours to keep.

YOU ARE ELIGIBLE TO OPEN AND FUND AN HSA IF:

- **You are covered by an HSA-eligible high deductible health plan.**
- **You are not covered by your spouse's health plan (unless it is a qualified HDHP), healthcare flexible** spending account (FSA) or health reimbursement account (HRA).
- You are not enrolled in the Healthcare FSA.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare, TRICARE or TRICARE For Life.
- The IRS recommends to stop contributions to your HSA six months before you apply or sign up for Medicare after the age of 65.

You can use HSA money to pay for qualified medical expenses now or in the future. Your HSA can be used for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP. Qualified expenses are defined by the IRS. These expenses include such things as doctor's office visits, deductibles, coinsurance and prescription drugs. IRS Publication 502 provides a complete list of eligible expenses and can be found at irs.gov.

We have partnered with Cigna and HSA bank to administer the HSAs opened by associates participating in the HDHP. You can elect to participate in the HSA and have deductions taken on a pre-tax basis and deposited into your account.

IMPORTANT INFORMATION

The IRS rules prohibit an associate from having a Healthcare FSA and an HSA at the same time.

Note:
If you had an HSA in 2024 and received a debit card, you will use the same card for 2025 if it's not expired.

THERE ARE THREE WAYS TO MAXIMIZE YOUR TAX SAVINGS

1. Contributions to an HSA are tax-free. (They can be made through payroll deductions on a pre-tax basis when you open an account with HSA Bank through Cigna.)
2. The money in this account (including interest and investment earnings) grows tax-free.
3. As long as the funds are used to pay for qualified medical expenses, they are spent tax-free.

HSA Funding and Limits

Associates are responsible for tracking annual limits. Funding limits include both employer and employee contributions. The 2025 IRS maximum contributions for these accounts are:

	2025 Calendar Year
Associate-Only	$4,300
All Other Tiers	$8,550
Individuals 55+ Years Old	Additional $1,000

IMPORTANT

- **Employees are automatically enrolled in HSA, but if the Customer Identification Program is not approved within 90 days, their HSA account will be closed.**
- **HSA Bank will first try and verify each enrollee identity based off initial enrollment info (name, address, SSN). If any of this does not match, HSA Bank will then mail out a letter requesting more info from employee. If a phone number is on file, they will also attempt a call to the employee.**

My Funds

Debit card	Use the Cigna branded Visa debit card to pay for out-of-pocket expenses
Online account access	Access your account online including the ability to transfer money directly to your personal account for reimbursement.
Checkbook	You can order a checkbook and write checks to pay for out-of-pocket expenses (deductibles and coinsurance). There is a fee associated with this option.

Regardless of how you access your HSA funds, all balance and transaction activity is available online at mycigna.com and the myCigna® App.

PAYING FOR MY FAMILY'S EXPENSES

You can use your HSA dollars for out-of-pocket expenses incurred by:

- You and your spouse
- Dependents you claim on your tax return
- Any person you could have claimed as a dependent on your tax return except if:
  - The person filed a joint return
  - That person had gross income of $4,000 or more
  - You, or your spouse if filing jointly, could be claimed as a dependent on someone else's tax return

We recommend you consult a tax advisor if you have a domestic partner or child you do not claim on your federal income tax.

WITHDRAWAL DEADLINES

There are no filing deadlines. As long as the expenses were qualified and incurred after the date the HSA was established, you can withdraw the funds from your HSA at any time, in this year or in future years.

KEEP YOUR RECEIPTS

The IRS requires you to keep your receipts in order to show:

- The funds were used to pay or reimburse qualified medical expenses
- The qualified medical expenses had not been previously paid or reimbursed from another source
- The expenses were not taken as an itemized deduction in any year

SPECIAL ALLOWANCES IF YOU ARE 65 OR OLDER

When you turn 65, your HSA becomes even more flexible. You can continue to use your HSA, tax-free, for expenses not covered by Medicare or other supplemental insurance — including dental and vision expenses. Or you can use your HSA as supplemental income in retirement. The IRS recommends to stop contributions to your HSA six months before you apply or sign up for Medicare after the age of 65.

If you choose to use your HSA as supplemental income in retirement, your withdrawal will be taxed as ordinary income, similar to a 401k. But once you reach age 65, the penalty for nonqualified distributions no longer applies.

Remember, you roll over whatever HSA dollars you do not use. The HSA belongs to you, regardless of whether you leave your employment or retire. So use your HSA wisely. Your HSA savings can help you manage your out-of-pocket medical expenses now and in the future.

