ORGANON
FLEXIBLE SPENDING ACCOUNTS SUMMARY PLAN DESCRIPTION

Health Care FSA/Dependent Care FSA

Effective January 1, 2023
Released July 1, 2023

ORGANON

This Summary Plan Description (SPD) describes the health care flexible spending account benefits and the dependent care flexible spending account benefits provided under the Organon LLC. Cafeteria Plan, which together are referred to as the Flexible Spending Accounts as they apply to U.S.-based[1] employees of Organon LLC and its wholly owned U.S. subsidiaries. The health care flexible spending account benefits are also provided under the Organon U.S. Health and Welfare Plan and are subject to the Employee Retirement Income Security Act.

Frequently Used Terms

Keywords that are frequently used in the SPD are capitalized and defined in the "Glossary."

The health care flexible spending account ("Health Care Flexible Spending Account" or "Health Care FSA") and dependent care flexible spending account ("Dependent Care Flexible Spending Account" or "Dependent Care FSA") benefits described in this SPD are referred to in this SPD as the "Flexible Spending Accounts" or "FSAs" or "Plan."

About This SPD

This SPD summarizes the benefits provided under the Flexible Spending Accounts effective January 1, 2023, to the employees described in this SPD. All benefits and coverages described in this SPD are subject to the terms of the official plan document. If there is any conflict between this SPD and the plan document, the plan document will always govern.

Right to Amend or Terminate the Plan

The Plan Sponsor reserves the right to amend the Organon LLC Cafeteria Plan and/or the Organon U.S. Health and Welfare Plan, including but not limited to the Health Care FSA and Dependent Care FSA benefits, in whole or in part or to completely discontinue the Organon LLC Cafeteria Plan, the Organon U.S. Health and Welfare Plan or the Health Care FSA and Dependent Care FSA benefits at any time.

Your privacy is important: Organon takes the privacy of your information very seriously. No individually identifiable personal health information related to your participation in any of the plans or programs herein will be shared with Organon. Organon will only receive aggregated, anonymous health data needed to evaluate the success of the plans and to design programs that meet employees' health and wellness needs. Information about your participation in the plans and programs may be shared by the third-party vendors with other organizations that support Organon health plans. When approved by Organon, third-party vendors may occasionally share de-identified, anonymous information about our workforce's participation with Organon's researchers and third-party research organizations that seek to improve public health. For more information, please review the Organon Health Plans Notice of Privacy Practices available online at **www.organon.com/privacy** or contact the Organon Privacy Office at **privacyoffice@organon.com**.

Note that by adopting and maintaining this benefit, Organon LLC has not entered into an employment contract with any employee. Nothing in the legal Plan documents or in the SPD gives any employee the right to be employed by Organon LLC or to interfere with Organon's right to discharge any employee at any time. Providing this SPD to you does not entitle you to benefits for which you are otherwise not eligible.

[1] A U.S.-based employee is an employee whose home country is designated in Organon's employee database as one of the 50 U.S. states or District of Columbia (and includes employees on temporary international assignment outside one of the 50 U.S. states or District of Columbia) and excludes employees whose home country is designated in Organon's employee database as a U.S. territory (e.g., Puerto Rico, Guam and U.S. Virgin Islands) or a country outside one of the 50 U.S. states or District of Columbia even if the employee is on temporary international assignment in one of the 50 U.S. states, District of Columbia or in a U.S. territory.

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INTRODUCTION

FLEXIBLE SPENDING ACCOUNTS

The Flexible Spending Accounts offer you the option to pay for qualified health care or dependent day care expenses on a Before-Tax basis. This section provides a brief overview of the options and resources that are available to you as an Eligible Employee.

Flexible Spending Accounts provide an easy way to set aside money for certain Eligible Expenses and at the same time, reduce your taxable income. There are two Flexible Spending Accounts described in this section:

- The Health Care FSA, and
- The Dependent Care FSA.

Participation is voluntary. Eligible Employees may elect to participate in the Health Care FSA, the Dependent Care FSA or both. Eligibility to elect to participate depends on your employment status. See "Flexible Spending Account Eligibility" in the "About Flexible Spending Accounts" section of this SPD for additional information.

Health Care FSA

The Health Care FSA allows you to reduce your taxable income and reimburse yourself for out-of-pocket Health Care Expenses. Eligible Expenses may include Copays, Deductibles and Coinsurance, as well as some expenses not covered by your or your Eligible Dependent's medical, dental or vision plan.

Dependent Care FSA

The Dependent Care FSA allows you to reduce your taxable income and reimburse yourself for **dependent day care** incurred so you (and your Spouse/Tax-Qualified Domestic Partner, if you are married) can work, look for work or go to school full time. Eligible Expenses may include child care and elder care costs for dependents who live with you.

Health care expenses for your dependents are not eligible for reimbursement from the Dependent Care FSA. Only the Health Care FSA can be used to reimburse health care expenses.

KEY POINT — THE INTERNAL REVENUE SERVICE (IRS) DETERMINES WHICH EXPENSES ARE ELIGIBLE

The IRS determines which expenses will be eligible for payment under the Health Care FSA and the Dependent Care FSA:

- A qualified "Health Care Expense" is any expense incurred for health care that qualifies as a federal income tax deduction under Code §213. For a list of eligible Health Care Expenses, refer to *IRS Publication 502: Medical and Dental Expenses*, which is available online at **www.irs.gov/publications/p502/index.html**.
- A qualified "Dependent Care Expense" is any expense that is considered to be an employment-related expense under Code §21(b)(2) (i.e., expenses for the care of a qualifying individual and expenses for household services, if incurred to enable a participant to have gainful employment). For a list of eligible Dependent Care Expenses, refer to *IRS Publication 503: Child and Dependent Care Expenses*, which is available online at **www.irs.gov/publications/p503/index.html**.

KEY POINT — THE HEALTH CARE FSA IS SEPARATE FROM THE DEPENDENT CARE FSA

- You may choose to participate in the Health Care FSA, the Dependent Care FSA or both.
- Your Health Care FSA is separate from your Dependent Care FSA. You cannot move money from one account to the other.

Benefits Contacts and Resources

Several vendors administer and help answer questions about the Flexible Spending Accounts. This chart will help you decide who to contact, depending on your needs.

When You Want to…	Contact	How
• Obtain plan literature and forms • View the SPDs • If you're an Eligible Employee: – Enroll in your benefits when first hired, during annual enrollment or when making changes to your coverage – Access information and updates about all of the Company's health and insurance benefits – Report a Life Event change – Update dependent information	Organon Benefits Service Center at Fidelity	**www.netbenefits.com** **800-767-3353** TDD: **888-343-0860** Customer Service Representatives are available Monday through Friday (excluding New York Stock Exchange holidays) between 8:30 a.m. and 8:30 p.m. ET. Overseas: Dial your country's toll-free AT&T USADirect® access number, then enter **800-767-3353**. In the U.S., call **800-331-1140** to obtain AT&T USADirect access numbers.
• Find out about eligible Health Care and/or Dependent Care Expenses • Submit a claim for reimbursement • Inquire about the status of a claim payment • Check your Account balance	Horizon BCBS Member Services	**www.horizonblue.com/OrganonFSA** **800-544-1112** Horizon BCBS Member Services Representatives are available Monday through Friday from 8:00 a.m. to 9:00 p.m. ET.

KEY POINT — ENROLLING IN FLEXIBLE SPENDING ACCOUNTS

Enrollment in the Flexible Spending Accounts is through the Organon Benefits Service Center at Fidelity. Eligible Employees can enroll in their Flexible Spending Accounts online or by phone. Please see "How to Enroll" for detailed enrollment instructions.

Organon Benefits Service Center at Fidelity

The Organon Benefits Service Center at Fidelity ("Benefits Service Center") can help you with enrollment and eligibility information and questions. It is administered by Fidelity Investments and available online and by phone.

Online

Fidelity NetBenefits® at **www.netbenefits.com**

If you have an existing NetBenefits account, use the same username/login information you used previously.

You can also navigate NetBenefits hands free by using eSSENTIAL Accessibility, a free assistive technology app that helps people who have trouble typing, moving a mouse or reading a screen. To download the app, visit **www.essentialaccessibility.com**.

By Phone

800-767-3353 or TDD at **888-343-0860**

Customer Service Representatives are available Monday through Friday (excluding New York Stock Exchange holidays) between 8:30 a.m. and 8:30 p.m. ET. For overseas calls dial your country's toll-free AT&T USADirect® access number, then enter **800-767-3353**. In the U.S., call **800-331-1140** to obtain AT&T USADirect access numbers.

KEY POINT — CONTACTING THE BENEFITS SERVICE CENTER

To contact the Benefits Service Center, online or by phone, you will need a password. Your password provides security to ensure that only you can access your benefits information. Keep your password in a confidential place.

You can establish your password directly online or by calling the Benefits Service Center.

If you have an existing NetBenefits account, use the same username/password information you used previously. If you have forgotten your username or password, you will need to reset it using "Forgot login?" on the login page. When you change your username or password, the change will apply to all your Fidelity accounts and services going forward.

Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBS) Resources

Horizon BCBS Member Services at 800-544-1112

If you have specific questions about your Flexible Spending Accounts or want to check the status of a claim, contact Horizon BCBS.

Horizon BCBS Website at www.horizonblue.com/OrganonFSA

Horizon's website is a secure self-service member website, available 24 hours a day and seven days a week. You can access benefits and health information, including claims, a list of who is covered, cost tools and a comprehensive health

encyclopedia. To register for Horizon's website, simply log on to **www.horizonblue.com/OrganonFSA** and complete the requested information.

GENERAL INFORMATION

ABOUT FLEXIBLE SPENDING ACCOUNTS

This section provides Eligible Employees with important information about the Flexible Spending Accounts — including eligibility, enrollment, contributions and when you can make changes to your benefits.

Flexible Spending Accounts Eligibility

If you are an Eligible Employee, you are eligible to participate in the Flexible Spending Accounts as of your date of hire, rehire or transfer. See “When Participation Begins” for more information.

You are *not eligible* to participate in the Flexible Spending Accounts if you are not an Eligible Employee or you are an Excluded Employee or Excluded Person.

Enrolling in Flexible Spending Accounts

You may choose from the following Flexible Spending Account options:

- Health Care FSA, and/or
- Dependent Care FSA.

KEY POINT — WHEN MAKING ENROLLMENT DECISIONS, CHECK THE ELIGIBILITY RULES CAREFULLY

When making enrollment decisions, make sure that your estimated expenses are for you and your Eligible Dependents only. Due to federal law, the definition of Eligible Dependent for Flexible Spending Accounts varies from the definition of Eligible Dependent under the Organon Medical, Dental and Vision Plans. See the definition of “Eligible Dependents” in this SPD for more information.

KEY POINT — RESTRICTIONS ON FLEXIBLE SPENDING ACCOUNTS

Federal law and Plan rules place some restrictions on Flexible Spending Accounts. Before you decide to participate in either of the two Flexible Spending Accounts, you should understand the rules that govern their use. Please read this section carefully.

- You may choose to participate in the Health Care FSA, the Dependent Care FSA or both.
- Your Health Care FSA is separate from your Dependent Care FSA. You cannot move money from one account to the other. You cannot pay for Health Care Expenses from your Dependent Care FSA; nor can you pay for Dependent Care Expenses from your Health Care FSA.
- Each year during annual enrollment, you determine the amount of money you wish to contribute toward your Flexible Spending Accounts for the next Plan Year up to the IRS maximum contribution limit ($3,050 in 2023). The dollar amount you designate will remain in effect for the Plan Year unless you have a Life Event that allows you to make a mid-year Permitted Plan Change. Also note that for the Dependent Care FSA additional rules may apply.
- You may roll over a balance of up to $610 (in 2023) or up to the IRS maximum carryover limit in your Health Care FSA from one Plan Year to the next. The rollover funds are available on January 1 of the following year to reimburse expenses incurred in the next plan year.
- You cannot roll over *any* balance in your Dependent Care FSA from one Plan Year to the next.
- The law requires all contributions remaining in your Health Care FSA after the end of a Plan Year that exceed the rollover amount (see above) and all contributions remaining in your Dependent Care FSA after the end of a Plan Year to be forfeited. This is known as the “use it or lose it” rule. Because of this rule, you should **carefully plan the amount you elect to contribute to a Flexible Spending Account when you enroll**.
- When you are reimbursed for an expense by an account, you cannot use that expense for an income tax credit (such as the credit for child and Dependent Care Expenses) or tax deduction (such as for medical expenses).
- The Health Care FSA requires that to be eligible for payment, expenses must be incurred while you are a participant in the Health Care FSA *and* by Dec. 31 of the calendar year. Tax laws allow plans like this to include either a grace period or a rollover. The Health Care FSA includes a rollover.
- For the Health Care FSA, you can be reimbursed up to the total amount you have elected to contribute during the Plan Year as of the first day of coverage. This is known as the uniform coverage rule. For example, if your annual contribution is $3,050, you are entitled to reimbursement of $3,050 of incurred medical expenses as of Jan. 1 of the Plan Year.
- For the Dependent Care FSA, you can only be reimbursed up to the amount you have contributed as of the date of the request. For example, if your annual contribution is $1,000 but only $200 has been deposited into your account as of the reimbursement request date, you can only be reimbursed up to $200. The rest of the claim will automatically be reimbursed as you continue to contribute to the account—until the expense is fully paid, or until you reach the annual amount elected. If you terminate employment with the Company, you can submit eligible dependent care expenses incurred after your termination of employment for reimbursement through the end of the calendar year, irrespective of whether or not you remain a participant in the Dependent Care FSA. Remember expenses are only eligible dependent care expenses if they are expenses incurred to allow you and your spouse to work, to look for work, or to attend school full-time.
- All eligible claims must be received by the Claims Administrator no later than April 15 of the following year to be reimbursed. If you submit a claim electronically or by fax, it is your responsibility to have a time and date stamp confirmation. If the Claims Administrator does not receive a mailed claim by April 15, proof must be provided that the claim was postmarked by April 15.

