It’s your life… live it well!

Your guide to ConGlobal’s 2024-25 benefits

Welcome

ConGlobal's benefits take a whole-person approach.

That's why ConGlobal's Total Rewards package includes high-quality, affordable benefits that promote physical, financial, and mental wellness so employees can operate at their best inside and outside work.

Employees can enroll in ConGlobal's benefits after working 90 days (new hires), during the annual open enrollment period, or when there is a qualifying life event.

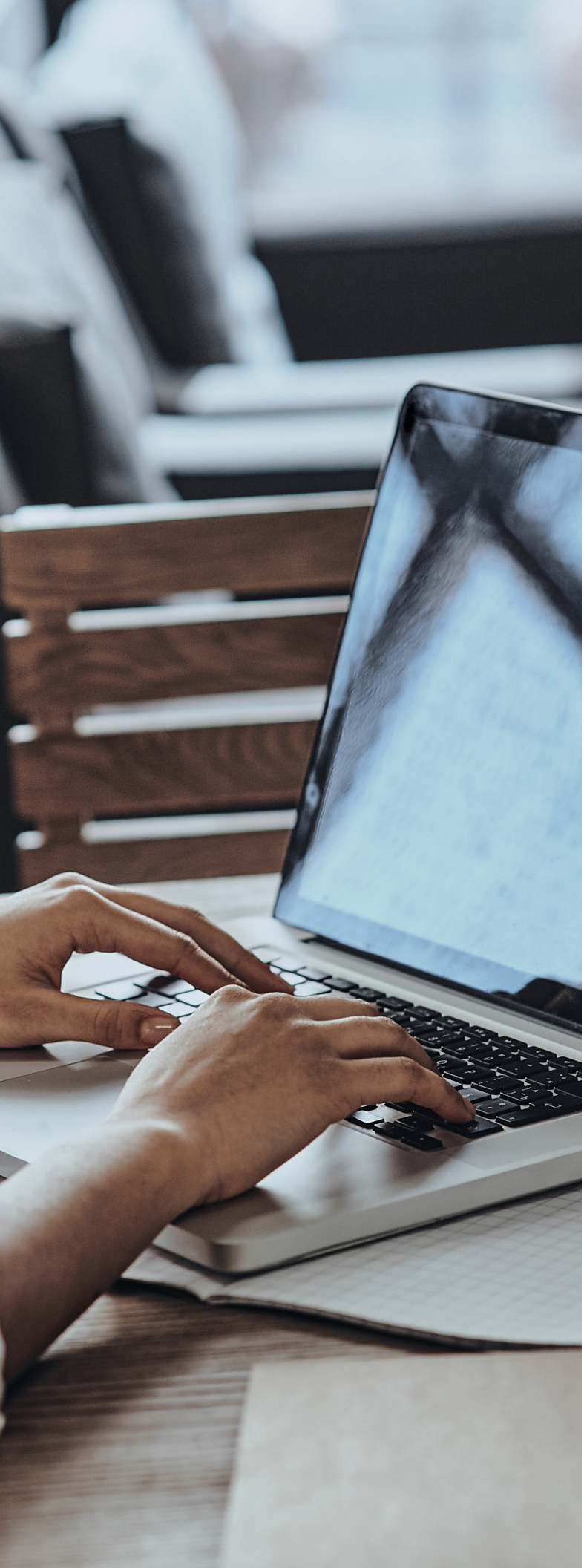
Here's how you can TAKE ACTION!

1. **REVIEW** the benefits guide to understand what benefit options ConGlobal offers and check out our benefits app at **conglobal.mybenefitsapp.com**.
2. **WATCH** educational videos posted on our benefits app. If you need help deciding on the benefits you and your family need, use our **new AI-powered tool** and get a custom recommendation from **Help Me Choose My Benefits** (**ourbenefits.guide/conglobal**).
3. **ENROLL** or **MAKE CHANGES** online at **dayforcehcm.com** or through the **Dayforce mobile app**. Take advantage of the benefits experts from iBTR to answer any questions and help you enroll. Schedule a free appointment online at **v3.rivs.com/schedule/conglobal/** or call 708-286-5274.

We've made every effort to provide you with accurate information. Full details of the plans are contained in the Summary Plan Description (SPD), which governs each of our offerings. The SPD will prevail if there is any discrepancy between the information and the policy/plan documents. You may obtain a copy of each SPD in the Benefits module in our benefits app.

We reserve the right to terminate, suspend, withdraw, or modify the benefits described in this guide. No statement in this or any other document and no oral representation should be construed as a waiver of this right.

What's Inside

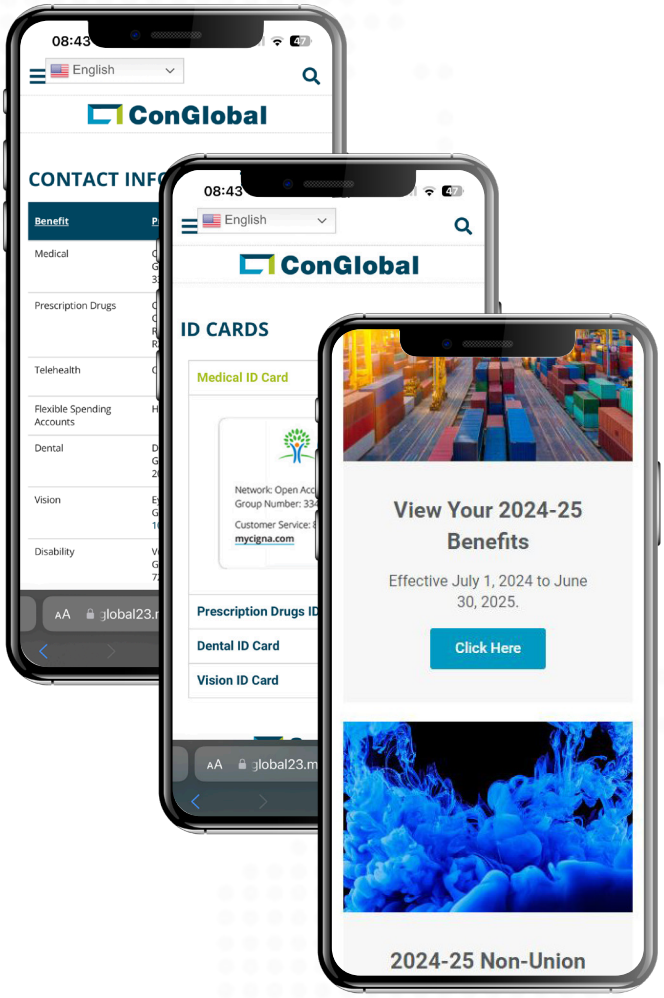


Benefits App

You'll have convenient access to your benefits and more through your smartphone or tablet — whenever, wherever and however you want!

Get started at **conglobal.mybenefitsapp.com** or scan the QR code below, then add to your home screen.

Whether you're in need of a doctor or simply need to know what your plan pays, it's all right there in the palm of your hand. The benefits mobile app is designed to give you 24/7 access to your benefits.



Eligibility

Employees

All full-time employees regularly working at least 30 hours per week are eligible to enroll themselves and their eligible dependents in medical, dental, and vision coverage following the waiting period.

- For exempt employees, you are eligible to enroll in life and disability coverage following 90 days of continuous employment.
- For non-exempt employees, you are eligible to enroll in life and disability coverage following one year from date of hire of continuous employment.

In order to continue eligibility throughout the year, you must regularly maintain at least 30 eligible hours per week.