MY BENEFICIARY

When you establish an HSA you will be asked to designate a beneficiary. If your spouse is the designated beneficiary, your HSA will be treated as your spouse's HSA after your death.

If your spouse is not your designated beneficiary, the account stops being an HSA and the fair market value of your account becomes taxable to the beneficiary in the year in which you die.

MY TAXES

It is important to know the impact an HSA account can have on your annual federal and state income taxes. Please visit irs.gov for more information under IRS Publication 969.

Telehealth

Life is demanding. It's hard to find time to take care of yourself and your family members as it is, never mind when one of you isn't feeling well. That's why your health plan through Cigna includes access to minor medical and behavioral/mental health virtual care.

Whether it's late at night and your doctor or therapist isn't available or you just don't have the time or energy to leave the house, you can:

- Access care from anywhere via video or phone
- Get minor medical virtual care 24/7/365 — even on weekends and holidays
- Schedule a behavioral/mental health virtual care appointment online in minutes
- Connect with quality board-certified doctors and pediatricians as well as licensed counselors and psychiatrists
- Have a prescription sent directly to your local pharmacy, if appropriate

To connect with an MDLIVE virtual provider, visit mycigna.com, locate the "Talk to a doctor or nurse 24/7" callout and click "Connect Now." To streamline this experience, it is suggested that you pre-register for MDLIVE so that when you need of the service, you can access it faster.

To locate a Cigna Behavioral Health provider, visit mycigna.com, go to "Find Care & Costs" and enter "Virtual counselor" under "Doctor by Type," or call the number on the back of your Cigna ID card 24/7.

Cigna One Guide

Let's face it, understanding and using your health plan isn't always easy. Well, not to worry. Your Cigna One Guide team is ready and waiting to help. It's Cigna's highest level of personal support available.

Simply call Cigna, click-to-chat on mycigna.com or use the myCigna app. You'll automatically be connected with a One Guide representative who will help guide you where you need to go.

Helping you save money and stay healthy. Your Cigna One Guide team can help you:

- Understand your plan
  - Learn how your coverage works
  - Get answers to your healthcare or plan questions
- Get care
  - Find an in-network healthcare provider, lab or urgent care center
  - Connect with health coaches, pharmacists and more
  - Connect with dedicated, one-on-one support for complex health situations
- Save
  - Get cost estimates to avoid surprises

Click, Call or Chat

Your personal guide is ready and waiting to help.

mycigna.com
myCigna app
800.244.6224

Download on the App Store
GET IT ON Google Play
Available on amazon apps kindle fire

New Cigna Programs

PATHWELL BONE & JOINT

Cigna Pathwell Bone & Joint and their dedicated care team can help guide you to the right care for your spine, knee, hip and shoulder pain. If enrolled in the medical coverage, this program is included in your medical plan at no additional cost, and you will have access to:

Guidance to the Care You Need

A Clinical Care Advocate can help you with:

- Finding the right treatment plan
- Understanding your benefits
- Access to in-network physical therapy, both in person and virtual
- Education on how lifestyle can impact musculoskeletal (MSK) health
- Pre- and post-surgery support and connection with other helpful resources

Online Tools and Resources

Our user-friendly digital tools enable you to communicate with your dedicated Clinical Care Advocate, and access personalized activities and articles to support your care plan.

Surgery Benefit

When surgery is right for you, a Benefit Specialist can help with:

- Finding quality, affordable surgeons who are part of the surgery benefit
- Understanding how to qualify for the zero or low-cost surgery benefit
- Reviewing the travel benefit of up to $600 when a designated surgeon isn't close to home
- Additional programs and support offered through your Cigna Healthcare benefits

Contact

Website: cignapathwellboneandjoint.com
Phone Number: 877.505.5875

OMADA

Omada is a personalized program, for those enrolled in medical coverage and eligible, that helps members lose weight and create healthier habits through one-on-one personal coaching and the tools needed to make long-lasting health changes. If you are at risk for type 2 diabetes or heart disease and accepted into the program, the program – up to a $700 value – is at no additional cost to you.

What You Get as a Member:

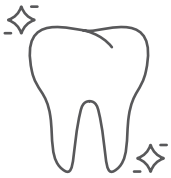
- A personal health coach
- A personalized care plan
- Weekly lessons
- Tools for managing stress
- Online peer group and communities
- Plus, you get a smart scale to track your progress, and it's yours to keep!