KEY POINT — ANNUAL CONTRIBUTION LIMIT TO HEALTH CARE FSA

Although the IRS may allow a maximum adjusted amount to be contributed to a Health Care FSA in any given year, the Organon FSA Plan limits how much you can contribute to the Health Care FSA to $3,050 in 2023.

Enrollment

Eligible Employees and Transferred Employees must enroll in the Flexible Spending Accounts to participate.

If You Enroll in Your Flexible Spending Account Option Within Your 30-Day Initial Enrollment Period

You may elect to participate in the Flexible Spending Accounts within your 30-day Initial Enrollment Period, by contacting the Benefits Service Center online or by phone. As long as you enroll for coverage within your 30-day Initial Enrollment Period, your coverage will be effective on your hire, rehire or transfer date. See “How to Enroll” for more detailed instructions.

If You Do Not Enroll Within Your 30-Day Initial Enrollment Period

If you do not elect to participate within your 30-day Initial Enrollment Period, you will not be able to participate for the remainder of the Plan Year. You will not be able to change your participation until the next annual enrollment period, for coverage effective the following Jan. 1, unless you experience a Life Event, which may include a special enrollment event, that allows you to make a mid-year Permitted Plan Change. See “When Life Changes” for more information.

If You Are Rehired Within the Same Calendar Year

Your previous active coverage will be reinstated for both the Health Care FSA and the Dependent Care FSA, as applicable, with the same contribution amount you had in effect on your last date of employment. If you return to work after more than 30 days and you choose to do so, you may elect a different contribution amount or waive coverage by selecting the No Coverage option, provided you do so within the 30-day time frame applicable to newly hired employees.

KEY POINT — LIFE EVENTS

You are permitted to make certain Plan changes during the year only if you have certain Life Events — for example:

- The birth or adoption of a child
- You get married or divorced
- Your covered child reaches the maximum coverage age, including a child reaching age 13 for the Dependent Care FSA
- One of your dependents dies, or
- Your Spouse’s/Tax-Qualified Domestic Partner’s employment status changes.

See “When Life Changes” for information about how your coverage may be affected by certain Life Events. Also note that for the Dependent Care FSA, additional rules may apply.

How to Enroll

You enroll in the Flexible Spending Accounts through the Benefits Service Center, either online or by phone.

Online

www.netbenefits.com

Follow these steps:

- Log on to NetBenefits.
- Click “Enroll in your Benefits Today” and then select “Review and Choose Benefits.”
- At the bottom of the welcome screen, click “Start Enrollment.”
- First, you will be asked to add or update your dependent information. Click “Save and Continue” when done.
- On the next page, select the benefits in which you would like to enroll. Then click “Next.”
- Review the benefits you have chosen. When you’re satisfied with your selections, click “Save and Submit.”
- A confirmation screen will display the elections you submitted. Print this page for your records as evidence of your successful enrollment.

KEY POINT — COMPLETING ENROLLMENT IS YOUR RESPONSIBILITY

When you enroll, it is your responsibility to complete *all* the required steps described above. You should print a copy of your enrollment confirmation statement and keep it with your important papers as evidence of your successful completion of the enrollment process.

By Phone

Customer Service Representatives can take your benefit elections by phone between 8:30 a.m. and 8:30 p.m. ET, Monday through Friday (excluding New York Stock Exchange holidays). Once you enroll by phone, it’s a good idea to confirm your benefit elections online and print your confirmation statement. If you are unable to print your confirmation statement and would like to request a paper copy, you can contact the Benefits Service Center.

- In the U.S.: Call **800-767-3353**.
- TDD service for the hearing impaired: Call **888-343-0860**.
- For overseas calls: Dial your country’s toll-free AT&T USADirect access number then enter **800-767-3353**. In the U.S., call **800-331-1140** to obtain AT&T USADirect access numbers. From anywhere in the world, access numbers are available online at **www.att.com/traveler** or from your local operator.

When Participation Begins

Your Flexible Spending Account participation begins on your hire, rehire or transfer date provided you enrolled in coverage within your initial 30-day Enrollment Period. See “How to Enroll.” Your contributions will begin as of the first day of the next following pay period.

An Example of When Participation Begins

If you become eligible to participate on May 15 and you complete your enrollment election on May 30, your participation in the Flexible Spending Accounts will begin on May 15 and contributions to the Flexible Spending Accounts will begin as of the first pay period following the May 30 election date.

Flexible Spending Account Contributions

You must contribute to the Flexible Spending Accounts in order to participate. You pay the full cost of the accounts through regular payroll deductions from your Base Pay:

- **Health Care FSA.** You may contribute an annual amount between $120 and $3,050 or such other amount as provided by Organon to your Health Care FSA provided under the Plan.. Note that your coverage under a general-purpose health care FSA will make you and your spouse ineligible to contribute to an HSA.
- **Dependent Care FSA.** You may contribute an annual amount between $120 and $5,000. Please note that if you are married and you and your Spouse/Tax-Qualified Domestic Partner file separate income tax returns, the maximum you may contribute to the Dependent Care FSA is $2,500. Also, if you and your Spouse/Tax-Qualified Domestic Partner each contribute to a Dependent Care FSAs, the maximum you and your Spouse/Tax- Qualified Domestic Partner may contribute together is $5,000. Please remember, the Plan Administrator does not monitor these limits. So, for example, if you and your Spouse/Tax-Qualified Domestic Partner both elect and receive more than the applicable limit, you (and your Spouse/Tax-Qualified Domestic Partner) will pay income taxes on the excess at the time you file your tax return.

See “Special Guidelines” in the “How the Dependent Care FSA Works” section of this SPD for additional information.

Before-Tax Contributions

Your contributions toward the cost of FSA participation are deducted from your Base Pay on a Before-Tax basis. This means your contributions come out of your Base Pay before federal income and Social Security taxes are deducted. Before-Tax contributions save you money by reducing your gross salary, which lowers your taxable income and, therefore, the amount of income tax you must pay. Treatment of your contributions for state income tax purposes will vary by state.

Please note that paying for your FSA participation on a Before-Tax basis could slightly reduce your future Social Security benefits since the earnings used to calculate your Social Security benefits at retirement will not include these payments.

If You Take an Approved Paid Leave of Absence

If you take an approved paid leave of absence, the Plan Administrator will continue to deduct your portion of the cost of Health Care FSA and Dependent Care FSA participation through payroll deductions. Deductions will be on a Before-Tax basis. Dependent Care Expenses incurred during a paid leave of absence, however, are not reimbursable from the Dependent Care FSA. Only Dependent Care Expenses incurred before the leave and after you return to active service will be reimbursable from the Dependent Care FSA.

Making Changes to Your Flexible Spending Account Participation

Annual Enrollment

Each year during annual enrollment, you may elect to participate in the Flexible Spending Accounts. Generally, the benefit elections you make will remain in effect for the entire Plan Year (Jan. 1 – Dec. 31) unless you experience a Life Event that allows you to make a Permitted Plan Change.

Changes made during the annual enrollment period are effective Jan. 1 of the following year. If you do not make a Flexible Spending Account election during annual enrollment, you will not participate in Flexible Spending Accounts for the new Plan Year. You must re-enroll every year to participate in Flexible Spending Accounts.

Each year, you will be notified of the annual enrollment procedures, participation limits and time frames for enrolling in your elections for the upcoming Plan Year. Since the Plan Sponsor may make changes to the Flexible Spending Accounts at any time, it is important to review your annual enrollment materials carefully when you receive them. You may access annual enrollment materials, obtain contact information, review plan design changes and confirm most benefits on **www.netbenefits.com** or by calling the Benefits Service Center at **800-767-3353**.

Between annual enrollment periods, you may change or enroll in (if you had waived participation) Flexible Spending Accounts only if you experience a Life Event, including a HIPAA special enrollment event for the Health Care FSA, that allows you to make a Permitted Plan Change. See “When Life Changes” for more information.

When Life Changes

Life Events and Permitted Plan Changes

During the year you may be eligible to make certain changes to your Flexible Spending Account participation if you experience a Life Event that allows you to make Permitted Plan Changes. Any requested change to your coverage due to a Life Event generally must be due to an event that affects eligibility for coverage and must be consistent with the Life Event.

In general, Life Events may include:

- A change in your employment status, including termination or commencement of employment or a change in work status (such as a switch from full-time to part-time hours)
- A change in your legal marital status, including marriage, divorce, legal separation/annulment (in states where legal separation equals divorce) or death of a Spouse/Tax-Qualified Domestic Partner
- A change in the number of your Eligible Dependents, including through birth, death, adoption or placement for adoption or foster care, or
- A change that causes your dependent to either satisfy or not satisfy the requirements to be an Eligible Dependent in the Flexible Spending Accounts.

For partial years (e.g., years where a Life Event allows you to make a Permitted Plan Change mid-year), participation will start on the date of the event and deductions will start as of the first payroll period following the date you request enrollment through the Benefits Service Center. For example, if you get married on July 2 and you contact the Benefits Service Center to request enrollment in the Health Care FSA on July 15, you will be allowed to receive payment for eligible Health Care Expenses incurred on or after July 2. The deductions for this election will begin as of the first payroll period following the July 15 enrollment date.

Special Considerations for Dependent Care FSAs

For Dependent Care FSAs, Life Events may also include changes to certain benefits resulting from other events, such as:

- Your Eligible Dependent day care expenses increase or decrease,
- Your day care provider changes, or
- Your Eligible Dependent reaches age 13 (and is no longer an Eligible Dependent for the Dependent Care FSA). Please note that in this case you are allowed only to reduce or stop your contributions to the Dependent Care FSA.

KEY POINT — PERMITTED PLAN CHANGES MUST BE MADE WITHIN 30 DAYS AFTER THE EVENT

If you have a Life Event that allows you to make a Permitted Plan Change, you must request your change through the Benefits Service Center within 30 days after the event. See “How to Make a Permitted Plan Change.”

Keep in mind that mid-year Dependent Care FSA contribution changes are subject to all of the following restrictions:

- You must adjust your contribution by at least $40 per month or $280 per year.
- A change in expenses for care provided by a relative does not qualify for a mid-year contribution adjustment.

How to Make a Permitted Plan Change

If you have a Life Event that allows you to make a Permitted Plan Change, you must request your change within 30 days after the event by contacting the Benefits Service Center online or by phone. Any requested change to your participation must be consistent with the Life Event. If you do not make your request within 30 days you will have to wait until the next annual enrollment period, for coverage effective the following Jan. 1, to change your Flexible Spending Account participation.

When Permitted Plan Changes Go into Effect

If you experience a Life Event that permits you to change your Flexible Spending Account participation during the year, the effective date for the change will generally be the date of the event. See “How to Make a Permitted Plan Change” above. Any changes to your contribution amount will take effect as of the first payroll period following the date of notification.

If you fail to notify the Benefits Service Center within 30 days after a Life Event, you will not be permitted to make a change until the next annual enrollment period, for coverage effective the following Jan. 1.

If You Take an Approved Unpaid Leave of Absence

If you take an approved unpaid leave of absence, the Health Care FSA and Dependent Care FSA are treated differently:

- For Health Care FSAs, you are not permitted to cancel your Health Care FSA coverage during the leave. Your Employer will pay your Health Care FSA contributions during the unpaid leave. Upon your return to work at the expiration of a leave, you will be required to repay your Employer for contributions paid on your behalf by your Employer from your initial paychecks on a Before-Tax basis. You will be entitled to seek reimbursement from your Health Care FSA of eligible Health Care Expenses incurred during the unpaid leave of absence. No changes to your elections are permitted as a result of return from leave to active status.
- For Dependent Care FSAs, your participation ends during your unpaid leave. You are not entitled to seek reimbursement of Dependent Care Expenses incurred during the leave of absence. You can continue to submit Eligible Expenses incurred during the calendar year before and after the leave of absence. If you want to re-enroll in your Dependent Care FSA upon your return from leave, you have 30 days from the date of your return to make an election to enroll in the Dependent Care FSA. If you do not enroll in the Dependent Care FSA within this 30-day period, you will have no coverage in the Dependent Care FSA for the remainder of the calendar year, but expenses incurred prior to the leave will still be reimbursable.

If You Receive LTD Benefits

- If you receive LTD Benefits, your eligibility to participate in and make contributions to the Health Care FSA and/or Dependent Care FSA end on the date you begin receiving LTD Benefits.
- You may be eligible to continue your participation and contributions under the Health Care FSA through COBRA. See “COBRA” in the “Health Care FSA” section of this SPD.
- For both accounts, you may submit claims for Eligible Expenses incurred during the calendar year in which your LTD Benefits began while you were a participant in the accounts (that is, for the period of the calendar year prior to your LTD commencement unless you are eligible for and elect COBRA).

