



Annual Enrollment Notices

July 1, 2026 - June 30, 2027

Privacy Officer:

ConGlobal Human Resources

708-225-2400

999 Oakmont Plaza Drive, Suite 340,

Westmont, IL

60559

Important: Paper copies of the following documents and/or notices are available by request, free of charge, by calling the ConGlobal Human Resources team at 708-225-2400 or emailing benefits@conglobal.com.

- Summary Plan Description (SPD)
- Summary of Material Modification (SMM), if applicable
- Summary of Benefits and Coverage (SBC)

Your Medicare Part D Notice is in the first section of this packet. Additional notices include:

- Notice of Special Enrollment Rights
- WHCRA
- NMHPA
- CHIP
- HIPAA Privacy Practices
- COBRA General Notice
- Notice of Coverage Options (Health Insurance Marketplace Notice)

Important Notice From Retail Services ConGlobal 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 Retail Services 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. 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:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. ConGlobal has determined that the prescription drug coverage offered through the Premier Plan and Saver Plan are, on average for all plan participants, 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.

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you decide to drop your current 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.

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 coverage will not be affected.

Prescription Drug Benefits	Premier Plan		Saver Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Tier 1	\$0 Copay	50% Coinsurance	20% after Deductible	20% after Deductible
Tier 2	\$50 Copay	50% Coinsurance	20% after Deductible	20% after Deductible
Tier 3	\$100 Copay	50% Coinsurance	20% after Deductible	20% after Deductible
Tier 4	\$250 Copay	50% Coinsurance	20% after Deductible	20% after Deductible

You can keep your coverage the plan even if you elect part D. See pages 7- 9 of the CMS Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals (available at cms.hhs.gov/creditablecoverage/), which outlines the prescription drug plan provisions/options that Medicare-eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under these plans is not creditable and depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 that 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 plan will not be affected. You can keep your coverage the plan even if you elect part D. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

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

Contact the Privacy Officer listed at the beginning of this packet 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 your employer 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](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Notice of Special Enrollment Rights for Health plan coverage

As you know, if you have declined enrollment in ConGlobal's health plan for you or your dependents (including your spouse) 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 31 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 31 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 31 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the 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 health plan.

Women's Health and Cancer Rights Act (WHCRA) notice

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. If you would like more information on WHCRA benefits, please contact the Privacy Officer noted at the beginning of this packet.

Newborns' and Mothers' Health Protection Act (NMHPA) notice

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). If you would like more information on maternity benefits, please contact the Privacy Officer noted at the beginning of this packet.

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](https://www.healthcare.gov).

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or 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](https://www.askebsa.dol.gov) or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State 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-MyARHIPP (1-855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program Website:

dhcs.ca.gov/hipp

Phone: 1-916-445-8322

Fax: 1-916-440-5676

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: flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html

Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

Phone: 1-678-564-1162, Press 1

GA CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra

Phone: 1-678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program

All other Medicaid

Website: in.gov/medicaid

in.gov/fssa/dfr

Family and Social Services Administration

Phone: 1-800-403-0864

Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: hhs.iowa.gov/medicaid

Medicaid Phone: 1-800-338-8366

Hawki Website: hhs.iowa.gov/medicaid/plans-programs/hawki

Hawki Phone: 1-800-257-8563

HIPP Website: hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program
(iowa.gov)

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: kancare.ks.gov

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

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: KIHIP.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

Enrollment 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: <https://mn.gov/dhs/health-care-coverage>

Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 1-573-751-2005

MONTANA – Medicaid

Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

Phone: 1-800-694-3084

Email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: ACCESSNebraska.ne.gov

Phone: 1-855-632-7633

Lincoln: 1-402-473-7000

Omaha: 1-402-595-1178

NEVADA – Medicaid

Medicaid Website: dhcfp.nv.gov

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program

Phone: 1-603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: state.nj.us/humanservices

dmahs/clients/medicaid/

Phone: 1-800-356-1561

CHIP Premium Assistance Phone: 1-609-631-2392

CHIP Website: njfamilycare.org/index.html

CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: health.ny.gov/health_care/medicaid

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: [medicaid.ncdhhs.gov](https://www.ncdhhs.gov/medicaid)

Phone: 1-919-855-4100

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 and CHIP

Website: healthcare.oregon.gov/Pages/index.aspx

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html

Phone: 1-800-692-7462

CHIP Website: pa.gov/agencies/dhs/resources/chip

CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: eohhs.ri.gov

Phone: 1-855-697-4347, or

1-401-462-0311 (Direct RlTe 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

Utah's Premium Partnership for Health Insurance (UPP)

Website: medicaid.utah.gov/upp

Email: upp@utah.gov

Phone: 1-888-222-2542

Adult Expansion Website: medicaid.utah.gov/expansion

Utah Medicaid Buyout Program Website: medicaid.utah.gov/buyout-program

CHIP Website: <https://chip.utah.gov>

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

Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: hca.wa.gov

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: dhhr.wv.gov/bms

mywvhipp.com

Medicaid Phone: 1-304-558-1700

CHIP Toll-free phone: 1-855-MyWVHIPP (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, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