Your Personal Omada Health Coach Will Help You:

- Eat healthier
- Gain more energy
- Sleep better
- Manage stress

Check to see if you are eligible and join today!
omadahealth.com/omadaforcigna

Delta Dental of NJ — Dental Coverage



Regular dental exams can help you and your dentist detect problems in the early stages when treatment is simpler and costs are lower. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease, and is an important part of maintaining your medical health.

Plan Provision	Delta Dental PPO Plus Premier		Delta Dental PPO Plus Premier — Buy-Up	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Individual/Family)	$50/$150		$50/$150	
Annual Maximum (Per Person)	$1,500		$2,500	
Diagnostic and Preventive Care: Includes cleanings, fluoride treatments, sealants and X-rays	100%, no deductible		100%, no deductible	
Basic Services: Includes fillings, periodontics, scaling and root planning, and oral surgery	90% after deducible	80% after deductible	90% after deducible	80% after deductible
Major Services: Includes crowns, bridges and full and partial dentures, implants	50% after deductible		50% after deductible	
Orthodontia (includes children and adults)	75% after deductible	50% after deductible	75% after deductible	50% after deductible
Orthodontia Lifetime Maximum	$1,500 lifetime max		$2,500 lifetime max	
Rollover Threshold/ Rollover Amount	Allows for carryover of up to 25% of unused benefit, to a maximum of $500/yr. Accumulated amount cannot exceed plan maximum.			

2025 Contributions	Premium	Associate Monthly Contribution	Associate Annual Contribution
Dental Plan Base			
Associate Only	$43.99	$8.81	$105.72
Associate + Spouse	$86.22	$17.24	$206.88
Associate + Child(ren)	$93.80	$18.77	$225.24
Associate + Family	$146.20	$29.24	$350.88
Dental Plan Buy-Up			
Associate Only	$53.44	$18.25	$219.00
Associate + Spouse	$104.68	$35.70	$428.40
Associate + Child(ren)	$113.90	$38.88	$466.56
Associate + Family	$177.53	$60.57	$726.84

VSP Vision Coverage

Proper vision care is an essential part of your health and safety. VSP will be our provider for vision coverage in 2025. The vision plan covers routine eye exams and a $150 allowance for frames or contact lenses.

VSP member ID cards will not be sent out to employees. When visiting your vision provider, all that is needed is the name of the covered employee, date of birth, and last four of the Social Security number. If a physical card is desired, we encourage employees to create a member account online at vsp.com to print out the ID card. From here, employees are able to create an individual 9-digit member number in lieu of their SSN.

Benefit	In-Network
Exam	$20 copay
Hardware	$20 copay
Frames (Retail Allowance)	**Up to $150**
Lenses	
Single Vision Lenses	100% after copay
Bifocal Lenses	100% after copay
Trifocal Lenses	100% after copay
Lenticular Lenses	100% after copay
Medically Necessary Contact Lenses	100%
Elective Contact Lenses in lieu of glasses	**Up to $150**
Exam, Frames, and Lenses Frequency	12 months

Please note, additional fess may apply for specific lens enhancements such as premium progressive lenses, custom progressive lenses, and UV protection. Additional detail can be found in the benefit summary. Associates can utilize VSP's vision benefit and obtain their prescription to utilize at an Essilor SightProtect provider that require safety glasses at work.

2025 Contributions	Premium	Associate Monthly Contribution	Associate Annual Contribution
Vision Plan			
Associate Only	$6.30	$6.30	$75.60
Associate + Spouse	$12.02	$12.02	$144.24
Associate + Child(ren)	$12.26	$12.26	$147.12
Associate + Family	$19.58	$19.58	$234.96

Flexible Spending Account (FSA)

Employee Benefits Corporation (EBC) will continue to be our administrator for FSA in 2025. A great way to plan ahead and save money over the course of a year is to participate in an FSA. An FSA lets you redirect a portion of your salary on a pre-tax basis into a reimbursement account, saving you money on taxes. Each year that you would like to participate in the FSAs, you must elect the amount you want to contribute.

EBC offers three types of FSAs that can help you save on a pre-tax basis for out-of-pocket expenses.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

Pair the PPO health plan with a healthcare FSA, which covers eligible medical, dental and vision expenses. The current contribution limit is **$3,300** (subject to change from the IRS).

LIMITED-PURPOSE FLEXIBLE SPENDING ACCOUNT

If you are enrolled in the HSA plan, you are eligible to enroll in the limited-purpose flexible spending account (LPFSA). A limited-purpose health FSA allows you to continue to contribute to an HSA. However, the main difference is that the limited-purpose account is set up to reimburse only eligible FSA dental and vision expenses. The current contribution limit is **$3,300** (subject to change from the IRS).