If You Terminate Employment

If you terminate employment, the Health Care FSA and Dependent Care FSA are treated differently:

- For Health Care FSAs, participation and your contributions end on the date you terminate employment. You may be eligible to continue your participation and contributions under the Health Care FSA through COBRA. See “COBRA” in the “Health Care FSA” section of this SPD.
- For Dependent Care FSAs, your participation and your contributions end on the date you terminate

employment. You may, however, continue to submit eligible Dependent Care Expenses incurred through the end of the Plan Year, up to the amount you contributed to your Dependent Care FSA, as long as the Dependent Care Expenses were incurred to enable you and your Spouse/Tax-Qualified Domestic Partner, if applicable, to have gainful employment, search for employment or to be a full-time student.

When Flexible Spending Accounts Participation Ends

Your participation in and your contributions to the Flexible Spending Accounts end on the earliest of:

- The date your employment terminates, including your retirement date
- The date you begin receiving LTD Benefits, unless you are eligible to participate under COBRA benefits. See "COBRA" section for more information.
- The date you are no longer eligible to participate, or
- The date the Flexible Spending Accounts are terminated by the Plan Sponsor.

HOW THE HEALTH CARE FSA WORKS

HEALTH CARE FSA

This section provides important information about your Health Care FSA, including participation, contributions, Eligible Expenses and your rights as a Health Care FSA participant.

About Health Care FSA Participation

The Health Care FSA offers you a convenient, tax-free way to pay for eligible Health Care Expenses. You authorize your Employer to redirect a portion of your salary — before federal income, Social Security and most state taxes are taken out — to your Health Care FSA. Then, when you or an Eligible Dependent has an Eligible Expense, you can be reimbursed from your Health Care FSA.

For purposes of the Health Care FSA, Eligible Dependents are only those individuals who are considered your dependents for federal income tax purposes, which generally include:

- Your Spouse/Tax-Qualified Domestic Partner, and
- Anyone else considered your dependent for income tax purposes. This means, for example, that if you have a parent who lives with you and depends on you for financial support, the parent's Health Care Expenses may be eligible for payment through the Health Care FSA.

In addition, your biological and adopted children, children placed with you for adoption, stepchildren and foster children are Eligible Dependents through the end of the year in which they attain age 26 regardless of whether the child is married, resides with you or is financially dependent on you.

KEY POINT — DOMESTIC PARTNERS ARE GENERALLY NOT ELIGIBLE DEPENDENTS

In general, federal law requires that Health Care FSAs limit payment of expenses to those expenses that are associated with dependents you claim as exemptions on your federal income taxes. If, however, your Domestic Partner is considered your dependent for federal income tax purposes, your Domestic Partner is an Eligible Dependent.

See the definition of "Eligible Dependents" for more information.

The Health Care FSA is administered by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBS).

Health Care FSA at a Glance

The chart below summarizes the Health Care FSA. See "Eligible Health Care Expenses" and "Ineligible Health Care Expenses" for more information.

Account	Coverage	Contributions
Health Care FSA	Payment for eligible Health Care Expenses such as certain out-of-pocket medical, prescription drugs, over-the-counter medications prescribed by a physician, dental and vision expenses not covered by any other plan for you and your Eligible Dependents.	Annual Minimum: $120 Annual Maximum for 2023:- $3,050

How Much You May Contribute

Generally, you may contribute an annual basis an amount between $120 and $3,050 or such other amount as provided by Organon.

For 2023, you may roll over up to $610 of your contributions from one Plan Year to the next. Any money you contribute in excess of $610 that is not used by the end of the year will be forfeited. If you are hired (or become eligible) during the year, you should estimate your expenses from the date your participation begins until the end of the year.

KEY POINT — "USE IT OR LOSE IT" IN THE HEALTH CARE FSA

To encourage more people to use **health care** FSAs, the IRS gave Plan Sponsors a choice of two options to modify the "use it or lose it" rule. Some companies chose a "grace period" that gives people more time to incur and claim Eligible Expenses.

Organon chose the "rollover" option. This choice allows you for 2023 to carry over up to $610 of your unused Health Care FSA balances remaining at the end of the Plan Year so you can use the rolled over amounts to reimburse expenses incurred in the following Plan Year. The rollover amount can be used to pay for any Eligible Expenses incurred beginning Jan. 1 of that year. Only amounts over the $610 carryover are forfeited under the "use it or lose it" rule.

The Health Care FSA requires that to be eligible for payment, services must be rendered while you are a participant in the Health Care FSA *and* by Dec. 31 each calendar year.

Plan carefully, because you cannot change the amount of your contribution to the Health Care FSA during the year except in limited circumstances as determined by the Plan Administrator in accordance with IRS guidelines. With careful planning, you should never lose any money in your account.

How the Health Care FSA Works

Your Health Care FSA works like a checking account. You decide how much money to contribute on an annual basis and make contributions through payroll deductions. When you have an Eligible Expense, you have two choices to access money in your account:

- You may use your Horizon MyWay FSA Prepaid VISA® Card ("Horizon FSA Card") to pay for Eligible Expenses, or
- You may seek payment by filing a timely paper claim for reimbursement. See "Filing a Claim" for details.

Payment may be made for an amount up to the total amount you elect when you enroll, regardless of the amount you have contributed at the time of your claim. For example, if your annual contribution is $1,000 but only $200 has been deposited into your account, you can still be reimbursed up to $1,000.

Payments you receive from your account when your claims are processed are not subject to income taxes. Expenses incurred before the date your elections under the Health Care FSA become effective are not eligible for reimbursement.

KEY POINT — USING THE HORIZON MYWAY FSA PREPAID VISA® CARD FOR HEALTH CARE FSAS

If you enroll in the Health Care FSA, you will automatically receive the Horizon FSA Card, known as the Horizon MyWay FSA Prepaid VISA® Card. If you incur eligible Health Care Expenses, and your share of the cost is known at the time of the service, present the card to the provider at that time and the provider will then charge the card as a credit purchase. The amount of the qualified purchase will be deducted from your Health Care FSA balance. If your portion of the cost of the service is not known at the time of service, wait for your provider to bill you for your portion of the cost and then either provide your FSA card number as a credit card number, or pay your portion of the cost and submit the bill and receipt to Horizon BCBS using a paper claim form. **Please be sure to keep your receipts in case you need to substantiate your purchases. For more information, see "Substantiation."**

Important Note: You can only use your debit card for services incurred during the current Plan Year. For claims incurred in the prior Plan Year, you can continue to submit them online, by fax or mail them up to April 15 of the current Plan Year.

KEY POINT — EXPENSES ARE INCURRED WHEN SERVICES ARE PROVIDED, NOT WHEN YOU PAY

Expenses are generally incurred when services are provided, not when you pay. Certain payments for orthodontia are an exception to this rule. If you are required to make advanced payments in order to receive services, and you actually make these payments, the advanced payments are eligible for reimbursement.

FSA Rollover

For 2023, the Organon FSA Plan allows up to a $610 rollover that is administered according to IRS rules. Up to $610 is available to you on Jan. 1 of the new Plan Year. You still have until April 15 of the following Plan Year to submit any Eligible Expenses incurred during the prior Plan Year and while you were a participant in the Plan. On April 16 of the following Plan Year, any unused amount in your account attributable to the prior Plan Year in excess of $610 will be forfeited.

How It Works

For example: You elected a $2,000 Health Care FSA for Plan Year 2023 and during annual enrollment, elect only $1,000 for Plan Year 2024. On Jan. 1, 2024, you have $300 of unused funds remaining in your 2023 account.

- Since you elected to participate in the Health Care FSA for 2024, the $300 of unused funds would then be rolled over and added to your existing 2024 account. As a result, for Plan Year 2024, you would have a total of $1,300 to use for Eligible Expenses incurred during 2024.

In the same example above, during annual enrollment, you instead elect not to participate in the Health Care FSA for 2024.

- On Jan. 1, 2024, because you had $300 of unused funds from your 2023 account, a 2024 Health Care FSA would be created for you with an annual amount of $300, which would be available to you to use for Eligible Expenses incurred during 2024. It's important to note, that even if you do not elect a Health Care FSA during annual enrollment for the following Plan Year, if you have any rollover funds available to you, Horizon BCBS will establish an account for you.

Lastly, let's say during annual enrollment, you elect the maximum annual amount of $3,050 for 2024.

- As in the first example, the $300 of unused funds would be rolled over and added to your existing 2024 account. Even though you had elected the Plan maximum of $3,050 for 2023, because you had rollover funds available to you, for 2024 you would now have a total of $3,350 to use for Eligible Expenses incurred during 2024.

Any rollover funds that become available to you on Jan. 1 of the following Plan Year will be reflected on the Horizon BCBS website and also will be loaded and available on your Horizon MyWay FSA Prepaid VISA® Card.

KEY POINT — COBRA PARTICIPANTS AND THE ROLLOVER

You must be a participant of the Plan as of Dec. 31 of the prior Plan Year in order to be eligible for the rollover provision. If your employment ended in the prior Plan Year, in order to be eligible for the rollover provision, you must elect to continue your participation under COBRA and have made all timely payments through Dec. 31.

The Tax-Free Advantage

You pay the full amount of your contribution to the Health Care FSA. The advantage is that you fund your Health Care FSA with Before-Tax dollars. Your contributions are deducted from your pay before any federal income taxes, Social Security taxes and, in most cases, state and local income taxes are applied. This lowers your taxable income and lowers the amount of income tax you pay. You also do not pay taxes when you withdraw your money from your account.

Please note that you will not be paying Social Security taxes on your contribution to the Health Care FSA. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these payments. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the Health Care FSA will normally be greater than any eventual reduction in Social Security benefits.

The tax advantage you will receive from the Health Care FSA will depend on your tax bracket. Another way of looking at the tax advantage is to consider how much you would have to earn to pay the same expenses using after-tax dollars compared to Before-Tax dollars.

KEY POINT — TAX ADVANTAGE MAY VARY

The tax advantage you will receive from the Health Care FSA will depend on your tax bracket.

An Example of How the Health Care FSA Can Save You Tax Dollars

Let us assume the following:

- You are single
- Your annual income is $50,000 a year, and
- You spend $2,000 on eligible out-of-pocket Health Care Expenses that are not reimbursed by your Medical Plan, Dental Plan, Vision Plan or another plan (e.g., dental work beyond what is covered by your Dental Plan option).

By contributing $2,000 for the year to the Health Care FSA on a Before-Tax basis, you lower your taxable income. Because your taxable income would be $48,000 instead of $50,000, you pay less in current income taxes. Based on the assumptions listed above, you could save roughly $393 each year by using a Health Care FSA.

Tax Comparison	With the Health Care FSA	Without the Health Care FSA
Your annual pay	$50,000	$50,000
Annual Before-Tax payments	- $2,000	- $0
Taxable income	$48,000	$50,000
Estimated federal income tax[1]	- $4,102	- $4,342
Social Security and Medicare tax	- $3,672	- $3,825
Take-home pay	$40,226	$41,833
After-tax health care	- $0	- $2,000
Net pay you can spend	$40,226	$39,833
Tax savings	**$393**	**$0**

Eligible Health Care Expenses

The IRS strictly defines the expenses that can and cannot be reimbursed through the Health Care FSA. Generally, any Health Care Expenses that would qualify as a deduction on your federal income tax return (except for premiums for health care coverage and long-term care services) qualify as Eligible Expenses under the Health Care FSA, provided they are not reimbursed through a health care plan.

For more information on Eligible Expenses, refer *to IRS Publication 502: Medical and Dental Expenses*, which is available online at **www.irs.gov/publications/p502/index.html**. While certain sections of the publication do not apply for purposes of the Health Care FSA, you may find the section entitled "What Medical Expenses Are Deductible" helpful in that it contains information on expenses that are deductible on your federal tax return and that may be Eligible Expenses for the Health Care FSA.

KEY POINT — OVER-THE-COUNTER DRUGS

A doctor's prescription is not required in order to use Health Care FSA funds for qualified over the counter (OTC) drugs. For a listing of Eligible Expenses, contact Horizon BCBS at **www.horizonblue.com/OrganonFSA** or call **800-544-1112**.

The following is a list of some common expenses that can be reimbursed through the Health Care FSA:

- Coinsurance and Copays
- Prescription drug Copays
- Prescription sunglasses
- Crutches
- Annual physical
- Deductible amounts
- Dental expenses
- Doctors' charges

[1] This example is based on 2019 federal income tax rates for a single employee claiming one personal exemption and the standard deduction. It is only an estimate and excludes state and local taxes. Your total tax savings will depend on your family income, your actual tax bracket and how much you contribute to the Health Care FSA.

- Eyeglasses, frames and contact lenses
- Routine eye exams
- LASIK surgery
- Feminine hygiene products
- Hearing aids and other related expenses
- Hospital bills
- Laboratory fees
- Licensed practical nurses
- Smoking cessation programs and related prescription drugs
- Physicals
- Wheelchairs
- X-rays, and
- Qualified non-prescription drugs used for medical care approved by Horizon BCBS. These may include aspirin, bandages and cold medicines, etc.