Family Members

If you are an eligible employee and elect coverage, you can also elect the following coverage for your eligible family members:

- Medical
- Dental
- Vision
- Flexible Spending Account / Dependent Care Spending Account
- Life and AD&D
- Disability
- Accident
- Critical Illness
- Hospital Indemnity

You must have coverage for yourself to enroll your eligible family members.

Your Eligible Family Members Include:

- Your legal spouse
- Your dependent children up to age 26 — including biological children, adopted children, stepchildren, or those for whom you have legal custody or guardianship by court decree
- A dependent child currently covered on your policy who is disabled mentally or physically, as defined by the Social Security Administration may continue on your policy

Qualifying Life Event

You can change your benefit elections during the plan year if you have a qualifying life status event as defined by the IRS.

Life Status Events Include:

- Marriage or divorce
- Birth, death, or legal adoption
- Associate gains or loses coverage
- Family member gains or loses coverage

Documentation for all qualifying life events must be submitted to Dayforce within 30 days of the event. Life event coverage will begin on the effective date of the covered event and documentation has been approved. You can report changes on **dayforcehcm.com**.

Important!

Be sure to have the Social Security numbers and birth dates for any eligible dependent(s) that you plan to enroll. You cannot enroll your dependent(s) without this information.

If you add a new dependent and elect coverage for them, applicable documentation must be submitted. To submit documentation, scan and email **benefits@conglobal.com**.

How to Enroll

dayforce

Get Started with Dayforce

All employees must either enroll or waive coverage for Medical, Dental and Vision by accessing the Benefits Module through Dayforce (**dayforcehcm.com**).

- **User Name:** Your Employee ID Number as 6 digits using leading zeros (i.e., 4956 becomes 004956)
- **Password:** Your date of birth as MMDDYYYY
  Forgot your password? Select CAN'T ACCESS YOUR PASSWORD to reset it or contact Managed Services at 888-297-4664. Your password reset will go to the email you listed in Dayforce.

How to Enroll

1. **Navigate to Benefits Section.** Log in to Dayforce and enter the **BENEFITS** section by clicking the **BENEFITS** icon
2. **Launching the Enrollment Process.** To begin the enrollment process, select **OVERVIEW** tab. Available enrollments will be listed at the top of the page. To begin the enrollment process, click **START ENROLLMENT**.
3. **Submit Your Elections.** Once you have completed your enrollment, be sure to click on **SUBMIT** and print or save your confirmation page.

Help Me Choose Benefits

At ConGlobal, forget the old-school way of scratching your head during open enrollment—now, we've got Help Me Choose Benefits (HMCB) software to save the day! With the wisdom of insurance pros and the speed of AI, HMCB makes navigating benefits a breeze. In less time than it takes to brew a coffee, HMCB interacts with you, gets your details, and dishes out personalized recommendations on which company-sponsored insurance products are just right for you.

Say goodbye to confusion and hello to stress-free benefits selection! **Click here** or visit **ourbenefits.guide/conglobal** to get started with HMCB.

Want to enroll on the Dayforce app?

- Download the Dayforce app on Download on the App Store or GET IT ON Google Play.
- Once installed, login using the following credentials:
  - Company ID: ITSC
  - User ID: Your employee number
  - Password: Your current password
- Tap the **Options Menu** in the upper left-hand corner. Tap **Benefits** to see your available enrollments.
- Click **Begin Enrollment** to get started.

iBTR is here to help you!

Need help deciding what benefits are right for you?
We want our employees and their families to thrive and have the benefits and resources to meet your unique needs.

So, we're offering a concierge program for enrollment where you can meet one-on-one with a benefits counselor to review plan options, ask questions, and complete your enrollment.

Offering resources like iBTR is just another way we're delivering on our every day mission of taking care of each other, our customers, and our business.

Scan the QR code to schedule an appointment with iBTR or call them at 708-286-5274.

Medical

The medical plan covers a wide range of services, from preventive and routine care to hospitalization and surgery. The medical plan includes a prescription drug benefit through CVS Caremark, which covers prescriptions at participating pharmacies and mail-order maintenance drugs. You will get a Cigna Medical ID card in the mail. **Please see the Summary Plan Description for more details.**

	Premier Plan	
Medical Plan	In-Network	Out-of-Network
Deductible*	$500 Individual / $1,000 Family	$1,250 Individual / $2,500 Family
Out-of-Pocket Maximum*	$9,450 Individual / $18,900 Family	$18,900 Individual / $37,800 Family
Coinsurance	20% after deductible	50% after deductible
Office Visit PCP	$10 copay	50% after deductible
Office Visit Specialist	$30 copay	50% after deductible
Preventive Care	No charge	50% after deductible
Telehealth	$0 copay	n/a
Telehealth: Behavioral Health	$30 copay	50% after deductible
Emergency Room	$500 copay	$500 copay
Inpatient/Outpatient Hospital Stay	20% after deductible	50% after deductible
Urgent Care Facility	$25 copay	50% after deductible

** Annual deductible and out-of-pocket maximums reset every January 1. Any expenses that have already been incurred toward your deductible and out-of-pocket maximums will continue to accumulate until January 1 of the following year.*

Please Note: ConGlobal will no longer offer the Saver medical plan option with Health Reimbursement Account (HRA). The plan remains available to currently enrolled participants, but after July 1, 2024, we will no longer offer it as an enrollment option to new participants. The good news is you can keep this plan with an increased premium. On January 1, 2025, ConGlobal will reduce its contribution to the HRA to $250 for individuals and $500 for families.

Get Started with myCigna

You will be able to find in-network services, manage and track claims, see cost estimates and more.

1. Go to **my.cigna.com** or download the myCigna app and select **REGISTER NOW**
2. Enter your requested information, review and submit

Network: Open Access
Group Number: 3343748

Customer Service: 800-244-6224
my.cigna.com

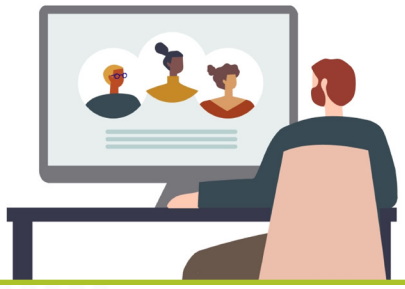
Included Health

At ConGlobal, we care about the health and well-being of you and your family. That's why we offer Included Health, a benefit to help you get the healthcare support you need, when you need it.

You have access to finding top doctors across the country. So if you're struggling with a complex health issue, they can help you:

- Find top specialists in your network and in your neighborhood
- Navigate the complexity of your benefits and healthcare
- Check your medical bills for errors and make sure you only pay what you need to.

To get started, download the Included Health App, or visit **includedhealth.com/conglobal**.



Frequently Asked Questions

If you enroll in the Cigna medical plan, you may use any provider for your care. However, when you see a provider in the Open Access Network, your out-of-pocket costs are limited to a $10 copay for primary care office visit and a $30 for specialists on the Premier plan. Out-of-network care is also covered, but you will pay more for your care. Most out-of-network costs are subject to an annual deductible and then are reimbursed at 50% of the reasonable and customary charge.

Can I go to any doctor and receive plan benefits?

Yes.

Do I pay less if I see certain doctors?

Yes. You will pay less out-of-pocket when you use preferred network doctors.

Do I need a referral to see a specialist?

No. You can always go directly to a specialist. However, you will receive out-of-network benefits if the specialist is not in the preferred network.

Do reasonable and customary limits apply? Will I receive balance due bills?

Only if you see a doctor outside the network. If the charge is above reasonable and customary, you will receive a balance due bill and you are responsible for any balance above the covered amount. In-network providers cannot balance bill you for any additional financial responsibility above the out of pocket parameters dictated by the benefits of the plan.