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Dependent care FSAs allow you to set aside money pre-tax to pay eligible out-of-pocket day care expenses so that you or your spouse can work or attend school full-time. You must contribute money through payroll deductions to your dependent care FSA before you can spend it.

During enrollment, you must decide how much to set aside for this account in 2025. You may contribute up to $5,000 a year for single individuals or married couples filing jointly, or $2,500 for a married person filing separately.

Changes to your dependent care FSA elections can be made only during enrollment or if you experience a qualifying life event during the plan year.

GRACE PERIOD AND RUNOUT PERIOD

An FSA is a use-it-or-lose-it account, meaning any funds remaining in the account following the close of the plan year will be forfeited. Our plan has a grace period that allows you to use your 2024 plan year election for claims incurred from January 1, 2025, through March 15, 2025. Any 2025 FSA election would have a grace period from January 1, 2026, through March 15, 2026. Please note, if you are newly enrolling in the HSA plan for 2025 and participated in the healthcare flexible spending account in 2024, you may only be reimbursed for dental and vision expenses incurred during the grace period running from January 1, 2025, through March 15, 2025.

The runout period to submit all claims from your 2024 FSA election is March 31, 2025. EBC will be responsible for managing all runout claims for your benefits. EBC will provide efficient processing, streamlined communication, and expert assistance with this transition. The runout period to submit all claims from your 2025 FSA election is March 31, 2026. Please note, IRS rules prohibit an associate form having a Healthcare FSA and an HSA at the same time.

COMMUTER BENEFITS

Employee Benefits Corporation (EBC) is our financial administrator for the commuter benefits. The provision of commuter benefits will align with state requirements.

How do I create and log in to my online account?

Once enrolled, you can create your username and password the first time you visit the participant portal on ebcflex.com.

1. Create your account
   - Go to ebcflex.com
   - Click Log in > Participants
   - Click Register
2. Log in to your account
   - Go to ebcflex.com
   - Click Log In > Participants
   - Enter your username and password

Employee Benefits Corporation:

E: participantservices@ebcflex.com
P: 800.346.2126 | 608.831.8445
ebcflex.com

Where can I shop?

Visit ebcflex.com/WheretoShop

If you enrolled in FSA for 2024 and received a Flex debit card, and you re-enroll in FSA for 2025, your debit card remains active and does not expire.

Life and Disability

Prudential

We are excited to partner with our new 2025 vendor, Prudential!

Life insurance and disability coverage are important components of your financial security, especially if others depend on you for support. Accidental death and dismemberment (AD&D) insurance is designed to provide a benefit in the event of accidental death or dismemberment.

Bel Fuse provides basic life and AD&D insurance to all eligible associates at no cost to you. Coverage amounts are two times your annual earnings to a maximum of $500,000.

DISABILITY INSURANCE

The goal of the disability plan is to provide you with income replacement should you become disabled and unable to work due to a non-work-related illness or injury. The Company provides eligible associates with disability income benefits at no cost.

SHORT-TERM DISABILITY

The length of time payments will be made and the percentage of your gross salary to be paid are related directly to your years of service as an associate.

Years of Service at Start of Disability	60% of Salary	75% of Salary	Weekly Benefit Maximum
Less than 1 year	0	0	No maximum
1 year but less than 5	26 weeks	0	No maximum
5 years or more		26 weeks	No maximum

LONG-TERM DISABILITY

Long-term disability will also be based on your years of service at the start of the disability. If you remain disabled after 26 weeks, the plan will review your eligibility for the long-term disability plan. If approved, the long-term disability benefit will be based on your years of service at the start of disability.

Years of Service at Start of Disability	% of Salary	Monthly Benefit Maximum
Less than 3 years	0%	$0
3+ years	60%	$10,000

Reminder: Please be sure to update or add your beneficiary information in ADP.

SUPPLEMENTAL LIFE/AD&D

- Associate
  - Elect up to 5x your salary in increments of $10,000 up to $850,000*
  - Guaranteed issue amount: **$200,000**
- Spouse/domestic partner
  - Elect up to 100% of the associate coverage amount in increments of $5,000 (not to exceed $500,000)*
  - Guaranteed issue amount: $25,000
- Child(ren)
  - Elect up to 100% of the associate coverage amount in increments of $2,000 (not to exceed $10,000)
  - Life coverage for dependents up to age 26
  - No EOI required

*Subject to reduced amounts due to age

With our new carrier, Prudential, employees, spouses, and children are now eligible for coverage up to the guaranteed issue maximum during this enrollment. The guaranteed issue has increased to **$200,000** for 2025.