KEY POINT — HEALTH CARE AND DEPENDENT CARE FSAS ARE SEPARATE

The Health Care FSA can be used to pay for eligible Health Care Expenses incurred by you and your Eligible Dependents. The Dependent Care FSA can be used to pay for Eligible Expenses **such as day care costs incurred for the care of your Eligible Dependents**. You cannot use the Dependent Care FSA to pay for your dependent's health care expenses.

You cannot use money from one account to cover expenses from the other account. If you accidentally contribute to the wrong account, in general federal law prohibits the transfer of monies from one account to the other.

Ineligible Health Care Expenses

The following is a list of some of the more common expenses that cannot be reimbursed from the Health Care FSA.

- Cosmetic surgery procedures (unless necessary to eliminate a deformity related to a birth defect, a personal injury resulting from an accident or trauma, or a disfiguring disease)
- Cosmetic dentistry
- Dermatologists, doctor's charges or prescription drugs for cosmetic surgery
- Expenses for recreation, health clubs and nutrition
- Weight reduction programs (unless prescribed by a physician to treat a specific medical condition)
- Qualified long-term care services
- Illegal operations or treatments
- Nursing care for a normal, healthy baby
- Over-the-counter vitamins, supplements, cosmetic products or bottled water
- Premiums paid for contact lens insurance
- Premiums paid for health, dental or long-term care insurance

- Expenses reimbursed from other sources
- Expenses claimed as itemized deductions on your federal tax return, and
- Expenses you incur while you are not a participant in the Health Care FSA.

Account Statements

Health Care FSA statements are available online at **www.horizonblue.com/OrganonFSA**. The statement will show your account balance as of the statement date and your total contributions and payments as of that date. In addition, you may call a Horizon BCBS Representative to verify your account balance.

How to File a Claim

KEY POINT — CLAIMS CAN BE FILED UNTIL APRIL 15 OF THE FOLLOWING PLAN YEAR

You have until April 15 of the year following the Plan Year in which your participation ended to submit completed claims to Horizon BCBS for Eligible Expenses incurred by Dec. 31 of the preceding Plan Year.

When you or your Eligible Dependents incur an Eligible Expense, you have a choice. You may either:

- Use your Horizon MyWay FSA Prepaid VISA® Card to pay for the Eligible Expense, or
- File a *Medical Expense Reimbursement Account Claim Form* and submit it along with a receipt or a copy of your Explanation of Benefits (EOB), if the expense is partially covered by a health care plan.

You can only be reimbursed for Eligible Expenses you incur between Jan. 1 and Dec. 31 of each Plan Year while you participate in the Health Care FSA. However, you can submit a claim for an expense you incur during this period until the following April 15. For example, if you have an expense in July 2023, you have until April 15, 2024, to file a claim for payment. Your claim must be received by the Claims Administrator no later than April 15 to be reimbursed. If you submit a claim electronically or by fax, it is your responsibility to have a time and date stamp confirmation. **Important Note: If the Claims Administrator does not receive a mailed claim by April 15, proof must be provided that the claim was postmarked by April 15.**

You may roll over up to $610 of your contributions from one Plan Year to the next. The IRS requires any unused amounts in excess of $610 that you contribute to be forfeited at the end of the year. Amounts forfeited may be used by the Plan Sponsor to pay Plan administration expenses.

Online Services

Horizon BCBS offers you online access to your Health Care FSA at **www.horizonblue.com/OrganonFSA**. You will be required to register for a user ID and password so that you can securely view your account balance, claims and payment history, as well as file FSA claims online.

You can also access your Health Care FSA using the Horizon Blue app. To download the app, search for Horizon Blue in the App Store® or Google Play™ or text **GetApp** to **422-272** to get a download link. Access your account(s) through the app by signing in and clicking “My Accounts – Out of pocket & spending accounts” and then “Horizon MyWay.”

Filing a Claim

For the Health Care FSA, you may either (i) use the Horizon MyWay FSA Prepaid VISA® Card at the point of sale/service; (ii) provide your Horizon MyWay FSA Prepaid VISA® Card number to your provider when you receive your bill for service or (iii) you may file a paper claim form to request payment from Horizon BCBS.

Using the Horizon MyWay FSA Prepaid VISA® Card at the Point of Service

The Horizon MyWay FSA Prepaid VISA® Card provides employees who enroll in a Health Care FSA with added convenience. You may use the card for office visits with doctors, dentists and vision care specialists, ***but only when your portion of the cost of coverage is known***, such as for a vision care provider's office visit Copay. You may also use the card for payment of Eligible Expenses at a pharmacy when you purchase health care items that qualify as Eligible Expenses.

Similar to a debit card, you simply present the Horizon MyWay FSA Prepaid VISA® Card to the provider or merchant at the point of sale or service. The amount of the qualified expense will be deducted automatically from your benefits account(s), and the Before-Tax dollars will be electronically transferred to the provider/merchant for immediate payment. When you have used up your account balance, the card will decline for insufficient funds.

Substantiation

When you use your Horizon MyWay FSA Prepaid VISA® Card, it's important that you keep copies of your receipts. Due to IRS requirements, you may be asked to prove (or substantiate) that the expenses you paid for with your Horizon MyWay FSA Prepaid VISA® Card were Eligible Expenses. Before contacting you, the Claims Administrator will try to substantiate your claims. If the Claims Administrator can't substantiate the claim, they will contact you directly asking you to provide the appropriate documentation (i.e., receipts and/or EOBs) to substantiate your claim and to certify that the expense is not being reimbursed from another source. **The documentation you provide should describe the service or product for which you are seeking reimbursement, the date the service was performed or the product was purchased, the name of the provider and the total amount of the service or product.**

Failure to comply may cancel your Horizon MyWay Prepaid VISA® Card or may result in adverse tax consequences to you.

Always Save Itemized Receipts

Employees should save their itemized receipts from every health care payment, Horizon MyWay Prepaid VISA® Card transaction and Explanation of Benefits (EOBs) they receive from health, pharmacy, dental and vision plans, etc. in order to provide documentation if they need to substantiate a claim. Typically, the Horizon MyWay Prepaid VISA® Card receipt alone will not be sufficient to substantiate the claim.

KEY POINT — KEEP YOUR RECEIPTS WHEN YOU USE YOUR HORIZON MYWAY PREPAID VISA® CARD

When you use your Horizon MyWay FSA Prepaid VISA® Card, it's important that you keep copies of your itemized receipts. Upon request, you may be asked to prove (or substantiate) that the expenses you paid for with your Horizon MyWay FSA Prepaid VISA® Card were Eligible Expenses. If you can't substantiate the expense, then your Horizon MyWay FSA Prepaid VISA® Card may be suspended and you will need to submit all subsequent claims using the paper claim form process.

Your Horizon MyWay FSA Prepaid VISA® Card Health Care FSA balance is funded as follows:

- Your account is funded on the first day of the year (or with the first paycheck as of your participation date) with the entire annual dollar amount that you chose when you elected to participate in the Health Care FSA.
- Payroll deductions are spread over the balance of the year, in equal installments.
- You may charge up to the entire balance, regardless of how many deductions have come out of your paycheck(s).

Using the Horizon MyWay FSA Prepaid VISA® Card When You Receive a Provider Bill

If your portion of the cost of the service is not known at the time of service, your provider will bill you for your portion of the cost at a later date, after it is determined what portion of the cost your health plan coverage will pay. You can then provide your Horizon MyWay FSA Prepaid VISA® Card number as a credit card number to pay for your portion of the cost.

The amount of the qualified expense will be deducted automatically from your benefits account(s), and the Before-Tax dollars will be electronically transferred to the provider/merchant for immediate payment. When you have used up your account balance, the card will decline for insufficient funds.

Filing a Paper Claim Form

To file a claim you will need to submit a completed claim form, with receipts, to Horizon BCBS.

You may obtain claim forms from Horizon BCBS or through the Benefits Service Center (**www.netbenefits.com**) or through Hera > HR.

Completed claim forms should be sent to the following email, mailing address or fax number:

Horizon BCBS FSA
P.O. Box 14836
Lexington, KY 40511

Fax: **866-231-0214**

Email: **HorizonMyWay.Documents@HelloFurther.com**

Alternatively, you may submit claims online by visiting **www.horizonblue.com/OrganonFSA**. Simply enter the data on the website as if you were completing a paper claim form. For Health Care FSA claims online, you will also need to submit the backup documentation of Eligible Expenses, such as itemized receipts, to Horizon BCBS via U.S. Mail, fax or email. Detailed instructions are provided online.

KEY POINT — FILING CLAIMS WITH AN EXPLANATION OF BENEFITS (EOB)

Many times you will not know your share of the cost of an Eligible Expense until sometime after you incur it — such as the cost of an inpatient hospital stay. You must wait until you receive an Explanation of Benefits (EOB) statement from your health plan before you file a claim for those expenses. The EOB shows you the amount you are responsible to pay. Be sure that amount matches the amount you are billed by the provider for that service.

If you pay that expense to the provider using your own funds, you should provide the EOB with your paper claim form as evidence of your Eligible Expense. Or you may pay the provider using your Horizon MyWay FSA Prepaid VISA® card and keep the EOB as your receipt.

Claims Processing

With the Health Care FSA, you can be reimbursed for Eligible Expenses up to the total amount of your elected annual contribution, minus any prior payment you may have received, regardless of how much you have actually contributed to your account. You do not have to wait until enough money has accumulated in your account to pay for Eligible Expenses.

Payment checks from the Health Care FSA are issued daily.

Payments

If a manual claim has been submitted, checks are payable to you and mailed to your home address. Between January 1 and April 15 of the following year (otherwise known as the run-out period), you can be reimbursed for a claim of any amount, provided the claim was incurred during the prior Plan Year and while you were a participant in the Health Care FSA. Claims for the prior Plan Year that are not postmarked or faxed by April 15 will not be processed.

You may establish direct deposit of your spending account reimbursements, by completing the *Authorization for Direct Deposit* form and submitting the completed form to Horizon BCBS. This authorizes your spending account payment to be made electronically rather than by check. You may obtain the *Authorization for Direct Deposit* form from Horizon BCBS or through the Benefits Service Center website (**www.netbenefits.com**).

Claims and Appeals

If you, your beneficiary or your authorized representative feel that the Claims Administrator has made an error concerning your benefits, you, your beneficiary or your authorized representative have the right to request reconsideration under the Plan in accordance with the following procedure. Please note that all requests for reconsideration shall be submitted in writing to the Claims Administrator. See “Contact Information for Written Appeals” for address information.

Initial Claim

The Claims Administrator is responsible for evaluating all benefit claims. The Claims Administrator will review your claim in accordance with its standard claims procedures, as required by ERISA. The Claims Administrator has the right to secure independent medical advice and to require other evidence as it deems necessary in order to decide the status of your claim. The Claims Administrator has up to 30 days to evaluate and respond to claims for benefits. The 30-day period begins on the date the claim is first filed. This 30-day period may be extended by 15 days, in certain circumstances.

Please note, in general all Health Care FSA claims submitted under the Plan are considered post-service claims. If you believe your Health Care FSA claim should be treated as a pre-service, urgent or concurrent care claim, please contact the Plan Administrator.

If Your Claim Is Denied

If the Claims Administrator does not fully agree with your claim, you will receive an “adverse benefit determination,” which is a denial, reduction or termination of a benefit. You will receive notice of a denial, which will include:

- The specific reasons for the denial
- The specific Plan provisions on which the denial is based
- If any internal rule, guideline, protocol or similar criterion was relied upon as a basis for the denial, either the specific rule, guideline, protocol or criterion, or a statement that a copy of such information will be made available free of charge to you upon request
- A description of any additional information required to reconsider the claim and an explanation of why this information is needed
- An explanation of how to appeal for reconsideration of the Claims Administrator’s decision
- For a denial based on medical necessity, experimental treatment or similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided upon request and free of charge, and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following a denial on appeal.

Appealing a Claim

If your claim for benefits is denied, in whole or in part, you or your authorized representative may appeal the denial within 180 days of the receipt of the written or electronic notice of denial. If you choose to appeal your claim, your appeal should be in writing and should explain why you believe the claim should be paid. See “Contact Information for Written Appeals.”

Upon your request, you will have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge. You may submit with your appeal any written comments, documents, records and any other information relating to your claim, even if you didn’t include that information with your original claim. See “Contact Information for Written Appeals.” Reviewers must take all the information into account, even if it was not submitted or considered in the initial decision. The review will not afford any deference to the initial claim determination.

A qualified individual who was not involved in the previous claim determination (and is not that person’s subordinate) will decide your appeal. If your appeal involves a medical judgment — including whether a treatment, drug or other item

is experimental, investigational or not medically necessary or appropriate — the review will be done in consultation with a health care professional who has appropriate training and experience in the relevant field of medicine involved in the medical judgment, who was not consulted in connection with the previous adverse claim determination and who is not that person's subordinate.

After receiving your appeal, the Claims Administrator will provide notice of its decision within 60 days following receipt of your appeal.

You will receive written notification of the determination of your appeal. If the claim on appeal is denied in whole or in part, the notice will include:

- The specific reasons for the denial
- The specific Plan provisions on which the denial is based
- A description of any additional information required to reconsider the claim and an explanation of why this information is needed
- If any internal rule, guideline, protocol or similar criterion was relied upon as a basis for the denial, either the specific rule, guideline, protocol or criterion, or a statement that a copy of such information will be made available free of charge to you upon request
- For such denial based on medical necessity, experimental treatment or similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided upon request and free of charge
- A description of any voluntary appeals procedures, including time limits applicable to such voluntary appeals, and
- A statement of your right to bring a civil action under Section 502(a) of ERISA.