How will I receive the payment details from Cigna for each of my claims?

All Explanation of Benefits (EOBs) are available electronically via the MyCigna member portal.

If my procedure/service requires pre-certification, who is required to submit?

Certain procedures require pre-certification prior to the services. In-network providers will be aware of the responsibility, however out-of-network providers may not. When receiving services out-of-network, it is the patient's responsibility to ensure the provider submits the initial request.

Telehealth

MDLIVE®

MDLIVE through Cigna

Life is demanding. It's hard to find time to take care of yourself and your family members as it is, never mind when one of you isn't feeling well. That's why your health plan through Cigna includes access to minor medical and behavioral/mental health virtual care. Whether it's late at night and your doctor or therapist isn't available or you just don't have the time or energy to leave the house, you can:

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

Minor Medical Virtual Care

Board-certified doctors and pediatricians can diagnose, treat and prescribe most medications for minor medical conditions, such as:

- Acne
- Allergies
- Asthma
- Bronchitis
- Cold and flu
- Diarrhea
- Earaches
- Fever
- Headaches
- Infections and more

Behavioral/Mental Health Virtual Care

Licensed counselors and psychiatrists can diagnose, treat and prescribe most medications for nonemergency behavioral/mental health conditions, such as:

- Addictions
- Bipolar disorders
- Child/Adolescent issues
- Depression
- Eating disorders
- Grief/Loss
- Panic disorders
- Parenting issues and more

Connect With Virtual Care Your Way

- Contact your in-network provider or counselor
- Talk to an MDLIVE medical provider on demand on **my.cigna.com**
- Schedule an appointment with an MDLIVE provider or licensed therapist on **my.cigna.com**
- Call MDLIVE 24/7 at 888-726-3171

General Visits: $0 copay

Mental Health: Medical Specialist copay applies

Cigna Programs

Cigna One Guide

Cigna One Guide service can help you make smarter, informed choices and get the most from your plan. It's our highest level of support that combines the ease of a powerful app with the personal touch of live service. One Guide personal support, tools and reminders can help you stay healthy and save money.

Download the myCigna app or call the number on the back of your ID card to talk with your personal guide.

Healthy Pregnancies, Healthy Babies

Pregnancy is a life-changing, medical event. While many women have healthy, uncomplicated pregnancies, others may need specialized support to deliver healthy babies.

How the Program Works

Women call to enroll or are identified through referrals from health coaches, doctors or their health assessment.

Once enrolled, each woman speaks with a maternity coach to discuss possible pregnancy risks. These might include gestational diabetes or premature labor. The coach then develops a personalized support plan and follow-up outreach schedule based on the discussion. Participants will receive prenatal education and support based on their level of risk, be it low, medium or high.

After the woman's baby is born, the same coach contacts her two more times to look for signs of postpartum depression and offer support for common newborn concerns, like breast feeding.

Women who are eligible for the Healthy Pregnancies, Healthy Babies program can receive preconception planning and infertility education if they contact the program before becoming pregnant. Coaches can also help them find network providers. The Maternity Coach guides moms to recommended tools and resources, such as reference materials and links to other resources on **my.cigna.com**.

The Incentive Program

Enroll during the first trimester to receive a **$150 VISA PRE-PAID CARD**. If enrolling in the second trimester it's $75. The award is not paid out until the mother completes the postpartum depression screening call. There's no incentive to enroll in the third trimester although you can still enroll any time up to their delivery day.

Healthy Rewards

Just use your Cigna ID wallet card when you pay and let the savings begin.

Get discounts on the health products and programs you use every day for:

- Nutritional Meal Delivery Service
- Fitness Memberships and Devices
- Vision Care, LASIK Surgery, Hearing Aids
- Alternative medicine
- Yoga Products and Virtual Workouts
- Real brands. Real discounts. Real easy.

Log into **my.cigna.com** and navigate to **HEALTHY REWARDS DISCOUNT PROGRAM** or call 800-870-3470 and press 3.

Talkspace

Talkspace is a digital space for private and convenient mental health support. With Talkspace, you can choose a dedicated therapist and/or prescriber from a list of recommended, licensed providers and receive support day and night from the convenience of your device.

Talkspace's clinical network features thousands of licensed, insured, and verified clinical professionals with specialties ranging from behavioral to emotional and wellness needs, including:

- Stress
- Anxiety
- Depression
- Relationships
- Healthy living
- Trauma & grief
- Eating disorders
- Substance use and more

To get started with Talkspace, visit **talkspace.com/cigna**. Complete the QuickMatchsurvey and review your best matches and choose your personal provider.

Headspace Care

Everyone deserves access to incredible mental healthcare. Headspace Care created the world's first integrated mental healthcare system where coaches, therapists, and psychiatrists work as a team to coordinate the best, personalized care right from your smartphone, whenever you need it. Headspace Care's mental health services are in-network and accessible through your behavioral health benefits. Visit **organizations.headspace.com/connect** to learn more.

Omada

Create lasting change with Omada ALL AT NO COST TO YOU!

Omada is a personalized program designed to fit seamlessly into your life. We'll help you make gradual changes to the way you eat, move, sleep, and manage stress—4 lifestyle behaviors that can directly impact your weight, blood glucose levels, blood pressure, and overall health.

What you'll get with Omada:

- Dedicated health coach & care team
- Interactive weekly lessons
- Smart devices, delivered to your door
- Healthier lifestyle in 10 minutes a day, anywhere, anytime
- Long term results through habit & behavior change

Omada will create a personalized path to help you get there.

- **Lose weight**
  - Ongoing one-on-one health coaching
  - Connected scale to monitor progress
  - Nutrition tips, ideas, and recipes
- **Stay on top of diabetes**
  - Specialized coaching from a certified diabetes specialist
  - Connected devices you need to monitor your glucose
  - Immediate feedback on glucose readings
- **Take control of your blood pressure**
  - Specialized health coaching for hypertension
  - Connected blood pressure monitor
  - Feedback to help you understand your readings
- **Improve your overall health**
  - Strategies to sleep better and manage stress
  - Interactive lessons to build healthy habits
  - Techniques to overcome challenges

omada

With Omada, there's a program for you!

Weight loss & overall health

Diabetes

High blood pressure

Do you have questions?

Contact Omada:

- Visit: **omadahealth.com/conglobal**
- By phone: 888-409-8687
- By email: **support@omadahealth.com**

Know Where To Go For Care

$	$	$	$	$
Telehealth	**Doctor's Visit**	**Urgent Care**	**Hospital Emergency Room**	**Freestanding Emergency Room**
MDLIVE can help you identify some options when you or a family member have a health problem or concern. What MDLIVE can help you with: > Allergies > Ear Problems > Flu > Fever > Pink Eye and more	Receive non-urgent care for illnesses and injuries, vaccinations, exams, screenings and specialist referrals. > Office hours vary > Generally the best place to go for non-emergency care > Doctor-to-patient relationship established and therefore able to treat, based on knowledge of medical history > Average wait time is 24 minutes	Receive urgent care for illnesses and injuries that are not life-threatening. > Generally includes evenings, weekends and holidays > Often used when your doctor's office is closed, and there is no true emergency > Average wait time is 11-20 minutes > Many have only and/or telephone check-in	Receive care for serious or life-threatening emergencies. > Open 24 hours, seven days a week > Average wait time is 4 hours, 7 minutes > Multiple bills for services such as doctor and facility	> Open 24 hours, seven days a week > Could be transferred to a hospital ER based on medical situation > Services do not include trauma care > Many freestanding ERs are out-of-network. If you receive care from an out-of-network provider, you may have to pay more. Providers outside the network may "balance bill" you, which means they may charge you more than your health plan's fee schedule. > All freestanding ERs charge a facility fee that urgent care centers do not. You may receive other bills for lab fees and each doctor you see.
Your Cost[1]: **$0 COPAY**	**Your Cost[1]:** Premier: $10 PCP/$30 Specialist	**Your Cost[1]:** Premier: $25	**Your Cost[1]:** Premier: $500	**Your Cost[2]:** Premier: $500

[1] Costs shown are for in-network services. [2] Freestanding ERs are usually out-of-network and charge an additional facility fee.