EVIDENCE OF INSURABILITY

- If you apply for an amount that requires satisfactory evidence of insurability to The Prudential Insurance Company of America, you must be actively at work on the date of approval for the amount requiring satisfactory evidence of insurability.
- Elections made outside of approved enrollment events and elections exceeding the guaranteed issue amount may require proof of good health.

LIMITATIONS/BENEFIT EXCLUSIONS

- Death caused by suicide

AGE REDUCTION

Coverage amounts will:

- Reduce to 65% of the original amount when you reach age 70
- Will reduce to 50% when you reach age 75
- Coverage may not be increased after a reduction

Critical Illness, Hospital Indemnity, and BTA

Bel Fuse associates who elect to enroll in the Cigna HSA plan will also be enrolled in the employer-paid critical illness and hospital indemnity plans. These plans will provide additional supplemental benefits in the event of an unexpected diagnosis or hospital admission to assist with these unanticipated expenses. Both employees and their dependent children will be enrolled at no cost to the associate. As this benefit is intended to assist with the high deductibles associated with the HSA plan, this benefit is not available to associates enrolled in the Cigna Silver PPO plan.

CRITICAL ILLNESS THROUGH PRUDENTIAL

Group critical illness can pay benefits for non-medical, critical illness-related expenses that your medical plan might not cover. The group critical illness benefit is in the form of a lump-sum payment, which is paid to the employee after a diagnosis is made. The associate flat benefit amount is $10,000 and the dependent child amount is $5,000.

- Benefits are paid directly to the associate unless benefits are assigned to someone else
- Employees enrolled in the HSA plan (and their dependent children) will automatically be enrolled at no cost to the associate
- You can take the coverage with you if you leave the company
- Covered conditions include heart attack, stroke, invasive cancer, coma, paralysis and more
- Coverage does not replace other group medical benefits. It is designed to supplement your medical plan coverage
- This coverage includes a wellness benefit that pays $50 per covered person per year for proof of a qualified health screening, such as a chest X-ray, colonoscopy, mammogram, pap smear, lipid panel and more
- Spouses are not covered

HOSPITAL INDEMNITY THROUGH PRUDENTIAL

Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital and/or ICU for a covered accident, illness or childbirth. You can receive $1,000 per calendar year for a hospital and/or ICU admission.

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.

Why is this coverage so valuable?

- Prudential pays you regardless of what your medical plan covers. Your benefits are paid directly to you to spend however you like, including out-of-pocket medical and non-medical costs and everyday living expenses.
- The benefits in this plan are compatible with a health savings account (HSA).
- You may take the coverage with you if you leave the company or retire, without having to answer new health questions. You'll be billed directly.

BUSINESS TRAVEL ACCIDENT INSURANCE COVERAGE THROUGH AIG

Business travel accident insurance covers you in the event of sickness, accidental death or dismemberment when traveling for business.

- 24-hour worldwide business travel protection
- Travel assistance services
- Emergency medical evacuation
- Medical Expense benefit up to $250K with $0 deductible

Employee ID Card

Policyholder: Bel Fuse, Inc.
Policy Number: 9150707
Phone Number (within the U.S.): 877.244.6871
Phone Number (outside the U.S.): 715.346.0859
Email: assistance@aig.com

Employee Assistance Program (EAP)

TELUS HEALTH

When you find yourself in need of some professional support to deal with personal, work, financial or family issues, your employee assistance program (EAP) can assist. You and your immediate family (spouse or domestic partner, dependent children, parents and parents-in-law) can use this confidential program to talk to a consultant 24/7, about a variety of topics, including:

- Marital and family conflicts
- Job-related difficulties
- Stress, anxiety and depression
- Parent and child relationships
- Legal and financial counseling
- Identity theft counseling
- Financial planning
- Various other related issue

TELUS Health

Call 800.433.7916 or
Visit one.telushealth.com
User ID: belfuse
Password: eap

Download the mobile app to have access to TELUS Health at your fingertips!

Pet Insurance

METLIFE PET INSURANCE

To Get Started

Please contact MetLife at 855.270.7387 or visit metlife.com.

Underwritten and issued by Independence American Insurance Company

MetLife pet insurance is simple, flexible and helps ensure that you can care for your pets. You can purchase coverage for all your dependents … even your four-legged ones:

- Flexible products with straightforward pricing options and customizable limits.
- Deductible savings — your deductible decreases if you go claim-free in a policy year.
- Quick 3-step enrollment and hassle-free claims experience — most claims are processed within 10 days.
- Multichannel support options — Caring and passionate pet advocates who have been serving pet parents and their communities for more than 15 years.