Exhaustion of Process

You must exhaust the appeals procedure before you initiate any litigation, arbitration or administrative proceeding regarding the denial of your appeal or any matter within the scope of the appeals procedure.

Claims and Appeals for Eligibility to Participate in the Health Care FSA

If you, your beneficiary or your authorized representative feel that an error has been made concerning your eligibility to participate in the Plan, you, your beneficiary or your authorized representative may request reconsideration under the Plan. All requests for reconsideration shall be submitted in writing to the Plan Administrator at the following address:

Organon LLC
Attn: Plan Administrator (GSA-HTR)
c/o Organon Benefits Service Center at Fidelity
P.O. Box 770003
Cincinnati, OH 45277-0065

Express mail address:

Organon LLC
Attn: Plan Administrator (GSA-HTR)
c/o Organon Benefits Service Center at Fidelity
Mail Zone KC1F-L
100 Crosby Parkway
Covington, KY 41015

The Plan Administrator will review your claim and respond to you with a determination. The decision of the Plan Administrator is final and binding.

Contact Information for Written Appeals

The following chart lists the appeals addresses for benefits and/or eligibility.

If a Claim Is Denied	Send Your Written Appeal to the Claims Administrator at this Address
Benefit Appeals	
Health Care FSA	Claims Administrator for the Flexible Spending Accounts: Horizon BCBSNJ FSA P.O. Box 14836 Lexington, KY 40511
Eligibility Appeals	
Health Care FSA	Plan Administrator for the Flexible Spending Accounts: Organon LLC Attn: Plan Administrator (GSA-HTR) c/o Organon Benefits Service Center at Fidelity P.O. Box 770003 Cincinnati, OH 45277-0065 Express mail address: Organon LLC Attn: Plan Administrator (GSA-HTR) c/o Organon Benefits Service Center at Fidelity Mail Zone KC1F-L 100 Crosby Parkway Covington, KY 41015

COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires that most employers sponsoring group health plans offer employees and their Eligible Dependents the opportunity for a temporary extension of health coverage (called COBRA coverage) at group rates in certain instances where coverage under the Plan would otherwise end (qualifying events). The following information is intended to inform you of your rights and obligations under COBRA. You do not have to show that you are insurable to choose COBRA coverage. However, you will have to pay the entire premium for your COBRA coverage plus a 2% administrative fee. There is a 30-day grace period for the payment of the regularly scheduled premium (other than the initial premium, which must be paid by its due date). Notwithstanding anything contained in this SPD to the contrary, COBRA coverage is provided under the Health Care FSA only to the extent required by federal law.

KEY POINT — MEDICAL COVERAGE OPTION UNDER COBRA

When you lose group health coverage, you may have other options available to you for **medical coverage** — *but not dental, vision or health care FSA coverage* — through the Health Insurance Marketplace. By enrolling in **medical coverage** through the Marketplace, you may qualify for lower costs on your monthly **medical coverage** premiums and lower out-of-pocket costs for medical care. 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?

Specific qualifying events are listed below. After a qualifying event occurs and any required notice of that event is properly provided to the Plan, COBRA coverage must be offered to each person losing plan coverage who is a "Qualified Beneficiary." You, your Spouse and your Dependent children could become Qualified Beneficiaries and would be entitled to elect COBRA coverage if coverage under the Health Care FSA is lost because of the qualifying event. (Certain newborns, newly adopted children and alternate recipients under QMCSOs may also be Qualified Beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Health Care FSA, Qualified Beneficiaries who elect COBRA coverage must pay for that coverage with after-tax dollars. COBRA coverage for the Health Care Flexible Spending Account if elected, will consist of the Health Care Flexible Spending Account coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-or-lose rule will continue to apply. All qualified beneficiaries who were covered under the Health Care Flexible Spending Account will be covered together for Health Care Flexible Spending Account COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary.

Who May Elect COBRA Coverage

If you are an Eligible Employee of the Company covered by the Health Care FSA, you are a Qualified Beneficiary and have a right to choose COBRA coverage if you lose your coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). An employment termination or reduction in hours that results in the loss of coverage under the Health Care FSA is a qualifying event under COBRA.

If you are the Spouse of an Eligible Employee of the Company covered by the Health Care FSA, you are a Qualified Beneficiary and have a right to choose COBRA coverage if you lose your coverage because of (i) a reduction in the hours of employment of the Eligible Employee or the termination of the Eligible Employee's employment (for reasons other than gross misconduct), (ii) divorce or legal separation or (iii) the death of the employee. Any of the foregoing events that result in a loss of coverage for the Spouse under the Health Care FSA is a qualifying event under COBRA.

If you are the dependent child of an Eligible Employee of the Company covered by the Health Care FSA, you are a Qualified Beneficiary and have a right to choose COBRA coverage if you lose your coverage because of (i) a reduction in the hours of employment of the Eligible Employee or the termination of the Eligible Employee's employment (for reasons other than gross misconduct), (ii) divorce or legal separation, (iii) death of the employee or (iv) you cease to qualify as a dependent. Any of the foregoing events that result in a loss of coverage for the dependent under the Health Care FSA is a qualifying event under COBRA.

If you have taken a leave of absence under the Family and Medical Leave Act (FMLA) and you do not return to work at the end of your FMLA leave, you, your Spouse or your dependent may elect COBRA coverage. In this situation, the qualifying event will occur on the last day of your FMLA leave, which is the earliest of:

- When you unequivocally inform your Employer that you are not returning at the end of the leave
- The end of the leave, assuming you do not return, and
- When the FMLA entitlement ends.

For purposes of an FMLA leave, you, your Spouse or your dependent will be eligible for COBRA, as described earlier, only if:

- You, your Spouse or your dependent are covered by the Health Care FSA on the day before your leave ends
- You do not return to employment at the end of the FMLA leave, and
- You, your Spouse or your dependent lose coverage under the Health Care FSA before the end of what would be the maximum COBRA continuation period.

If you are illegally denied Health Care FSA coverage, you may elect COBRA coverage after what would have been a qualifying event.

If you, your Spouse or your dependent lose coverage in anticipation of a qualifying event described earlier, then you are a Qualified Beneficiary and may elect to receive COBRA coverage. This may occur, for example, if your Employer ends your coverage in the Health Care FSA in anticipation of your employment termination.

Note: An Employee must have a positive balance in the Health FSA account as of the time of the COBRA qualifying event. If the Employee has a negative balance, or has been reimbursed more than has been contributed in the Health FSA account as of the time of the COBRA qualifying event, the Employee is no longer eligible to elect COBRA.

Organon's Duties Under the Law

The Plan Administrator will cause the COBRA Administrator to notify Qualified Beneficiaries of the right to elect continued coverage automatically (without any action required by you) if termination of employment (for reasons other than gross misconduct) or reduction in hours results in a loss of coverage.

Your Duties Under the Law

For the other qualifying events (divorce or legal separation, death or a dependent child's losing eligibility for coverage as a dependent child) causing a loss of coverage, a COBRA election will be available only if you, your Spouse or your dependent child notifies the Health Care FSA's COBRA Administrator in writing within 60 days after the date of the qualifying event. If the notice is not provided to the Health Care FSA during the 60-day notice period, all Qualified Beneficiaries will lose their right to elect COBRA coverage.

Electing COBRA Coverage

Under the law, a Qualified Beneficiary must elect COBRA coverage within 60 days from the date the Qualified Beneficiary would lose coverage because of one of the events described earlier, or if later, 60 days after the COBRA Administrator provides the Qualified Beneficiary with notice of the right to elect COBRA coverage. A third party, such as a group health plan provider, also may elect and pay for coverage on behalf of a Qualified Beneficiary. If COBRA coverage is not elected within the time period described above, the Qualified Beneficiary will lose the right to elect COBRA coverage.

A Qualified Beneficiary may change or revoke an election to receive COBRA coverage until the election period expires. If a Qualified Beneficiary waives COBRA coverage prior to the end of the election period, the Qualified Beneficiary will be permitted to revoke the waiver and elect coverage at any time before the election period ends. In that case, COBRA coverage shall begin with the date the waiver is revoked, which will be considered the COBRA election date.

Duration of COBRA Coverage

The law requires that a Qualified Beneficiary be afforded the opportunity to purchase COBRA coverage with after-tax dollars under the Health Care FSA until the end of the calendar year in which a qualifying event occurs such as a termination of employment or reduction in hours. In no event will you be able to elect Health Care FSA participation for the year following the year in which a qualifying event occurs, even if your COBRA continuation period is still in effect for your other health care coverage(s).

KEY POINT — CARRYING OVER UP TO $610 TO THE NEXT YEAR UNDER COBRA

While you continue coverage under COBRA, if you have money left in your Health Care FSA at the end of a Plan Year, you may carry over up to $610 for 2023, or other amount as provided by Organon to be available for Eligible Expenses you incur during the next Plan Year.

However, **you must incur those expenses during the period of your COBRA continuation period (18 or 36 months from the date of the qualifying event)**. Any funds remaining in your Health Care FSA after your COBRA continuation period expires must be forfeited. No premium will be charged for the subsequent Plan Year.

Early Termination of COBRA Coverage

The law provides that a Qualified Beneficiary's COBRA coverage under the Health Care FSA may be cut short prior to the expiration of the calendar year in which a qualifying event described above occurs for any of the following reasons:

- Your Employer no longer provides a Health Care FSA to any of its employees
- The premium for COBRA coverage is not paid within 30 days of the due date; or the initial premium payment is not paid within 45 days after the initial election
- The Qualified Beneficiary becomes covered — after the date COBRA is elected — under another health care account, or
- The Qualified Beneficiary becomes entitled to Medicare after the date COBRA is elected.

COBRA coverage is provided subject to your eligibility for such coverage. Organon reserves the right to terminate your coverage retroactively in the event it is determined that you are ineligible for COBRA.

Paying for COBRA Coverage

COBRA coverage will not take effect until a Qualified Beneficiary elects COBRA and makes the required payment. A Qualified Beneficiary has an initial grace period of 45 days from the date of election, to make the first premium payment. Thereafter, payments for COBRA coverage are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If a COBRA participant pays part but not all of the premium, and the amount paid is not significantly less than the full amount due, then the COBRA Administrator may inform the COBRA participant of the amount of the underpayment and allow the COBRA participant a reasonable period of time to pay the outstanding amount due (such as 30 days).

If a COBRA participant does not make payments on a timely basis as described above, COBRA coverage will terminate as of the last day of the month for which a timely payment is made.

Your COBRA premiums may change in certain circumstances — for example, if the COBRA Administrator has been charging less than the maximum permissible amount.

COBRA Administration/Notices

If you have any questions about COBRA coverage or the application of the law, please contact the COBRA Administrator at the address listed below. Also, if you and your Spouse experience a change in marital status, or you, your Spouse or a dependent have changed addresses, or a dependent ceases to be a dependent eligible for coverage under the terms of the Plan, you must notify the COBRA Administrator in writing immediately at the address listed below. Fidelity Investments is the COBRA Administrator. If you have questions about your COBRA rights, contact the Benefits Service Center.

All notices and other communications regarding COBRA should be directed to the following address:

HealthEquity/WageWorks
P.O. Box 660212
Dallas, TX 75266-0212

Your Rights Under ERISA

As a participant in the Health Care FSA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to the following:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Health Care FSA, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration Office.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated SPD. The administrator may charge a reasonable fee for the copies.
- Receive a summary of the Plan's annual financial report, if applicable. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if applicable.

Enforcing Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. For more information, see "Claims and Appeals."

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you a fine that accrues on a daily basis (based on amounts set by the Department of Labor) from the time the materials were due to you until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in federal court after you exhaust your administrative remedies described above (for more information, see "Claims and Appeals"). In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees — for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Health Care FSA, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance of the Employee Benefits Security Administration at:

Division of Technical Assistance/Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 2022 0

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at **866-444-3272** or accessing their website at **www.dol.gov/ebsa**.

HOW THE DEPENDENT CARE FSA WORKS

DEPENDENT CARE FSA

This section provides important information about your Dependent Care FSA, including participation, contributions and Eligible Expenses.

About Dependent Care FSA Participation

The Dependent Care FSA offers you a convenient, tax-free way to pay for Eligible Dependent day care expenses. You authorize your Employer to redirect a portion of your salary — before federal income, Social Security and most state taxes are taken out — to your Dependent Care FSA. Then when you have an Eligible Expense, you simply file a claim to be reimbursed from your account.

For purposes of the Dependent Care FSA, Eligible Dependents generally include:

- Children under age 13 whom you are entitled to claim as exemptions on your federal income tax return (if you are divorced or separated) and for whom you have custody for the majority of the year, and
- Any dependent age 13 or older whom you are entitled to claim for federal income tax purposes, who is in your household at least eight hours a day, and who is physically or mentally incapable of self-care.

For Dependent Care FSAs, your participation and your contributions end on the date you begin receiving LTD Benefits.