Prescription Drugs

A prescription for better health. Making sure you have access to affordable medication and convenient options for filling is our priority. With CVS Caremark, you can decide the most convenient way to fill your Rx – with options like contact-less delivery to your door or pickup at a pharmacy in your network. You will get a CVS Caremark ID card in the mail.

Prescription Drugs	Premier Plan
Generic	$0 copay
Formulary Brand	$40 copay
Non-Formulary Brand	$80 copay
Specialty	$100 copay
Home Delivery	$0 / $80 / $160 / $200

Prescription Formulary

You will have access to the Standard Control Formulary with Prior Authorization Option and the Advanced Control Specialty Formulary.

To find out more, visit **caremark.com**

Home Delivery

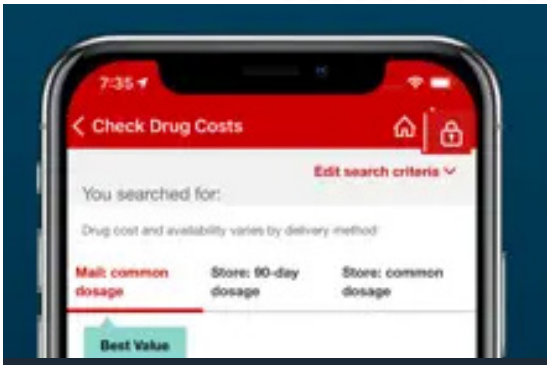
You can get a 90-day supply of medications you take regularly delivered right to your door. For even more convenience, start automatic refills, too.

You'll need a new 90-day prescription to get started.

- Step 1: Register for an account at **caremark.com**. Then, select Start Rx Delivery by Mail from the Prescriptions tab, and you'll be taken directly to the Check Drug Cost tool. Search for your medication name and dose.
- Step 2: Select an option with 90-day supply mail service and click Request a New Prescription.
- Step 3: Review your order and click or tap Submit Refills to request a new 90-day supply of your Rx. CVS Caremark will contact your doctor for approval and then process your order.

Customer Service & Mail Order: 844-203-6363
Specialty Rx: 800-237-2767
caremark.com

RXGRP: RX21AV
RXBIN: 004336
RXPCN: ADV



CVS Caremark Mobile App

The CVS Caremark mobile app is available on Google Play and the App Store. After you download the app, you can create your own user name and password that will give you access to everything you need to manage your prescriptions.

GET IT ON Google Play

Download on the App Store

Flexible Spending Accounts

Our Flexible Spending Accounts (FSAs) are administered through Chard Snyder (formerly HR Simplified). FSAs run on a calendar year basis from **January 1 to December 31 of each year**. There is an open enrollment in November to sign up for the FSAs; effective January 1 of the following year. New Hires are eligible to enroll after 90 days of service.

You must make new elections each year; elections cannot be carried over. If total incurred expenses are less than contributions, the excess contributions cannot be returned at the end of the plan year. However, you have until March 15th of the following year to use whatever money you contributed to the FSA in the previous plan year. You have until March 31st of the following year to submit claims for eligible expenses incurred during the previous calendar year.

You have the option to contribute to Health Care and Dependent Care Flexible Spending Accounts (FSAs). Money contributed to these accounts will be deducted from your paycheck on a pre-tax basis. There are two accounts in which you can choose to participate in.

Health Care FSA

The 2024 annual contribution limit is $3,200. You can spend your Health Care FSA funds on:

- Expenses not covered by the health plan, such as deductibles, coinsurance, copayments, etc.
- Dental and vision expenses

Eligible Expenses

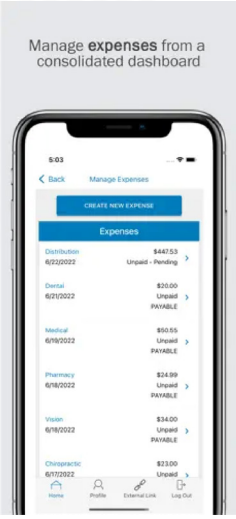
- Coinsurance, copay amounts, and deductibles
- Contact lenses and cleaning solutions
- Dental care and procedures not covered under the plan
- Eye surgery not covered under the plan
- Eyeglasses not covered under the plan (including prescription sunglasses)
- Hearing aids and batteries
- Orthodontia not covered under the plan

Dependent Care FSA

Eligible expenses for this account include dependent care expenses for children under age 13 or dependents of any age that are unable to care for themselves due to mental or physical handicap. These services must allow you or your spouse to work or attend school full-time. The 2024 annual contribution limit is $5,000 per household.

Eligible Expenses

- Au pair fees
- Babysitting fees
- Before and after school care
- Day camp where primary purpose is custodial care
- Eldercare
- FICA/FUTA taxes of day care provider
- Nursery school, preschool, or pre-kindergarten



Questions? Please call Chard Snyder at 800-982-7715 or visit chard-snyder.com.

Access the Chard Snyder Mobile App

- Download the Chard Snyder app in Google Play or App Store
- Set up your account by selecting Register and follow the steps

Once your account is set up, you will have access to your benefit accounts and transaction details, claims, cards, alerts and more.

Dental

DELTA DENTAL®

Our dental plans encourage early detection of dental problems by paying the most toward diagnostic and preventive services, such as routine check-ups and cleanings. You will get a Delta Dental ID card in the mail.

	Enhanced Plan		Basic Plan	
Dental Plan	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible*	$50 Individual / $150 Family		$75 Individual / $225 Family	
Calendar Year Maximum*	$2,500		$1,500	
Reimbursement Levels	Based on negotiated fees	90% of usual and customary after deductible	Benefit reimbursement for all dentists is based on the Delta Dental PPO allowed network fees	
Class I: Preventive & Diagnostic	No charge		No charge	
Class II: Basic Restorative Care	10% after deductible	10% after deductible	20% after deductible	20% after deductible
Class III: Major Restorative Care	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Class IV: Orthodontia	50% up to $1,500 lifetime maximum per child Available to children under age 26		No Ortho	
Orthodontia Lifetime Maximum	$1,500		No Ortho	

** Annual deductible and calendar year maximums reset every January 1. Any expenses that have already been incurred toward your deductible and maximums will continue to accumulate until January 1 of the following year.*

Example of Your Copayment

- **Delta Dental PPO:** Lowest out-of-pocket costs and network protection.
- **Delta Dental Premier:** Higher out-of-pocket costs than PPO, but may be lower than non-network and network protection.
- **Non-network:** You may have the highest out-of-pocket costs.

How to Find a Provider

- Visit **deltadentalil.com** and click the provider search link. Select "Find a Network Dentist" from the drop down menu. To start your search, you can either enter the location where you want to locate network dentists (search by city/state or ZIP code), or search for a particular dentist or practice by name and ZIP code.
- Call 800-323-1743

DELTA DENTAL®

Enhanced Network: PPO
Basic Network: Premier
Group Number: 20497
Customer Service: 800-323-1743
deltadentalil.com

Vision

Vision coverage helps pay the cost of periodic vision examinations and necessary lenses and frames. Regular eye examinations serve to determine your need for corrective eyewear and can help to detect health problems at an early stage. You will get an EyeMed Vision ID card in the mail.