Experian Financial Expert

MY FINANCIAL EXPERT®

Bel is excited to continue offering financial wellness and identity protection through Experian.

Experian's Elite benefits plan features Digital Financial Manager — providing you tools to help manage your finances and credit profile in a single experience.

- Digital Financial Manager
  - 360° financial views: Link all of your accounts to stay on top of your daily spending with recommended budgets powered by AI and machine learning of past transactional behavior.
  - Exclusive credit insights: 50+ unique recommendations to help achieve financial goals sooner including activity, spending, and budgeting improvements.
- As identity theft continues to increase, an evolving suite of identity products help you monitor any potential threats to your identity and alerts you if there are any areas of concern. You will also have digital privacy tools that can help you keep passwords and other personal information private and secure while surfing the web.

	Monthly Rates
Employee	$7.25
Family	$14.50

LegalShield

LegalShield™

Unexpected legal questions arise every day. Bel offers LegalShield to help address these scenarios and provide the legal protection you and your family need and deserve. With LegalShield, you'll have access to a quality law firm for covered personal situations, even 24/7 for emergency situations, no matter how traumatic or how trivial they may seem. Since LegalShield's dedicated law firms are prepaid, their sole purpose is to serve you, rather than bill you.

Follow these steps to create your LegalShield account.

1. CREATE your account at accounts.legalshield.com.
2. ENTER your member number and create a username and password.
3. DOWNLOAD the LegalShield mobile app.

	Monthly Rates
Employee	$21.50
Family	$21.50

401(k) Retirement Savings Plan

The Bel Fuse 401(k) retirement savings plan offers a convenient way to save for your future through payroll deductions.

ELIGIBILITY

You are eligible to participate in the plan as of the first day of the month following date of hire with the Company.

ASSOCIATE CONTRIBUTIONS

Contributions from your pay are made on a pre-tax basis — up to the IRS annual limit. If you are 50 years of age or older, (or if you will reach age 50 by the end of the year), you may make a catch-up contribution in addition to the normal IRS annual limit. The plan allows for post-tax Roth contributions.

For additional details about the 401(k) retirement savings plan or to enroll or change your contribution rates or investment elections, please contact Principal Financial at principal.com or by phone at 800.547.7754 for further information. Investment Questions? Contact Bridgehaven at 866.867.3859

EMPLOYER MATCHING

Bel matches 100% of the first 1% of gross pay that you contribute plus 50% of the next 5% of gross pay that you contribute. An employee contribution of 6% results in the maximum employer match. Employer matching contributions will be invested in the plan's Employer Class A Common Stock Fund.

VESTING

Vesting refers to your right of ownership to the money in your account. You are immediately vested in your contributions and earnings. However, there is a two-year waiting period prior to you being vested in your earned company match.

Reminder: Please be sure your beneficiary information is current at principal.com.

Medicare Resource

Whether you're preparing for retirement or are approaching age 65 and are considering Medicare, we have a resource for you!

MYLO

Mylo has a large bench of carriers and coverage. A licensed Mylo advisor can:

- Recommend the right type of Medicare for you
- Shop Medicare policies from 40+ carriers
- Find you the best rate

If you are interested in connecting with a Mylo advisor, please visit choosemylo.com/kansascity or call 844.893.9881.

Medical Opt-Out

- Voluntarily opt out of company sponsored medical benefits
- Associate must provide verification of other coverage
- Documentation of coverage must include associate name and effective date
- Associates enrolled in the state exchange will not qualify
- $2,000 annual payment made via payroll at end of each quarter
- Qualifying event eligibility
- Associate may re-enroll in medical benefits during the plan year
- Pro-rated amount will be calculated for the period that benefits were not elected
- Medical opt-out participation form and documentation required to receive payment. Please contact your local Human Resource representative to obtain the form and provide documentation.