ConGlobal HIPAA privacy notice

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by ConGlobal health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: medical, dental, and vision. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not ConGlobal, as an employer — that's the way the HIPAA rules work. Different policies may apply to other ConGlobal programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The Privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing “behind the scenes” plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed, or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with ConGlobal

The Plan, or its health insurer, may disclose your health information without your written authorization to ConGlobal for plan administration purposes. ConGlobal may need your health information to administer benefits under the Plan. ConGlobal agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. The Internal HR Team, Benefits Department, HRIS Team, and Legal Department are the only ConGlobal employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and ConGlobal, as allowed under the HIPAA rules:

- The Plan, or its insurer may disclose "summary health information" to ConGlobal, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer, may disclose to ConGlobal information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option offered by the Plan.

In addition, you should know that ConGlobal cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by ConGlobal from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care.

Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation: Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws.

Necessary to prevent serious threat to health or safety: Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody.

Public health activities: Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects.

Victims of abuse, neglect, or domestic violence: Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk).

Judicial and administrative proceedings: Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information).

Law enforcement purposes: Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises.

Decedents: Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties.

Organ, eye, or tissue donation: Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death.

Research purposes: Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project.

Health oversight activities: Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws.

Specialized government functions: Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates.

HHS investigations: Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information.

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals.

However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested.
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint.
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete.

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested.
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint.
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures.
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2026. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice via email.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, please contact the Privacy Officer noted at the beginning of this packet.

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, please contact the Privacy Officer noted at the beginning of this packet.

COBRA Continuation Coverage General Notice

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies.
- The parent-employee's hours of employment are reduced.
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both).
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment.
- Death of the employee.
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the WIS Human Resources office at 800-888-8210.

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage.

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

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [healthcare.gov](https://www.healthcare.gov).

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit [medicare.gov/medicare-and-you](https://www.medicare.gov/medicare-and-you).

If you have questions

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified at the beginning of this packet. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [dol.gov/ebsa](https://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [healthcare.gov](https://www.healthcare.gov).

Keep your Plan informed of address changes.

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.96% 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 9.96% of the employee's household income.^{1,2}

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

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.

¹Indexed annually; see [irs.gov/pub/irs-drop/rp-25-25.pdf](https://www.irs.gov/pub/irs-drop/rp-25-25.pdf) for 2026.

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

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. 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?

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.

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 Address: 999 Oakmont Plaza Drive, Suite 340,	Employer Phone Number: 708-225-2400	
City: Westmont	State: IL	Zip-Code: 60559
Who can we contact about employee health coverage at this job? ConGlobal Benefits Team		
Phone Number (if different from above): 708-225-2400	Email Address: benefits@conglobal.com	

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

As your employer, we offer a health plan to:

- All employees. Eligible employees are: Full-Time – 30+ hours/week
- Some employees. Eligible employees are: Full-time or part-time, non-union Employees who regularly work at least 30 hours per week.

With respect to dependents:

- We do offer coverage. Eligible dependents are: Legally married spouses, biological or adopted children, stepchildren, and children for whom you are legal guardian.
- We do not offer coverage.
- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Note: 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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [healthcare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

Employer Name:	ConGlobal
Employer State of Situs:	IL
Name of Issuer:	Cigna
Plan Marketing Name:	Premier Plan
Plan Year:	2026

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

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

2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes (limited)
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes (via hearing aids benefit)
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Yes (with limits)
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes (via home health, limited)
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes (coverage varies by place of service)
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes (restricted / case-by-case)
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes (with limits)
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Not clearly specified
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Not clearly specified
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes (with limits)
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes (with limits)
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Not covered under medical (pharmacy carved out)
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes (covered under MH/SUD services, details not explicit)
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Not covered under medical (pharmacy carve-out)
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	Not covered (medical plan)
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Not covered
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Not covered (carve-out)
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes (implied under preventive care)
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes (implied under preventive care)
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes (with limits)
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes (with limits)

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

Employer Name:	ConGlobal
Employer State of Situs:	IL
Name of Issuer:	Cigna
Plan Marketing Name:	Saver Plan
Plan Year:	2026

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

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

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3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Yes (with limits)
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes (limited)
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes (varies)
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes (restricted)
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes (with limits)
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Not clearly specified
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Not clearly specified
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes (with limits)
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes (with limits)
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Not covered under medical (pharmacy carved out)
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes (medical services; pharmacy not included)
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Not covered under medical (pharmacy carve-out)
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	Not covered (medical plan)
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Not covered
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Not covered (carve-out)
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes (implied/program-based)
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes (implied under preventive care)
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes (with limits)
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes (with limits)

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