The plan allows you to see any provider, but you will receive the highest level of benefits when you utilize in-network providers through EyeMed. The benefit frequency for vision exam, lenses, frames and contacts are every 12 months.

Vision Plan	In-Network	Out-of-Network
Exam **Every 12 months**	$10 Copay: then, covered in full	Reimbursed up to $45
Lenses **Every 12 months**	$25 copay: then, single vision, bifocal and trifocal lenses are covered in full	Reimbursed up to: Single vision - $45 Bifocal - $55 Trifocal - $80
Frames **Every 12 months**	Covered up to $150 (20% discount off balance)	Reimbursed up to $45
Contact Lenses **Every 12 months**	Covered up to $150 (15% discount off balance for conventional / 10% discount off balance for disposable)	Reimbursed up to $105
Contact Lenses **(Fit follow-up)**	Standard daily wear: $40 Standard extended & Specialty wear: 10% off retail	n/a

How to Find A Provider

- Log onto **eyemed.com**
- Log In/Register at the top right of the page
  - To register, enter your name, date of birth, and either your Member ID or the last 4 digits of your SSN
  - Don't have time to register? Simply click **FIND AN EYE DOCTOR** at the top of the right page, select the **INSIGHT NETWORK** in the drop down and enter your ZIP code.
- You can also call Customer Service at 866-939-3633.

Network: Insight
Group Number: 1022502
Customer Service: 866-939-3633
eyemed.com

PLUS Providers

Staying in-network helps you save money on eye exams, frames and lenses. Visiting a PLUS Provider is designed to help you save even more.

And since PLUS Providers are already in our network, the additional perks are built right into your vision benefits. No promo codes, no coupons, no paperwork. The same vision benefits, plus a little more savings.

$0 exam copay

$200 frame allowance

$200 contact allowance

Contact EyeMed at 866-804-0982.

Disability

Short Term Disability

Short term disability (STD) will be offered as a company-paid benefit. All locations are eligible for this benefit with the exception for California employees and New Jersey non-exempt employees. CA employees and NJ non-exempt employees have access to the state disability program only.

STD coverage is offered through Voya. This plan replaces a portion of your weekly income if you should become disabled. If you become disabled for longer than 7 days, you may be eligible to receive STD benefits.

For further information, please refer to the ConGlobal short term disability policy document that is posted on the benefit overview page in Dayforce.

Short Term Disability Benefits

- **Exempt:** Replaces 60% of your weekly base earnings with a weekly benefit maximum of $1,500
- **Non-exempt:** Replaces 60% of your weekly base earnings with a weekly benefit maximum of $500
- Benefits begin after the elimination period of 7 consecutive days of absence due to illness or accident
- Benefit duration is up to 12 consecutive weeks of non-work related disability (the 12 consecutive weeks start on the 8th day of disability)
- Pre-existing condition exclusion of 3 months applies to employees during the initial 12 months of coverage under the STD plan

Voluntary Long Term Disability

ConGlobal offers you the opportunity to purchase long term disability (LTD) coverage to replace your income in the event of an extended illness or injury.

LTD coverage is offered through Voya. If you become disabled for longer than 90 days, you may be eligible to receive LTD benefits.

For further information, please refer to the ConGlobal long term disability policy document that is posted on the benefit overview page in Dayforce.

Long Term Disability Benefits

- Income replacement begins after 90 days of sickness or disability
- Offers a 60% income replacement of monthly earnings
- Maximum of $10,000 per month of income replacement
- Pre-existing condition exclusion of 3 months applies to employees during the initial 12 months of coverage under the LTD plan

Evidence of Insurability (EOI)

Evidence of insurability (EOI) is a health questionnaire that documents your overall health and helps the insurance carrier determine whether you qualify for coverage.

If you are a new hire and enroll within your initial eligibility date, you may apply for Voluntary LTD coverage without EOI. If you apply for coverage more than 30 days after your initial eligibility date (i.e., Qualifying Life Event/annual open enrollment), you will be required to provide EOI and be approved by Voya to qualify for coverage.

To calculate the applicable payroll deduction for your LTD coverage, scan the QR code to view the rate sheet on the mobile app.

For questions, contact Voya by calling 800-955-7736 or visit **voya.com**.

Life & AD&D

Your family depends on your income for a comfortable lifestyle and for the resources necessary to make their dreams, such as a college education, a reality. Like anyone, you don't like to think of the scenario where you're no longer there for your family. However, you do need to ensure their lives and dreams can continue if the worst should occur.

Basic Life/AD&D Insurance

Voya life insurance plan pays benefits if you die or are seriously injured. The basic life insurance is automatically provided by ConGlobal. IRS regulations require that the imputed value of life insurance in excess of $50,000 be reported on your W2 as taxable income.

Basic Life	Coverage Amount
Exempt Employees	1.5x your annual base salary, up to $500,000
Non-Exempt Employees	$15,000
Basic AD&D Coverage	Matches Basic Life coverage
Age Reduction	Age 65: Reduced to 67%; Age 70: Reduced to 45%; Age 75: Reduced to 30%
Guarantee Issue	$500,000

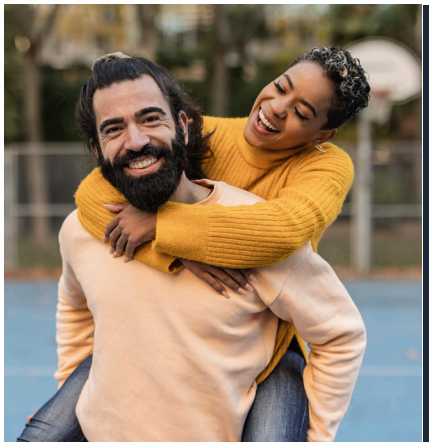
Supplemental Life/AD&D Insurance

You have the freedom to select adequate levels of life insurance coverage to protect the well-being of your family. ConGlobal offers supplemental life and supplemental accidental death & dismemberment through Voya. Supplemental life insurance and supplemental accidental death and dismemberment insurance are available for you and your family. These premiums are 100% paid for by you and are based on your age.

To cover your spouse or dependents, you as the employee must also participate in the supplemental life coverage. Depending on the amount you elect, you may have to answer questions about you or your spouse's health.

ConGlobal uses the employee's age for spouse coverage. The employee is always the beneficiary for dependent coverage.

Supplemental Life	Coverage Amount
For Yourself	Increments of $50,000 up to $1,000,000
For Your Spouse	$25,000 or $50,000
For Your Eligible Children	$10,000
Age Reduction	Age 65: Reduced to 67%; Age 70: Reduced to 45%; Age 75: Reduced to 30%
Guarantee Issue	Employee: $500,000 Spouse: $50,000 Child: $10,000



Beneficiary Designation

Your beneficiary designation is the person you name to receive your life insurance benefits in the event of your death and includes any life insurance benefits available through the Company. Benefits payable for a dependent's death are payable to you if living; otherwise, benefits may, at the option of the insurance company, be payable to your surviving legal spouse or to the executors or administrators of your estate.

Visit **dayforcehcm.com** to update your beneficiary throughout the year.

Questions? Contact Voya at 800-955-7736 or voya.com.

Life & AD&D

Evidence of Insurability

Evidence of insurability (EOI) is a health questionnaire that documents your overall health and helps the insurance carrier determine whether you qualify for coverage.

If you are a new hire and you and your eligible dependents enroll within 30 days of your initial eligibility date, you may apply for any amount of life insurance coverage up to the guaranteed issue limit of the lesser of 3x your salary or $500,000 for yourself and up to $50,000 for your spouse without EOI.