Contacts

Plan	Contact	Phone Number	Website
Medical	Cigna	800.244.6224	mycigna.com
Vision	VSP	800.877.7195	vsp.com
Cigna Nurse Line	Cigna	800.244.6224	mycigna.com
Cigna MDLive/Telehealth Connection	Cigna	888.726.3171	mdliveforcigna.com
Cigna One Guide	Cigna	800.244.6224	mycigna.com
Rx Mail Order	Cigna	800.285.4812	mycigna.com
Dental	Delta Dental of NJ	800.452.9310	deltadentalnj.com
Health Savings Account	HSA Bank	800.357.6246	hsabank.com
Flexible Spending Accounts	EBC	800.270.2126	ebcflex.com
Life & AD&D Insurance	Prudential	800.524.0542	prudential.com
Short-Term & Long-Term Disability Insurance	Prudential	800.842.1718	prudential.com
Critical Illness & Hospital	Prudential	844.455.1002	prudential.com
Leave Management (STD & LTD)	Prudential	877.367.7781	prudential.com
Business Travel Accident Insurance	AIG	800.826.4919	aig.com
Employee Assistance Program (EAP)	TELUS Health	800.433.7916	one.telushealth.com
Bel Wellness	WellRight	312.724.6906	belwellness.wellright.com
401k	Principal	800.547.7754	principal.com
401k — For Investment Questions	Bridgehaven	866.867.3859	bridgehavenfp.com
Employee Advocate/Benefits Counselor	Lockton on Call	833.934.2717	belbenefits@lockton.com
ADP Self-Service	ADP		workforcenow.adp.com
Medicare Resource	Mylo	844.893.9881	choosemylo.com/kansascity
COBRA	EBC	800.346.2126	ebcflex.com
Pet Insurance	MetLife	855.270.7387	metlife.com
Financial Wellness & Identity Protection	Experian	855.797.0052	experian.myfinancialexpert.com/login
Legal	Legal Shield	888.807.0407	shieldbenefits.com/belfuse
Commuter	EBC	880.346.2126	ebcflex.com

Questions on Bel's Benefits?

LOCKTON ON CALL

Available to all Bel U.S. Associates

If you have questions regarding your benefits plan, please call 833.934.2717 or email belbenefits@lockton.com**.**

Your benefits specialist can:

- Help you enroll in benefits after November 11, 2024
- Answer questions regarding qualifying events and waiting periods
- Help find in-network providers and request ID cards
- Provide help understanding EOBs and billing from providers
- Assist with claims questions or issues

DISCOVER YOUR PATH TO WELL-BEING

All it takes to achieve better health and well-being is a plan. Did you know you have access to the WellRight wellness program, even if you're not enrolled in any of Bel's medical plans? This program is designed to provide you with the support you need to live healthy and be well. Visit the WellRight website, belwellness.wellright.com, and get started by participating in upcoming annual and quarterly challenges. You can also access it via their mobile app. As you participate and complete regular challenges, you will earn points that may be redeemed at the Rewards Mall. At the end of the year, you may cash out your points for gift cards; please note, points will not roll over to the next year.

BEL WELLNESS PROGRAM DESIGN

Plan Year 01/01/2025 — 12/31/2025

Challenges End — 11/30/25. Please be sure to enter your points in the Wellright portal prior to 11/30/25 in order to redeem your points in December 2025.

- All associates can participate
- Total of 100 points can be earned
- Cash-out period 12/01/25 — 12/31/25 for $75.00 reward

Annual challenges Open the entire plan year to complete	Points
AgeGage — health risk assessment	15
MeasureUp — complete your biometric screening	25
Say Aah — you completed an preventive annual exam	25
Protect You — receive a preventive shot (flu, covid, shingles, etc)	15
Eye Exam — visit your eye doctor	25
Open Wide — dental visit (minimum one per year)	25
Healthy U — complete three university courses of your choosing	15
Quarterly challenges	

Quarter 1

(02/01/25-02/28/25)
February: Drop Pop
The Drop Pop Challenge invites you to avoid consuming pop for 25 out of 30 days. Pop, soda, Coke. Whatever you call it, it's a no-no for your health. Regular sodas are packed with sugar and ingredients you can't pronounce. Diet sodas may save you some calories, but they are also packed with chemicals and they trigger the same responses in your body as sugar. Track "Yes" each day you go without soda. To complete the challenge, track "Yes" for 25 days.

Quarter 2

(04/01/25-04/30/25)
April: Home Brew
The Home Brew Challenge invites you to skip the coffeehouse and make your coffee at home. We are spending more and more on the convenience of coffee shops and consuming tons of extra sugar and calories by ordering irresistibly fancy drinks from their menus. So start making your coffee at home. Track "Yes" each day you make your coffee at home. To complete the challenge, track "Yes" for 25 days.

(05/01/25-05/31/25)
May: Hello Sunshine Step Challenge
The Hello Sunshine Step Challenge invites you to attain as many steps as you can for the month of May. Sunshine is by far the best source of vitamin D, which strengthens your immune system and is necessary to build strong bones.