KEY POINT — GENERALLY, DOMESTIC PARTNERS ARE NOT ELIGIBLE DEPENDENTS

In general, federal law requires that Dependent Care FSAs limit payment of expenses to those expenses that are associated with dependents you claim as exemptions on your federal income taxes.

You may want to consult a tax expert for help in determining whether expenses will qualify for reimbursement through the Dependent Care FSA.

See the definition of “Eligible Dependents” for more information.

The Dependent Care FSA is administered by Horizon BCBS.

Dependent Care FSA at a Glance

The chart below summarizes the Dependent Care FSA. See “Eligible Dependent Care Expenses” and “Ineligible Dependent Care Expenses” for a complete list of covered services and any applicable additional limitations under the Dependent Care FSA.

Account	Coverage	Contributions
Dependent Care FSA	Payment for Eligible Dependent day care expenses, such as out-of-pocket day and/or home care expenses incurred for the care of your Eligible Dependents.	Annual Minimum: $120 Annual Maximum: $5,000 See “Special Guidelines” in the “How the Dependent Care FSA Works” section of this SPD.

How Much You May Contribute

Generally, you may contribute an annual amount between $120 and $5,000.

Any money you contribute that is not used by the end of the calendar year will be forfeited. If you are hired (or become eligible) during the year, you should estimate your expenses from the date your participation begins until the end of the year.

KEY POINT — USE IT OR LOSE IT

Under the IRS “use it or lose it” rule, any money left in your Dependent Care FSA after all Eligible Expenses have been paid will be forfeited.

The Dependent Care FSA requires that to be eligible for payment, services must be rendered while you are a participant in the Dependent Care FSA and by Dec. 31 each calendar year.

Plan carefully, because you cannot change the amount of your contribution to the Dependent Care FSA during the year except in limited circumstances as determined by the Plan Administrator in accordance with IRS guidelines. With careful planning, you should never lose any money in your account.

How the Dependent Care FSA Works

Your Dependent Care FSA works like a checking account. You decide how much money to contribute on an annual basis (subject to certain limits) and make contributions through payroll deductions. After you incur your dependent day care expenses, you withdraw money to reimburse yourself for the Eligible Expenses. For more information, see “Filing a Claim.”

You can only be reimbursed up to the amount you have contributed to date. For example, if your annual contribution is $1,000 but only $200 has been deposited into your account, you can only be reimbursed up to $200. The rest of the claim will automatically be reimbursed as you continue to contribute to the account — until the expense is fully paid, or until you reach the annual amount elected.

The reimbursements you receive from your account when your claims are processed are not taxable. Expenses incurred before the date your elections under the Dependent Care FSA become effective are not eligible for reimbursement.

Special Guidelines

There are IRS guidelines that affect how much you may contribute to your Dependent Care FSA:

- The amount of your contribution cannot be greater than your income or your Spouse's/Tax-Qualified Domestic Partner's income, whichever is lower. So, if your Spouse/Tax-Qualified Domestic Partner earns less than $5,000 a year, you cannot contribute more than your Spouse's/Tax-Qualified Domestic Partner's income to the Dependent Care FSA.
- If your Spouse/Tax-Qualified Domestic Partner is a full-time student and has no income or is disabled, your Spouse/Tax-Qualified Domestic Partner is considered to have income of $200 a month for one child or $400 a month for two or more children in each month that your Spouse/Tax-Qualified Domestic Partner is a full-time student or incapable of self-care. So if your Spouse/Tax-Qualified Domestic Partner is a full-time student for the entire year, the most you can contribute to the Dependent Care FSA is $2,400 for one Eligible Dependent and $4,800 for two or more Eligible Dependents.
- If you and your Spouse/Tax-Qualified Domestic Partner both participate in a Dependent Care FSA, the most you can be reimbursed for Dependent Care Expenses from both plans combined in one year is $5,000.
- If you are married and file separate returns, the maximum you can receive from the Dependent Care FSA is $2,500.

The Plan Administrator does not monitor these limits so you and your spouse should make sure your combined contributions are within applicable limits. So, for example, if you and your Spouse/Tax-Qualified Domestic Partner both elect and receive more than the applicable limit, you (and your Spouse/Tax-Qualified Domestic Partner) will pay income taxes on the excess at the time you file your tax return.

The Tax-Free Advantage

You pay the full amount of your contribution to the Dependent Care FSA. The advantage is that you pay for your Dependent Care FSA election with Before-Tax dollars. Your contributions are deducted from your pay before any federal income taxes, Social Security taxes and, in most cases, state and local income taxes are calculated. This lowers your taxable income and lowers the amount of income tax you pay. You also do not pay taxes when you withdraw your money from your account.

Please note that you will not be paying Social Security taxes on your contribution to the Dependent Care FSA. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these payments. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the Dependent Care FSA will normally be greater than any eventual reduction in Social Security benefits.

KEY POINT — TAX ADVANTAGE MAY VARY

The tax advantage you will receive from the Dependent Care FSA will depend on your tax bracket.

An Example of How the Dependent Care FSA Can Save You Tax Dollars

Let us assume the following:

- You are single
- Your annual income is $50,000 a year, and
- You spend $4,000 on child care.

By contributing $4,000 for the year to the Dependent Care FSA on a Before-Tax basis, you lower your taxable income. Because your taxable income would be $46,000 instead of $50,000, you pay less in current income taxes. Based on the assumptions listed above, you could save roughly $786 each year by using a Dependent Care FSA.

Tax Comparison	With the Dependent Care FSA	Without the Dependent Care FSA
Your annual pay	$50,000	$50,000
Annual Before-Tax payments	- $4,000	- $0
Taxable income	$46,000	$50,000
Estimated federal income tax[1]	- $3,862	- $4,342
Social Security and Medicare tax	- $3,519	- $3,825
Take-home pay	$38,619	$41,833
After-tax dependent care	-$0	-$4,000
Net pay you can spend	$38,619	$37,833
Tax savings	**$786**	**$0**

The Federal Tax Credit

The current tax laws provide two means of saving on Dependent Care Expenses: dependent care assistance plans (such as the Dependent Care FSA) and the federal dependent care tax credit. The tax credit applies to the same expenses that are eligible for reimbursement through your Dependent Care FSA. You can take a tax credit on your federal income tax return of 20% to 35% of your eligible Dependent Care Expenses, depending on your adjusted gross income. The amount of the credit offsets your tax liability dollar for dollar. The expenses covered by the credit are limited to a maximum of $3,000 for one dependent and $6,000 for more than one dependent. The credit equals a percentage of your Dependent Care Expenses up to the maximum limit on expenses.

The percentage is determined according to a chart that's available online at **www.irs.gov/pub/irs-pdf/p503.pdf**.

Using a Dependent Care FSA reduces the tax credit available to you. Specifically, every dollar used from a Dependent Care FSA reduces the expenses you can claim under the tax credit. So, if you pay $1,400 through your Dependent Care FSA for expenses for one child, you can only apply $1,600 ($3,000 single child limit minus $1,400 used from your Dependent Care FSA) towards the tax credit.

Because you will not be able to take advantage of the tax credit for amounts reimbursed through your Dependent Care FSA, you may wish to consider which of the two methods will save you more in tax dollars. Your individual tax situation will determine which approach is better for you. You may want to consult a tax expert for help in determining whether the Dependent Care FSA is more advantageous than the tax credit, as individual circumstances must be considered. You may also refer to *IRS Publication 503: Child and Dependent Care Expenses*, available by request from the IRS.

Eligible Dependent Care Expenses

The IRS strictly defines the expenses that can and cannot be reimbursed through the Dependent Care FSA. Generally, you can use the Dependent Care FSA for the same employment-related expenses that qualify for the federal tax credit.

For more information on Dependent Care Expenses, you may want to contact the IRS to receive *IRS Publication 503: Child and Dependent Care Expenses*, which contains information on expenses that are deductible on your federal tax return and that may be Eligible Expenses for the Dependent Care FSA. You can also download the publication through the IRS website.

Here's a list of some common Dependent Care Expenses that can be reimbursed from the Dependent Care FSA:

[1] This example is based on 2019 federal income tax rates for a single employee claiming one personal exemption and the standard deduction. It is only an estimate and excludes state and local taxes and does not address child tax credit. Your total tax savings will depend on your family income, your actual tax bracket and how much you contribute to the Dependent Care FSA.

- Care at licensed nursery schools or day camps (not including expenses for grades kindergarten and above or expenses for overnight camps). To qualify, the school or center must comply with state and local laws and receive a fee for its services if it cares for seven or more children
- Payment to a housekeeper who is also responsible for providing day care and claims the income on their federal tax return
- Payment to someone who provides care in your home, as well as related taxes you pay on that person's behalf
- Care provided at an adult day care facility (but not expenses for an overnight nursing home facility)
- Care provided by before-school or after-school programs
- Care provided inside or outside your home by anyone (other than your Spouse/Tax-Qualified Domestic Partner, a person you list as your dependent for income tax purposes or your child under age 19)
- Household services related to the care of an Eligible Dependent who lives with you, and
- Any other qualified Dependent Care Expense as defined by the Internal Revenue Code.

KEY POINT — DEPENDENT CARE AND HEALTH CARE FSAS ARE SEPARATE

The Dependent Care FSA can be used to pay for Eligible Expenses, such as day care costs incurred for the care of your Eligible Dependents. The Health Care FSA can be used to pay for eligible Health Care Expenses incurred by you and your Eligible Dependents.

You cannot use money from one account to cover expenses from the other account. If you accidentally contribute to the wrong account, federal law prohibits the transfer of monies from one account to the other.

Ineligible Dependent Care Expenses

Here is a list of some of the more common expenses that cannot be reimbursed from the Dependent Care FSA:

- Amounts paid for the care of a person in a nursing home or convalescent facility
- Amounts paid to your Spouse/Tax-Qualified Domestic Partner or child under the age of 19 for day care services (for example, you cannot be reimbursed for payments to one of your teenage children to care for your younger children)
- Cost of food, clothing, shelter, insurance, medical treatment or vacations of an Eligible Dependent
- Payment for care that is not necessary for you to work (for example, a babysitter while you go to the movies)
- Education expenses for any child in or beyond kindergarten
- Items you intend to claim as a credit for federal tax purposes
- Expenses for services that have not yet been provided (e.g., prepaid day care expenses)
- Overnight camp expenses
- Expenses you incur while you are not a participant in the Dependent Care FSA
- Expenses you incur for a dependent who does not qualify as an Eligible Dependent, and
- Any other Dependent Care Expense that does not qualify under the Internal Revenue Code.

Account Statements

Dependent Care FSA statements are available online at **www.horizonblue.com/OrganonFSA**. You may check the status of your Dependent Care FSA, and it will show your account balance as of the statement date and your total

contributions and payments as of that date. In addition, you may call a Horizon BCBS Representative to verify your account balance.

How to File a Claim

KEY POINT — CLAIMS CAN BE FILED UNTIL APRIL 15 OF THE FOLLOWING PLAN YEAR

You have until April 15 of the year following the Plan Year in which your participation ended to submit completed claims with receipts for Eligible Expenses to Horizon BCBS if the expense was incurred by Dec. 31 of the previous year.

When you incur an Eligible Expense, you must complete a *Daycare Expense Reimbursement Claim Form* and submit it along with:

- A written statement from the dependent care provider that the expense has been incurred, and
- The amount of the claim (cancelled checks are not enough).

On your *Daycare Expense Reimbursement Claim Form* (and on your income tax return), you must:

- Identify the name, address and Social Security number of the person who provides dependent care (or Taxpayer Identification Number if you use a day care center).

You can only be reimbursed for Dependent Care Expenses you incur between Jan. 1 and Dec. 31 of each Plan Year. If your participation ends during the Plan Year — for example, if you leave your Employer — your contributions to the Dependent Care FSA will stop, but you may continue to submit claims for Dependent Care Expenses incurred through the end of the year, up to the amount you contributed to your Dependent Care FSA, as long as the expenses were incurred to enable you and your Spouse/Tax-Qualified Domestic Partner, if applicable, to have gainful employment, search for employment or to be a student. You cannot be reimbursed for expenses that were incurred before your participation in the Dependent Care FSA began.

You can submit a claim for an expense incurred during this period until the following April 15. For example, if you have an expense in July 2023, you have until April 15, 2024, to file a claim for payment. Your claim must be postmarked or faxed by this deadline in order to be processed. Expenses are incurred when the service is provided, not when you pay for it.

The IRS requires any unused money you contribute to your Dependent Care FSA to be forfeited at the end of the year. Amounts forfeited may be used by the Plan Sponsor to pay Dependent Care FSA Plan administration expenses.

Online Services

Horizon BCBS offers you online access to your Dependent Care FSA at **www.horizonblue.com/OrganonFSA**. You will be required to register for a User ID and password so that you can securely view your account balance, claims and payment history.

Filing a Claim

To file a Dependent Care FSA claim, you will need to submit a completed claim form to Horizon BCBS. You may obtain claim forms from Horizon BCBS, through the Benefits Service Center website (**www.netbenefits.com**) or through Hera.

Completed claim forms should be sent to the following email, mailing address or fax number:

Horizon BCBSNJ FSA
P.O. Box 14836
Lexington, KY 40511

Fax: **866-231-0214**

Email: **HorizonMyWay.Documents@HelloFurther.com**

Alternatively, you may submit claims online by visiting **www.horizonblue.com/OrganonFSA**. Simply enter the data on the website as if you were completing a paper claim form. Detailed instructions are provided online.