If you apply for coverage for yourself or your dependents more than 30 days after your initial eligibility date (i.e., qualifying life event) or choose coverage above the guaranteed issue limit, you will be required to provide EOI and be approved by Voya in order to qualify for coverage.

If you already have Supplemental Life coverage, you may increase your coverage during the annual open enrollment, by one increment of $50,000 without EOI, if you don't exceed 3x your salary.

To calculate the applicable payroll deduction for your Supplemental Life and AD&D coverage, scan the QR code to view the rate sheet on the mobile app and use this formula.

VOYA FINANCIAL™

Bereavement Support, Funeral Planning & Will Preparation

Empathy helps families prepare for the future and navigate the emotional and practical challenges associated with loss.

From planning a funeral to the logistics of winding down an estate, Empathy offers an impactful solution to employees and their families after the loss of a loved one. Empathy's bereavement support is also fully accessible to employees' loved ones and various family members can share and join their account.

Bereavement Support

On-demand dedicated bereavement concierge includes:

- Custom Care Plan tailored to the family's most urgent needs
- For each family, a dedicated Care Manager, working with them step-by-step

Funeral Planning services

Holistic funeral assistance with access to wide range of funeral resources such as:

- Guides and checklists
- Concierge support
- Funeral home finder
- Online planning and price comparison

Will Preparation services

Digital will, healthcare directive and POA access and support for such things as:

- Drafting a will
- Outlining your last wishes
- Issuing a financial power of attorney
- Articulating an advance healthcare directive

Questions? Contact Voya at 800-913-8318 or voya.com.

Stress and anxiety

Substance use

Grief and loss

Relationship problems

Depression

Financial planning

Dependent care

Legal Issues

Employee Assistance Program

We've all experienced some type of personal problem, concern, or emotional crisis at one time or another. That's why ConGlobal has partnered with SupportLinc to provide a new, redesigned EAP.

The SupportLinc EAP combines technology and personalized advocacy to provide you with advanced emotional health support. These services are **NO COST** for you and your dependents. You have access to counseling sessions, financial expertise, legal consultations, and other convenience resources.

Licensed clinicians are available 24/7 to confidentially discuss personal problems, planning for life events, or simply managing daily life which can affect your work, health and family. You can access up to **8 COUNSELING SESSIONS** in-person or via video.

These counselors can assist with a variety of issues, including:

- Financial Expertise
- Burnout/Stress
- Anxiety/Coping
- Family/Marital Problems
- Addictive Behaviors
- Isolation/Depression
- Dependent Care Issues
- Legal Consultation

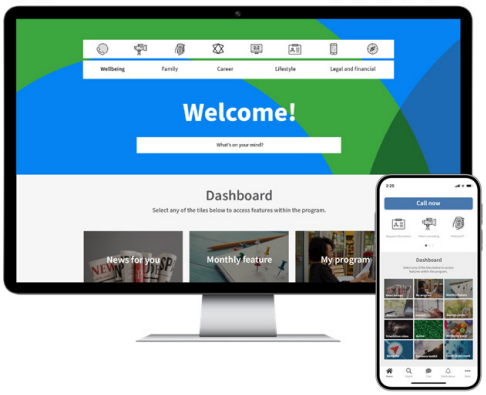
You also have access to the following resources:

- Financial consultations/planning
- Legal consultations
- Referrals for child/pet/elder care
- Referrals for home repair, education, and housing needs
- Emotional fitness evaluations and much more

Please visit the SupportLinc site or call for more information and resources.

supportlinc.com
Registration code:
conglobal

888-491-5217



supportlinc
EMPLOYEE ASSISTANCE

401(k) Retirement Plan

One of the best ways to make sure you will be financially secure in your retirement years is to begin saving right now. The 401(k) plan is administered by Principal.

- Employees who have completed 90 days of service are eligible with the following pay period to receive 50% employer match up to first 6% contribution.
- Employees are always 100% vested in their contributions, and in any earnings resulting from their contributions. For the company matching portion, a 5-year vesting schedule is followed:

401(k) Plan	Vesting Schedule
Years of Service	Vesting Percentage
1 year	20%
2 years	40%
3 years	60%
4 years	80%
5 years	100%

Contributing to the Plan

Once you become eligible, you'll be able to save for retirement in this plan. You decide how much of your salary you want to contribute directly from your paycheck, up to $23,000 in 2024, with before-tax contributions.

Catch-Up Contribution

If you are age 50 or over or will turn 50 during the plan year, and you are contributing the maximum allowed, you may contribute up to an additional $7,500 (2024 IRS limit) during the year to help you increase your savings in the remaining years left before you reach retirement.

Contact Principal

For questions, call 800-547-7754 or visit **principal.com**.

Note: Federal law limits the dollar amount of your pretax contributions.

Will Prep

If you've been putting off preparing a will, you're not alone. But now you can make it happen with ARAG—at no cost to you. You can also prepare healthcare power of attorney, HIPAA authorization, durable power of attorney and more legal documents.

Enrich Resources

Money stress is a universal experience and how we respond can impact our financial wellbeing. For many of us, staying on top of our finances can feel stressful at times. You have a lot on your plate, let the Enrich Money Mindfulness hub help you find more clarity with meditation, mindfulness, and personality tools and resources.

Student Loan Repayment

If you have student loan debt, you're not alone. 75% of college students graduate with debt and paying it off all by yourself can feel overwhelming. Luckily, you don't have to! You have access to educational resources through Enrich that can make your long-term goals seem closer. Plus, the Enrich Student Loan Repayment Program offers support from your employer so you can achieve other savings goals while paying off your loans.

For questions, call 800-547-7754 or visit principal.com.

Voluntary Plans

Voluntary plans are offered through Voya.
For assistance, contact 800-955-7736 or visit **voya.com**.

Critical Illness

Critical illness insurance provides a lump sum benefit paid upon the first diagnosis of a covered work or non-work related critical illness or event. Benefits are paid directly to you and can be used in any way you like including toward deductibles, copays or any other medical expenses.

Wellness Benefit

Coverage is offered for $10,000 or $20,000, in addition to a **$50 wellness benefit** for each covered person per calendar year. Premiums are based on the amount of coverage you elect, your age and the coverage tier you elect.

Accident Insurance

Accident insurance provides a cash benefit to employees who have been injured in a covered work and non-work related accident. The benefit does not coordinate with existing medical insurance coverage, therefore it can be used toward deductibles, copays, prescriptions, or anything that you choose.

Hospital Indemnity

Hospital indemnity insurance provides cash benefits to you if/when you are admitted to the hospital for a work or non-work related incident. Benefits are paid directly to you and can be used in any way you like.

Critical Illness	Coverage Amount
Heart attack, stroke, invasive cancer, paralysis, benign brain tumor, coma, major organ transplant, end stage renal failure, advanced Alzheimer's, advanced Parkinson's	100% Benefit Payout
Coronary bypass surgery, Infectious Disease, carcinoma in situ, Bone Marrow Transplant, Stem Cell Transplant	25% Benefit Payout
Skin Cancer, Pacemaker, Ruptured or Dissecting Aneurysm, Coronary Angioplasty	10% Benefit Payout

Accident	Coverage Amount
Initial Hospital Confinement	$1,750
Daily Hospital Confinement	$275
Intensive Care Unit Confinement	$450
Dislocation Fracture	Up to $8,000 Up to $10,000
Ground or Air Ambulance	$400 Ground $2,000 Air
Physician's Treatment	$100
X-Ray	$90
Urgent Care/ Emergency Room	$250
AD&D and Functional Loss	up to $28,000

Hospital Indemnity	Coverage Amount
First Day Hospital Confinement	$1,300
Daily Hospital Confinement	$300 (maximum of 10 days)
Hospital Intensive Care	$600 (maximum of 10 days)

To view the applicable payroll deduction for your voluntary benefits coverage, scan the QR code to view the rate sheet on the mobile app.