Quarter 3

(07/01/25-07/31/25)
July: Stand Up
The Stand Up Challenge invites you to get up from your desk for at least 1 minute every hour of your workday for 15 days. Including short movement and exercise breaks throughout the workday can boost your energy, engagement, and efficiency. Whether it's stretching periodically in your cubicle or walking to a coworker's desk rather than sending that intra-office email, small actions can go a long way. Track "Yes" each day you stand up every hour. To complete the challenge, track "Yes" for 15 days.

(08/01/25-08/31/25)
August: Brown Bag
The Brown Bag Challenge invites you to pack your lunch every workday for a month. With the convenience of quick stops like Subway, Chipotle, McDonald's, and more on every corner, it's become commonplace to run out and grab something quick at lunch. This has us spending more money and consuming more calories than we should. Even if you work from home, prep your lunch ahead of time so you're not tempted to run out and grab something or have food delivered to your home. Track "Yes" each day you pack your lunch for work. To complete the challenge, track "Yes" for 20 days.

Quarter 4

(10/01/25-11/30/25)
October-November: Litter Bug
The Litter Bug Challenge invites you to make the world cleaner by picking up one piece of trash for 21 out of 30 days. You can pick up more trash each day if you want to, but you only need to pick up one item to get credit for the day. The goal is to make it a habit, not just a one-time major cleanup day. Pick up trash that has blown into your yard — before it blows into someone else's yard! Pick up something in the parking lot as you head into work or a store. Every little bit makes a difference. Track "Yes" each day you pick up one piece of trash. To complete the challenge, track "Yes" for 21 days.

COMMUNITY ENGAGEMENT AND VOLUNTEER PROGRAM

All full-time, regular associates are eligible for 16 hours of paid time off per calendar year to participate in non-paid volunteer community service activities.

*See HR for program details

INVESTING IN YOU!

Bel's Educational Assistance Program reimburses you for up to 100%* of tuition costs for approved courses. Putting you one step closer to your next certification, license or degree.

*See HR for program details

Bel Fuse Inc.

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 Bel Fuse Inc. About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE FROM BEL FUSE INC. ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

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

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

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

Enrolling in Medicare—General Rules

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

Late Enrollment and the Late Enrollment Penalty

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

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

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

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

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

Compare Coverage
You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the Bel Fuse Inc. Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

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

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

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call 630-705-6027. **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 Bel Fuse Inc. changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	October 15, 2024
Name of Entity/Sender:	Grace Szpajer
Contact—Position/Office:	Benefits Manager
Address:	300 Executive Drive Suite 300 West Orange, New Jersey 07052
Phone Number:	630-705-6027

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

BEL FUSE INC.
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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

This notice is provided to you on behalf of:

Bel Fuse Inc. Health & Welfare Benefit Plan*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its

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

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

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

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

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

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

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

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to

the compliance date; or (4) pursuant to an individual's authorization.

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

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

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

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

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

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

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

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

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

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

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

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

21. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right

to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 24).

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

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

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

Privacy Official

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

Grace Szpajer
Benefits Manager
630-705-6027

Effective Date

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

BEL FUSE INC. EMPLOYEE HEALTH CARE PLAN

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

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

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

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within *30 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Grace Szpajer
Benefits Manager
630-705-6027

**** 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:

Grace Szpajer
Benefits Manager
300 Executive Drive Suite 300
West Orange, New Jersey 07052
630-705-6027

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

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

Bel Fuse Inc. Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at 630-705-6027.

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

You do not need prior authorization from Bel Fuse Inc. Employee Health Care Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Bel Fuse Inc. Employee Health Care Plan at:

Grace Szpajer
Benefits Manager
630-705-6027

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

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

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The Bel Fuse Inc. Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please refer to the Plan's Summary Plan Description or Summary of Benefits and Coverage for applicable deductibles and coinsurance.

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

Grace Szpajer
Benefits Manager
630-705-6027

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

Bel Fuse Inc. Wellness Program is a voluntary wellness program available to all eligible members and dependents. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others.

Details about the wellness program, including criteria and incentives, can be found in the Open Enrollment Guide.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Grace Szpajer at 630-705-6027 or grace.szpajer@belf.com.

The information from the Biometric Screening and the Health Risk Assessment will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as education, coaching, additional testing, or free or reduced diabetes testing supplies. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Bel Fuse Inc. may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) a registered nurse, a doctor, and a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Grace Szpajer at 630-705-6027 or grace.szpajer@belf.com.

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

FS: 4290270