Claims Processing

With the Dependent Care FSA, you can be reimbursed for Dependent Care Expenses up to the total amount you have contributed to the account, minus any prior reimbursement you may have received. You must wait until enough money has accumulated in your account to pay for the Dependent Care Expenses you have submitted for reimbursement.

Reimbursement checks from the Dependent Care FSA are issued once a week.

Payments

If a manual claim has been submitted, checks are payable to you and mailed to your home address. Between Dec. 31 and April 15, you can be reimbursed for a claim of any amount, provided the claim was incurred during the prior calendar year and while you were a participant in the Dependent Care FSA. Claims for the prior calendar year that are not postmarked or faxed by April 15 will not be processed.

You may establish direct deposit for your spending accounts by completing the *Authorization for Direct Deposit* form and submitting the completed form to Horizon BCBS. This authorizes your spending account reimbursement to be issued electronically rather than by check. You may obtain the appropriate forms by visiting the Horizon BCBS website (**www.horizonblue.com/OrganonFSA**) or the Benefits Service Center website (**www.netbenefits.com**).

Claims and Appeals

If Horizon BCBS denies all or part of your claim, you will be notified in writing. The notice will include:

- Specific reasons why the claim was denied
- Specific references to applicable provisions of the document on which the denial is based
- A request for any additional information required to reconsider the claim and an explanation of why this information is needed, and
- An explanation of how to appeal for reconsideration of Horizon BCBS' decision.

You have a right to review all documentation that was used to make a decision about your claim. If you disagree with Horizon BCBS' decision, you have 60 days after receiving the notice of denial to file a written appeal to Horizon BCBS at the following address:

Horizon BCBSNJ FSA
P.O. Box 14836
Lexington, KY 40511

Your claim will be reconsidered, and you will receive written notice of the decision within 60 days after your appeal was received unless special circumstances require an extension for reviewing, in which case written notice of such extension will be furnished to you before the expiration of the initial 60-day period. In that case, the decision will be made no later than 120 days after your appeal was received. This notice will include the reason for the decision, with references to pertinent plan provisions. If the decision on your appeal is not given to you within the applicable time period, your appeal will be considered denied.

Claims and Appeals for Eligibility to Participate in the Dependent Care FSA

If you, your beneficiary or your authorized representative feel that an error has been made concerning your eligibility to participate in the Plan, you, your beneficiary or your authorized representative may request reconsideration under the Plan. All requests for reconsideration shall be submitted in writing to the Plan Administrator at the following address:

Organon LLC
Attn: Plan Administrator (GSA-HTR)
c/o Organon Benefits Service Center at Fidelity
P.O. Box 770003
Cincinnati, OH 45277-0065

Express mail address:

Organon LLC
Attn: Plan Administrator (GSA-HTR)
c/o Organon Benefits Service Center at Fidelity
Mail Zone KC1F-L
100 Crosby Parkway
Covington, KY 41015

The Plan Administrator will review your claim and respond to you with a determination. The decision of the Plan Administrator is final and binding.

Contact Information for Written Appeals

The following chart lists the appeals addresses for benefits and eligibility.

If a Claim Is Denied	Send Your Written Appeal to the Claims Administrator at this Address
Benefit Appeals	
Dependent Care FSA	Claims Administrator for the Flexible Spending Accounts: Horizon BCBSNJ FSA P.O. Box 14836 Lexington, KY 40511
Eligibility Appeals	
Dependent Care FSA	Plan Administrator for the Flexible Spending Accounts: Organon LLC Attn: Plan Administrator (GSA-HTR) c/o Organon Benefits Service Center at Fidelity P.O. Box 770003 Cincinnati, OH 45277-0065 Express mail address: Organon LLC Attn: Plan Administrator (GSA-HTR) c/o Organon Benefits Service Center at Fidelity Mail Zone KC1F-L 100 Crosby Parkway Covington, KY 41015

IMPORTANT INFORMATION ABOUT THE PLAN

ADMINISTRATIVE INFORMATION

This section contains information on the administration and funding for the Flexible Spending Accounts. While you may not need this information for day-to-day participation in the Flexible Spending Accounts, you should read through this section. It is important for you to understand your rights, the procedures you need to follow and the appropriate contacts you may need in certain situations.

Your Rights Under USERRA

Health Care FSA

The Health Care FSA is subject to the "continuation coverage" requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and will be administered in accordance with USERRA and the military leave rules established by the Plan Administrator. As a result, you will be entitled to elect to continue coverage under the Health Care FSA during your military leave while you are an employee of an Employer for a period of up to twenty-four (24) months. You do not need to take any action to continue coverage under the Health Care FSA when you begin your military leave. However, if you want to drop or otherwise change your coverage under the Health Care FSA when you begin your military leave, you must contact the Benefits Service Center within 30 days after your leave begins. If you do not contact the Benefits Service Center within that 30-day period, your coverage under the Health Care FSA will continue as described below.

If you are eligible to continue to receive Base Pay from your Employer during your military leave, coverage will continue in accordance with the Health Care FSA's terms and conditions applicable to an employee on a paid leave of absence. Your employee contribution will continue to be deducted from your pay; to the extent your pay is insufficient to pay the required contributions, unpaid contributions for the year in which your leave begins will be accumulated and payable by you when you return to active employee status.

If you are not eligible to continue to receive Base Pay from your Employer during your military leave, coverage will continue while you are an employee of an Employer in accordance with the Health Care FSA's terms and conditions applicable to an employee on an unpaid leave of absence. Organon will continue to make contributions to the Health Care FSA for the remainder of the year in which the leave began, and your missed employee contributions will accumulate and be payable by you on a Before-Tax basis when you return to active employee status.

Whether you are on paid or unpaid leave, while you are an employee of an Employer and a participant in the Health Care FSA on military leave, you may drop or otherwise change your coverage during your military leave only during annual enrollment (for coverage changes effective the following Jan. 1) or mid-year if you have a Life Event that allows you to make a Permitted Plan Change and you timely notify the Benefits Service Center. Also note that if you wish to continue to participate in the Health Care FSA after the end of the calendar year in which your military leave begins, you must make an election during the applicable annual enrollment period(s) for coverage effective the following Jan. 1. If you make an election to continue participation in the Health Care FSA for a year following the year in which your **paid** military leave begins, contributions will be taken from your pay. If your pay is not sufficient to cover all contributions, unpaid contributions will accumulate and be payable by you on a Before-Tax basis when you return to active employment status. If you make an election to continue participation in the Health Care FSA for a year following the year in which your **unpaid** military leave begins, all contributions will be made by your Employer on your behalf, and these missed contributions will accumulate and be payable by you on a Before-Tax basis when you return to active employment status.

If you elect not to continue coverage during a paid or unpaid military leave, you will be entitled to reinstatement of coverage upon your return to active employee status. Coverage provided under USERRA will run concurrently with any coverage provided under COBRA. For more information regarding your rights during a military leave, contact the Benefits Service Center or refer to Organon's Military Leave Policy, available on Hera or by request to the Organon HR Support Center.

Dependent Care FSA

The Dependent Care FSA is not subject to the "continuation coverage" requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

If you are eligible to continue to receive Base Pay from your Employer during your military leave, coverage will continue in accordance with the Dependent Care FSA's terms and conditions applicable to an employee on a paid leave of absence. Your employee contribution will continue to be deducted from your pay; to the extent your pay is insufficient to pay the required contributions, unpaid contributions will be accumulated and payable by you when you return to active employee status. You do not need to take any action to continue coverage under the Dependent Care FSA when you begin your military leave. However, if you want to drop or otherwise change your coverage under the Dependent Care FSA when you begin your military leave, you must contact the Benefits Service Center within 30 days after your leave begins. If you do not contact the Benefits Service Center within that 30-day period, your coverage under the Dependent Care FSA will continue as described and you will be able to seek reimbursement of Dependent Care Expenses that are incurred to allow you and your Spouse/Tax-Qualified Domestic Partner to be employed.

While you are an employee of an Employer and a participant in the Dependent Care FSA on military leave, you may drop or otherwise change your coverage during your military leave only during annual enrollment (for coverage changes effective the following Jan. 1) or mid-year if you have a Life Event that allows you to make a Permitted Plan Change and you timely notify the Benefits Service Center. Also note that if you wish to continue to participate in the Dependent Care FSA after the end of the calendar year in which your military leave begins, you must make an election during the applicable annual enrollment period(s) for coverage effective the following Jan. 1.

If you make an election to continue participation in the Dependent Care FSA for a year following the year in which your paid military leave begins, contributions will be taken from your pay. If your pay is not sufficient to cover all contributions, unpaid contributions will accumulate and be payable by you on a Before-Tax basis when you return to active employment status.

If you are not eligible to continue to receive Base Pay from your Employer during your military leave, coverage will terminate as of the end of the month in which your unpaid military leave begins.

Plan Disclosure Information

Employer/Sponsor

Organon LLC sponsors the Organon LLC Cafeteria Plan and the Organon U.S. Health and Welfare Plan. The employer identification number assigned to Organon LLC by the IRS is #85-0540903. The address and phone number for Organon LLC is:

Organon LLC
Attn: Plan Administrator (GSA-HTR)
c/o Organon Benefits Service Center at Fidelity
P.O. Box 770003
Cincinnati, OH 45277-0065

Express mail address:

Organon LLC
Attn: Plan Administrator (GSA-HTR)
c/o Organon Benefits Service Center at Fidelity
Mail Zone KC1F-L
100 Crosby Parkway
Covington, KY 41015

Telephone: **215-631-MySC (215-631-6972)**

Plan Administrator/Claims Administrator

For purposes of ERISA, the Plan Administrator for the Organon U.S. Health and Welfare Plan is Organon LLC. Administration of the Plan is the responsibility of the Plan Administrator. The Claims Administrators determine which claims are payable under the Plan in accordance with the official Plan documents. For the list of Claims Administrators, see the “Plan Funding and Administration Chart.”

The Plan Administrator has the exclusive discretion to construe and interpret the terms of the Flexible Spending Accounts as follows:

- To adopt such rules for the administration of the Plan as it considers desirable
- To make factual determinations, interpret and construe the Plan, correct defects, supply omissions and reconcile inconsistencies to the extent necessary to effectuate the Plan, resolve all questions arising in the administration, interpretation and application of the Plan, and such action will be conclusive upon the Employer, the Plan, participants, employees, their dependents and beneficiaries
- To decide all questions of eligibility and participation
- To prescribe procedures and election forms to be followed by participants to make elections to this Plan
- To accept, modify or reject elections under the Plan
- To authorize disbursements on behalf of the Plan
- To prepare and distribute to participants information explaining the Plan and the benefits available hereunder in such a manner as the Plan Administrator deems appropriate
- To settle any lawsuit against the Plan or Plan Administrator, and
- To request and receive from all participants such information as the Plan Administrator will from time to time determine to be necessary for the proper administration of the Plan.

The Plan Administrator has reserved the right to delegate all or any portion of its authority described above to a representative. The Plan Administrator has delegated all of its authority described above with respect to authorizing disbursement for benefits and adjudicating claims and appeals for benefits (and handling any resulting lawsuits) under the Flexible Spending Accounts to the Claims Administrator. That means that the Claims Administrator has the sole authority to determine such matters under the Plan and the Plan Administrator will not and cannot substitute its judgment for that of the Claims Administrator on such matters. It also means the Claims Administrator has all of the discretion described above to the extent it relates to the Claims Administrator’s duties under the Flexible Spending Accounts — for example, regarding eligibility for benefits, according to the broad discretion set forth above.

Contact the Plan Administrator if you have any questions about the Flexible Spending Accounts other than routine questions or questions about the filing or status of claims under the Plan. For routine questions, contact the Benefits Service Center. For questions about the filing status of claims, contact the Claims Administrator at the address listed in “Contact Information for Written Appeals.”

Agent for Service of Legal Process

If, for any reason, you want to seek legal action against the Flexible Spending Accounts, you can serve legal process on Organon LLC by directing such service to the following address:

Organon LLC
Attn: Benefits and Executive Compensation Legal Group
30 Hudson Street
33rd Floor
Jersey City, NJ 07302

Service of legal process may also be made upon the Plan Sponsor or the Plan Administrator.

Plan Funding and Administration

The Flexible Spending Accounts are financed entirely by contributions of participating employees made through the Organon Cafeteria Plan. The Company is set up to reserve on its books for the amounts directed to each participant's Flexible Spending Account. Payments are made by the Company to the Claims Administrator from the Company's general assets. While no trust is created, the Company does have an obligation to make payments when due and the participants have all the rights of a general creditor.

Plan Funding and Administration Chart

Official Plan Name and Plan Type	Plan Number	Benefits Type	Claims Administrator	Type of Administration	Insured or Self-Insured
Flexible Spending Accounts					
Organon U.S. Health and Welfare Plan	502	Welfare / Reimbursement Account	FSAs: Horizon BCBS	Contract administration	Self-insured by the Company

Reductions For Certain Highly Compensated Employees

If you're considered a Highly Compensated Employee (HCE) as defined by the IRS, under certain circumstances your Flexible Spending Account elections may be reduced to the extent necessary to comply with non-discrimination requirements imposed by the Internal Revenue Code. The IRS definition of an HCE is subject to change each year. Based upon this definition the Plan Administrator will perform testing and may need to adjust one or both of your Flexible Spending Account balances in order to ensure these requirements are satisfied. You will be notified if you are affected by these restrictions.