Commuter Benefits

Eligible

This benefit is only available to those working in IL; NJ; Seattle, WA; and Oakland, Richmond, Benicia and Milpitas, CA locations. All full-time employees who work an average of 30 hours per week in the previous calendar month are eligible to participate in the Commuter Benefits Program.

Employees are able to deduct up to $315/month from your paycheck on a pre-tax basis for transit (mass transit or vanpool), and/or an additional $315/month for parking (parking at your transit/vanpool pick-up location or city parking if you drive to work.)

Note: The parking benefit should be used for work parking only. Employees cannot use the parking benefit to pay for parking for their apartment building or near their apartment building.

All employees who commute to work by public transit (bus, rail, or ferry) or vanpool can pay their fare with pre-tax dollars. In addition, your parking fee for the transit/vanpool pick-up location or city parking if you drive to work can be paid with pre-tax dollars as well. The parking benefit should be used for work parking only. Employees cannot use the parking benefit to pay for parking for their apartment building or near their apartment building. The federal tax code allows employees to exclude up to $315 per month for both transit or vanpool costs AND parking fees from their taxable income.

Program Options

This program offers the following options:

- **Transit:** commute to work by public transit (i.e., bus, rail, ferry) OR vanpool
- **Parking:** parking fee for the transit/vanpool pickup location or city parking if you drive to work

Pre-tax Benefit

Employees can set aside pre-tax dollars to pay for transit or parking costs. This savings affects your taxable income each year.

Monthly Deduction

Changes to your deductions are allowed monthly. However, all changes must be submitted by the 15th of the month to be effective for the first paycheck of the following month. For example: Change amount for March must be submitted by February 15th to be effective for March 1st. The new amount will be included in the first paycheck with the March 1st date.

Debit Card

Once enrolled, first time pre-tax plan employees will receive a debit card mailed to their home address on file that can be used to pay for either transit or parking expenses. If you already have a card from Chard Snyder, it will automatically be able to access your new transit and/or parking account. The card is funded after each payroll. The debit card will be funded approximately three (3) days after the amount is deducted from the paycheck.

Direct Deposit

If you prefer your reimbursements be deposited in to your bank account, complete the Direct Deposit Information found on the Chard Snyder website under MyAccount, and Reimbursement Preference. If you currently have the direct deposit option, it will continue with the new plan year.

Questions? Please call Chard Snyder at 800-982-7715 or visit chard-snyder.com.

Smart Connect

SmartConnect™ POWERED BY SMARTMATCH

See how much you could save with Medicare

We want to introduce you to a new benefit for those who are Medicare-eligible, whether you plan on retiring soon or want to continue working. That's right — even if you plan to keep working, you can still switch to Medicare!

SmartConnect is an exclusive service to help you (and family members) find potential savings and extra health care benefits. This service is free and available to you now.

You can move to Medicare at any time. Even if you are enrolled in ConGlobal's benefits, you can still explore and enroll in a Medicare plan with no penalty.

Here's how SmartConnect helps you make the right coverage decision:

- Compare your current health care coverage to a variety of Medicare plans to uncover potential savings.
- Answer all of your questions to make sure you fully understand your health insurance options.
- If you find a Medicare plan you like, your agent will help you enroll.

Schedule a free consultation today!

- 833-859-1314
- **gps.smartmatch.com/conglobal**

Pet Insurance

Nationwide® is on your side

Pet Insurance from Nationwide® is the nation's oldest, largest, and number one veterinarian-recommended pet health insurance provider.

With comprehensive plans designed to protect you financially when the unexpected occurs, affordable coverage from Nationwide allows you to focus on providing optimal healthcare for your pet rather than worrying about the cost of treatment. You can be reimbursed for veterinary expenses such as surgeries, diagnostic tests, hospitalization, prescriptions, vaccinations, and more.

Rates are determined by species, age of pet, breed, type of plan selected, and state of residence. Please note, this benefit is direct bill and will not be taken out of your paycheck. You must enroll directly through Nationwide.

How to Enroll

- Visit ConGlobal's unique address at **benefits.petinsurance.com/conglobal**
- Call 877-738-7874. Please mention that you are an employee of ConGlobal.

ConGlobal Perks

Special Perks Just for You

Access deals and limited-time offers on the products, services, and experiences you need and love.

- Scan QR code below or visit **conglobal.savings.workingadvantage.com**
- Choose the best deals and offers
- Find amazing exclusive offers & deals
- More savings, more of what makes you happy

Explore these and hundreds of other offers at **conglobal.savings.workingadvantage.com**.

- **Discount Hotel Reservations:** Enjoy exclusive savings up to 60% off hotel rates
- **Theme Parks and Attractions:** Save on tickets to theme parks nationwide
- **Walt Disney World Resort:** Save up to $100 off gate prices
- **Discount Flight Reservations:** Save up to 20% on flights
- **Discount Movie Tickets:** Save up to 40% at theaters near you
- **Apple:** Exclusive employee savings on select products

Terms You Need To Know

Annual Maximum: Total dollar amount a plan pays during a calendar year toward the covered expenses of each person enrolled.

Coinsurance: A percentage of the medical costs, based on the allowed amount, you must pay for certain services after you meet your annual deductible.

Copayment: A set dollar amount you pay for network doctors' office visits, emergency room services, and prescription drugs.

Deductible: Total dollar amount, based on the allowed amount, you must pay out-of-pocket for covered medical expenses each calendar year before the plan pays for most services. The deductible does not apply to network preventive care and any services where you pay a copayment rather than coinsurance. Some of your dental options also have an annual deductible, generally for basic and major dental care services.

Brand Formulary Drugs: The brand formulary is an approved, recommended list of brand-name medications. Drugs on this list are available to you at a lower cost than drugs that do not appear on this preferred list.

Generic Drugs: These drugs are usually most cost-effective. Generic drugs are chemically identical to their brand-name counterparts. Purchasing generic drugs allows you to pay a lower out-of-pocket cost than if you purchase formulary or non-formulary brand-name drugs.

Maintenance Drugs: Prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma, and diabetes.

Non-Formulary Drugs: These drugs are not on the recommended formulary list. These drugs are usually more expensive than drugs found on the formulary. You may purchase brand-name medications that do not appear on the recommended list, but at a significantly higher out-of-pocket cost.

Out-of-Pocket Maximum: The maximum amount of coinsurance a plan member must pay towards covered medical expenses in a calendar year for both network and non-network services. Once you meet this out-of-pocket maximum, the plan pays the entire coinsurance amount for covered services for the remainder of the calendar year. Deductibles and copays apply to the annual out-of-pocket maximum.

Primary Care Physician (PCP): The healthcare professional who monitors your health needs and coordinates your overall medical care, including referrals for tests or specialists.

Provider: Any type of healthcare professional or facility that provides services under your plan.

Network: A group of healthcare providers, including dentists, physicians, hospitals, and other healthcare providers, that agrees to accept pre-determined rates when serving members.

Qualifying Event: An occurrence that qualifies the subscriber to make an insurance coverage change outside of the open enrollment.

Reasonable and Customary Charge (R&C): R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentist's in the same geographic area for the same or similar services as determined by SunLife.

Specialty Drugs: Prescription medications that require special handling, administration, or monitoring. These drugs may be used to treat complex, chronic, and often costly conditions.

Important Notices

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with ConGlobal and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the Plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- ConGlobal has determined that the prescription drug coverage offered by the Insurance plan is, on average for all plan Employees, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll from October 15th through December 7th. If you enroll from October 15th through December 7th, your coverage will begin on January 1.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When Will you Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with ConGlobal and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have the coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through ConGlobal changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-633-4227 TTY users should call 1-877-486-2048

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

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

What happens to your current coverage if you decide to join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current ConGlobal coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current ConGlobal coverage, be aware that you and your dependents will not be able to get this coverage back.

HIPAA Special Enrollment Notice

Notice of Special Enrollment Rights for Medical Plan Coverage

As you know, if you have declined enrollment in ConGlobal health plan for you or your dependents (including your spouse/domestic partner) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

ConGlobal will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in ConGlobal group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another medical plan. Any other currently covered dependents may also switch to the new plan in which you enroll.

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please see the Plan's Summary Plan Description for details of the Plan's deductible, benefit percentage, and copayment requirements. If you would like more information on WHCRA benefits, contact HR.

Newborns' & Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours)."

Continuation Coverage Rights Under COBRA

You are receiving this notice because you have recently become covered under ConGlobal's group health plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other Employees of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact HR.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse/domestic partner, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse/domestic partner of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse/domestic partner dies;
- Your spouse/domestic partner's hours of employment are reduced;
- Your spouse/domestic partner's employment ends for any reason other than his or her gross misconduct;
- Your spouse/domestic partner becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse/domestic partner.

If the Plan provides health care coverage to retired Employees, the following applies: filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a qualified beneficiary with respect to the bankruptcy. The retired Employee's spouse/domestic partner, surviving spouse/domestic partner, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after ConGlobal has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, in the event of retired Employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify ConGlobal of the qualifying event.

Required Notice

You must give notice of some qualifying events for the other qualifying events (divorce or legal separation of the Employee and spouse/domestic partner or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How is COBRA Coverage Provided?

Once ConGlobal receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses/domestic partners, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitle to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries, other than the Employee, lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse/domestic partner and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify ConGlobal in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact ConGlobal and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse/domestic partner and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse/domestic partner and dependent children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse/domestic partner or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to ConGlobal. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep ConGlobal informed of any address changes. You should also keep a copy, for your records, of any notices you send to ConGlobal.

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

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

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

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

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

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

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

ALABAMA – Medicaid
Website: **myalhipp.com**
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: **myakhipp.com**
Phone: 1-866-251-4861
Email: **customerservice@myakhipp.com**
Medicaid Eligibility: **health.alaska.gov/dpa/pages/default.aspx**

ARKANSAS – Medicaid
Website: **myarhipp.com**
Phone: 1-855-692-7447

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program: **dhcs.ca.gov/hipp**
Phone: 916-445-8322
Fax: 916-440-5676
Email: **hipp@dhcs.ca.gov**

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: **healthfirstcolorado.com**
Health First Colorado Member Contact Center: 1-800-221-3943 / State Relay 711
CHP+: **hcpf.colorado.gov/child-health-plan-plus**
CHP+ Customer Service: 1-800-359-1991 / State Relay 711
Health Insurance Buy-In Program (HIBI): **mycohibi.com**
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: **flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: **medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: 678-564-1162, Press 1
GA CHIPRA Website: **medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: **in.gov/fssa/hip**
Phone: 1-877-438-4479
All other Medicaid
Website: **in.gov/medicaid**
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: **dhs.iowa.gov/ime/members**
Medicaid Phone: 1-800-338-8366
Hawki Website: **dhs.iowa.gov/hawki**
Hawki Phone: 1-800-257-8563
HIPP Website: **dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: **kancare.ks.gov**
Phone: 1-800-792-4884
HIPP Phone: 1-800-766-9012

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: **chfs.ky.gov/agencies/dms/member/pages/kihipp.aspx**
Phone: 1-855-459-6328
Email: **kihipp.program@ky.gov**
KCHIP Website: **kynect.ky.gov**
Phone: 1-877-524-4718
Kentucky Medicaid Website: **chfs.ky.gov/agencies/dms**

LOUISIANA – Medicaid
Website: **medicaid.la.gov** or **ldh.la.gov/lahipp**
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Website: **mymaineconnection.gov/benefits/s/?language=en_US**
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: **maine.gov/dhhs/ofi/applications-forms**
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: **mass.gov/masshealth/pa**
Phone: 1-800-862-4840
TTY: 711
Email: **masspremassistance@accenture.com**

MINNESOTA – Medicaid
Website: **mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: **dss.mo.gov/mhd/participants/pages/hipp.htm**
Phone: 573-751-2005

MONTANA – Medicaid
Website: **dphhs.mt.gov/montanahealthcareprograms/hipp**
Phone: 1-800-694-3084
Email: **hhshippprogram@mt.gov**

NEBRASKA – Medicaid
Website: **accessnebraska.ne.gov**
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA - Medicaid
Website: **dhcfp.nv.gov**
Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: **dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: **state.nj.us/humanservices/dmahs/clients/medicaid**
Medicaid Phone: 609-631-2392
CHIP Website: **njfamilycare.org/index.html**
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: **health.ny.gov/health_care/medicaid**
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: **medicaid.ncdhhs.gov**
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: **hhs.nd.gov/healthcare**
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: **insureoklahoma.org**
Phone: 1-888-365-3742

OREGON – Medicaid
Website: **healthcare.oregon.gov/pages/index.aspx**
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: **dhs.pa.gov/services/assistance/pages/hipp-program.aspx**
Phone: 1-800-692-7462
CHIP Website: **dhs.pa.gov/CHIP/Pages/CHIP.aspx**
CHIP Phone: 1-800-986-5437

RHODE ISLAND – Medicaid & CHIP
Website: **eohhs.ri.gov**
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: **scdhhs.gov**
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: **dss.sd.gov**
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: **hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program**
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: **medicaid.utah.gov**
CHIP Website: **health.utah.gov/chip**
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: **dvha.vermont.gov/members/medicaid/hipp-program**
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: **coverva.dmas.virginia.gov/learn/premium-assistance/famis-select**
coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: **hca.wa.gov**
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: **dhhr.wv.gov/bms**
mywvhipp.com
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-699-8447

WISCONSIN – Medicaid and CHIP
Website: **dhs.wisconsin.gov/badgercareplus/p-10095.htm**
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: **health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility**
Phone: 1-800-251-1269

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

U.S. Department of Labor Services
Employee Benefits Security Administration
dol.gov/agencies/ebsa
866-444-3272

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2026)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

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

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

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

Employer Name: ConGlobal
Employer Identification Number (EIN): 36-4427852
Employer Phone Number: 708-225-2400
Employer Address: 999 Oakmont Plaza Drive, Suite 340, Westmont, IL 60559
Contact About Coverage: ConGlobal Benefits Team

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

- As your employer, we offer a health plan to:
- Some employees. Eligible employees are full-time employees and employees who work an average of 30 hours per week.
- With respect to dependents:
- We do offer coverage. Eligible dependents are spouses/domestic partners and children.

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

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

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

Notice of Availability of HIPAA Privacy Notice

Under the Health Insurance Portability and Accountability Act (HIPAA) health plans are required to provide covered individuals with a Privacy Notice that describes, among other things, the uses and disclosures of protected health information that may be received by the plans, your rights regarding that information and the plan's responsibilities.

The ConGlobal Medical Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact:

Please contact us for more information:

ConGlobal Benefits Team, 708-225-2400

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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