No Right to Employment

Nothing in this SPD represents or is considered an employment contract, and neither the existence of the Flexible Spending Accounts nor any statements made by or on behalf of the Company or the Employer shall be construed to create any promise or contractual right to employment or to the benefits of employment. The Company, the Employer or you may terminate the employment relationship without notice at any time and for any reason.

Plan Amendment or Termination

The Plan Sponsor reserves the right to amend the Flexible Spending Accounts in whole or in part or to completely discontinue the Flexible Spending Accounts or any benefits or eligibility for any benefits at any time. However, following a "change in control," as defined in the Organon Incentive Stock Plan as in effect from time to time, certain limitations apply to the ability of Organon LLC or its subsidiaries to amend or terminate the Flexible Spending Accounts.

Amendments may be retroactive; however, no amendment or termination shall reduce the amount of any benefit otherwise payable under the Flexible Spending Accounts for charges incurred prior to the effective date of such amendment or termination.

If a benefit is terminated and surplus Plan assets, as determined under ERISA, remain after all liabilities have been paid, such surplus shall be used in a manner permitted under applicable law. If a benefit is terminated and amounts remain which are not ERISA Plan assets, such surplus shall revert to the Plan Sponsor.

For two years following a "change in control" (as defined in the Separation Benefits Plan), the material terms of the Flexible Spending Accounts (including terms relating to eligibility, benefit calculation, benefit accrual, cost to participants, subsidies and rates of employee contributions) may not be modified in a manner that is materially adverse

to individuals that participated in the Plan immediately before the “change in control.” During that two-year period, the Company will pay the legal fees and expenses of any participant that prevails on at least one material item of the participant’s claim for relief in an action regarding an impermissible amendment (other than ordinary claims for benefits).

Plan Documents

This SPD is intended as merely a summary of the official Plan documents and should be retained as part of your permanent records. It does not describe every Plan provision in full detail, and it does not alter the Plan or any legal instrument related to the Plan’s creation, operations, funding or benefit payment obligations. Every effort has been made to ensure that this SPD accurately reflects relevant Plan provisions currently in effect. However, the Plan documents, which may include written agreements with service providers (each of which are held on file with the Plan Sponsor), will govern in the event of any conflict between those documents and this SPD any verbal representation, or with respect to any provision not discussed in this SPD.

Plan Year

The Plan Year for the Flexible Spending Accounts begins on Jan. 1 and ends on Dec. 31 of each year. The financial records of the Flexible Spending Accounts Plan are kept on a calendar-year basis.

GLOSSARY

This section defines key words that are frequently used in the SPD. These terms are capitalized throughout the SPD.

Base Pay — Your annual rate of compensation before any Before-Tax deductions, excluding bonuses, overtime, shift differential, incentives, lump sum merit increases, non-recurring incentives, commissions and sales cash incentives, and other forms of special compensation or other extra pay as determined by the Company in its sole discretion. For Regular Part-Time Employees, Base Pay reflects your regularly scheduled hours. For example, if the annual pay for the position is $100,000 for a 40-hour work week, if your regularly scheduled hours are 24 hours per week, your Base Pay is $60,000.

Before-Tax — Contributions for benefits coverage that are deducted from an employee's pay before federal (and certain state) income and employment taxes are deducted.

Casual Employee — A person who may be called by the Employer at any time for employment in the U.S. on a non-scheduled and non-recurring basis, and becomes an employee of the Employer only after reporting to work for the period of time during which the person is working and who is not classified as a Regular Full-Time Employee, Regular Part-Time Employee or Organon Temporary Employee in the Company's employee database.

Claims Administrator — Horizon Blue Cross Blue Shield of NJ (Horizon BCBS).

COBRA Administrator — Organon Benefits Service Center administered by Fidelity Investments.

Coinsurance — The percentage of covered expenses that you are required to pay after you have met your Deductible.

Company — Organon LLC and its wholly owned subsidiaries.

Copay — A flat-dollar amount that you pay for certain services in some health care plans.

Deductible — The amount of money you pay each year before a health care plan begins to pay benefits for covered medical expenses for you and your covered family members.

Dependent Care Expense — Any expense that is considered to be an employment-related expense under Code §21(b) (2) (i.e., expenses for the care of a qualifying individual and expenses for household services, if incurred to enable a participant to have gainful employment).

Domestic Partner/Domestic Partnership — Two people in a spouse-like relationship who share an ongoing, exclusive, emotionally committed relationship (and intend to do so indefinitely) and meet all of the following criteria:

- Are at least age 18 and mentally competent to enter into a legal contract
- Are not related by blood or adoption to a degree closer than permitted by state law for marriage
- Are not married to another person under statutory or common law of the United States nor in a Domestic Partnership with another person
- Are jointly responsible for each other's welfare, financial and other obligations, and
- Reside together in the same household — and have done so for at least 12 months.

Eligible Dependents — For the purposes of the Health Care FSA, only those individuals who are considered your dependents for federal income tax purposes (which generally includes your Spouse/Tax-Qualified Domestic Partner and other individuals who reside with you and are dependent on you for support). In addition, for the Health Care FSA an Eligible Dependent includes your biological and adopted children, children placed with you for adoption, stepchildren and foster children through the end of the year in which they attain age 26 regardless of whether the child is married, resides with you or is financially dependent on you. Your Eligible Dependents do not have to be enrolled as covered dependents under an Organon Medical Plan.

For the purposes of the Dependent Care FSA:

- Children under age 13 whom you are entitled to claim as exemptions on your federal income tax return (if you are divorced or separated, see below) and for whom you have custody for the majority of the year, and

- Any dependent age 13 or older whom you are entitled to claim for federal income tax purposes, who is in your household at least eight hours a day and who is physically or mentally incapable of self-care.

You must claim an exemption on your federal income taxes for a child under age 13 to be your Eligible Dependent under the Dependent Care FSA. However, if you are the custodial parent (even if you do not claim the exemption), your child will be treated as your Eligible Dependent under the Dependent Care FSA. If you are the non-custodial parent, your child is not an Eligible Dependent under the Dependent Care FSA. If you are divorced or separated and you share custody of the child, the child is an Eligible Dependent under the Dependent Care FSA if you have custody of the child for the greater portion of the year.

KEY POINT — GENERALLY, DOMESTIC PARTNERS ARE NOT ELIGIBLE DEPENDENTS

In general, federal law requires that the Flexible Spending Accounts limit payment of expenses to those associated with dependents you claim as exemptions on your federal income taxes.

You may want to consult a tax expert for help in determining whether expenses will qualify for payment through the Flexible Spending Accounts.

Eligible Employees — Regular Full-Time Employees, Regular Part-Time Employees, U.S. Expatriates and Organon Temporary Employees, in each case, who are not legal Excluded Employees or Excluded Persons.

Eligible Expenses — Those expenses eligible for payment. See “Health Care Expense” and “Dependent Care Expense.”

Employer — Organon LLC and its wholly owned subsidiaries.

ERISA — Employee Retirement Income Security Act of 1974, as amended.

Excluded Employees — Casual Employees, Intern/Graduate/Cooperative Student Associates, and LTD Employees.

Excluded Persons — A person who is an independent contractor, or agrees or has agreed to be an independent contractor, or has any agreement or understanding with the Company, or any of its affiliates, not to be an employee or an Eligible Employee, even if the person previously had been an employee or Eligible Employee or is employed by a temporary or other employment agency, regardless of the amount of control, supervision or training provided by the Company or its affiliates, or is a “leased employee” as defined under section 414(n) of the Internal Revenue Code of 1986, as amended. An Excluded Person is not eligible to participate in the Flexible Spending Accounts Plan even if a court, agency or other authority rules that this person is a common-law employee of the Company or its affiliates.

Explanation of Benefits — The statement you receive after a health claim is processed that describes the expenses submitted, any exclusion or Deductible and the benefits paid, if any.

Flexible Spending Accounts/Organon Flexible Spending Accounts — Collectively, the Health Care FSA and the Dependent Care FSA.

Health Care Expense — Any expense incurred for health care that qualifies as a federal income tax deduction under Code §213.

Horizon MyWay FSA Prepaid VISA® Card — The Horizon MyWay FSA Prepaid VISA® Card is a special stored-value card that draws on the value of your annual Health Care FSA election amount. It gives you an easy, automatic way to pay for qualified Health Care Expenses not covered by your health insurance. Each time you incur a qualified Health Care Expense at a health-related business (like a pharmacy or doctor’s office) that accepts VISA, simply use your Horizon MyWay FSA Prepaid VISA® Card. The amount of your qualified purchases is deducted automatically and the Before-Tax dollars are electronically transferred to the provider for immediate payment.

Initial Enrollment Period — The 30-day period that starts when you are hired, rehired or transferred (if you qualify as a Transferred Employee), as applicable, or the date of the cover letter provided in your enrollment materials from the Benefits Service Center, whichever is later.

Intern/Graduate/Cooperative Student Associate — A student hired by an Employer as a participant in the Company Intern/Graduate/Cooperative Associate Program. The student must be designated as a participant in that program at least annually by the Company.

Life Event — Certain events in your life that may allow you to change some of your benefit choices or coverage levels during the year (e.g., marriage, divorce, birth or adoption of a child, etc.). For more information about Life Events — and Permitted Plan Changes — see "When Life Changes" or contact the Benefits Service Center.

LTD Benefits — Income replacement benefits provided under the Organon U.S. Health and Welfare Plan.

LTD Employee — An employee who is receiving LTD Benefits who on the day the employee became eligible for LTD Benefits was considered by an Employer to be a Regular Full-Time Employee, Regular Part-Time Employee, Organon Temporary Employee or U.S. Expatriate and not an Excluded Employee or an Excluded Person. LTD Employees shall be eligible for coverage as described in this SPD, but eligibility for this coverage may be amended by Organon at any time.

Organon — Organon LLC and its wholly owned subsidiaries.

Organon Temporary Employee — An employee hired and paid by an Employer (rather than an agency) for a specific position in the United States for a designated length of time that is normally not more than 24 consecutive months in duration, who is committed to leave the Employer at the end of that time, who is not classified as a Regular Full-Time Employee, Regular Part-Time Employee or Casual Employee in the Company's employee database and who is not an Excluded Employee or an Excluded Person.

Permitted Plan Change — Changes in benefit choices or coverage levels during the year that are consistent with a Life Event and comply with applicable regulations under the Internal Revenue Code and the guidelines established by the Plan Administrator (subject to periodic change). For more information about Permitted Plan Changes — and related Life Events — see "When Life Changes" in the "About Flexible Spending Accounts" section of this SPD or contact the Benefits Service Center.

Plan Administrator — Organon LLC or its delegate.

Plan Sponsor — Organon LLC.

Plan Year — The calendar year, Jan. 1 through Dec. 31, on which the records of the Plan are kept.

Qualified Beneficiary — For the purposes of COBRA:

- An employee who is eligible for continuation coverage under the Health Care FSA under COBRA because of the employee's status on the day before a qualifying event, or
- An individual covered under the Health Care FSA as of the day before a qualifying event takes place.

Regular Full-Time Employee — An employee employed by an Employer in the United States on a scheduled basis for a normal work week, who is not classified as a Regular Part-Time Employee, Organon Temporary Employee or Casual Employee in the Company's employee database and who is not an Excluded Employee or an Excluded Person.

Regular Part-Time Employee — An employee employed by an Employer in the United States who works on a scheduled basis for less than the number of regularly scheduled hours for the employee's site and is not classified as a Regular Full-Time Employee, Organon Temporary Employee or Casual Employee in the Company's employee database and is not an Excluded Employee or an Excluded Person.

SPD — Summary Plan Description.

Spouse — The person recognized as your legal spouse under statutory or common law of the United States.

Substantiation — When you use your Flexible Spending Accounts, the IRS mandates that you substantiate or prove that the expenses qualify as Eligible Expenses. With the Dependent Care FSA you simply send in receipts along with your provider's Employee Identification Number (EIN). With the Health Care FSA, when you file a paper claim, your itemized receipts serve to substantiate the claim. When you use the Horizon MyWay FSA Prepaid VISA® card, you must keep copies of your receipts in case you need to later provide additional proof of your claim.

Tax-Qualified Domestic Partner — A Domestic Partner who qualifies as the Eligible Employee's dependent under federal income tax rules.

Transfer Date — The date a Transferred Employee becomes a Regular Full-Time Employee or a Regular Part-Time Employee.

Transferred Employee — An employee of Organon LLC (or its subsidiaries) who transfers to a position as an Eligible Employee, and who on the day before was not an Eligible Employee.

U.S. Expatriate — A U.S. citizen or individual with U.S. Permanent Resident status who is employed by a foreign subsidiary of the Company as a foreign service employee, provided that the individual has not elected coverage under any retirement plan of the foreign subsidiary if the subsidiary is covered by an agreement entered into by the Company, under Section 3121(l) of the Internal Revenue Code (dealing with Social Security benefits) and who is not an Excluded Person.

The information contained herein has been provided by Organon LLC and is solely the responsibility of Organon (and its subsidiaries).

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